

Leading Pan American Health

*Quadrennial Report
of the Director, 1994-1997*



LEADING PAN

A Statement of Mission

The Pan American Sanitary Bureau is the Secretariat of the Pan American Health Organization, an international agency specializing in health. Its mission is to cooperate technically with the Member Countries and to stimulate cooperation among them in order that, while maintaining a healthy environment and charting a course to sustainable human development, the peoples of the Americas may achieve health for all and by all.

The Aim of this Report

This report is a presentation of accounts. Every four years, PAHO's Member Governments meet at the Pan American Sanitary Conference to set hemispheric policy. Policy adopted by the Conference in 1994, in the form of Strategic and Programmatic Orientations, committed the Pan American Sanitary Bureau to concrete lines of action in health and human development, health systems and services development, health promotion and protection, environmental protection and development, and disease prevention and control. What we have accomplished in those areas is the story told in the pages that follow.

AMERICAN

HEALTH

A Message to All Holding Stake in the Health of the Hemisphere

In the past, the Report of the Director of the Pan American Health Organization has been an account of the work of the Secretariat and the countries. On this occasion, instead of a description of activities carried out at the various levels and in the various parts of the Organization, the Report seeks to describe the impact of our work over the past four years and to determine to what extent we have contributed to the progress in health that the countries of the Americas have made. It examines the commitments made four years ago and the results of our actions in fulfilling them. The companion PAHO publication, *Health in the Americas*, describes in detail the changes in health that have taken place and analyzes some of the major trends in our Region.

As changes in health are slow, four years afford a better time frame than 12 months to measure the impact of our work. We seek to do so, because we represent an institution. It behooves all institutions—most especially public ones—to examine the results of their efforts. An examination of PAHO is best cast in the light, not only of what we have done, but of the impact of our efforts in advancing the countries' health status. At all levels of the Organization we are giving increasing importance to the concept and practice of evaluation and to the development of instruments that will allow us to program so that we can establish the results we aim to achieve and for which we are responsible and the health situations we wish to see changed as a consequence of our work.

Over the years, the Organization's contribution to health throughout the Region has been significant, and explains why our Member States have come to expect us to assume a leadership role in Pan American health. What exactly do we mean by "Pan American health"?

We see health within the framework of a wider Pan Americanism, a definable cultural reality worth preserving and enhancing. Indeed, ours is a history of Pan American union; the cooperation among our countries, "united in heart," has at times recalled the lofty vision of Simón Bolívar's grand *patria*:

The imagination cannot conceive without admiration the magnitude of such a colossus which, like Homer's Jupiter, will cause the earth to quake with a glance. Who shall oppose an America united in heart, subject to one law, and guided by the touch of liberty?

The term "Pan Americanism" arose in the latter part of the 19th century in relation to the International American Conferences in which the free republics of the New World explored, at first

Contents

Leading Pan American Health	1
Partnering for Health in the Americas	6
Enhancing Health and Human Development	1 8
Preventing and Controlling Diseases	2 8
Supporting the Development of Health Systems and Services	4 0
Promoting and Protecting Peoples Health	5 0
Protecting and Developing the Environment	5 8
Administering Resources to Work for the Countries	6 6

timidly and in time more vigorously, their common interests. Those interests were often the subject of impressive rhetoric—as iterated in an address by the United States Secretary of State, Elihu Root, to his peers in Rio de Janeiro in 1906:

We deem the independence and equal rights of the smallest and weakest member of the family of nations entitled to as much respect as those of the greatest empire; and we deem the observance of that respect the chief guaranty of the weak against the oppression of the strong. We neither claim nor desire any rights or privileges or powers that we do not freely concede to every American republic. We wish to increase our prosperity, to expand our trade, to grow in wealth, in wisdom and in spirit; but our conception of the true way to accomplish this is not to pull down others and profit by their ruin, but to help all friends to a common prosperity and a common growth, that we may all become greater and stronger together.

The references to equality of nations and the concept that all would benefit from cooperative action strike, for us, a most resonant chord.

In the early years of the century, men of great vision sought to translate these noble sentiments into action that would benefit the health of all, establishing—first among other actions of hemispheric import—the Pan American Sanitary Bureau. Over the intervening years, the principles that mark Pan Americanism have become clearer, and have been characterized by one author as “...independence, representative government, territorial integrity, law instead of force, non-intervention, equality, and cooperation.”

Enthusiasm for the Pan American approach has waxed and waned. We saw it revived in the decade of the sixties with the “Alliance for Progress” and the Charter of Punta del Este, which established the basis for cooperative action in the fields of social service, among them health. Recently, more sustained initiatives have targeted development of a genuinely hemispheric agenda. The Heads of Government meeting at the Miami Summit in 1994 developed a joint plan of action to preserve and strengthen the community of democracy in the Americas, promote prosperity through economic integration and free trade, eradicate poverty and discrimination, and guarantee sustainable development while conserving the natural environment. The Presidential Summit held in Santiago in 1998 recaptured much of the spirit of Miami, evaluated progress attained since then, and focused on education and, again, on the reduction of poverty. Meetings of Heads of State at the Ibero-American Summits have provided the opportunity for renewing and strengthening the ties between the countries of Latin America, Spain, and Portugal.

Some attribute the driving force behind renewal of the Pan American spirit to the concern for trade and aid. Certainly, the possibility of an American Free Trade Agreement has attracted considerable attention, and evokes a *déjà vu* of the common market envisioned in the Pan American spirit of the sixties. Global integration, and the information and technological revolutions on which it is grounded, are creating ever more porous national boundaries and playing a principal role in the resurgence of the Pan American spirit. While massive flows of capital are the prime mover of global intercourse, the interchange of ideas and the disconcerting approximation of the rich and the poor areas of the globe are engendering a keener appreciation of the interconnectedness of peoples. No universal consensus prevails that these global forces will result in benefits for all, and some fear that the gaps will widen between those who are at the top of the economic spectrum and those at the bottom.

The economics of globalization are but one of the issues in question. Other aspects of human development merit attention as well. The provision of a safe and healthy environment has major international dimensions, and the perception of the environment as a global commons is more than a figurative allusion. Changes in the environment, both micro and macro, have repercussions on a global scale. El Niño is one of a number of examples of the widespread effects of various types of climate change.

Our work, of course, centers on the international dimension of health and its Pan American character. History shows that health has figured in every Pan American

initiative that the powers of the hemisphere have, together, undertaken. Our Sanitary Code is the most significant expression of the centrality of health to interchange among the nations of the Americas. The Miami Summit embraced the call for equitable access to health services as an important consideration in attending to the needs of the poor. The Santiago Summit acknowledged that investment in health and education could not be dissociated, and in that meeting the Heads of State endorsed the initiative put forward by the Pan American Health Organization that health technologies could be a force for uniting the Americas.

Our focus on Pan American health is therefore in the tradition of Pan Americanism, adapted to the realities of the Americas of today. The overarching problem for health in the Americas continues to be inequity. It is this concern for equity that links all of our activities to the global goal of Health for All, which holds equity as its essential value system. This goal has been interpreted by us as a call for social justice and a removal of those barriers that have risen up to block the sun from the large numbers of humanity who most need it. Differences in health status between and within countries are now, and ever will be, unacceptable and unjust. In my first Annual Report, entitled *In Search of Equity*, I explored the inequities in health services as well as possible solutions based on an analysis of the nature and location of those inequities. I described equality of access, equality of utilization, and equality of results of actions taken in the services as a first approximation to providing empirical data that could be used for management.

Nevertheless, this approach might result in an incomplete scenario. Indeed, for the countries of our Region it might be equally important to think of equity in terms of other determinants of health. Equity of access to services is important, but to the extent that health care services contribute modestly to a state of health, they should not be the only area of concern. The search for equity in health should address equity in terms of the availability of those social and environmental conditions that so powerfully impact on health. The demonstrated association between income and various health indicators supports the argument that a reduction in income differentials will contribute to better health.

While acknowledging the association between poverty and health, we have over the past four years argued more vigorously that it is the *roots* of economic inequality that must be addressed. Indeed, inequality of social and environmental assets—such as education, clean water supply, and a healthy environment—contributes to the continual heavy burden of poverty in the Americas. With Abraham Lincoln, we cherish “the hope that in due time the weights should be lifted from the shoulders of all men and that all should have an equal chance.” Inequality of access to land, to education, and to health are major barriers to achieving significant and rapid reduction of poverty in the Americas. Traditional approaches to seeking economic growth and providing a safety net for those who, according to the basic tenets of the market, must inevitably be left behind no longer suffice. We at PAHO continue to prefer the thesis that investment in health can, through a variety of mechanisms, both reduce income inequality and be an instrument for economic growth.

Of course, it is true that problems in other spheres of national life affect health, and—given the manner in which our political systems are structured—the health sector, or that part of government with the political responsibility for health, does not have direct oversight over these spheres. This does not, however, remove or reduce health agencies’ responsibility to address health in terms of the relationships that exist and to argue vehemently for the elaboration of policies in those other areas that will be, at best, positive for health ... or, at worse, not inimical to it. The inability to draw these intersectoral relationships is often attributed to the popular concept of health as a “negative” good—valued only in its absence. If the argument is made that public health should be seen both in terms of the moral good and as a critical resource for human development, more attention will be given to reducing inequities in those other areas that are related to, and determinant of, health.

This view of health and the concept of individuals acting rationally to pursue self-interest, said to be the hallmark of neo-liberal thinking, need not be in conflict. Humankind need only comprehend that self-interest has a health component as well as an economic one. While we would not advocate a return to classical narcissism, society could well benefit from a different view of the value of health, both individually and collectively. It is a function of organizations such as ours to advocate and advance such a view.

The essence of our Pan American approach to health must be in joint and collaborative action by the countries of the Americas, and the sustainability of joint action must be based on results. This Report shows clearly the results we have achieved in a number of areas. Agreement is almost universal that there are essential functions, derived from our interconnectedness, that are best performed through collaborative effort. We have been able to show this approach at its very best in the programs of immunization and against vectors and other agents of disease that can cross national boundaries—programs that have measurably succeeded through joint effort. But it is not only in such disease-specific areas that a Pan American approach has proved useful. Collaboration also characterizes the countries' sharing of skills and experiences and their development of joint policies. The Pan American approach does not signify that each and every country must participate in cooperative alliances to the same extent. Subregional initiatives that we have promoted, cross-border programs that we have supported, and the assistance that we have mobilized to countries afflicted by disasters are all expressions of the same movement. We are also stepping up our emphasis on surveillance of diseases and have begun, slowly but surely, to put in place the pieces of a regional surveillance system that can build and expand on other successful efforts in this field.

It is 96 years since the establishment of the Pan American Sanitary Bureau—in itself a manifestation of the Pan American spirit. The active participation of Member Governments in the Governing Bodies and the faithful discharge of their financial responsibilities to PAHO are indicative that Pan American health is alive and well.

By what token do we claim leadership in this Pan American venture? We are conscious that the leadership of organizations, like the leadership of individuals, does not devolve onto us by right—we must earn it. Leadership involves a clear articulation of those aspects of health in the Americas that call for a joint approach while, at the same time, taking into consideration specific local conditions that affect intimately the lives of individuals. The essence of this leadership function turns around several factors.

First, there is the absolute requirement to make the creation and dissemination of information a central piece of all our activities. It is for this reason that over the past four years PAHO has dedicated considerable intellectual, financial, and human resources to this information function. It is gratifying to see more and more countries accepting our challenge and producing basic health data and establishing systems to keep them current. It is satisfying to note the growing acceptance that it does not suffice to show average data from countries and that the trend toward decentralization must be accompanied by an ever more refined disaggregation of data. It is rewarding to note the progress in disseminating high-quality scientific and technical information and to see PAHO proposing that its Latin American Center on Health Sciences Information cast off its physical shackles and form a virtual library with a potential so enormous as to be the stuff of dreams. PAHO has made great strides in the past four years in producing information for its various constituencies in all the countries such that more and more people are aware of what we do and for what we stand. Information is the loom upon which we weave the Pan American shawl that embraces all our countries and facilitates the description and reduction of inequities in health that must be our constant concern.

Second, the Organization's leadership finds expression in the innovations we bring before our Member Governments. We have produced the empirical observations that lead us to work in new areas. Health and tourism is one such. The movement of peoples is a major aspect of modern life, and the health sector cannot be so hidebound as to disregard its

role in tourism. Violence that leads to injury is another, as we continue to show that the health sector has an important role in defining the causes of violence and supporting the facilities needed to treat the sequelae of violence and injury. Our cautious but firm approach to religious institutions is another example of our willingness to seek new alliances and new partners in the increasingly powerful civil society—always with the specific aim of furthering the cause of health. Striking alliances and partnerships, in search of areas of mutual interest among institutions, is an essential function of leadership.

Third, our leadership derives from our ability to anticipate, with foresight, trends and movements so that we are on the crest of the wave of social change and not in its trough. Health sector reform, and the sectoral analyses that are the underpinnings of the sector-wide approach, is an example of a trend we have accompanied. The Organization has led and must continue to lead in articulating the essential elements of reform of the health sector. And while PAHO will never supply the financial resources—often construed, mistakenly, to drive the process—it has the presence, the credibility, and the intellectual resources to counsel the best practices. Indeed, the Pan American approach facilitates the sharing of such practices.

And, finally, the retention of leadership in Pan American health implies the ability to change our method of functioning and the structures we have in support of our functions. Over the past four years the changes we have introduced have been evolutionary rather than revolutionary, and have eschewed the many passing fads that promise the road to management nirvana. Changes undertaken include consolidating our programmatic and fiscal transparency, developing further our human resources, and deepening an understanding of the meaning of technical cooperation and management practices that give priority to openness and communication. Organizations such as PAHO—those that are highly specialized, multicultural, and a part of the United Nations, which maintains practices and systems predicated on personnel philosophies of another era—do not thrive on revolutions, constant shocks, and precipitate, indeliberate action. A balance must be struck between consistency of focus and readiness to innovate. Often, success is best testified when major changes go unnoticed.

The Pan American Health Organization is the Regional Office of the World Health Organization. We understand our role as being an integral part of a global enterprise, but our eyes are firmly fixed on our Pan American history and constituency. We posit that the experience of the countries of the Americas can in many ways serve as a laboratory for the rest of the world, convinced, as we are, that the diversity of our experience will fortify and enrich global action.

This Report is an account of the work of the Pan American Sanitary Bureau at the service of, and in collaboration with, the countries of the Americas ... and made possible through the confidence reposed in us by our Member Governments. May that confidence continue and redound to the benefit of the peoples of the Americas. We certainly do not intend for the Report to sound triumphalist nor to simply recount victories. Yet, if we speak and write of our work and responsibilities passionately, it is because we agree with Hegel that “nothing great in the world has ever been achieved without passion.”

In closing, we give thanks to the countless institutions and individuals who have partnered with the peoples of the Americas in their progress toward better health. Much have we achieved. Much remains to be done. We look forward to working with you, in the years to come, to attain our common ultimate purpose: health for all.



George A.O. Alleyne
Director

A group of people are performing a human pyramid on a sandy beach. In the foreground, a man in a blue t-shirt and a man in a blue and white plaid shirt are on their hands and knees. A woman in a yellow bikini top is leaning over the man in the blue t-shirt. Another woman in a pink bikini top is leaning over the man in the plaid shirt. The background shows a blue sky with white clouds and a body of water. The text "Partnering for Health in the Americas" is overlaid on the image in a white, italicized font.

*Partnering
for Health
in the Americas*

A group of five people, three women and two men, are on a beach. They are all wearing swimwear and are leaning forward in a playful, almost crouching pose. The background shows the ocean and a clear blue sky. The overall mood is joyful and active.

THE FOCUS

Achieving health for all will require the orchestration of many players. The countries of the Region are increasingly cooperating with each other to satisfy the health needs of their peoples, with the Organization frequently acting as liaison. At the same time, PAHO is striking strategic alliances—with funding agencies, the media, religious organizations, and a myriad of other institutions—to improve the health of the peoples of the Americas.

Since the resources needed to address the hemisphere's health needs exceed the total funding PAHO's member countries can contribute toward that end, to complement the countries' funds PAHO seeks partners to meet the Region's ever-increasing and progressively more complex health demands. The search in recent years has been fruitful: the Organization's budget, once solely dependent on country quotas, is today half comprised of voluntary contributions from the international community—individual governments, multilateral and nongovernmental organizations, and the private sector. Since 1994, PAHO has channeled some US\$400 million toward health projects in the Region and, as importantly, played a key role in strengthening donor coordination and assuring the effective use of all funding aimed at reducing inequities in health.

PAN AMERICANISM

AT ITS MOST EFFECTIVE...

*...countries cooperating with countries
to benefit their people's health*

Meeting the challenge of assuring the health of all peoples will require national competence—the capability of countries to solve their health problems. PAHO has been working with the countries of the Americas for almost a century to build self-reliant capabilities in health, by strengthening national institutions, fostering research, training health workers, mobilizing resources, and promoting the exchange of technical information and experts. As a result, the countries have now attained a level of competence that enables them to cooperate with each other ... and to reap the benefits afforded by technical excellence throughout the hemisphere—a strategy labeled “technical cooperation among countries” or TCC. In effect, all countries in the Region have become both the givers and the recipients of technical cooperation. Some countries—Brazil, Canada, Chile, Colombia, and the United States—have established their own agencies for technical cooperation; others—Peru and Venezuela—are in the process of doing so; and still others—Argentina and Mexico—have established funds to finance their cooperative outreach.

In this context, PAHO serves the critical role of liaison—identifying the supply of and demand for technical expertise in the Region and helping countries pool, share, and utilize it for their common weal. All of PAHO's regional programs involve TCC: good cases in point include the programs on immunization, emergency preparedness and disaster relief, and essential drugs and technology. And, while the Organization has established special TCC funds to be used to catalyze intercountry activities, the countries themselves are increasingly the fount of innovative technological solutions for health development in the Americas. The Central American, Caribbean, Andean, and Southern Cone health initiatives—launched in the 1980s under agreements between the countries and PAHO and since then strengthened as part of the various economic integration processes ongoing in the Region—seek to organize cooperation in health in areas of mutual interest.

The pages that follow tell the story of some of the successes in technical cooperation among countries achieved thus far. Examples shown here are but a sampling of the many experiences under way...

● *Cuba & the United States*

An outbreak of epidemic neuropathy that began in Cuba in mid-1992 and lasted for several years, affecting over 50,000 people, prompted PAHO to coordinate an investigation to determine its cause, bringing together Cuban researchers and U.S. scientists from the National Institutes of Health and the Centers for Disease Control and Prevention. Their cooperative study of the clinical, epidemiological, nutritional, toxicological, and viral aspects of the epidemic led to a joint presentation of findings at an international conference on the disease in 1994 and resulted in Cuba's instituting the recommended control measures.

● *Central America*

The border-sharing countries of Central America have taken their technical cooperation from discrete efforts to control rabies and cholera and to conduct immunization campaigns against the vaccine-preventable diseases to more comprehensive efforts to provide health services across borders.

● *United States & Mexico*

The determination to deal jointly with common health problems has prompted the creation of sister city projects along the United States-Mexico border.

◆ *Bolivia & Mexico*

Bolivia and Mexico have worked together regarding the practices of traditional birth attendants and have collaborated to achieve greater effectiveness of their national reproductive health programs.

◆ *Panama, Honduras & the Dominican Republic*

In light of an innovative community mental health program in Panama, PAHO has arranged internships so that residents in psychiatry from Honduras and the Dominican Republic could learn from the Panamanian experience.

◆ *Venezuela & Colombia*

An equine encephalitis epidemic that started in Venezuela in 1996 and quickly spread to Colombia prompted the two countries to work together to identify areas of increased risk, develop their health professionals' ability to diagnose and deal with the disease, and draft a joint plan to monitor and prevent it.



Canada & the English-speaking Caribbean

The PAHO/WHO Collaborating Center on Clinical and Administrative Nursing located in Mount Sinai Hospital in Toronto, Canada, is working with several countries in the English-speaking Caribbean to enable them to align better nursing personnel supply and demand.

Haiti & Cuba

The bacteriology laboratory in Haiti's University General Hospital is now fully functional, following PAHO's mobilization of resources and Cuba's loan of an expert microbiologist to oversee design of norms and procedures, equip the laboratory, and train its personnel.

Guyana, Trinidad & Tobago

Following resolutions on shared services adopted at a meeting of the Caribbean Ministers of Health, Guyana and Trinidad and Tobago established an agreement allowing Guyanese citizens to receive specialized health care in Trinidad.

Jamaica & Suriname

Jamaica is helping strengthen Suriname's nursing services by training nurses from the Paramaribo Academic Hospital at the Kingston Public Hospital.

The English-speaking Caribbean

The English-speaking countries of the Caribbean cooperated on mass measles immunization campaigns covering over 90% of all children and developed sensitive systems for surveillance of outbreaks of the disease ...as a result, no laboratory-confirmed cases of indigenous measles have been reported in that region since 1992.

Barbados & the Caribbean

Barbados has made tremendous progress in the area of drug services and is sharing its technology and expertise in developing a drug formulary with other countries in the Caribbean. Those countries are pursuing mechanisms to establish joint procurement of essential drugs, thereby lowering costs, and to share hospital maintenance and tertiary care services such as radiology, ophthalmology, neurology, and dermatology.

Brazil & Paraguay

The success of a joint rabies control program executed by Brazil and Paraguay induced the two countries to pursue other cooperative activities related to veterinary public health and prevention and control of leptospirosis and leishmaniasis.

Peru & Ecuador

Health authorities in Peru and Ecuador, with PAHO's support, have been pursuing opportunities to cooperate across their border. Following the border conflict between the two countries, it became more evident that the health sector can contribute to building a durable peace.

Argentina & the Southern Cone

An outbreak of hantavirus in Chile in an area bordering Argentina motivated the Southern Cone countries to undertake joint efforts to strengthen the region's epidemiological services—surveillance, outbreak investigation, clinical and laboratory diagnosis, biosafety, and control measures—and to capitalize on the strong capabilities of Argentina's National Laboratory and Health Institutes Administration.

SUSTAINING THE INITIATIVE FOR HEALTH IN CENTRAL AMERICA

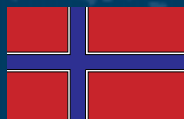
Project execution in Central America total disbursements, 1994-1997.

Major Financial Partners

*Government of Sweden
\$27,280,912*



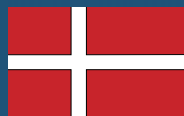
*Government of Norway
\$2,539,925*



*Government of the Netherlands
\$6,156,306*



*Government of Denmark
\$3,285,819*



*Local Governments
\$11,826,057*

*Others—The W.K. Kellogg Foundation, the Organization of Petroleum Exporting Countries, UNDP, WHO, and the Governments of Canada, France, Great Britain, Italy, Spain, and the United States—
\$9,798,419*

**Total
\$60,887,438**

An initiative to have health serve as a “bridge for peace” in Central America—launched in 1984 in support of the Esquipulas treaty that brought to a close decades of war in the region—has become a pivotal factor in the integration of the seven countries of the isthmus—Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama. With strong political endorsement from the heads of state, technical and financial administration by PAHO, and significant funding from the international community, especially the Nordic countries, the Initiative is proving that health can play a key role in the pursuit of peace, development, and democracy. PAHO has closely accompanied efforts to unify the peoples of Central America in their approach to health problems, applying common strategies aimed to improve the quality and coverage of services and seeking new forms of association that take greater advantage of resources in the region.

In response to the countries’ identification of their priority needs, the Initiative has targeted the extension of health care coverage by developing the service network so as to assure universal access and by supporting health sector reform efforts; the strengthening of national capabilities, especially in the areas of human resources, equipment maintenance, physical resources, and technical and scientific information; better access to essential drugs; inclusion of security institutions in integrated health systems; organization and preparation in case of disasters, particularly studies of hospital infrastructure vulnerability; and progress in environmental health by protecting and developing water sources and maintaining water supply systems, preventing pesticide poisoning, and developing institutions.

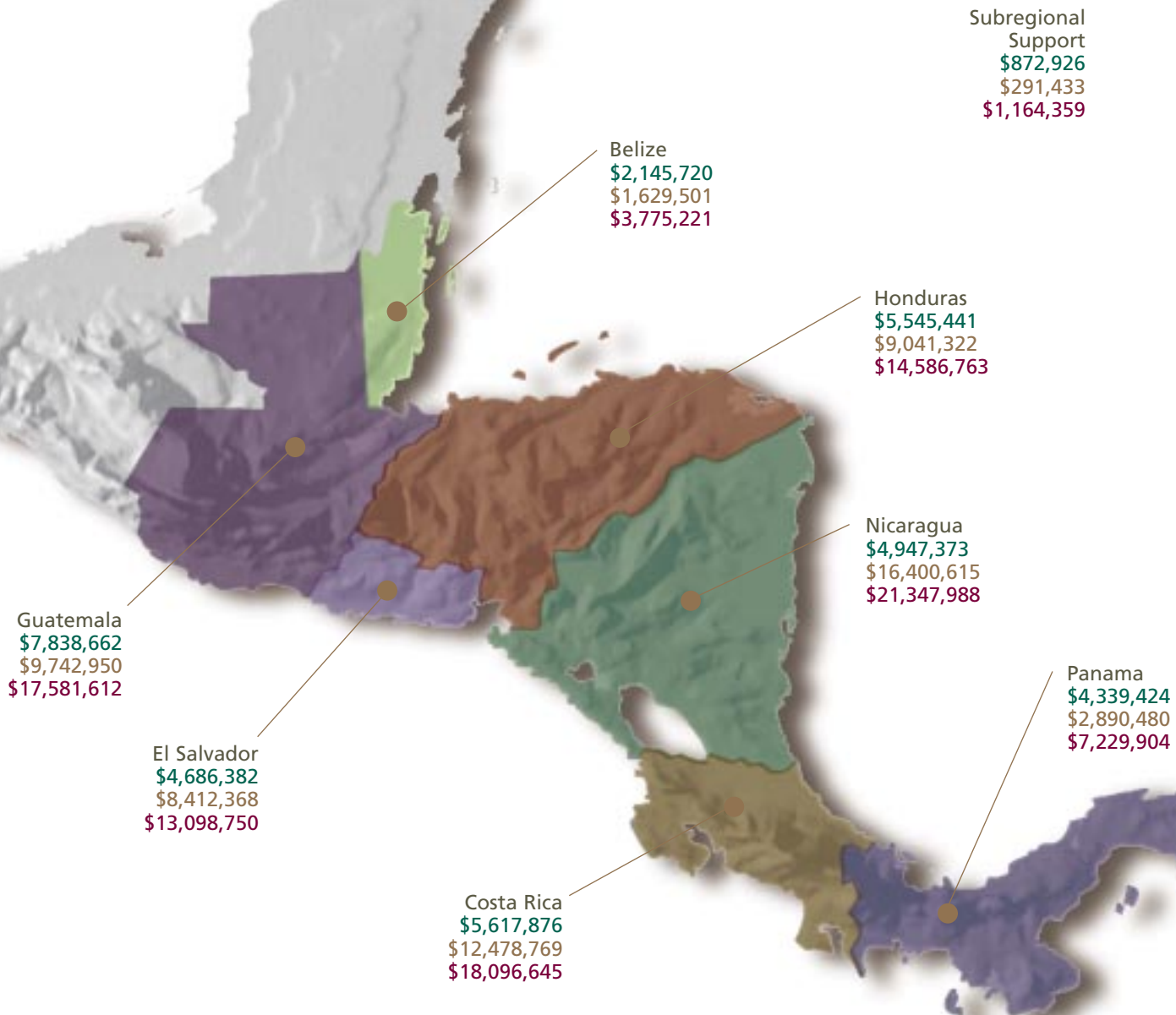
As a result of the Initiative, the countries are making gains in health sector reform, in fortifying the steering role of Ministries of Health, in building the health services network, and in striking alliances with nongovernmental organizations, religious institutions, and other private agencies that deliver public health services. They are forming networks for healthy settings, for economics and health, and for technological development of health services and elaborating common policies for food safety and nutrition, the use of traditional practices and plants, healthy borders, and shared services. Closer relations are under way with the Inter-American Center for Social Security Studies, the Red Cross Inter-American Blood Bank Network, the Inter-American Network on Health Economics and Financing, and other institutions working to strengthen integration in the region. Crowning achievements are the eradication of poliomyelitis and measles from the region and the elimination of neonatal tetanus as a public health problem.



Today the nations of Central America are for the most part at peace, growing economically and putting behind them the bloodshed of the past. Refugees and the internally displaced are returning to their homes, attempting to build new lives and a better future. They still face the specter of poverty, ill health, and poor environmental conditions, as well as natural disasters. Yet much has been accomplished in Central America in large measure thanks to the sustained support of the international community—bilateral and multilateral organizations, and most especially the efforts of Denmark, Norway, Sweden, and the Netherlands. Their collaboration with PAHO has supported a range of activities, from latrine building to medical training, to development of local health systems, prevention of maternal mortality, control of HIV/AIDS, help for indigenous women, and community health education.

Henceforth the aim will be to assure that health projects carried out in the region have a sustained impact on community health, as they become an integral part of stronger national health systems. PAHO will continue to mobilize the international community's support, to strive to ensure that the impact of national and international investments in the region is lasting, and to contribute to progressive consolidation of the Central American Health Agenda.

- PAHO/WHO Regular Funds, 1994–1997
- External Funding, 1994–1997
- Total



The international community has strongly supported PAHO's technical cooperation in Central America. Recognizing the Organization's long-standing presence in the region and the cadre of experts it has in place in the countries who can support health initiatives at the local level, bilateral and multilateral agencies have sought to channel their investments in health through PAHO. By mobilizing financial resources in the international community, PAHO was able to almost triple technical cooperation for health projects in Central America from 1994 to 1997. During that period, PAHO/WHO regular funds accounted for US\$36 million and external funding for \$61 million—yielding a total of almost \$100 million for health in the isthmus.

COUNTRY-TO-COUNTRIES COLLABORATION



PAHO's success in attracting international funding in support of technical cooperation in the Americas derives from its comparative institutional advantages: it has technical expertise in health; it knows the Region; it can coordinate action among the countries; it has a presence in each country; it works directly with national authorities; it can relate with nongovernmental organizations; it has gained a reputation for sound and transparent administration; it is politically neutral; and it has a history of work at the service of the countries. The examples of Spain and the United States illustrate PAHO's ability to mobilize resources for hemispheric health.

From 1995 to 1997, Spain's Agency for International Cooperation invested \$5,160,000 in health projects in the Americas:



HIV/AIDS and sexually transmitted diseases	\$915,000
Measles elimination	1,369,000
Acute respiratory infections and diarrheal diseases	1,395,000
Regional investment in health and environment	593,000
Basic rural sanitation	686,000
Women in health and development	202,000



In 1996 and 1997, the United States Agency for International Development signed commitments for over US\$17,400,000 to target major regional health projects:



Measles elimination	\$8,000,000
Immunization and decentralized health services	1,900,000
Reducing maternal mortality	2,250,000
Equitable access to health care	2,450,000
Management of childhood illnesses	2,800,000

TAKING HEALTH TO THE SUMMIT

PAHO's twofold tenet that the health of a people depends on society as a whole, not just the health sector, and that health in turn is a key factor in human development has reached the political agenda at the highest level—summits convening the presidents of all the countries of the Americas. The First Summit of the Americas, held in Miami, Florida in 1994, launched an initiative “Equity Access to Health Services” that assigned PAHO a coordinating role and enabled the Organization to mobilize some \$20 million in support of regional projects aimed at reducing maternal mortality, strengthening the health sector, eradicating measles, and preventing violence against women. The Second Summit, held in Santiago, Chile in 1998, declared unacceptable the inequities in health among and within countries; proclaimed the power of improvements in health to ameliorate poverty; and adopted a new initiative, “Health Technology Linking the Americas,” that spurs the collective countries to develop and use effective low-cost technologies in their quest for equity and sustainable development. PAHO has also advanced regional health priorities in Ibero-American Summits, bringing together Spain, Portugal, and the countries of Latin America and the Caribbean.



The First Lady of the United States, Hillary Rodham Clinton—shown here with the Director of the Pan American Health Organization, George A.O. Alleyne, and the Minister of Health of Chile, Alex Figueroa—in an address to PAHO on 16 April 1998 preceding the II Summit of the Americas, in Santiago, Chile, urged that “We certainly should use the promise of technology in every way possible, and PAHO has led us the way here. The PAHO-sponsored initiative for health technology linking the Americas has enormous potential to reduce the inequities that now exist.”

Mrs. Clinton further noted that “it is a significant sign of progress that the proposed declaration, as well as the plan of action, for this Summit includes health as a very important component of the effort to end poverty and ensure economic growth and prosperity.”

Declaration of Santiago II Summit of the Americas, 19 April 1998

“Overcoming poverty continues to be the greatest challenge confronted by our Hemisphere. We are conscious that the positive growth shown in the Americas in past years has yet to resolve the problems of inequity and social exclusion. We are determined to remove the barriers that deny the poor access to proper nutrition, social services, [and] a healthy environment ... We will ... use new technologies to improve the health conditions of every family in the Americas, with the technical support of the Pan American Health Organization, achieving greater levels of equity and sustainable development.”

COLLABORATING WITH THE MEDIA

Convinced that the mass media are effective channels for the delivery of health information that is engaging and persuasive, and that health is one of the topics of priority interest to people, PAHO works with the media to provide information on how people can maintain their health, prevent disease, and recover from illnesses and accidents. One of the first initiatives in this area was that of the PAHO/WHO Country Office in Peru which, together with the Ministry of Health, began preparing a weekly health supplement, Vida, in 1991 that for five years was distributed by the newspaper La República. Whereas when Vida started health topics rarely appeared in the local media, today they are covered by all the country's major newspapers and magazines. Given that experience, PAHO collaborated with the Ministry of Health of Panama to prepare weekly health supplements that are picked by national media and inspired one of Colombia's newspapers to regularly publish a health supplement based on Peru's Vida.

Television stations all over the Americas have shown public service announcements produced by PAHO, providing people information about health issues ranging from safe motherhood to the dangers of smoking.

In immunization campaigns, the media have played important roles in getting out the word about vaccinations, helping authorities reach target groups in urban as well as rural settings.

PAHO is working with UNESCO and the 300-member Latin American Federation of Schools of Social Communication on a project to incorporate health in the undergraduate, graduate, and continuing education programs of journalists and social communicators. Research has found that about 6.5% of media space in Latin America is dedicated to health, compared to about 40% in the United States. The Organization is also preparing a distance-learning CD-ROM on health journalism in Spanish.

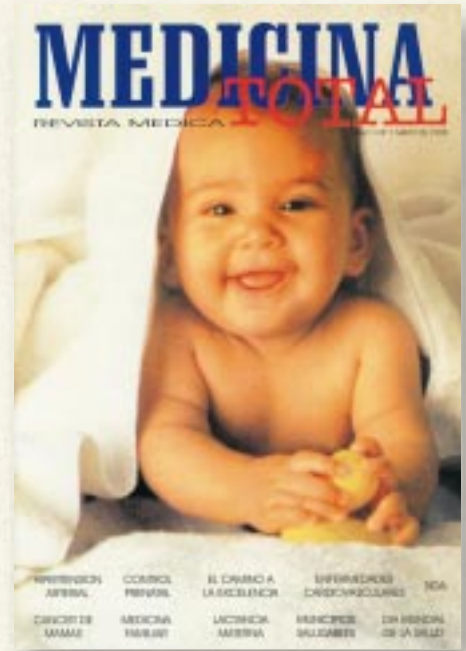


The Organization's technical experts convey vital health information to thousands of listeners in the United States, Latin America, and the Caribbean through radio and television programs.

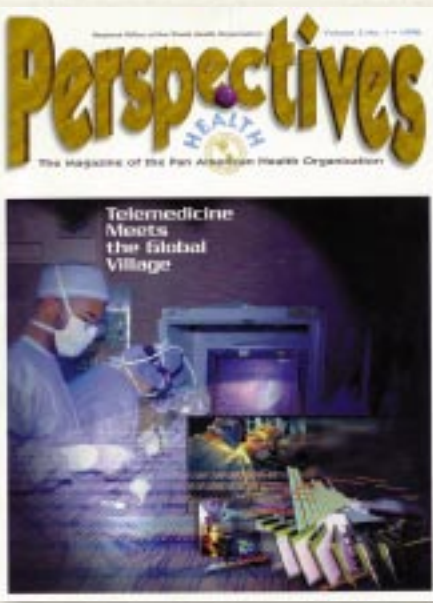


PAHO provides the mass media critical in-depth information through its scientific and technical publications.

The media increasingly are becoming key partners in health, communicating both messages and news to the general public, thus enabling people to make informed decisions about personal health issues. The relationship is mutually beneficial: the media capitalize on the general interest in health, and the health sector accesses critical channels for communicating its messages.



PAHO's Web site—<http://www.paho.org>—provides information in Spanish and English about the Organization, its areas of work, and country health profiles, and enables linkage to other health sites throughout the world, especially in Latin America and the Caribbean—thereby promoting the exchange of information among countries in the hemisphere. By taking advantage of the Internet, PAHO is able to disseminate information widely, timely, and inexpensively and to create channels of communication among its constituency and others interested in health in the Region.



PAHO produces a twice-yearly magazine, Perspectives in Health, that shows the human face of public health.

Newspapers, magazines, and wire services frequently use PAHO press releases, reaching readers throughout the Americas with information on the Organization, its programs, and current health issues.

ALLYING WITH RELIGIOUS FAITHS TO PROMOTE HEALTH

Religious organizations hold close relationships with individuals and communities, have a presence even in the most remote reaches of the Americas, support peace and social behaviors conducive to health, and provide humanitarian assistance and health care to those most in need. The dovetailing of these traits and its own objectives have prompted PAHO to establish contacts with several religious institutions to explore opportunities for joint action in the countries in support of community health promotion. Among efforts in this regard are a survey of religious groups involved in health programs in the countries; visits to health facilities operated by religious organizations; contacts with the Church of Latter-day Saints, the Vatican, the Latin American Episcopal Council, B'nai B'rith, the World Council of Churches, the United States National Council of Catholic Bishops, and the Latin American Council of Churches; and preparations for a special meeting of religious groups, to share views on health promotion strategies, identify common interests, and discuss the prospects for pooling efforts in support of health in the Region. ■



PAHO sought to work more closely with religious organizations to enhance awareness of international public health issues. As part of its efforts to prevent childhood illnesses, the Organization initiated collaboration with the Catholic Medical Mission Board to promote a standardized protocol for control of intestinal parasites in children in Central America. Representatives of the Board met with the Director of PAHO in June 1997 to sign the collaborative agreement.

PARTNERS HONOR ROLL

Contributors to Health Projects in the Americas

Executed by the

Pan American Health Organization, 1994—1997

*Member and Participating Governments**

Argentina
Barbados
Bolivia
Brazil
Canada
Chile
Colombia
Costa Rica
Cuba
Dominican Republic
Ecuador
El Salvador
France
Guatemala
Guyana
Haiti
Honduras
Jamaica
Mexico
Netherlands
Nicaragua
Panama
Paraguay
Peru
Suriname
United Kingdom
United States
Uruguay
Venezuela

Other Governments

Denmark
Finland
Germany
Italy
Norway
Spain
Sweden
Switzerland
Tunisia

International Organizations

Caribbean Commonwealth Secretariat
Caribbean Council for the Blind
Caribbean Development Bank
European Commission
Food and Agriculture Organization

Inter-American Development Bank
International Atomic Energy Agency
International Decade for Natural Disaster Reduction
International Labor Organization
Organization of Petroleum Exporting Countries
Foundation for International Development
Organization of American States
United Nations Children's Fund
United Nations Development Program
United Nations Disaster Relief Office
United Nations Industrial Development Organization
United Nations Population Fund
United Nations Joint Program on AIDS
United Nations University
World Bank
World Health Organization

Private and Public Sector Organizations

Agency for Assistance Development and Resources
American Cancer Society
American Foundation for AIDS Research
American Public Health Association
Applied Diarrheal Disease Research Project
CARE
Carnegie Corporation of New York
Center for Human Services
Ciba-Geigy, Ltd.
Clapp and Mayne, Inc.
Cooperazione Internazionale
Edmonton General Hospital
Eli Lilly Foundation
Emory University
European Federation of Networks
F. Hoffmann-La Roche & Co.
Family Health International
H.B. Fuller Company
Instituto Centro Americano de Investigación y Tecnología Industrial
International Nutrition Foundation for Developing Countries
International Association of Infant Food Manufacturers
International Association of Neurosciences

International Diabetes Federation
International Life Sciences Institute
International Organization for Agricultural Health
International Science and Technology Institute, Inc.
International Vitamin A Consultative Group
Jamaican Private Corporations
Johns Hopkins University
John Snow
Latin American Society of Nutrition
Leprosy Relief Work Emmaus
Liberty Health
MACRO
Medical Research Council
Medical Women's International Association
Merck, Sharp, and Dohme International
Micronutrient Initiative
National Polytechnic Institute of Mexico
Negri Institute (Italy)
Nestle Foundation
Novo Nordisk Pharmaceuticals, Inc.
Pan American Health and Education Foundation
Plan Internacional
Roche Products
Rand Foundation
Regional Initiative for AIDS in Latin America and the Caribbean
River Blindness Foundation
Rockefeller Foundation
Rotary International
Royal Commonwealth Society for the Blind
Sandoz, Ltd.
Société Générale, Cooperation Française
Spain's National Organization for the Blind
Third World Academy of Sciences
Thrasher Research Fund
Tropical Disease Research
Tuskegee University
Universidad San Francisco de Quito
University of California Regents
University of Texas
W. K. Kellogg Foundation
World AIDS Foundation
Yale University

* Governments making extrabudgetary contributions in addition to their regular quota assessments.

$$=28$$

$$3 \times 9 = 27 \sqrt{\text{☺}}$$

$$3 - 1 = R2$$

$$12 + 12 = 24 \checkmark$$

$$52 =$$

$$6 - 1 = R$$

*Enhancing Health
& Human
Development*



THE COMMITMENT

In 1994, the Pan American Sanitary Conference instructed the Bureau to orient its technical cooperation with the countries to:

- develop the capacity for policy analysis, planning, and formulation, and for the development and management of projects in the health sector;
- develop national capabilities in epidemiological practice and encourage the development, implementation, and effective use of information systems that will make it possible to monitor changes in the population and in living and health conditions, with emphasis on health levels and inequities among the population;
- promote the participation of the health sector in integrated programs to combat poverty;
- monitor the impact of macroeconomic policies on health and analyze the economic worth of the production and consumption of health goods and services;
- enhance coordination of the activities of social security institutions, community organizations, local governments, and the private sector in the production of goods and services;
- strengthen the capacity of the parliamentary institutions to address issues in health and promote the development of national legislation that will permit effective exercise of the rights and responsibilities of citizens, the State, and private institutions with regard to health;
- monitor and analyze health research, collaborate with the national agencies engaged in formulating policies and managing health science and technology, and promote cooperation among countries in the development and use of technology;
- support the development of new and better vaccines, as well as quality control and good manufacturing practices in this field;
- identify, review and promote the implementation of policies and programs related to bioethics;
- develop national capabilities for the organization and operation of national health information systems as an integral part of a Latin American and Caribbean health sciences information system;
- promote the development, harmonization, and use of technology to achieve more effective indexing, processing, and retrieval of scientific and technical information;
- focus attention on the importance of women's health, the interaction among women, health, and development, and the development of gender awareness at all levels.

THE RESULTS

Assessing Regional Health Status and Trends

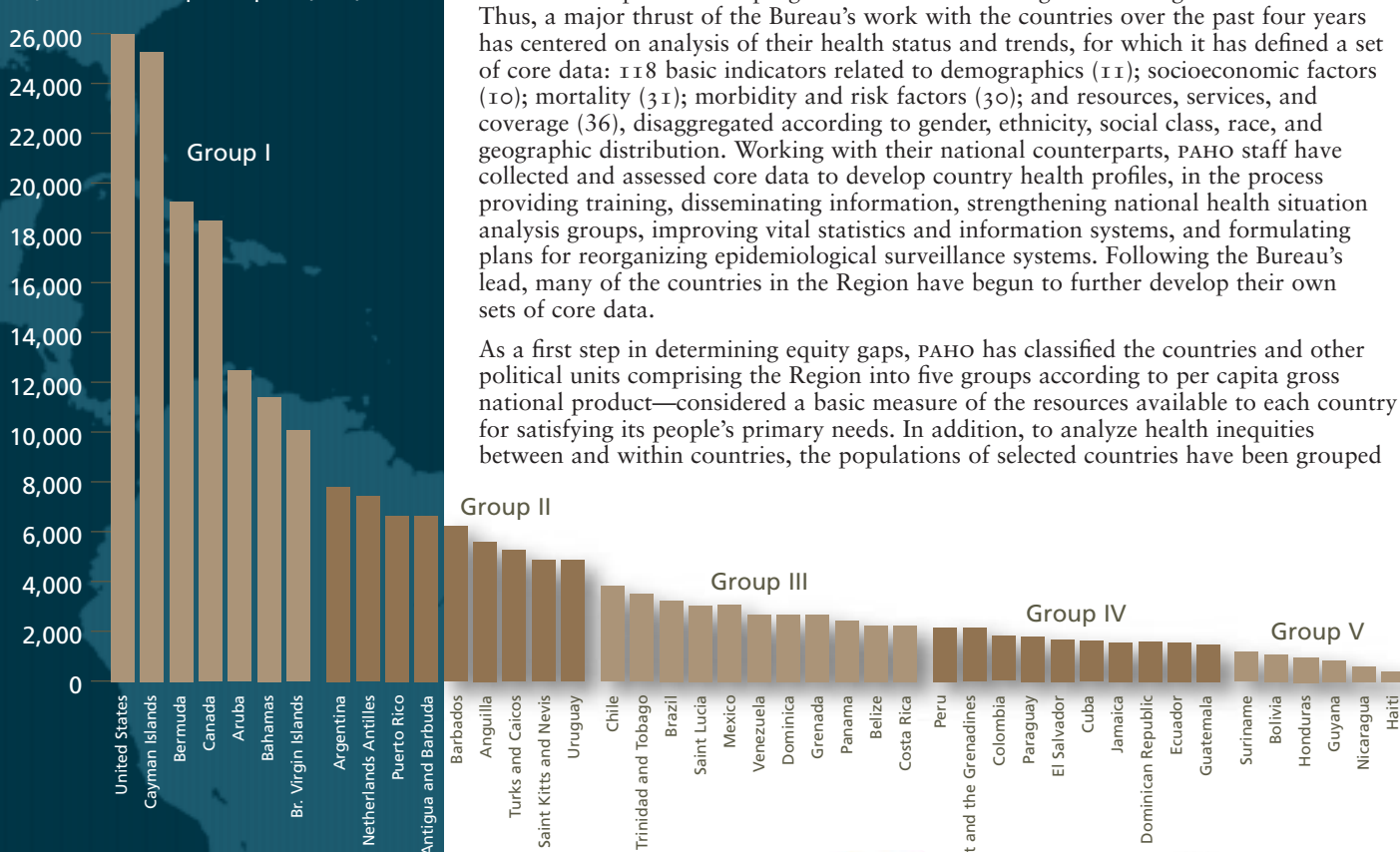
To begin to determine equity gaps, PAHO has grouped the countries in the Region according to gross national product (GNP) per capita.

The Region of the Americas shows some of the greatest social inequities in the world. Complex economic and social adjustments in the countries of the hemisphere throughout the 1990s have further aggravated disparities in health conditions and access to health care among countries and of population groups within them. These changes have hampered the ability of health institutions to provide equitable services to vulnerable segments of the population, bringing to the fore the problem of inequity in health and human development. Solving that problem will require a full understanding of its dimensions.

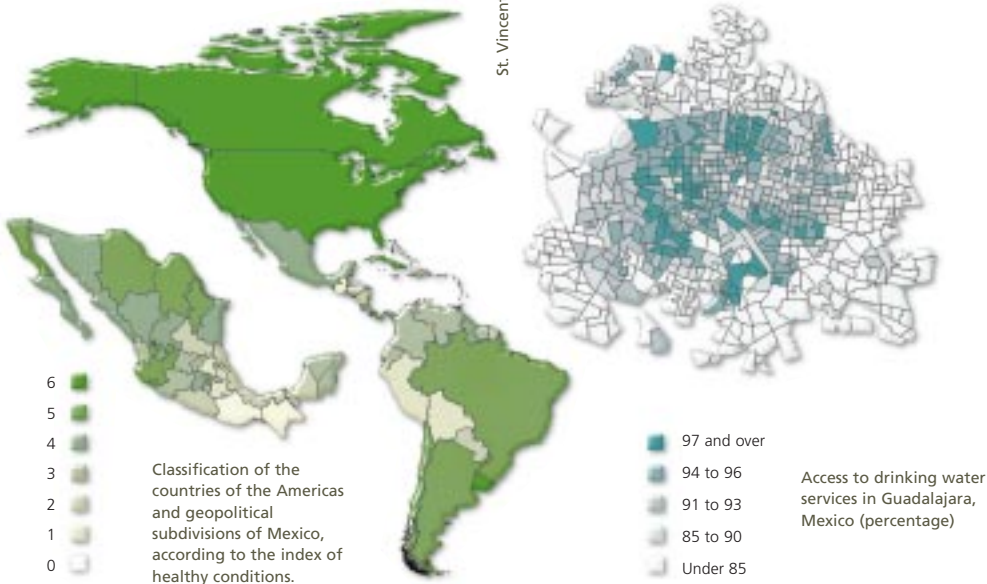
Sound health policies and program decisions must be grounded in good information. Thus, a major thrust of the Bureau's work with the countries over the past four years has centered on analysis of their health status and trends, for which it has defined a set of core data: 118 basic indicators related to demographics (11); socioeconomic factors (10); mortality (31); morbidity and risk factors (30); and resources, services, and coverage (36), disaggregated according to gender, ethnicity, social class, race, and geographic distribution. Working with their national counterparts, PAHO staff have collected and assessed core data to develop country health profiles, in the process providing training, disseminating information, strengthening national health situation analysis groups, improving vital statistics and information systems, and formulating plans for reorganizing epidemiological surveillance systems. Following the Bureau's lead, many of the countries in the Region have begun to further develop their own sets of core data.

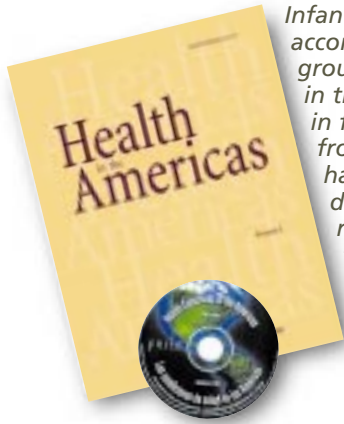
As a first step in determining equity gaps, PAHO has classified the countries and other political units comprising the Region into five groups according to per capita gross national product—considered a basic measure of the resources available to each country for satisfying its people's primary needs. In addition, to analyze health inequities between and within countries, the populations of selected countries have been grouped

GNP per capita (US\$)



PAHO has developed a computerized geographic information system in epidemiology that stores, handles, analyzes, and projects geo-referenced information that makes it possible to map the health situation and draw epidemiological risk profiles at the national, district, and local levels. Mexico is a good case in point: within the Region, Mexico has a relatively good index of healthy conditions, yet within the country some states have an even higher index while others are much lower than the national norm, and even within metropolitan areas, such as Guadalajara, significant disparities can be discriminated. This breakdown enables PAHO and the country to target populations most in need of health services and to redress inequities in health.





Infant mortality rates, according to the GNP grouping of countries in the Americas and in five-year periods from 1950 to 1994, have trended downward. A regional analysis of these groups is presented in *Health in the Americas, 1998 Edition, Volume 1*.

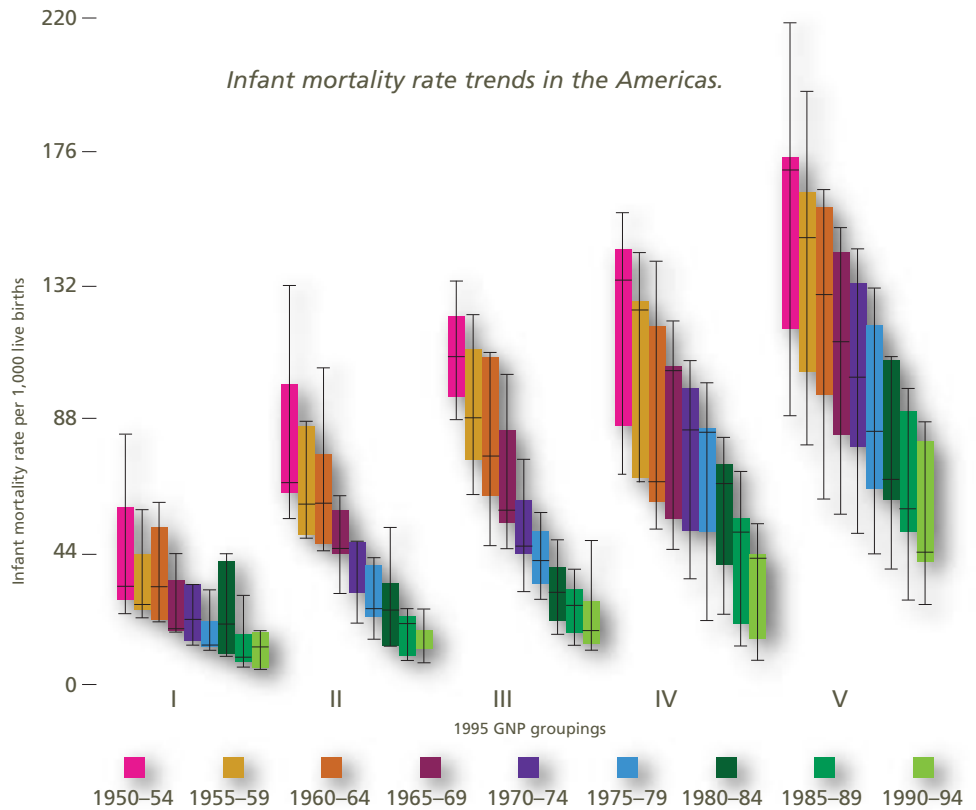
into quintiles according to key indicators of living conditions and health status, permitting an analysis of the disparities of these indicators at the regional, national, district, and local levels.

The resulting analyses show the distribution and magnitude of the indicators studied, make it possible to identify maximum and minimum values, and indicate which health conditions require priority attention.

The impact of this initiative is clear: reliable information based on core data is already being used to shape political and strategic planning and health program management, redirect the Bureau's technical cooperation with the Organization's Member Countries, inform investment proposals, mobilize financial resources, and define research priorities. Most importantly, all those working to improve health in the Americas can now discriminate and target the most needy... and begin to redress the problem of inequity in health and human development.

International Classification of Diseases in the Americas

Statistics on births, deaths, health, and diseases are vital to an understanding of the social status of a nation and its people. Consequently, over a century ago the community of nations reached a consensus establishing a single international list of causes of death, the 1893 Bertillon Classification, that would enable them to assess health status and evaluate health care. Since its founding, the World Health Organization has been responsible for revising, every decade or so, what has come to be known as the International Classification of Diseases. The Tenth Revision, published in 1992 and comprising a three-volume set (tabular list, instructions manual, and alphabetical index) with an expanded title (*International Statistical Classification of Diseases and Related Health Problems*), was over a decade in the making and involved consultation with a myriad of specialist groups and individual experts. While, as in past revisions, the latest emphasizes conditions that are frequent, costly, and of public health importance, it replaces the erstwhile numeric coding with a more flexible alphanumeric scheme; adds new chapters and



diseases, such as AIDS; presents definitions, standards, and reporting requirements related to mortality in different groups; and sets forth rules and instructions for identifying cause coding for mortality and main condition coding for morbidity.

Improving vital statistics in the countries is one of PAHO's essential functions. The Organization's Collaborating Center for the Classification of Diseases in Brazil prepared and published the Portuguese version of the Tenth Revision. The Spanish version, abbreviated CIE-10, was prepared by PAHO/WHO's Collaborating Center in Venezuela and edited and published, in print and electronic editions, by PAHO, which also printed a special low-cost edition for national health services. Working with those two Collaborating Centers and a third in the United States, PAHO held subregional and national seminars for coders to assure effective implementation of the CIE-10, prepared a special list for tabulating mortality data that enables comparison with the Ninth Revision, consistency tables for mortality codified according to the Tenth Revision, and technical definitions and studies of the impact on health statistics of the change from the Ninth to the Tenth Revision. Many of the countries of the Region have already adopted the Classification, and the remaining ones are expected to do so by yearend 1998. The International Classification of Diseases-Tenth Revision, in its various language versions, will enable the countries to improve their vital statistics and information systems and, by extension, their ability to analyze the national health situation and make sound policy and program decisions.

Promoting Bioethics



The countries of the Region have mandated that the Organization provide technical cooperation in the conceptual, normative, and applied development of bioethics in relation to health. PAHO has responded by establishing, with the Government of Chile and the University of Chile, a Regional Program on Bioethics that initiated its activities in Santiago in 1994. The program has set up a network of professionals and institutions engaged in bioethics activities in Latin America and the Caribbean, offered training through seminars and workshops, gathered and disseminated information on the field including preparation of a CD-ROM in conjunction with BIREME, and provided advisory services on a range of topics—assisted fertilization, organ transplants, cloning, the human genome project, euthanasia, and assisted suicide, among others. The program joined the universities of Chile and Madrid in sponsoring an International Master's in Bioethics course, which in 1997 graduated 37 health professionals from throughout the Americas.

PAHO works with all the national parliaments to promote health legislation... and keeps collaborators abreast of its activities via the World Wide Web.



Sister city projects along the United States–Mexico border deal with tuberculosis, HIV/AIDS and other sexually transmitted diseases, immunization, women's health, health promotion and control of substance abuse, environmental health, and the development of health and mortality profiles.

Health along the United States–Mexico Border

In the realm of international public health, border health is one of the most challenging phenomena. The busiest open border in the world between two countries is the one separating the United States (four states) and Mexico (six states). With the North American Free Trade Agreement, socioeconomic activities and concerns between the two countries have increased in number and intensity, and public health—at the federal, state, and local levels of government—has become even more complex. PAHO—ideally situated, with an office in El Paso, Texas, charged with supporting U.S. and Mexican health interests since 1942—disseminates information required for border health profiles, particularly the “sister cities,” mobilizes resources, fosters border partnerships, and serves as secretariat for the United States–Mexico Border Health Association.

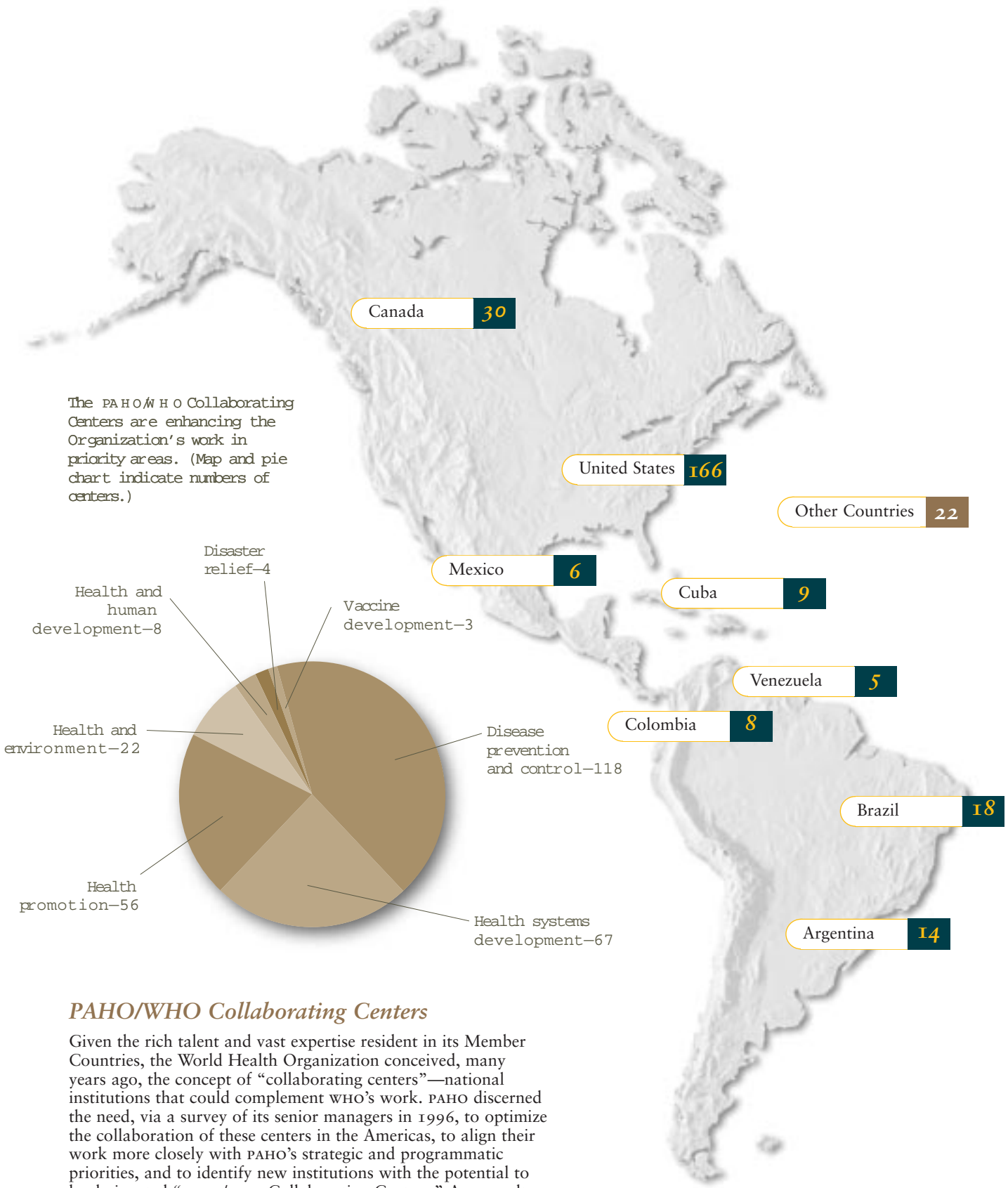
Health Legislation and Regional Pacts

PAHO has promoted the creation of interdisciplinary commissions to analyze draft health laws and codes in Costa Rica, the Dominican Republic, Ecuador, Guatemala, Nicaragua, and Venezuela; drawn up frameworks for better relations between the State and civil society in Cuba; defined the legal ramifications of modernizing public health system structures in Bahamas, Ecuador, Venezuela, and Paraguay; and defined financing schemes and control mechanisms for private lending and insurance agencies in Ecuador, Paraguay, and Peru. The Organization was instrumental in creating the Working Subgroup on Health of MERCOSUR that serves to advocate the inclusion of health priorities in negotiations of the Free Trade Area for the Americas and for analyzing the challenges and opportunities for the health sector with other regional trade groups. PAHO has provided counsel on a wide range of human rights legislation related to the elderly, the mentally ill, children and adolescents, and safe motherhood, leading to general health legislation in Paraguay and Guatemala and laws supporting vaccination in Ecuador, the elderly in Honduras and Guatemala, and blood banks and health insurance in Peru.



Policies and Parliaments

PAHO works closely with the Latin American, Andean, Central American, and Indigenous People's Parliaments to promote agendas that reflect the Organization's priorities: mental health, health care financing, pharmaceuticals, workers' health, food policy, health technology, tourism, and disaster mitigation, among others. Most recently, in December 1997, PAHO promoted a resolution by the Latin American Parliament “to adopt the draft model law on blood banks, blood transfusion services, and serology control prepared by [its] Health Committee and to send it to all the member parliaments so that they promote its incorporation in their national legislation ... [and] requests all member parliaments to review existing legislation to assure that persons with HIV/AIDS are not discriminated against and to protect their privacy and safety.”



PAHO/WHO Collaborating Centers

Given the rich talent and vast expertise resident in its Member Countries, the World Health Organization conceived, many years ago, the concept of “collaborating centers”—national institutions that could complement WHO’s work. PAHO discerned the need, via a survey of its senior managers in 1996, to optimize the collaboration of these centers in the Americas, to align their work more closely with PAHO’s strategic and programmatic priorities, and to identify new institutions with the potential to be designated “PAHO/WHO Collaborating Centers.” As a result, PAHO designated 25 new centers in 1996: 11 in Latin America, 3 in Canada, and 11 in the United States. A total of 278 centers now partner with PAHO.



Preventing and Controlling Domestic Violence against Women

The countries of the Americas have made great efforts to halt violence against women. PAHO—backed by funding from the Netherlands, Norway, and Sweden totaling more than US\$7 million since 1994—manages a project to improve the health sector's capacity to identify and refer women living in situations of domestic violence in Belize, Bolivia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Panama, and Peru. At the project's outset, a study conducted of 26 communities in 10 countries yielded an assessment of the situation and suggested appropriate interventions. Thus grounded, the project established community networks to prevent violence against women in the home and to provide health care to those who have been abused. Members of the networks—representing the health, education, legal and law enforcement sectors as well as civil society, especially women's groups and religious organizations—meet regularly to coordinate a community response to gender abuse. Trained facilitators teach battered women self-help and target correcting the behavior of those who abuse them. National and regional legislation has been passed and policies adopted to strengthen the capability of institutions to respond to domestic violence. Mass media in the countries are communicating the message that violence against women is unacceptable. Thus far, the project has succeeded in increasing collective awareness of the problem, strengthening local communities to combat it, and training community members to care for the victims of abuse. In the process, it has led to development of a model integrated, intersectoral approach to preventing and handling violence against women in the Americas.



PAHO has published, and continues to conduct research, on the issues of violence and gender as they relate to public health. Meanwhile, communities throughout the Americas are joining forces to put a stop to violence.

Researching Violence

Violence is one of the most serious threats to people's health and safety in the Americas. While it is known to be the first cause of death among young males in a number of countries in the Region and the largest source of years of life lost, information and comparative studies are lacking that would shed light on the socioeconomic, psychosocial, and cultural factors associated with violence. PAHO therefore initiated a project to evaluate violence, as well as related norms and attitudes, in selected cities of the Americas and in Spain. Using a cross-sectional design to survey a representative sample of the population between 18 and 70 years of age, national researchers questioned almost 12,000 people in late 1996 about violent behaviors in families and communities in 10 cities: Salvador-Bahia and Rio de Janeiro, Brazil; Santiago, Chile; Cali, Colombia; San José, Costa Rica; San Salvador, El Salvador; Madrid, Spain; Austin and Houston, Texas, United States; and Caracas, Venezuela. Among findings thus far are that (1) young men 20 to 35 years old are the group most likely both to be victimized by urban crime and to perpetrate it; and (2) individuals exhibiting the most violent behavior are the most likely to assert the need to bear firearms to protect their homes and families. The findings from this research will be used to orient policies and design intervention programs aimed at mitigating and preventing violence in the cities of the Americas.



Addressing Inequities in Health

Poverty is the root cause of most of the preventable deaths and disease in the Region. Nearly 350,000 children in Latin America and the Caribbean die each year before their first birthday—deaths which, for the most part, would never have happened in a more equitable world. PAHO—in collaboration with UNDP, CARICOM, CARICAD, CDB, and CLAD—is conducting a study to determine the impact of health reforms, specifically decentralization and health financing options, on the poor.

Income inequality is related to poor health. PAHO, in collaboration with the IDB and ECLAC, is conducting studies to examine the thesis that investing in health increases economic growth and reduces income inequality.

PAHO's Latin American and Caribbean Center of Health Sciences Information (BIREME) is developing a virtual library to strengthen the communication of scientific and technical literature in health, making optimal use of the Internet.



Canada

Emphasizes mobilization of public support, highlighting product and service improvements, and offering job security for staff at decentralized units linked to performance.



Trinidad and Tobago

Has adopted legislation establishing decentralized units, guaranteeing their funding, and paving the way for increased access by communities to the services offered.



Jamaica

Uses communications technology to increase cost consciousness among producers and consumers and has improved its hospital billing system.



Suriname

Has produced guarantees to increase coverage of the state health insurance scheme from 60% to 75% by yearend 1998.

Inter-American Network on Health Economics and Financing

The health sector in countries of the Region is conditioned by both external and internal factors: macroeconomic and development policies impact health, and the sector itself requires sound economic and financial management, to make it more equitable and efficient. To foster beneficial developments in these areas, PAHO, the World Bank, and the Inter-American Center for Social Security Studies joined forces in 1995 to establish the Inter-American Network on Health Economics and Financing, commonly referred to as REDEFS and headquartered in Mexico City, with subsequent support coming from the IDB, USAID, the IDRC, and the United Kingdom's Department of International Development. The Network—currently comprising 23 groups and associations in 20 countries throughout the Americas—acts as a catalyst to promote and strengthen training, research, collaboration, and information exchange in the area of health economics and financing. The Network has created greater awareness in the Americas of the importance of health economics and financing, both as a policy area and as a technical discipline for achieving equity and efficiency in the health sector.

EXPLORING THE NEXUS AMONG HEALTH,



An avid ecotourist embarks on an exploration of nature, ill-informed about the possible health risks of backpacking through the jungle. A week after her return home, she comes down with unusual symptoms and goes to her doctor, who has never seen such a syndrome and is baffled as to what tests to run. Meanwhile, her home country epidemiological surveillance service is trying to determine how to improve notification of imported diseases.

Another tourist asks his doctor what vaccinations to get before going on vacation. The doctor, "just to make sure," has him vaccinated against a myriad of diseases, including rabies. Although there has been no rabies for three decades where the man is going, he submits to the unpleasant, expensive process—not knowing any better but determined not to ruin his vacation.



A businessman decides to add a few days to his trip abroad to relax and, while there, enjoys sex with a local woman. Long after he has gone, leaving no address, she is found to have some sexually transmitted disease.



At beach resorts every tourist season, traffic, boating, and other accidents due to alcohol intoxication increase the load of patients in hospital emergency rooms, straining local health care resources and requiring complicated transnational insurance arrangements.

DEVELOPMENT, & TOURISM



Medical personnel in a country are highly trained and have the technology to offer advanced care for a number of illnesses at a fraction of the cost that would be involved if a foreigner were to get the same treatment at home. Whereas offering those services could be an important source of local revenue and could make it possible for some to get treatment they otherwise could not afford, doing so poses certain ethical, legal, and regulatory concerns.



Word spreads about an area known for its pristine coral reefs, and more tourists than it has the infrastructure to handle begin to arrive. Not only is the sustainability of the reefs and fishing endangered, but water supply and waste disposal facilities are overwhelmed, jeopardizing the quality of service to foreigners and nationals alike.



A hotel notices a repeated pattern of illness among its clients, but management hides the information from local authorities, concerned that the hotel could be held liable for some negligence. As a result, time and accurate data are lost in what turns out to be an outbreak unrelated to staying at the hotel.

These are but a few examples of some of the issues involved in the nexus among health, development, and tourism—one that PAHO began to explore in 1991. At that time the foreign exchange impact of tourism in the Region was clear: tourism was outranking export industries in a growing number of countries. Equally important, PAHO determined, was assessment of the more intricate association with health and economic development—an association whose implications for health policy were growing as a result of the sheer volume of international tourism. In 1992 PAHO's Directing Council concurred with the importance of this subject, adopting a resolution that urged the Organization to explore it.

In response, the Bureau set up an interprogrammatic working group that is developing a body of knowledge, technical guidelines, and collaborative projects covering areas such as food safety, water and sanitation, and outbreak surveillance and control in tourist zones. The group's findings thus far underscore the importance of a regulatory and advisory role in tourism for the health sector and the need to gather accurate data and make public what information is known. The Bureau is building a health database for tourist areas and sharing information with other organizations, has struck agreements with the private sector to assist in assessing health matters involved in tourism's infrastructure, and plans to issue a scientific publication—the first of its kind—that will address these issues in full. ■



A tourist gets sick and is sure it was the local food. Frustrated, he shares his story with chat groups on the Internet. Word spreads, the area gets a bad reputation, and tourist arrivals diminish. Although it turns out that his sickness had nothing to do with the food, by then the damage has been done.



*Preventing
& Controlling
Diseases*



THE COMMITMENT

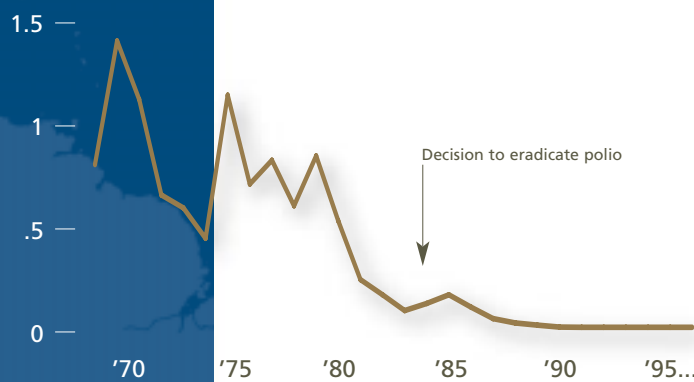
In 1994, the Pan American Sanitary Conference instructed the Bureau to orient its technical cooperation with the countries to:

- establish and sustain programs of immunization for effective vaccination against diseases of major public health importance;
- eradicate or control certain health problems, including poliomyelitis, measles, leprosy, rabies transmitted by dogs, onchocerciasis, and transmission of *Trypanosoma cruzi* by blood transfusion and by domiciliary *Triatoma infestans*;
- develop a more complete understanding of the causes and risk factors responsible for foodborne and diarrheal diseases and methods for their prevention;
- on the basis of improved knowledge, implement simple and cost-effective measures in communities and families to maintain food and water free of infectious agents, in order to reduce mortality from diarrheal diseases;
- support national efforts to coordinate activities for the control and prevention of HIV/AIDS and for reducing its impact on populations and on infected persons;
- strengthen local capacity to prevent, diagnose, and treat sexually transmitted diseases, especially in primary health care services;
- target programs to known risk groups and risk factors, employing the basic approaches of risk analysis and stratification;
- improve capacity to detect changes in the occurrence of infectious diseases and to assess potential impact on the public's health, so as to implement timely and effective prevention and control;
- support national efforts for the control and eventual eradication of prevalent zoonoses and other infectious diseases that threaten human health or compromise agricultural productivity;
- strengthen national capacity to organize and develop integrated food protection programs and epidemiological surveillance systems for foodborne diseases;
- collect relevant information about the distribution and determinants of health problems as an essential prerequisite for the planning, execution, and evaluation of programs;
- enhance national and local capacity to assess the social and economic impact of violence, injuries, and chronic diseases, so as to establish priorities and secure resources for interventions;
- promote the integration of disease control programs into health services, particularly at district and local levels, with appropriate decentralization of authority and resources.

THE RESULTS

Immunizing for Life

For 20 years, PAHO's Expanded Program on Immunization (EPI) has led the Region's efforts to reduce sickness and deaths due to diseases that can be prevented by vaccines. Throughout the Americas, committed governments, involved communities, united countries, and collaborating organizations together achieved, first, the eradication of smallpox in 1971 and, then, of polio in 1991, with regional certification in 1994. The rest of the world—in the hopes of following suit and attaining global eradication of polio—is putting into practice strategies pioneered in the Americas.



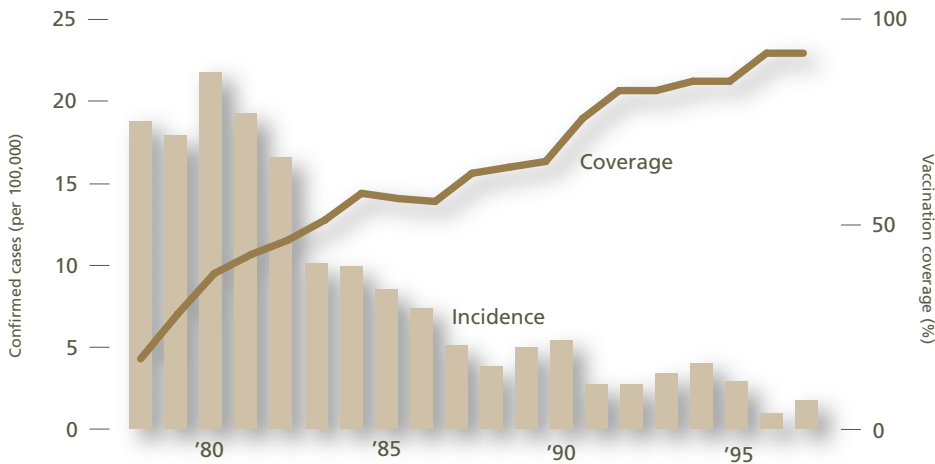
Annual incidence of polio in the Americas, from 1969 to the present.

Today, the lives of over 200,000 children in Latin America and the Caribbean are saved each year as a result of regional vaccination campaigns to prevent measles, neonatal tetanus, and whooping cough. Most of the countries in the

Americas have interrupted transmission of measles for several years, and some countries for over six years. Neonatal tetanus has been eliminated as a public health problem. As a result of EPI's efforts, governments' commitment, and the broad base of support attained by national EPIS, over 80% of children under 1 year of age are now vaccinated for diphtheria, pertussis, tetanus (DPT), poliomyelitis (OPV), measles, and tuberculosis (BCG), whereas when the program started only some 25% of children were covered.

The program now sets its sights on reaching the remaining 20% of children, maintaining the Region's polio-free status, achieving eradication of measles by 2000, holding to the marked reduction in cases of neonatal tetanus by identifying high-risk areas and routinely immunizing women of childbearing age, and introducing new vaccines. To do so will require the continued leadership of national governments. PAHO works closely with the countries to achieve more effective delivery of sustainable and high-quality immunization services by improving the policy environment, expanding and enhancing immunization delivery by public and private sectors, and strengthening and supporting the measles surveillance system. Efforts target the training of health workers on recent developments in epidemiological surveillance, better supervision and program management, promotion of adequate regulations, and strengthening logistics for delivering vaccines and other material. PAHO is also working with national and subregional parliaments to promote legislation that will finance the recurrent costs of immunization programs.





Annual incidence of pertussis and vaccine coverage with DPT3 in children less than 1 year of age—Region of the Americas, 1978–1997

In 1995 PAHO's Member Countries collectively committed to the eradication of measles—which causes 42 million cases and nearly 1 million deaths worldwide each year—by the year 2000. Their action plan targets achievement and maintenance of 95% measles vaccine coverage in all municipalities or districts in every country of the Region, by supplementing routine vaccination activities with periodic follow-up campaigns aimed at preventing the accumulation of susceptible preschool children. The countries' collaboration will be crucial to the campaign's success, given the highly infectious nature of measles and the steadily increased movement of people within and among countries. An integration of the 11 reference laboratories comprising the measles laboratory network with national epidemiological surveillance systems will stimulate collaboration in serological studies and the testing of suspected measles cases. Although there was a resurgence of measles cases in Brazil in 1997, the number of cases was only about 10% of all cases reported in the Region in 1990, and the outbreak teaches all countries the lesson that the absence of measles virus circulation in the Americas does not mean the absence of risk from measles infection while there is circulation in other regions of the world.

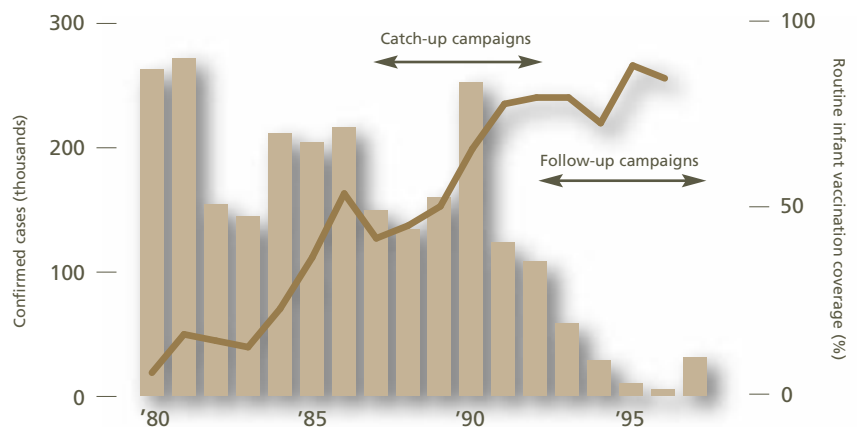
The First Ladies of the Americas are key players in emphasizing the importance of immunization: outlining a Plan of Action to follow up PAHO's measles eradication activities in the countries in their meeting in Bolivia in 1995 and reiterating their collective commitment in Panama in 1997. Like many of her counterparts throughout the hemisphere, the First Lady of Mexico, Mrs. Nilda P. Velasco de Zedillo (shown, left), has participated actively in her country's vaccination program.

The introduction of new vaccines into routine immunization programs is gaining ground. Vaccines against measles, rubella, and mumps are in use in 80% of the countries; all but one of the countries where yellow fever is endemic are routinely vaccinating for the disease; all countries that have identified areas and groups at high risk for hepatitis B and yellow fever have introduced these vaccines; and increasingly more countries are including *Haemophilus influenzae* type b vaccine in their programs.

The costs of developing, producing, and delivering these vaccines are high, while countries' financial resources are limited. PAHO thus urges implementation of sensitive surveillance systems that can accurately determine disease burden and the cost-effectiveness of introducing new vaccines, advocates the importance of developing vaccines of high quality, fosters a product-oriented research and development culture among laboratories in the Region, and promotes intercountry collaboration to make optimal use of existing capabilities.

Networking for Vaccine Quality Control

Vaccine production and quality control policies and practices vary widely throughout the Region. Some countries have not yet set up well-defined national control authorities to ensure that manufacturers follow established standards, while others have already organized national quality control laboratories. In seeking to assure the quality of vaccines used by all the countries in their immunization programs, taking into account this diversity of situations, PAHO advocates the forging of effective partnerships between governments and vaccine manufacturers in support of the Regional System for Vaccines (SIREVA). A regional network of vaccine quality control laboratories among the eight DPT-producing countries comprises the National Institute of Microbiology of Argentina, the National Institute of Quality Control for Health of the Oswaldo Cruz Foundation of Brazil, the Institute of Public Health of Chile, the National Institute of Food and Drug Surveillance of Colombia; the Center for State Drug Control of Cuba, the Institute of Tropical Hygiene and Medicine of Ecuador, the National Laboratory of Public Health of Mexico, and the National Institute of Hygiene of Venezuela. PAHO serves as the secretariat of a technical advisory committee that monitors the activities of the network, which focuses on developing and standardizing regional reference reagents, promoting good manufacturing and good laboratory practices, and collaborating on studies to develop materials and regional reference standards for vaccines for measles, BCG, recombinant hepatitis B, pertussis, and polio. The Organization has also established a program, and provided related training and guidelines, to certify vaccine producers, which will ensure adherence to international regulations and good manufacturing practices.



Reported measles cases in the Americas, 1980–1997.



The regional network of quality control laboratories fosters development of standard reference reagents.

Regional Vaccine Initiative

Impressive developments in the basic sciences and biotechnology in recent decades have led to improvements in existing vaccines and development of new ones. Most of these activities are conducted in the developed countries in close collaboration between governments and private biotechnology and vaccine-producing laboratories. Whereas the new vaccines tend to be more powerful, less reactogenic, and technologically more complex, they are protected by patents and copyrights—limiting their wide use in routine immunization programs in the Americas. Health authorities in the Region face the dual challenge of maintaining high coverage with vaccines currently in use and of developing strategies to facilitate the incorporation of important new vaccines.

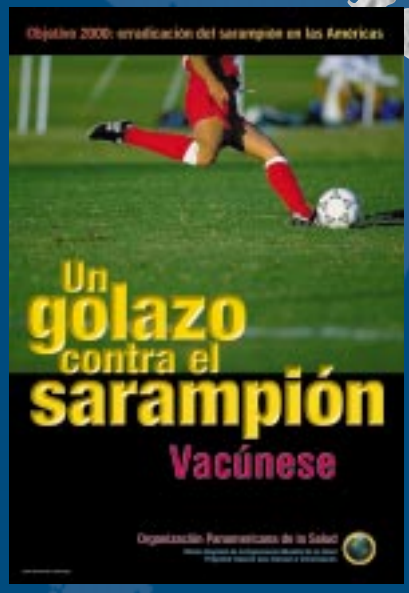
Vaccine development entails multidisciplinary teams and a long maturation period, along with the ever-present risk of an ineffective end product. While governments recognize that vaccines are key to the control and elimination of vaccine-preventable diseases, most countries are not engaged in research and development for vaccine production, and those that are lack the financial and human resources to adequately sustain vaccine research, development, production, control, and management.

In order to make the most of individual countries' activities, PAHO, through a regional initiative for vaccine development established in 1996, encourages vaccine-producing institutions to guarantee adequate investments and expertise in support of multi-institutional, multi-country projects. The initiative has already scored important successes.

The first multi-country program—involving Brazil, Chile, and Mexico—targeted development of a conjugated vaccine against *Salmonella typhi* and resulted in production and purification of the capsular polysaccharide (Vi antigen), production and purification of the carrier proteins (*S. typhi* porins), and a conjugation methodology for the polysaccharide to either porin or tetanus toxoid. Efforts now center on attracting interest of a local manufacturer for further production of this vaccine.

Regional laboratory networks have proven effective in providing surveillance of vaccine-preventable diseases. To complement the networks for polio and measles, PAHO has set up a pneumococcal surveillance network that initially connected Cuba (Finlay Institute), Brazil (Butantan Institute, Bio-Manguinhos/FIOCRUZ), Argentina (Malbrán Institute), and Uruguay (Institute of Hygiene), whose collective aim is to develop a pneumococcal conjugated vaccine. Having now recruited the involvement of laboratories in other countries, the network is assessing the prevalence and antimicrobial resistance of *Streptococcus pneumoniae* serotypes by participating laboratories in Argentina, Brazil, Chile, Colombia, Cuba, Dominican Republic, Guatemala, Mexico, Peru, and Uruguay; conducting study protocols to determine the disease burden due to *S. pneumoniae* and *H. influenzae* type b, the findings of which are helping to assess vaccine effectiveness and to assure adequate vaccine formulation; collaborating on molecular studies to establish the genetic relation of pneumococcal strains in the Region; and including additional pathogens—particularly those producing meningitis and pneumonia—within the network's scope of work.

To bolster regional disease prevention and control efforts, PAHO produces books, periodicals, and promotional materials for a broad range of audiences.

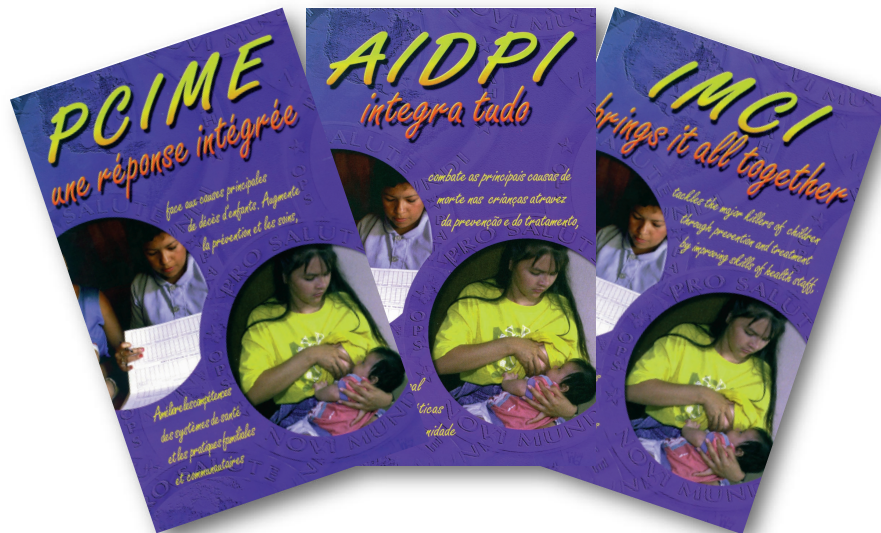




Integrated Management of Childhood Illnesses

Children's deaths due to diarrhea and acute respiratory infections (ARI), mainly pneumonia, have dropped dramatically in the Americas: deaths from diarrhea fell 54% and from ARI 43% in 18 countries in the Region between 1980 and 1990. Notwithstanding, mortality due to these two causes still accounted for one-fourth of all deaths among children under 5 at the start of this decade. The countries, PAHO and WHO, and UNICEF thus joined forces in 1992 to put in place an integrated strategy to manage the major illnesses that affect children under 5 years of age. In addition to efforts to combat diseases preventable by immunization, this integrated approach targets diarrheal diseases, acute respiratory infections, malnutrition, and intestinal helminth infections, which together account for more than 50% of child mortality each year in the Americas. Although the strategy is still too new to measure impact in terms of reductions in child mortality, it has already bolstered national planning, programming, and follow-up activities and has furthered technical cooperation among countries in the areas of training, information exchange, and networking among individuals and institutions.

Diarrheal diseases continue to rank among the five leading causes of death in infants under 1 year old in most of the developing countries in the Region and account for more than 15% of deaths in this group in 15 countries. PAHO works with the countries to strengthen national control programs by promoting training in case management and the use of oral rehydration therapy and by educating the population, especially mothers, about handling children with diarrhea at the household level. Since the outbreak of the cholera epidemic in 1991 the disease has been responsible for over 1.2 million cases and 11,950 deaths. Although the high incidence of cholera witnessed in the early years of the epidemic has subsided, the disease now appears to be endemic in a number of countries. The low case fatality

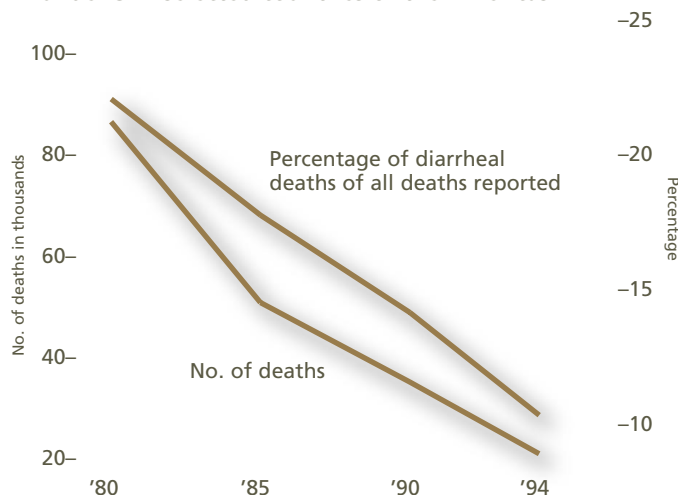


rate—around 1%—attests to the effectiveness of concerted action by national and international communities aimed at public health protection. From 1991 to 1996 PAHO mobilized over US\$12 million to support country projects for preventing and controlling cholera; has coordinated its work with other international agencies—the U.S. Centers for Disease Control and Prevention, UNICEF, USAID, and BASICS; and is now strengthening laboratory surveillance systems in light of possible drug resistance to first-line antibiotics.

Acute respiratory infections rank among the top three causes of death and the first cause of morbidity in children under 5 in developing countries of the Region. Pneumonia, the number one reason for

deaths due to ARI, is among the five main causes of death in children under 5 and among the three main causes of death in children between 1 and 4 years in most of the developing countries of the Americas. Community studies indicate that, on average, four to six yearly episodes occur per child, representing approximately half of all consultations and a third of all hospitalizations of children under 5. The Organization and the countries have strengthened activities to meet the target of the World Summit of Children: a 30% reduction in pneumonia deaths by the year 2000. PAHO has set up a regional database on mortality due to pneumonia and other ARI and training programs to improve case management and prevention at health facilities and within the community.

Diarrheal diseases—Reduction of deaths in children under 5 in selected countries of the Americas.*



*Argentina, Brazil, Chile, Colombia, Costa Rica, Cuba, Ecuador, Mexico, Paraguay, and Venezuela.

Emerging and Reemerging Diseases

One of PAHO's strengths as an institution is its ability to rapidly and efficiently coordinate the resources of many sectors and to galvanize the involvement of the international health community when an epidemic strikes. Recognizing the need to take swift and concerted action in the face of new, emerging, and reemerging infectious diseases, the Organization drafted a regional plan of action in 1995 for their prevention and control that targets (1) strengthening regional networks for surveillance of infectious diseases; (2) establishing national and regional infrastructures for early warning systems to alert people to the risk of infectious diseases and provide a rapid response through strengthened laboratories and multidisciplinary training programs; (3) promoting applied research in rapid diagnosis, epidemiology, and disease prevention; and (4) enhancing regional capacity to implement effective prevention and control strategies. In recent years, one of the Region's most threatening infectious diseases is that caused by hantavirus, which by the end of 1997 had resulted in 376 cases and 171 deaths or a rate of 45.5%. PAHO cooperates with the countries in combating hantavirus, by arranging for training in diagnosis of the disease for professionals from the Southern Cone countries at the U.S. Centers for Disease Control and Prevention (CDC) and the Center for Hemorrhagic Fevers in Argentina and facilitating the production of a guide on hantavirus hosts and a manual on trapping and sampling small mammals for virological studies.



Monitoring changes in dengue virus types at PAHO's Caribbean Epidemiology Center (CAREC) in Port-of-Spain, Trinidad and Tobago, allows prediction of outbreaks and timely implementation of control measures.



Intestinal parasite diseases—mainly ascariasis, trichuriasis, and hookworm infections—affect an estimated 25–30% of the population in the Americas and in highly endemic areas account for prevalence rates reaching 80%. These infections can be successfully controlled, however, through programs that treat children periodically and educate the community. A standardized approach entails chemotherapy, improved health education, social communication, and environmental sanitation.

Schools promoting health in Central America teach children how to prevent diseases caused by intestinal parasites.

Status of PEPIN —a protocol for controlling intestinal parasites in children aged 2 to 14—in four Central American countries as of year 2007			
Country	State of the Protocol	Children Covered	Sites/Areas Included
Guatemala	1st dosage	328,000	76 communities
El Salvador	3rd dosage	352,883	74 municipalities
Honduras	3rd dosage	380,000	Four departments with their archdioceses
Nicaragua	3rd dosage	1,025,193	PEPIN protocol carried in four districts and national health days

Leprosy

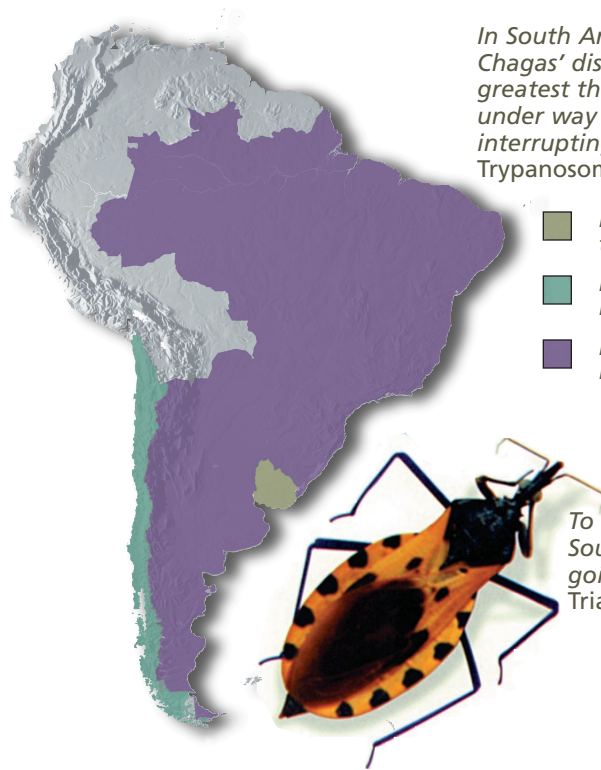
The burden of leprosy has been reduced by 65% in the Americas since 1992 and program coverage using multidrug therapy, proven both inexpensive and effective in curing the disease, has reached almost 90%. PAHO is cooperating with the endemic countries of the Region, especially with those where the disease continues to pose a problem—Brazil, Paraguay, and Suriname—as well as with those that have reached the elimination target, by assessing the epidemiological and operational situations, defining areas where prevalence is suspected to be high; identifying focal points; conducting activities based on local health systems, and promoting cooperation among countries in training, information exchange, and epidemiological surveillance, in areas of both high and low prevalence.

Onchocerciasis

Encouraging results of community-based treatment with the drug ivermectin, provided free of charge by Merck, have lent new credibility to efforts to eliminate onchocerciasis as a public health problem in the Americas by the year 2007. The elimination strategy, which relies on the use of sustained annual or biannual delivery of the drug to eligible individuals at risk of the disease, is promoted through a multinational, multiagency, multidonor regional coalition to support and coordinate national plans to combat the disease in six endemic countries—Brazil, Colombia, Ecuador, Guatemala, Mexico, and Venezuela—and through binational border efforts of those countries. Given the progress attained, authorities are now developing internationally accepted standards to certify elimination of onchocerciasis.

Chagas Disease

Cooperation among the Southern Cone countries in their campaign to eliminate *Triatoma infestans*—the main vector of *Trypanosoma cruzi*, the causative agent of Chagas' disease—has recorded measurable progress. In 1991, Argentina, Brazil, Chile, Paraguay, Uruguay, and Bolivia established an intergovernmental control commission, with PAHO acting as its secretariat, that meets regularly and has determined that routine strategies to tackle the vector are the most effective: house spraying with residual insecticides, health education, community participation, and housing improvements. Together these six countries have contributed over US\$230 million to extend efforts to eliminate *T. infestans* by spraying over 1.7 million houses and to interrupt transfusional transmission of *T. cruzi* in blood banks. Uruguay has achieved interruption of both vectorial and transfusional transmission; Chile, Argentina, and Brazil have achieved a significant drop in transmission of *T. cruzi*; and Bolivia has passed a law to ensure blood screening.



In South American countries where Chagas' disease has posed the greatest threat, major progress is under way in reducing the disease by interrupting transmission of *Trypanosoma cruzi*.

- Interruption of transmission achieved
- Interruption achieved in 1999-2000
- Interruption achieved in 2004

To tackle Chagas' disease, Southern Cone countries are going after the "vinchuca"—*Triatoma infestans*.

Dengue and Dengue Hemorrhagic Fever

The past four years have registered a major increase in cases and deaths due to dengue and dengue hemorrhagic fever, which are now endemic in much of the Region. The only way to prevent the disease is to eliminate or drastically reduce the mosquito vector, *Aedes aegypti*. PAHO helped the countries prepare national prevention and control strategies, gave training in clinical diagnosis and treatment and in vector control, strengthened quality control in 35 laboratories in 19 countries, and—mobilizing funds from Norway and the United Kingdom—contributed to development of self-sufficiency in the production of dengue reagents in Central America. Evidence of *A. aegypti* was found in 1997 in Uruguay, which had been free of the vector since 1958. Responding immediately, PAHO promoted cooperation between Uruguay and Brazil in training on surveillance and vector control and on clinical and serological diagnosis. Also in 1997 a task force convened by PAHO proposed a hemispheric plan for combating *A. aegypti* that was subsequently approved by PAHO's Directing Council.

Malaria

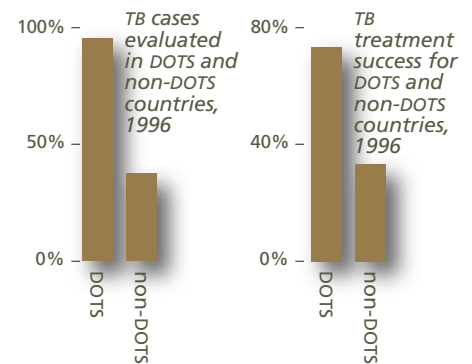
Almost a quarter of a billion people in the Region (218 million) live in areas that favor the transmission of malaria. Epidemiological stratification has enabled control programs to concentrate their

resources proportionately in areas according to whether they pose high, moderate, or low transmission risk recognizing a large non-risk area—a strategy that has resulted in the number of malaria cases stabilizing over the past decade, to one million per year, despite massive demographic occupation of high-risk forested areas in endemic countries. The Organization and the countries endorse and apply the global malaria control strategy, which has reoriented control programs to focus their attention on early diagnosis and immediate treatment. PAHO promotes continuous surveillance, has prepared guidelines on diagnosis and treatment of malaria, and encourages incorporation of control efforts in local health services. Malaria control activities are thus resulting in expanded health care service coverage and better access by the population to those services, leading to fewer malaria deaths and reduced severity of cases.

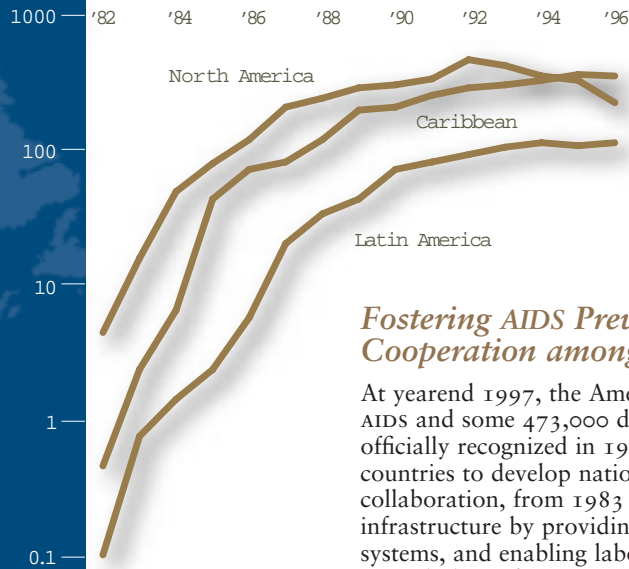
Tuberculosis

Tuberculosis remains a public threat in every country in the Americas, despite the availability of means to control it. More than 50,000 people are estimated to have died due to the disease in each of the past four years. Some 5% of all new cases in the Region are attributable to co-infection with human immunodeficiency virus (HIV), with a significant increase in cases of this type in Argentina, Brazil, the Dominican Republic, Haiti, and Honduras. PAHO

promotes the DOTS—directly observed treatment shortcourse—strategy and seeks to improve awareness of the tuberculosis epidemic, mobilizes resources for effective and sustainable programs—adequate drug supply, personnel supervision, training, program evaluation and laboratory network strengthening—and encourages investigation of new interventions. To achieve the cure rate and case-finding targets set for the year 2000, PAHO is redoubling its efforts to improve application of the DOTS, stepping up use of standardized evaluation methods for case finding and treatment, and stimulating the sharing of successful experiences among countries in the Region.



Case-finding and cure rates are significantly higher in countries that have followed the directly observed treatment shortcourse (DOTS) strategy promoted by PAHO.



Although the total number of reported cases of AIDS in the Region is decreasing—from 104,000 in 1992 to 73,000 in 1996—due to a decline in North America, incidence rates in Latin America and the Caribbean continue to increase.

Fostering AIDS Prevention through Technical Cooperation among Countries

At yearend 1997, the Americas recorded over 800,000 cases of AIDS and some 473,000 deaths since the disease was first officially recognized in 1981. PAHO has worked closely with the countries to develop national AIDS programs: the first phase of collaboration, from 1983 to 1988, focused on building program infrastructure by providing training, establishing surveillance systems, and enabling laboratories to detect HIV infection; the second phase, from 1989 to 1994, targeted program consolidation, entailed the design of national medium-term plans for AIDS prevention and control, and promoted the development of in-country expertise and intercountry collaboration; and the third phase, from 1995 to the present, expanded the response to include other sectors under the aegis of UNAIDS. PAHO has sponsored annual meetings of directors of national AIDS programs, providing a regional forum for these leaders to coordinate a collective “agenda for action” to combat the disease, a strategy which, in 1996, led to establishment of the Technical Group for Horizontal Cooperation. PAHO’s collaboration has already scored a number of successes, particularly in the areas of improved situation analysis, epidemiological surveillance, and blood safety; future steps will involve the exchange of experiences and information, training, advice regarding patient management, and strategic planning. A number of countries—Brazil, Mexico, Chile, and Argentina, among them—have become self-reliant in all areas of HIV/AIDS prevention and control and are now sharing their expertise with other countries in the Region. As a result of this cooperation, the countries are now prepared to undertake appropriate strategies aimed at reducing the number of future infections and providing timely and adequate care for people living with HIV/AIDS.



To combat AIDS in the Americas, PAHO has worked with the countries in developing infrastructure, designing national AIDS prevention and control plans, and producing material, including videos, on the disease.

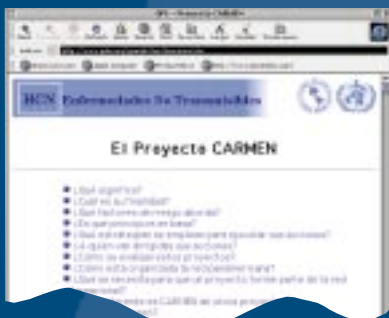
Reducing the Risk of Noncommunicable Diseases

Noncommunicable diseases, largely attributable to risk factors that can be modified, account for nearly two-thirds of all deaths in the Americas. In 1995, to improve people’s health throughout Latin America and the Caribbean by reducing these risk factors, PAHO initiated a project, CARMEN (so called after its Spanish acronym), the main objective of which is to create national and local coalitions that set policies and carry out interventions focusing on such risk factors as smoking, high blood pressure, overweight, diabetes, and excessive alcohol consumption.

The project disseminates practical guidelines for cost-effective management of risk factors, provides professional education to reorient health services toward prevention, and recruits political, private sector, and social involvement.

In each participating country, which must qualify on the basis of a proposed action plan, CARMEN begins as a demonstration project that applies existing prevention knowledge and services and, on the basis of experience gained, is then extended throughout the country. A CARMEN project initiated in Valparaiso, for example, is being evaluated in terms of its feasibility, performance, and impact, and will then be generalized throughout Chile. Argentina, Costa Rica, Cuba, and Puerto Rico are also proposing projects.

CARMEN uses an integrated approach, combining clinical prevention for individuals with health promotion directed at the general population, that reaches people in the community, the workplace, schools, and local health



Preventing and Controlling Cervical Cancer

It is a tragedy of major proportions that at least 25,000 women die each year of cervical cancer in Latin America and the Caribbean, despite the fact that the disease is mostly preventable. The Americas exhibits the highest incidence and mortality from the disease in the world, with 60% of cases of invasive cervical cancer occurring in women 35 to 60 years of age—women in their prime productive years.

New knowledge of the natural history of the disease, including the role of human papillomavirus, as well as the recent development of simplified technology for treating precursor lesions, has enabled PAHO to devise a strategic approach for the prevention and control of cervical cancer involving three intervention components.

The first intervention component is to promote, by educating and involving the community, the accessibility to health services of middle-aged women, especially poor women. Although screening with PAP smears has been available for over 30 years, low-risk young women attending maternal care and family planning clinics tend to be the ones routinely screened, rather than the higher-risk middle-aged women. PAHO is supporting the conduct of qualitative studies to learn about the perceptions of middle-aged women and health care providers, as well as about their health and prevention practices, particularly PAP smear screening.

The second intervention component is to support quality control in cytology laboratories through establishment of a regional cytopathology network.

The third component is to facilitate access to treatment, for which purpose PAHO collaborated on a study in Aragua, Venezuela, resulting in an increase in follow-up from 18% to 89% after an abnormal smear due to introduction of a new technique—a “loop” electrosurgical procedure—to treat women with cervical intraepithelial neoplasia in an outpatient clinic rather than in a hospital.

To support this strategy PAHO is developing a regional information system to monitor progress and a cost analysis approach to assess program efficiency and identify areas of further improvement.

Declaring against Diabetes

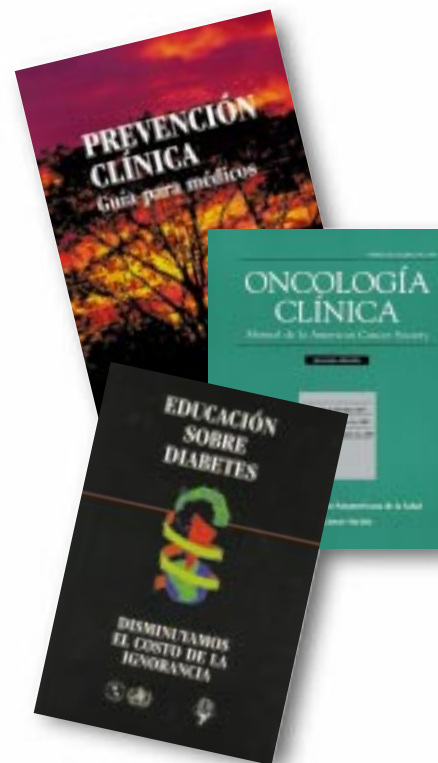
Diabetes afflicts an estimated 110 million people in the world, one-fourth of whom live in the Americas—15 million in the United States and Canada, and 13 million in Latin America and the Caribbean. Without effective prevention, by the year 2010 the Latin American and Caribbean caseload will reach 20 million. Fortunately, large-scale studies have proven that healthy diets and physical activity can reduce future incidence by half, and improved clinical management and patient education can reduce complications by an equivalent proportion. The challenge, then, lies in converting these promising research findings into practical action.

Toward that end, in 1996 PAHO and the International Diabetes Federation, with funding from an industry consortium, cosponsored a meeting of over 200 people from North, South, and Central America and the Caribbean that culminated in the Declaration of the Americas on Diabetes. A month later, PAHO's Directing Council recognized the growing burden of diabetes throughout the Region and endorsed the Declaration as a “guide for national program development.”

Since the Declaration was launched, PAHO, IDF, and the industry have drafted and disseminated essential goals and targets. In partial response, PAHO conducted a baseline survey that revealed that diabetes accounts for <5% of mortality in most countries (median 3.6%), ranking sixth overall among major causes, and that most countries lack information on the most important complications of the disease—amputation, blindness, and end-stage renal disease. For their part, the countries are appointing diabetes focal points within their ministries of health and identifying partners to combat diabetes; most have decided to integrate diabetes with their noncommunicable disease programs; and some have adopted a national diabetes strategy and formed a consultative group. PAHO's commitment is to work with the countries to realize the aims of the Declaration.



PAHO promotes the education of women as a critical strategy to prevent cervical cancer ... and disseminates information on cancer, diabetes, and other chronic diseases to public health workers, researchers, clinicians, and the community at large.





Food safety—from farm to fork—is the objective of a PAHO-promoted strategy: hazard analysis at critical control points.



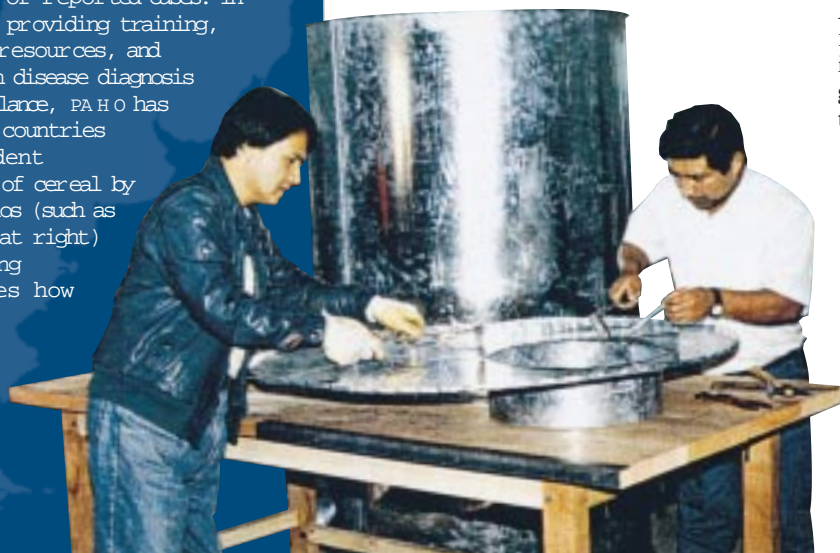
Ensuring Food Safety while Promoting Trade

Outbreaks of foodborne diseases have always been underreported, making it difficult to determine the tools and strategies to employ to control and prevent them. To address this problem, PAHO's Institute for Food Protection and Zoonoses, INPPAZ, put into place a regional system for epidemiological surveillance of foodborne diseases to which 20 countries of the Region now report. INPPAZ trains nationals to participate in the system, collects and analyzes information the countries send in, and then disseminates that information back to the countries.

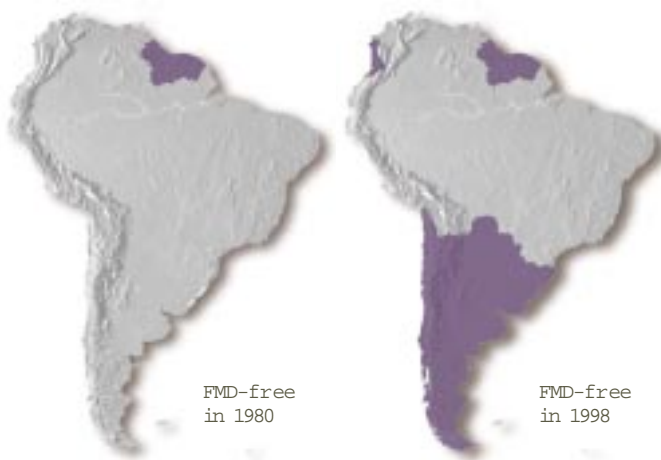
Food exportation to the United States alone is the major source of revenue to the countries of the Americas, totaling more than US\$8.5 billion per year. In the interests of both favoring international trade and protecting public health, INPPAZ has initiated a regional information system that compiles all the food legislation and regulations that have been adopted in the MERCOSUR countries and puts them on a CD-ROM, for use by those countries as well as the countries to which they export food.

Silos to Prevent Plague

Plague prevention and control has been the object of stepped-up collaboration by PAHO and the European Community Humanitarian Office during the past several years, leading to a significant reduction in the number of reported cases. In addition to providing training, mobilizing resources, and assisting in disease diagnosis and surveillance, PAHO has helped the countries prevent rodent infestation of cereal by building silos (such as that shown at right) and teaching communities how to use and maintain them.



In 1906 Upton Sinclair published a book, *The Jungle*, which so horrified the people of the United States that the inspection of slaughterhouses became law. While that was a definite step forward, it did not solve all the problems of food safety, many of which originate along the food chain from production to consumption. Real progress came in 1981 when the Pillsbury Company, charged with ensuring that the food to be used by astronauts was safe, developed a new approach—the hazard analysis at critical control points, thenceforth known as HACCP. Following several major *Escherichia coli* outbreaks leading to deaths in the United States, consumers lobbied for better inspection systems, and HACCP—entailing not only visual but microbiological inspection and not only of slaughterhouses but all along the food chain, earning the motto “food safety from farm to fork”—became federal law in the United States in 1996. HACCP is also gaining ground in Latin America and the Caribbean. INPPAZ and PAHO's Country Office in Panama, for instance, began working in 1996 with the government of that country to apply this technique in rural hospital cafeterias. Focusing on safe handling of raw materials, basic sanitation, proper storage, adequate procedures, staff education, and improved equipment, the approach has been so successful that the Ministry of Health decided to extend it to hospitals in the capital.



Countries and regions of South America that have been officially declared free of foot-and-mouth disease, showing the impact of the countries' commitment to eradication.

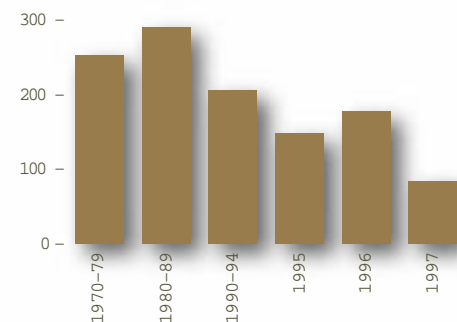
Eradicating Foot-and-Mouth Disease

Until recently, foot-and-mouth disease had been a major problem in South America. While the Darién Gap that separates South America from Central America prohibited the movement of livestock northward and thus ensured protection of countries in the North, countries in the Andean region continue to be endemic. After Chile achieved eradication of foot-and-mouth disease in 1981, the rest of South America determined to follow suit, and in 1987 pacted to eradicate the disease throughout the hemisphere. PAHO's Foot-and-Mouth Disease Center, PANAFTOSA, developed an oil-adjuvanted vaccine that reduced the cost of vaccination by 50%, set up a continental system to pinpoint where the disease occurs, and worked with the countries to organize livestock producers into eradication committees to improve surveillance and promote application of differential diagnostic techniques. As a result of PAHO's and the countries' efforts, today—in addition to Chile—Uruguay, Argentina, Paraguay, Brazil's three southern States, and the northwest region of Colombia are FMD-free. The pace of success has been so swift that the original date for achieving eradication, 2013, has been moved up to 2007. With so many countries having graduated from control to eradication, prevention is now the aim, and PANAFTOSA is working with the countries to manage risk through application of a risk-analysis approach. Among the benefits accrued: Uruguay has doubled its exportation of meat from 1995 to 1996, and Argentina has exported beef to the United States for the first time in 60 years.

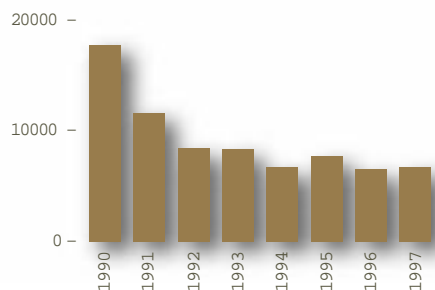
Eradicating Rabies

In 1983 the countries of the Region decided to undertake the eradication of urban rabies and, to do so, sought PAHO's collaboration. Since 98% of rabies cases are transmitted by dogs, it was determined that vaccinating 80% of dogs would interrupt transmission and eliminate human cases. PAHO provided technical support and mobilized resources to prepare national plans of action, make vaccines available, vaccinate dogs, conduct surveillance of cases, and provide medical care of humans exposed to the disease. The key to rabies eradication has been application of the Fuenzalida-Palacios vaccine developed by the Pan American Center for Zoonoses (forerunner of INPPAZ), and now produced by Brazil, Colombia, Chile, the Dominican Republic and, through PAHO, supplied to all the nonproducing countries of the Region: 98% of the vaccines used in the Americas over the past 48 years are the Fuenzalida-Palacios vaccine, and today the vaccine is available for 21 cents per dose. In 1983, when the countries undertook the rabies eradication campaign, 8 out of 21 capital cities in Latin America were free of human rabies; today, thanks in good measure to PAHO's collaboration and financial assistance from the European Community and the Arab Gulf Fund for United Nations Development, 18 of them are, and the Caribbean is totally free of dog-to-human rabies. In 1997, for the first time, the number of human rabies deaths reported in the Region was less than 100.

Cases of rabies in humans—Latin America, 1970–1997.



Cases of canine rabies—Latin America, 1990–1997.



The countries of the Region, with PAHO's full support, are vaccinating dogs and, as a direct consequence, reducing human rabies deaths.

Conserving Primates, Advancing Biotechnology

The development of hepatitis A and B vaccines, malaria vaccine, and other important biomedical research have been made possible by collaboration between the Government of Peru and PAHO to conserve neotropical primates in Iquitos. Prior to PAHO support, up to 55,000 animals were indiscriminately taken from the wild every year, 90% of which died before reaching their destination. Now in its 25th year, the project has prevented the extinction of endangered primate species, demonstrated that periodic harvesting of between three and five years in defined areas helps maintain stable populations, developed the first model of island breeding of nonhuman primates, and made available some 500 animals a year—the only legal source of neotropical primates for the biomedical research community in the world. ■





*Supporting the
Development of
Health Systems &
Services*



THE COMMITMENT

In 1994, the Pan American Sanitary Conference instructed the Bureau to orient its technical cooperation with the countries to:

- foster the development of leadership and managerial capacity in the Ministries of Health and other institutions of the sector and promote the development of sector analysis at the national and local levels in the context of decentralization, social participation, and intersectoral coordination for the development of local health systems;
- analyze and develop options for the organization and financing of health systems, services, and institutions, including the use of local strategic administration, the development of information systems, and the improvement of maintenance of physical facilities;
- stimulate implementation of the Regional Plan for Investment in the Environment and Health;
- promote the development of human resources in all fields critical for the efficient functioning of health services;
- promote the use of approaches that target health care toward priority population groups, women, and mothers and children;
- support the formulation of policies on essential drugs that deal with legislation, regulation, production, marketing, use, and financing, and promote the strengthening of pharmaceutical services, knowledge of drugs among health care personnel, and health education for the public in order to encourage the rational use of drugs;
- strengthen the development of clinical laboratory services, blood banks and transfusion services, and diagnostic imaging and radiotherapy services, especially in relation to policy formulation, quality assurance, and biosafety;
- strengthen the capacity of the health sector and other relevant sectors in the areas of disaster preparedness, prevention, and mitigation.

THE RESULTS



Organizing and Managing Health Services

To revise and adjust existing processes to fit the new scenario resulting from modernization of the State and sector reform, the Bureau evaluated the regional experience in developing local health systems, conducted activities with HPS and CLAD in support of decentralization, provided training on strategic administration, and mobilized resources for local development in 12 countries. With the aim of improving the quality of health services, efforts targeted hospital accreditation and quality assurance in service networks. To foster managerial capacity and the changes necessary to make the institutional culture more participatory, strategic, and results-oriented, the Bureau elaborated a managerial information system, disseminated materials and, together with teaching institutions, strengthened administrative capacity.

Supporting Health Sector Reform Processes

PAHO's Governing Bodies have given priority attention to the issue of health sector reform in recent years, and the Bureau has supported national reform processes—through policy formulation and planning, direct technical assistance, information, training, resource mobilization, and research—with the aim of achieving greater equity, efficiency, effectiveness, sustainability, and social participation. The First Presidential Summit of the Americas (December 1994) assigned PAHO responsibility for holding a special meeting on health sector reform and for monitoring its progress in the Region. The special meeting, cosponsored by the World Bank, IDB, OAS, UNICEF, ECLAC, UNFPA, USAID, and the government of Canada (Washington, D.C., 1995) discussed a regional agenda to reform the health sector. Thereafter, the quest for equity through health sector reform became a prime mover of PAHO's technical cooperation. Resources have been mobilized to develop reform-related instruments and methodologies. PAHO and USAID are spearheading a special five-year project, to which each agency is contributing some US\$2.5 million, targeting equitable access to basic health services. Another major project with the IDB, World Bank, Caribbean Development Bank, and CARICOM entails design and execution of a study of health sector reform in the Caribbean to evaluate the sector's priority problems and the progress of national reforms that will lead to adoption of national policies and external support.

Strengthening Ministries of Health

In support of the steering role of ministries of health and sector leadership in advocating the importance of health in human development, the Bureau gave attention to the sector's basic functions, operational aspects of those functions, and requirements for developing the ministries' institutional capacity to allow for greater breadth and complexity and applying new concepts, tools, practices, and personal skills.

Conducting Sector Analyses

The Bureau developed methodological guidelines for elaboration of health sector analyses and, with the government of Spain's critical support to the Regional Plan for Investment in the Environment and Health as well as that of the IDB and UNDP, conducted sector analyses resulting in master plans for investment in health in Chihuahua State, Mexico; Cuba; and the English-speaking Caribbean countries.

Assessing Health Technologies

The Bureau conducted courses throughout the Region on health technology assessment concepts and methodologies and on the relationship of this field with health sector reform and promoted the creation of health technology assessment units and technical groups in the countries.

Promoting Investment Projects

The Bureau worked with Brazil, Costa Rica, Ecuador, Jamaica, Paraguay, and Venezuela in preparing and executing sector investment projects financed by the World Bank and the IDB, the aim of which is to support sector reform in the countries, especially the areas of financing, human resources, and decentralization.

Developing Human Resources

Essential to accomplishing the aims of health sector reform are the health workers who will make it happen. PAHO therefore collaborates with the governments and educational institutions throughout the Americas to solve countries' problems with respect to shortfalls in qualified health care providers of a range of categories; deficiencies in type and level of



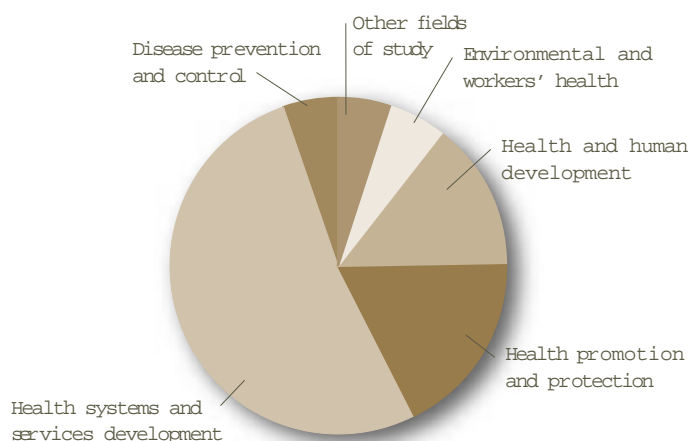
training required; and inequitable availability of health care workers. Cooperative efforts include:

- conducting policy analysis and planning.
- designing and putting in place programs for medical and other health personnel and formulating national action plans for nursing and midwifery, assessing nursing education programs, and establishing and strengthening regulatory and accreditation mechanisms for nursing schools.
- promoting health work force planning tools, including accreditation, self-evaluation, and curricular innovation.
- strengthening institutions' ability to offer in-service training and continuing education, to the extent that Paraguay and the countries of Central America and the Andean subregion have developed the capacity for integral management of in-service training projects based on continuing education and have produced tools to identify needs and evaluate training activities that can be used throughout the Region.
- advising on strategic matters such as employment, labor relations, competitiveness, and decentralization of health services.
- gaining qualitative improvement of health worker performance through continuing education, distance learning, and development of the ability to analyze work force performance.
- making educational materials accessible and affordable to health workers and students through the Expanded Textbook Program, which now serves more than 600 participating institutions.
- forming leaders in health through the International Health Residency Program, in which 34 professionals from 19 countries participated over the past four years.

Fellowships

To develop leaders and strengthen institutions for the countries' health sector, PAHO provided fellowships for training and study in health to 1,050 fellows from the Americas during the period 1994–1997, in addition to receiving approximately 1,100 new fellows from other regions of the world.

Fellows' fields of study.



Fellowships administered by PAHO, 1994–1997.

Country...	... of origin	... of study
Antigua and Barbuda	19	0
Argentina	33	4
Bahamas	4	0
Barbados	32	19
Belize	7	0
Bolivia	10	9
Brazil	21	56
British territories	34	0
Canada	22	19
Chile	108	105
Colombia	9	7
Costa Rica	11	20
Cuba	20	36
Dominica	21	1
Dominican Republic	2	0
Ecuador	2	2
El Salvador	29	8
French Guiana	0	3
Grenada	28	0
Guatemala	81	124
Guyana	19	0
Haiti	14	0
Honduras	40	0
Jamaica	283	389
Mexico	26	25
Netherlands Antilles	1	0
Nicaragua	35	0
Panama	7	1
Paraguay	23	1
Peru	5	1
Puerto Rico	3	0
St. Christopher and Nevis	11	0
St. Lucia	13	0
St. Vincent/Grenadines	17	0
Trinidad and Tobago	15	19
United States of America	22	95
Uruguay	12	14
Venezuela	11	7
European Region		81
Eastern Mediterranean Region		3
Western Pacific Region		10

Essential Drugs

The acceleration of free trade and regional economic integration is proving a boon to the availability, quality, and cost of drugs in the Americas. PAHO is working with all the players—representatives of the national and international pharmaceutical industry, health and drug regulatory authorities, consumer groups, and the regional economic blocs in the Andean, Central American and MERCOSUR countries—to assure that policies and practices consider not only the economic aspects of integration but those affecting the public's health as well. The Organization makes the argument that regulation is the key to rational use of drugs and is helping the countries develop national policy in the areas of drug selection, legislation, manufacture, and quality assurance. Among the gains thus far are the achievement of a technical consensus for development of common standards for drug registration in the Andean and Central American countries and the adoption by MERCOSUR countries of the Organization's requirements for good pharmaceutical manufacturing practices. Efforts to include the essential drug concept in health policies and sector reform have resulted in most countries having drawn up their essential drug list, which in turn will contribute to rationalizing drug use. In addition, through regional conferences on pharmaceutical education that bring together deans and those responsible for reforming university curricula, PAHO promotes an expanded role for the pharmacist—as a health care provider in a broad sense rather than just as a supplier and dispenser of drugs.



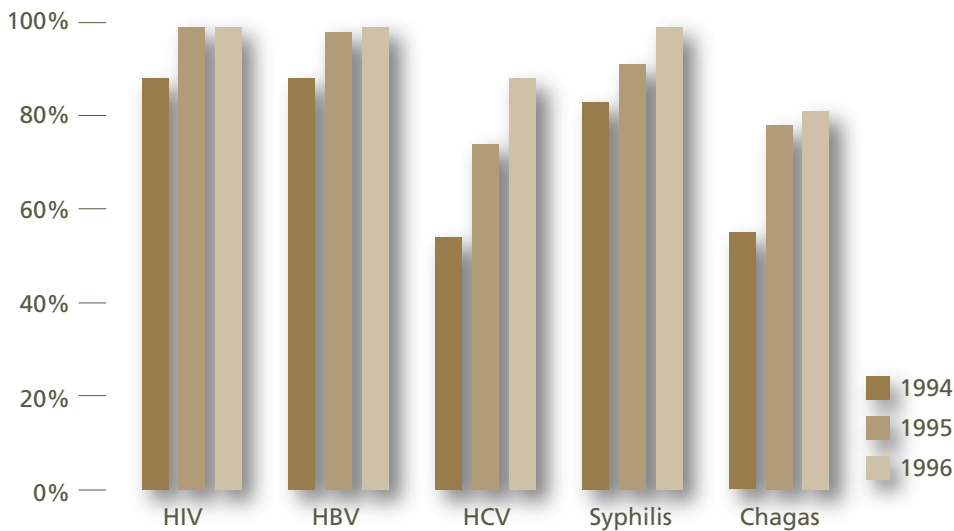
Radiological Health

Repeated failure of radiological equipment in Haiti prompted PAHO to investigate, leading to discovery of a flawed system and forcing the manufacturer to redesign it—benefiting not just Haiti but countries throughout the world that were using the equipment. PAHO helped organize shared radiology services—facilities and personnel—and a teleradiology pilot project in 11 countries in the Eastern Caribbean. In radiation therapy, which targets improved patient survival, the Organization supported regional quality assurance programs that annually monitor high-energy teletherapy equipment throughout the Region to assess whether it is functioning properly, in order to avoid patient and operator overexposure. Following endorsement in 1994 by the Pan American Sanitary Conference of the international basic safety standards for protection against ionizing radiation and for the safety of radiation sources, PAHO promoted the standards throughout the Region by fostering and reviewing national regulations, holding training courses and workshops, and disseminating pertinent information. A regional seminar held in Cuba in 1997 reached a consensus on coordinating preparedness and response programs in case of radiological emergencies.



disseminating pertinent information. A regional seminar held in Cuba in 1997 reached a consensus on coordinating preparedness and response programs in case of radiological emergencies.

Rate of blood screening in all blood banks
in selected countries of the Americas.*



*Bolivia, Colombia, Ecuador, El Salvador, Honduras, Nicaragua, Panama, Paraguay, Uruguay, and Venezuela.

With the aim of halting transmission of diseases through blood transfusions, PAHO works with the countries to establish a comprehensive program of standards and procedures, based on external quality assessment schemes, that will ensure blood safety, emphasizing the testing of donated blood for HIV, hepatitis B and C viruses, syphilis, and Chagas' disease. All but two of the countries in Latin America have passed national laws requiring serological testing for these infections. A reference laboratory network has been set up among 13 countries—Bolivia, Brazil, Colombia, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Panama, Paraguay, Peru, Uruguay, and Venezuela—to promote quality control in blood services. As a result, from 1994 to 1995 the risk of disease transmitted by blood transfusion dropped by one-half; the proportion of blood units that are screened for the five infections, as well as the testing of sensitivity and specificity, have increased significantly in the Region during the last four years; and transmission of HIV through blood has diminished to very low levels in the Americas thanks to training and direct technical cooperation by PAHO, UNAIDS, and the Spanish Ministry of Health and Consumer Affairs.

Laboratory and Blood Bank Services

As part of the regional trend toward strengthening the regulatory role of ministries of health, many of the countries have developed national standards for clinical diagnostic laboratories operating in the public and private sectors, including social security agencies, and have initiated a process of laboratory registration and external quality assessment schemes for

good laboratory practice, leading in some countries to a national accreditation system. In support of public health laboratories' efforts to bolster their epidemiological surveillance systems, PAHO promoted the establishment of a regional network for surveillance of enteric bacteria resistance to antibiotics in 15 countries in Latin America and the Caribbean.

Health Services Physical and Technological Infrastructure

PAHO's work in support of health services physical and technological infrastructure encompasses many operational concerns, among them safety and biosafety; efficient use of energy; environmental sanitation, especially in hospitals; and structural sturdiness in the event of disasters. A Netherlands-funded, PAHO-executed project to strengthen engineering and maintenance services in health establishments in Central America resulted in the six countries of the isthmus adopting policies, organizing programs, training professionals, and disseminating information—taking full advantage of the Internet—all of which has significantly bolstered the region's health infrastructure. The success of the project has prompted the Andean countries to propose a similar one for their region.

The emergence of new technologies and the need to improve and increase equipment available to health services is requiring different skills of those who manage and operate engineering and maintenance services. PAHO is helping the countries provide for the education of hospital and clinical engineers and set up and train groups responsible for administering new technologies.





Indigenous Health

More than 43 million indigenous people live in the Americas. Although information regarding their health status and disease profile is unreliable, studies have pointed up the need to intensify efforts to eliminate serious and widespread inequities in their health situation and in the health services at their disposal. The PAHO Directing Council approved an indigenous peoples' health initiative in 1993 that proposed an integral approach to indigenous health, the right of indigenous communities to self-determination, and respect for indigenous cultures and their revitalization. PAHO has worked with the countries to strengthen capacity and develop alliances; launch national and local projects in priority program areas; and disseminate scientific, technical, and public health information.

Rehabilitation

To assure full integration of the disabled into society and equity of care for those with disabilities, PAHO conducted studies to assess the number of people with disabilities in Latin America and the Caribbean and sought to assure rehabilitation services for the disabled by promoting national policies, providing training, and coordinating the involvement of many agencies. Activities targeted health promotion and disability prevention, as well as incorporation of a community-based rehabilitation strategy.

Ocular Health

Working with a number of nongovernmental organizations, PAHO has provided direct technical support to 27 countries in the Region to develop blindness prevention plans and programs; prepared a draft regional policy on ocular health to be included in the basic health packages under consideration as part of health sector reform; provided training; and facilitated the manufacture of low-cost eyeglasses that were distributed to over 42,000 people in 20 countries at a savings of over US\$2 million.

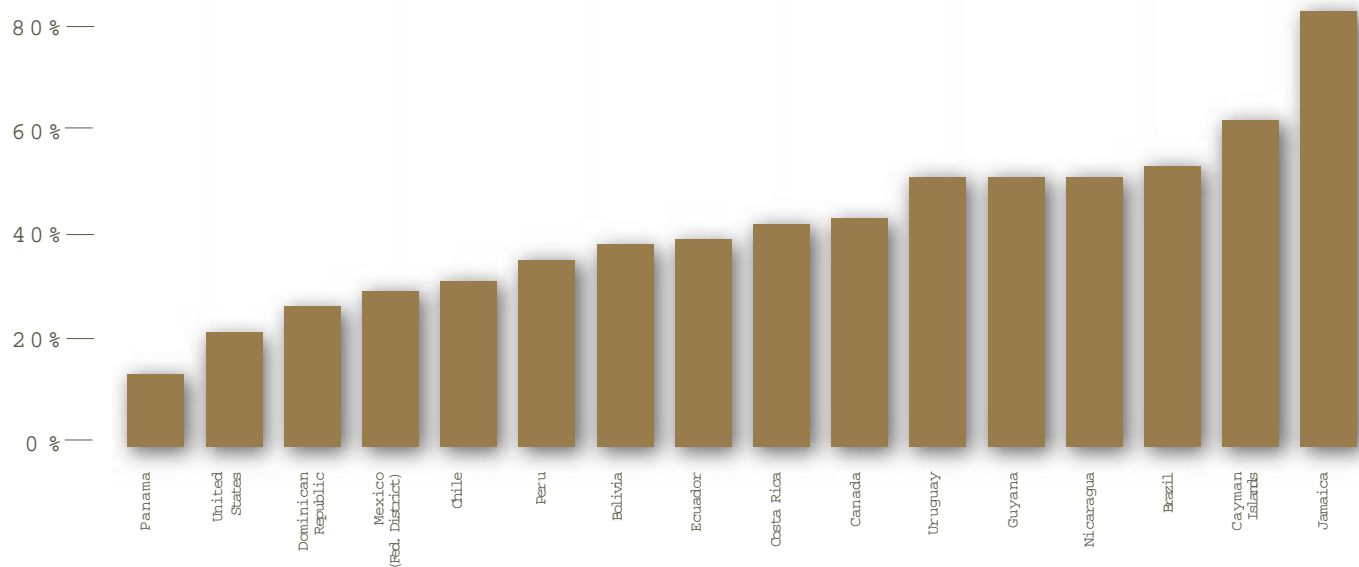


Health Services Information Systems

Information systems and informatics are vital to the countries' determination to improve their people's health, quality of life, productivity, and, more specifically, to manage their health services. PAHO therefore promotes, coordinates, and supports development of national health information systems and, in general, information management in health services by preparing guidelines, standards, and specifications; supporting the selection, purchase, and development of applications; providing health professionals education and training; and seeking strategic alliances with other entities to advance these systems in the Region. PAHO installed a drug information management system in Brazil, Colombia, Jamaica, Mexico, and Venezuela, and helped garner funding from the W. K. Kellogg Foundation to develop and train health informatics professionals in the English-speaking Caribbean with the aim of improving information management systems for community health services.



Dramatic progress in reducing dental caries in the Americas: Percentage reduction in caries over the past decade.



Oral Health

The best way to assess people’s dental health is by determining the number of decayed, missing, and filled teeth, or DMFT, they have. PAHO has used this indicator to analyze the situation in all the countries of the Americas and, on that basis, to tailor its regional strategy. The multi-year oral health plan places countries into three groups: “emergent” (most needy)—those with more than 5

DMFT per child at the age of 12; “growth”—those with 3–5 DMFT; and “consolidation”—those with established programs and with fewer than 3 DMFT per child—the goal for the Region. Jamaica has already met that goal, and Chile, Costa Rica, Ecuador, Mexico, Panama, and Uruguay are on the verge of attaining it.

PAHO has partnered with numerous agencies, most notably the W. K. Kellogg Foundation, to improve the countries’ oral health conditions, emphasizing those with

the greatest burden of disease, and to help them develop accessible, effective, and sustainable oral health services. Studies, training, surveillance, information dissemination, and the promotion of national legislation in support of fluoridation have rendered dramatic results.

PAHO’s ability to attract over US\$2.5 million in extrabudgetary funds for oral health in the past two years testifies to the success of its efforts in this area.



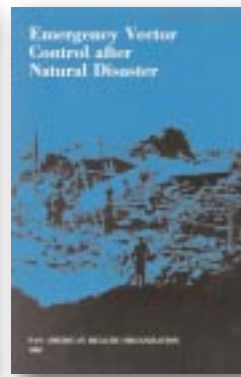
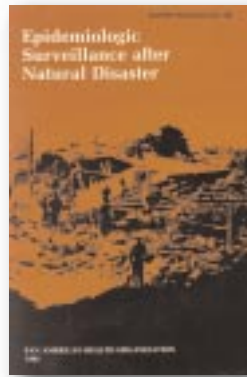
PAHO is helping the countries develop the capacity to produce fluoridated salt for preventing dental caries.

Towards a hemisphere of healthy smiles

Dental problems are becoming a thing of the past thanks to fluoride: today, for 6 cents per child per year, a country can fluoridate its salt and eliminate dental caries among its children. Jamaica—with an 84% reduction in dental caries—has proved it’s possible.



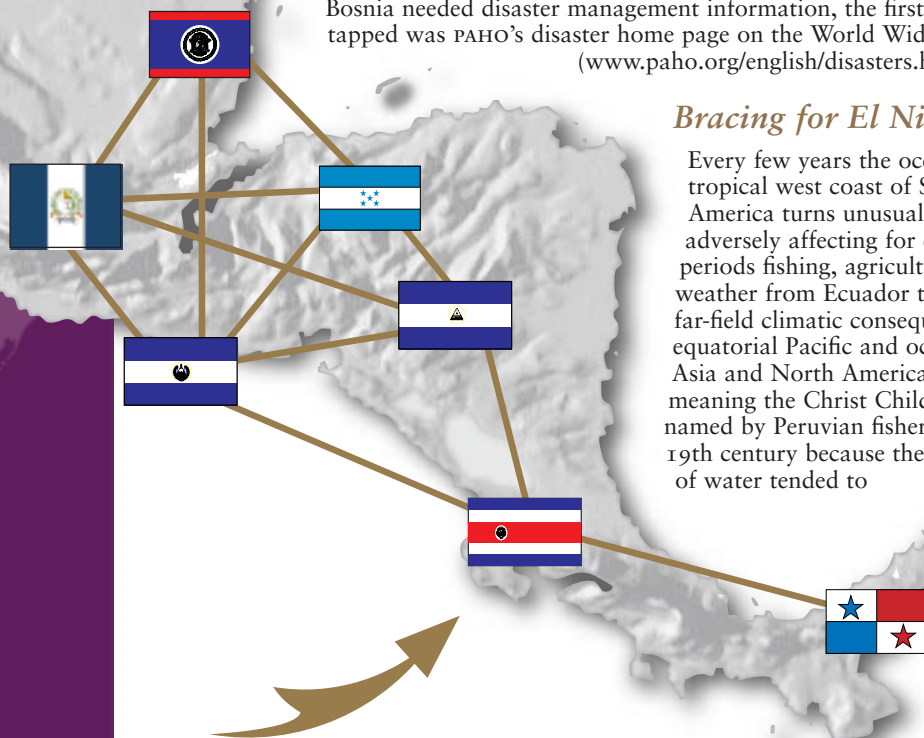
PAHO's publications on emergency preparedness and disaster relief have been bestsellers—sold out and reprinted numerous times and often translated. Shown here is the Japanese translation of PAHO's Health Service Organization in the Event of Disaster, which Japan's Bureau of International Cooperation undertook following the Kobe earthquake.



Networking to Prepare for Emergencies and Relieve Disasters

Latin America and the Caribbean are highly vulnerable to natural and manmade disasters. PAHO works closely with the countries to strengthen their ability to deal with disasters, to enact the necessary policies and build community awareness about disaster preparedness, and, when disasters strike, to assess health needs and manage humanitarian supplies. The Region boasts many experts in the field of disaster management—from physicians to structural engineers to supply logisticians—working in the health sector but also civil defense, planning, nongovernmental organizations, as well as other sectors. To enable these experts to share experiences and pursue common objectives, PAHO, in collaboration with the U.S. National Aeronautics and Space Administration and the European Union, set out in 1995 to harness the power of the Internet, first launching an electronic disaster management project in Central America. The aim of the project was two-fold: to improve communication by making the

Internet's basic, practical services—electronic mail, FTP, and discussion groups or listservs—available to an electronic network connecting disaster managers and to make it easier to access global sources of disaster information. User training and technical support were important strategies. The project was such a success that now hundreds of nationals communicate regularly via e-mail, and several major Web sites have been developed including one offering online Internet access to a database of more than 11,000 articles, books, and technical documents on disasters (www.netsalud.sa.cr/crid). Testimony to the usefulness of the network is the flurry of messages exchanged when Hurricane Caesar hit Nicaragua and Costa Rica in 1996. And the beneficiaries of PAHO's Internet endeavors range far afield: when health workers in Bosnia needed disaster management information, the first site they tapped was PAHO's disaster home page on the World Wide Web (www.paho.org/english/disasters.htm).



Bracing for El Niño

Every few years the ocean along the tropical west coast of South America turns unusually warm, adversely affecting for extended periods fishing, agriculture, and local weather from Ecuador to Chile, with far-field climatic consequences in the equatorial Pacific and occasionally in Asia and North America. El Niño—meaning the Christ Child and so named by Peruvian fishermen in the 19th century because the warm flow of water tended to



when countries in the Region channeled resources for damages following the disaster, this time most of the funds went to preparedness and mitigation.

PAHO cooperated with the countries on general emergency preparedness; epidemiological surveillance of vector- and waterborne diseases such as malaria, diarrhea, and leptospirosis; environmental health; public education; and other public health measures that have strengthened the capacity of ministries of health. In addition to cooperating with the countries in preparing emergency projects and relief responses, PAHO is spearheading a study of the relationship between infectious disease outbreaks and this phenomenon that fosters an eco-epidemiological approach to health management in the Americas and aims to prepare communities in El Niño's way to protect themselves from its harm. ■

come around Christmas time—causes extremes in precipitation, temperature, and humidity, and these climatic factors can be detrimental to the public's health and welfare. El Niño hit especially hard in 1997–1998, causing heavy rainfalls in the equatorial region of South America; major flooding in Ecuador, Peru, Chile, Bolivia, Colombia, Brazil, and Central America; and greater than normal precipitation along the Pacific coastline of Mexico and the United States. Although no causal relationship has been proven between this natural disaster and major outbreaks of communicable diseases, the risk of transmission of water-, food-, and vector-borne diseases such as cholera, malaria, and dengue is greater when the public works infrastructure and health services are disrupted. In contrast with the occurrence of El Niño in 1982–1983,





*Promoting &
Protecting People's
Health*

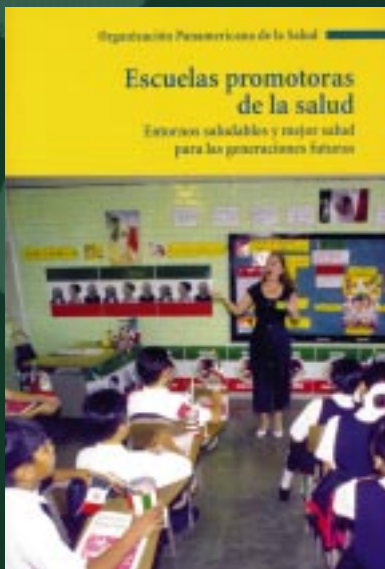


THE COMMITMENT

In 1994, the Pan American Sanitary Conference instructed the Bureau to orient its technical cooperation with the countries to:

- foster social development based on the principles of equity and the right of all people to health and well-being through the formulation and application of health-oriented public policy relating to food and nutrition, drug addiction and smoking, and prevention and control of violence;
- encourage the development of a culture of health founded on a healthy environment and the adoption of lifestyles that promote health through the development of strategic interventions designed to create healthy options for the population;
- support the development of the health sector's capacity to identify and lead intersectoral processes that will promote and protect physical and mental health, recognizing that it is at the local level that health promotion and protection activities must be implemented, and supporting local efforts to mobilize resources and improve health and well-being;
- support the generation, evaluation, dissemination, and use of information relating to health in general and health promotion and protection in particular;
- promote the development of policies and programs relating to population issues, reproductive health, fertility regulation, and the health concerns of adolescents and children, and enhance the coordination of health promotion activities and reproductive health services;
- seek continued improvements in the nutritional status of all population groups, promoting breastfeeding as an important strategy for ensuring good childhood nutrition.

THE RESULTS



Health-promoting schools contribute to social and economic development, increased productivity, and a better quality of life for all by promoting the healthy development of youth.



Tapping Social Capital for Community Health

Social capital—a force comprising an intricate web of relationships, norms of behavior, values, obligations, and information channels—can provide the ties that lead to a community's well-being and prosperity. More specifically, community bonds can serve as a powerful agent of change in health. PAHO has therefore fostered a healthy settings movement—encompassing municipalities, cities, communities, schools, and workplaces—in all the countries of the Americas. Networks of healthy municipalities and health-promoting schools have evolved, providing important vehicles for practitioners, researchers, and teachers in the countries to share their experiences and identify good practices. Each municipality prepares a plan of action, based on priorities identified by the people, that demonstrates political commitment, allocates resources for inclusion of health promotion and human welfare in local development, and assures full involvement of the community in efforts to improve environmental and social conditions. Sharing experiences and information has been the objective of PAHO-sponsored international meetings of municipal health secretaries (Fortaleza, Brazil, 1995, and Havana, Cuba, 1997) and of mayors (Campinas, Brazil, 1996, and Boca del Río, Mexico, 1997). PAHO has also supported the founding of the Latin American Network of Health-promoting Schools, which first convened health and education sector representatives from 14 countries in San José, Costa Rica in 1996 and which brought together representatives from 22 countries at its latest meeting in Mexico in 1998.



Among the healthy settings projects in which PAHO is cooperating...



Chile

The national plan of action for healthy communes set up a planning committee of public and private sector representatives committed to community involvement in delivering primary health care. The communes of Viña and Quillota have established healthy hospitals, and several others have adopted a primary environmental care strategy to deal with solid waste and industrial pollution.



Colombia

"Healthy communities for peace" target prevention of violence, with community members-political, civil, military and religious leaders, private and public entities, business executives and workers, individuals and families-dedicating their efforts to improving living conditions, fostering healthy environments, and strengthening community well-being.



Cuba

A network of 57 healthy settings comprises schools, markets, cooperatives, communities, universities, workplaces, and clinics. Schools promote students' understanding of diet, personal hygiene, and sexually transmitted diseases as well as better lighting, ventilation, and equipment. High-risk pregnant women cared for in maternal cooperatives are nourished by wholesome food from farmers' associations, resulting in the lowest rate of perinatal deaths in 1997 ever recorded in the country. Popular councils foster better nutrition, water supplies, sanitary latrines, and healthy living conditions.



Costa Rica

In 1996 the PAHO Country Office instituted an annual award for the best proposals to create healthy "cantones," with first and second place prizes of US\$6,000 and \$2,000 to be used for improvements in local health and environment. Granted by a committee of public sector and PAHO representatives, the award serves to stimulate sound health and environmental planning and programming. Canton projects submitted for the award range from sanitary landfills, to waste recycling and anti-littering campaigns, to prevention of drug abuse.



Panama

A network of "municipios for the 21st century" has strengthened community health committees' role in local health promotion and local development. A project to develop health-promoting schools has brought together the health and education sectors to analyze students' needs and how best to address them, resulting in a student health program emphasizing health promotion.



Peru

Local authorities and neighborhood leaders in the municipality of Tacna prepared a strategic plan for environmental management and health improvement that resulted in construction of a sanitary landfill, creation of green areas irrigated with treated wastewater, and attention to air and land pollution.



Trinidad and Tobago

Each region of the country has developed healthy communities based on their members' identification of priority needs: to control pests (rats, cockroaches, flies, and mosquitoes), the Don Miguel Women's Group sought training as litter wardens; to compensate for lack of land for home gardening, the La Beta Self Health Group in Beetham Gardens learned container gardening; and to address the problem of neglected children, the Capildeo Lands Settlement Community Group gave training in parenting skills to a cadre of mothers, who in turn are teaching those skills to mothers of families at risk.



Paraguay

A committee to promote healthy communities identified national and international institutions operating at the local level, elaborated a "basket of available technical resources" to support local needs-especially elimination of measles and Chagas' disease-and disseminated information in support of the movement, leading to organization of 13 municipios and a proposal to develop health-promoting schools.



Health of Adolescents

PAHO has pioneered an approach to adolescent health based on a plan of action, adopted by the Directing Council in 1997, that advocates placing the issue on the political agenda; improving countries' ability to satisfy adolescents' needs by adopting public policies and preparing human resources; strengthening adolescent health plans, programs, and services; developing networks of professionals and institutions working in adolescent health; and promoting adolescents' participation in their and their communities' health. As a result of the plan and PAHO's technical cooperation in this area: Argentina, Brazil, and Mexico have developed national and state programs for the integral health of adolescents with health services, counseling, and education components; the English-speaking Caribbean countries have taken the lead in health-promoting schools where students are taught lifestyle changes, development of healthy eating habits, and prevention of problems caused by smoking, drug abuse, and sexual promiscuity; and adolescents in many countries are acting as agents of social change, as exemplified by AYUDA—American Youth Understanding Diabetes Abroad—a group of adolescents in the United States that supports the cause of diabetic adolescents in Ecuador.



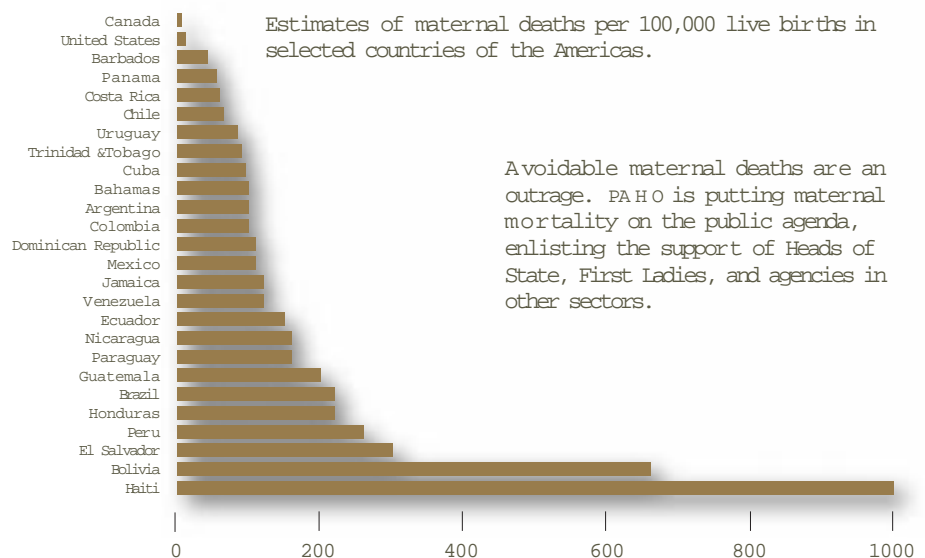
Mass media campaigns supported by the government and often the First Lady aimed at reducing maternal mortality have been launched in Bolivia, Ecuador, Mexico, and Peru.

Making Motherhood Safe

Each year around 26,000 women in the Americas lose their lives as a direct consequence of being pregnant. The vast majority die for want of timely, accessible, and competent care—tragic deaths made all the more so because of the loss they represent to the women's families. To make death in childbirth a thing of the past, PAHO promotes pregnant women's access to quality prenatal care and delivery, obstetric emergency services, sex and reproductive health education, and family planning. Progress to date in this area includes: 13 countries with national health plans to reduce maternal mortality; a regional project sponsored by PAHO, USAID, and Mother Care and Quality Assurance to improve emergency obstetric care in 11 countries; another PAHO project with UNFPA to prevent adolescent pregnancies

in 14 countries; and the leadership of First Ladies in the countries in support of safe motherhood. The emphasis is on improving the quality of care through better management and participative approaches; one such approach in Bolivia resulted in a doubling of the national hospital occupancy rate in a two-year period.

The Latin American Center for Perinatology and Human Development (CLAP) focuses its efforts on improving the perinatal health of mothers and newborns. The Center has developed a common data registry system for the Region that makes it possible to establish regional priorities; has produced a series of evidence-based norms, procedures, and technologies; and has trained thousands of health workers in perinatology.

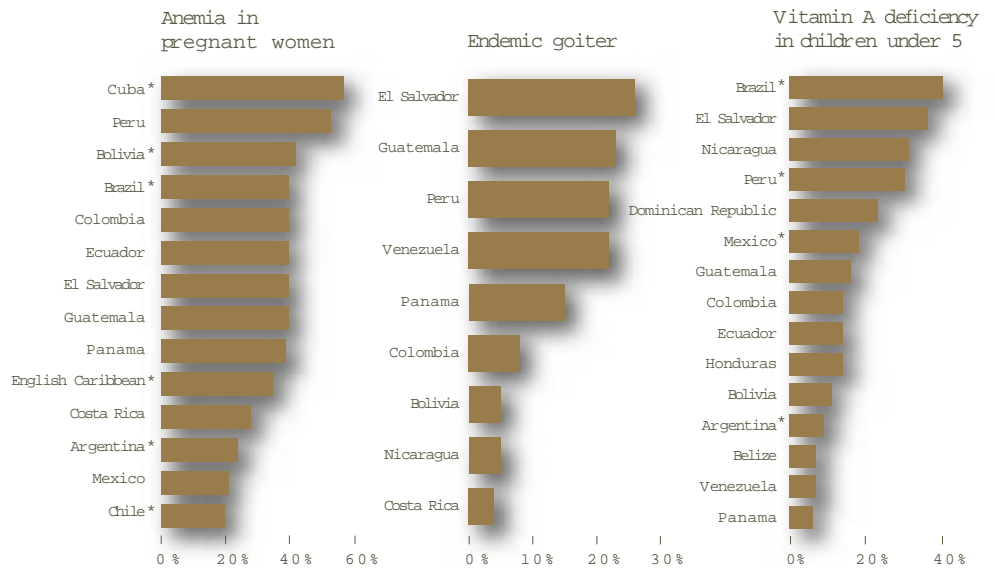


Avoidable maternal deaths are an outrage. PAHO is putting maternal mortality on the public agenda, enlisting the support of Heads of State, First Ladies, and agencies in other sectors.

Promoting Healthy Diets and Good Nutrition

With the aim of improving people's nutritional status, PAHO and the countries are targeting three micronutrients: iron, iodine, and vitamin A. As part of their national food and nutrition plans, 18 countries—Argentina, Barbados, Belize, Bolivia, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Jamaica, Nicaragua, Panama, Peru, Trinidad and Tobago, and Venezuela—have put in place low-cost programs to fortify food with iron and, in some cases, folic acid in order to reduce the high prevalence of iron-deficiency anemia and neural tube defects, respectively, targeting young children and pregnant women in particular. Another major advance is the fortification of salt with iodine, resulting in three countries—Bolivia, Colombia, and Ecuador—having been declared free of iodine-deficiency disorders, principal among which is endemic goiter. Fortification of sugar with vitamin A has been carried out in countries with a high prevalence of vitamin A deficiency.

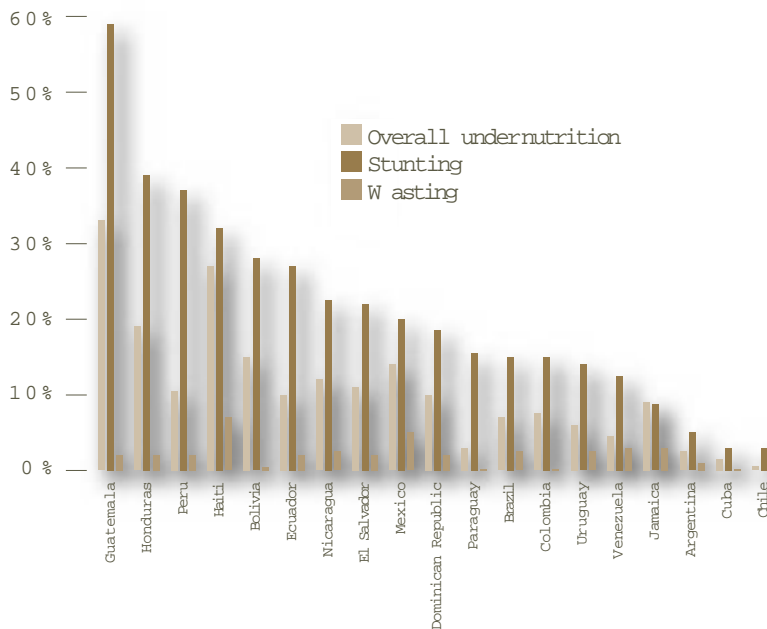
Nutrition-related problems PAHO and the countries are determined to solve (bars show percentage of the population affected in selected countries).



*Estimates based on partial, not national, studies.

At the same time, the Organization is researching the current situation of obesity in the Region and advocating its designation as an emerging health problem. PAHO's two centers—the Caribbean Food and Nutrition Institute (CFNI) and the Institute of Nutrition of Central America and Panama (INCAP)—work with the countries in their regions to deal with protein-energy malnutrition, micronutrient deficiencies, and obesity.

Protein-energy malnutrition in children under 5 is on the decline due to a number of specific interventions, among them the promotion of breastfeeding.



PAHO has revamped the concept of dietary guidelines as practical indications to help people select and consume better food and thereby attain their nutritional goals, taking into account their dietary habits and social, economic, and cultural factors; 13 countries—Argentina, Brazil, Costa Rica, Chile, Cuba, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, the United States, and Venezuela—have implemented or are in the process of validating these guidelines. Shown clockwise from top right, are the guideline icons of Canada, Chile, and Guatemala.



Mental Health

Demographic and social changes under way in the Americas are increasing people's mental health care needs. In support of countries' efforts to address those needs, PAHO/WHO, the World Federation for Mental Health, the Carter Center, and Harvard University among others convened an international meeting of women leaders—many of them First Ladies—for mental health (PAHO Headquarters, 1996) with representation of 20 countries in the Region. Participants signed a declaration that committed them personally to promote mental health in the Americas. Since then the First Ladies have participated actively every year in World Mental Health Days on 10 October and presided over national advisory committees on mental health. In 1997, PAHO's Directing Council reviewed the Bureau's activities in this area and urged that countries carry out mental health programs as an integral component of national health plans and that they reorient mental health services from an institutional to a community approach. The Council's initiative has served as a model for other regions in the world.



In Trinidad and Tobago, with PAHO's support, the government declared all public offices "smoke-free" on World No Tobacco Day and the Minister of Health announced that, thenceforth, smoking would be banned at all institutions under the ministry and a national no-smoking policy would be developed.

Fighting Tobacco, Drugs, and Alcohol

In countries throughout the Region, PAHO is working with the Organization of American States to boost the efforts of national commissions to control and prevent the abuse of harmful substances—efforts aimed at developing national programs, enacting legislation and regulations, and accrediting treatment centers. In support of the Region's interagency tobacco and health action plan, PAHO provides training and information, conducts baseline and epidemiological studies, and mobilizes funds to promote anti-tobacco legislation, smoking cessation programs, and smoke-free environments. PAHO is also working with three collaborating centers in Canada, Costa Rica, and Mexico to develop knowledge and standards for monitoring public drinking and designing public policies on alcohol-related health issues.

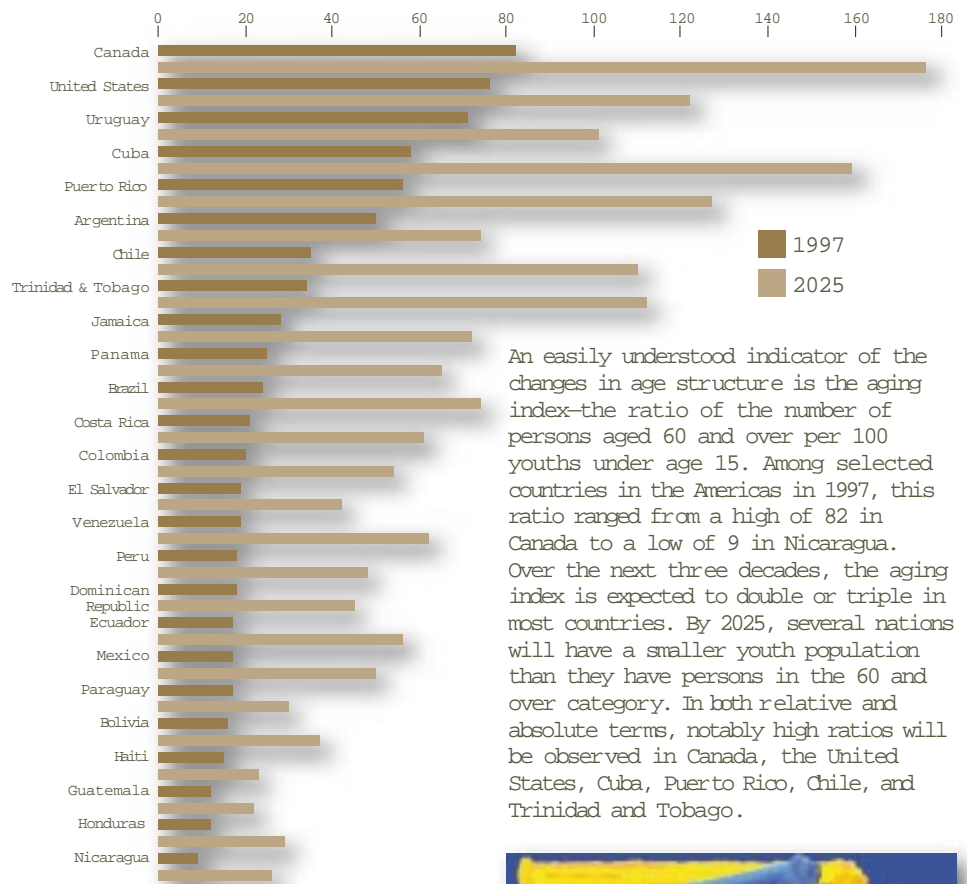


First Ladies and other leaders from throughout the Americas have committed to promote mental health in the Region.

Health, Well-being, and Aging

How healthy are people 60 and older? What illnesses, handicaps, and pains do they suffer? Do gender, income, and education make a difference in their health? What makes for a healthy old age? What kind of relationships do older adults have with younger members of their families? How does the aging of a population affect the operation of health insurance systems? The answers to these and many other questions are the focus of a regional study on health, well-being, and aging that PAHO is coordinating among universities, collaborating centers, and ministries of health in Barbados, Brazil, Chile, Costa Rica, Cuba, Mexico, Uruguay, and the United States that will collect, compare, and analyze data in metropolitan areas of the selected countries. PAHO and the Latin American Parliament sponsored an international forum on aging (Montevideo, 1997), with 115 delegates from 21 countries throughout the Region issuing a declaration that recommends changes in attitudes about aging, promotes actions aimed at eliminating age discrimination and bias, and proposes a comprehensive healthy aging policy that encompasses social security and medical care services, health promotion and social well-being, housing and community services, intergenerational relations, and active aging. In Chile, the Ministry of Health has developed national guidelines for the health care of older persons; Uruguay has created the National Institute of Aging; and Guatemala has developed a national plan on aging. ■

Aging index in selected countries of the Americas.



An easily understood indicator of the changes in age structure is the aging index—the ratio of the number of persons aged 60 and over per 100 youths under age 15. Among selected countries in the Americas in 1997, this ratio ranged from a high of 82 in Canada to a low of 9 in Nicaragua. Over the next three decades, the aging index is expected to double or triple in most countries. By 2025, several nations will have a smaller youth population than they have persons in the 60 and over category. In both relative and absolute terms, notably high ratios will be observed in Canada, the United States, Cuba, Puerto Rico, Chile, and Trinidad and Tobago.



In Panama, as part of the healthy municipalities initiative, a situation analysis in two health regions pointed up the importance of involving the elderly in communities in determining their health needs and resulted in local action plans for the regions' health services.



A close-up photograph of a young child with curly brown hair drinking from a water fountain. The child is wearing a red jacket with a tan textured patch on the shoulder. The background is a chain-link fence. The text "Protecting & Developing the Environment" is overlaid in white cursive font at the bottom of the image.

*Protecting &
Developing the
Environment*



THE COMMITMENT

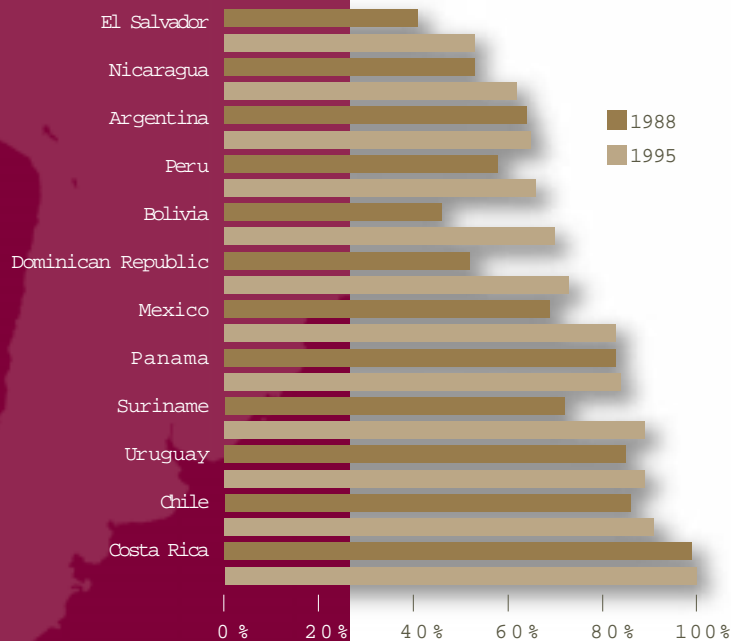
In 1994, the Pan American Sanitary Conference instructed the Bureau to orient its technical cooperation with the countries to:

- ensure implementation of the Regional Plan for Investment in the Environment and Health;
- develop the managerial, financial, and planning capacity of the sector and its institutions in the areas of drinking water supply, sanitation, solid waste disposal, and protection of water sources;
- support technological development, research, and human resource training in the areas of evaluation and control of environmental hazards, including risks to human health in work environments;
- promote respect for the principles of universality and equity in the delivery of basic sanitation services, as well as respect for the right of “informed consent” with regard to the placement of infrastructure works, industry, services, and any other activity that might be detrimental to health or well-being;
- support the institutional and organizational development of the various entities and agencies responsible for environmental and natural resource management, including local governments, communities, and other types of governmental and nongovernmental organizations.

THE RESULTS

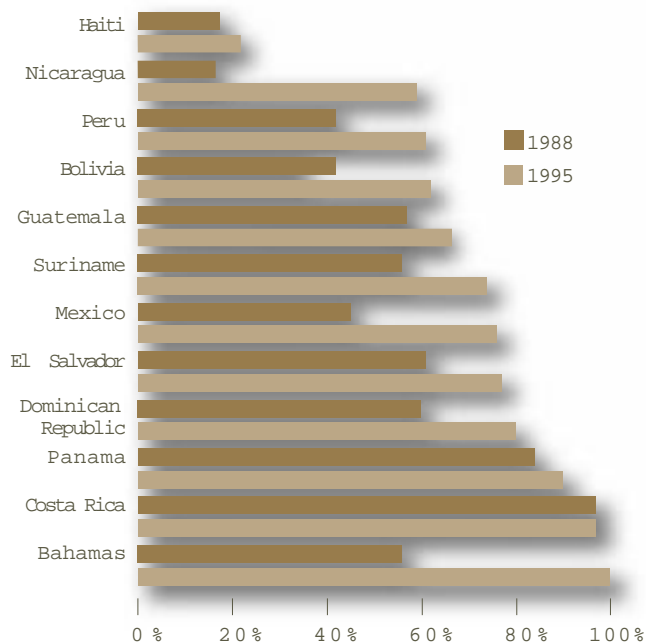
Linking Environment, Health, and Development

To cultivate a shared understanding of the interplay among health, environment, and development and to devise mechanisms in support of it, PAHO sponsored the Pan American Conference on Health and Environment in Sustainable Human Development (Washington, D.C., 1995), bringing together 340 political and social leaders, including 78 ministers and vice-ministers of health, environment, finance, and planning. With support of the IDB, World Bank, OAS, UNEP, and UNDP as well as of numerous nongovernmental organizations and universities, the Conference culminated in a Pan American Charter of principles undergirding sustainable development and a regional plan of action that identifies priorities to further socioeconomic development in accordance with people's well-being, a protected environment, and appropriate use of natural resources. As a direct result of the Conference, and with the aim of integrating health, environment, and development, 14 countries have made formal political commitments, 7 have initiated national plans of action, 5 have reengineered their sector institutions, and 17 have set up permanent working groups. At the Summit Conference of the Americas for Sustainable Development (Santa Cruz de la Sierra, Bolivia, 1996) and at various subregional meetings, the countries' heads of state have reaffirmed their endorsement of the Charter.



Improved rates of water supply coverage in selected countries of the Americas.

Improved rates of sewage and excreta disposal coverage in selected countries of the Americas.



Supplying Households Safe Drinking Water

Unsafe drinking water can trigger many illnesses—among them, hepatitis, diarrheal diseases, and cholera. Yet proportionately large numbers of people throughout the Region lack access to drinking water services. As alternatives to a public supply system, practical, simple, low-cost technologies to disinfect and store household water are at the core of a project sponsored by PAHO, the government of Peru, and the Adventist Agency for Development and Assistance Resources. The project has enabled five communities in Peru’s coastal, mountain, and jungle regions to establish a source-to-consumption system to disinfect water used for drinking and food preparation. Today those communities, which have assumed the costs of the systems, have made water disinfection part of their daily lives and, as a result, significantly improved their health conditions. Now PAHO is arranging to launch a similar project, on a larger scale, to benefit some 200,000 people throughout the Andes.

A largely indigenous population in Darién, Panama, has benefited from PAHO’s orchestration of efforts to improve basic environmental sanitation in the province: Bolivian experts have shared manual well-drilling, pump, and sanitation technologies and taught the community how to build and use them; Nicaraguan experts have given courses on acute diarrheal disease diagnosis and treatment, water disinfection, and construction and use of household sand filters for water clarification; and a private U.S. company has donated solar-powered water disinfection equipment.

MASICA Stands for Environment and Health in Central America

At this decade’s outset, following years of strife and suffering, the countries of Central America began to build a future founded on peace, democracy, and development. Recognizing the importance of a sound environment and a healthy populace, they sought PAHO’s cooperation in building the managerial capacity to control environmental risks that threaten health, endanger ecosystems, and compromise the very resources necessary for development. PAHO, with critical financial support from the Nordic countries, responded by launching MASICA—the Spanish acronym for the program. MASICA catalyzes governments’ and civil society’s efforts to effect the political commitments they have made to integrate the environment, health, and development.





Removing Arsenic from Water, Improving Rural Health

Arsenic in rural communities' drinking water supplies affects the health of millions of people in the Americas and can lead to skin discoloration, foot and hand deformities, and various forms of cancer. A serious problem in Argentina, the country sought PAHO's cooperation in 1994 on a project to reduce sickness and death due to excessive levels of arsenic. The project uses a multisector, multidisciplinary approach to update environmental and epidemiological analyses and to test new technologies to reduce arsenic in rural water sources, explore the economic feasibility of their broad-scale use, and then apply them. PAHO's Pan American Center for Sanitary Engineering and Environmental Sciences (CEPIS) developed a product to reduce arsenic in water—ALUFLOC—that has had positive results and is now being developed commercially by a private laboratory in Argentina. A pilot project in the province of Salta demonstrated that the community accepts the reduction methodology, the product can be made locally, and the treated water is better physically, chemically, and bacteriologically. The approach has now been applied in all countries of the Region that have this problem and is being adapted as far afield as Bangladesh.

The International Development Research Center of Canada (IDRC) and the Technical Cooperation Agency of Germany (GTZ) have been powerful partners with PAHO for environmental health in the Americas.



Controlling Exposure to Pesticides in Central America

With PAHO cooperation and Danish government funding, the seven countries of Central America started a project—PLAGSALUD—in 1994 to build a fund of information about the effects of pesticides on health and to devise better means of controlling the risk factors of occupational and environmental exposure to pesticides. Epidemiological surveillance systems throughout the isthmus have developed a common chart for registering cases of acute pesticide poisoning; have prepared a regional course on pesticide surveillance; and have improved registration of cases, which in turn has enabled the countries to control acute pesticide poisoning outbreaks.



Throughout Nicaragua local committees—comprised of representatives from the health, labor, environment, education, political, and law enforcement sectors—have formed to deal with problems arising from exposure to pesticides. Following an analysis of the committees' work, PAHO and national authorities recommended that the country's efforts concentrate in those municipios where pesticide poisoning poses the greatest threat, that municipios exchange experiences, and that all sectors commit to success of the project. Now municipios are monitoring biological exposure to pesticides, controlling agrichemical wastes, and training students and teachers to prevent pesticide poisoning. In Panama numerous multinational agencies, national sector institutions, and local groups are working together to deal with problems arising from inadequate use of, and ready access to, pesticides.



*Reducing wastes in the Caribbean—
With PAHO's cooperation, the countries of the Caribbean struck an alliance in 1997 to promote waste reduction on all the islands in the region by bolstering recycling efforts and organizing community involvement in the campaign.*



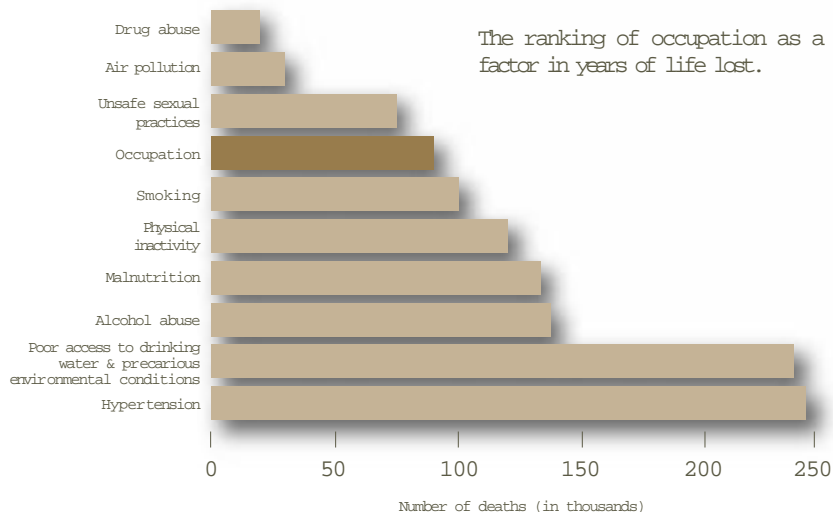
Managing Wastes, Assuring Sustainable Development

Since toxic and hazardous substances pose serious threats to people's social and economic development, all society has a vested interest in their management—the producers of goods and services, the governments that regulate industry, and communities at large. Minimizing the production and improving the management of these wastes are the primary objectives of REPAMAR—a regional network of national networks in Argentina, Brazil, Colombia, Costa Rica, Ecuador, Mexico, Panama, and Peru that is coordinated by CEPIS and financially supported by the Technical Cooperation Agency of Germany (GTZ). To achieve its objectives, the network is building consensus among all parties about the importance of managing toxic and hazardous wastes, disseminating information and training business and academic leaders to garner support for the initiative, fostering legislation and regulatory mechanisms, promoting appropriate technologies and approaches such as recycling, and conducting pilot projects—among them, projects on the rational use of water in dry cleaners, control of the environmental impact of chemical products from the textile industry, and reuse of solid wastes from tanneries.

Eliminating Lead in Gasoline Throughout the Americas

Exposure to lead—a chemical agent that, once ingested, does not decompose—causes serious health problems. Leaded gasoline is typically responsible for 90% of the lead in the atmosphere in most urban areas where leaded gasoline is still in use—representing an immediate health risk through inhalation, accumulating in the soil, contaminating drinking water, and entering the food chain. PAHO is therefore collaborating on a multi-agency project to assist governments in formulating and implementing national plans to eliminate leaded gasoline. By yearend 1997, 14 countries in the Region had eliminated lead from gasoline: Antigua and Barbuda, Argentina, Bahamas, Bermuda, Bolivia, Brazil, Canada, Colombia, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and the United States; nine others have targeted elimination in the near term.





The ranking of occupation as a factor in years of life lost.

In Latin America and the Caribbean, "occupation" ranks as the second most important risk factor for years lived with disability; the fourth for years of life lost; and the seventh for attributable mortality.

Enhancing Workers Health in Latin America and the Caribbean

In light of the close relationship between occupation and health, PAHO cooperates with all the countries of the Region to improve the health and welfare of workers as part of a general strategy to attain social progress and economic development, justly and equitably.

As a result of PAHO's efforts to foster national and regional plans in this area, the CARICOM countries formally recognized workers' health as an environmental priority in the Caribbean Cooperation in Health Initiative.

The Organization is allying with private industry to promote "healthy workplaces" throughout Central America and the Caribbean as well as in Chile, Colombia, and Mexico. ■

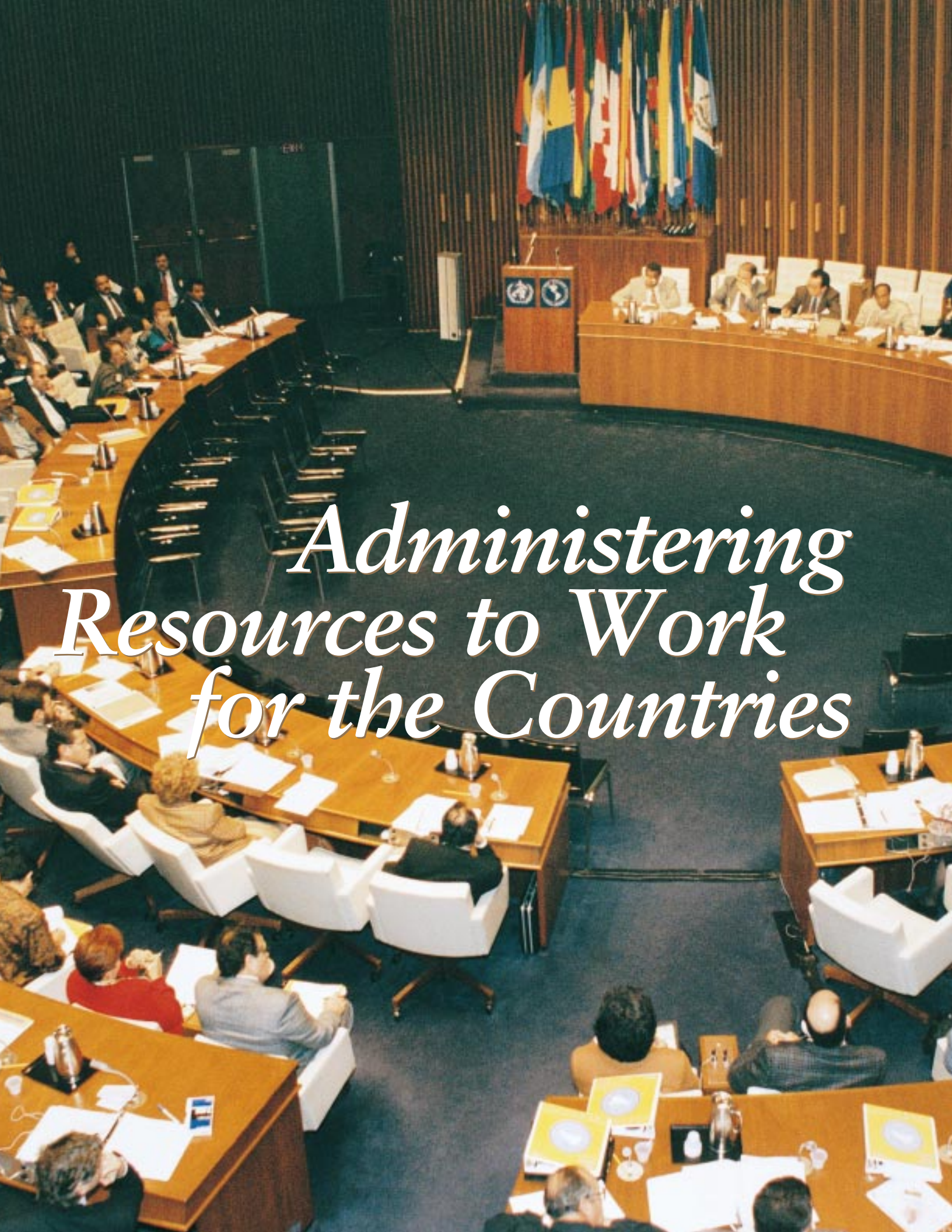
"WIZARD"—an information system made available through PAHO's Web site www.paho.org/english/hep/hepwizar.htm—enables workers' health programs to take preventive actions based on the identification of occupational risks, their association with morbidity and mortality, and calculation of the costs of occupational diseases and accidents.



PAHO and the government of Canada collaborated to improve the health of workers in the Caribbean by reviewing policies and plans, promoting a

common understanding of the issues—among them, substance abuse, HIV/AIDS, health promotion, training, research, and information systems—and devising appropriate strategies.





*Administering
Resources to Work
for the Countries*



THE FOCUS

PAHO is participating in a worldwide movement, based on a rethinking of the issue of governance and the role of governments, that is reforming the purpose and practice of international public service. Countries are putting forward proposals to make the policies of the international cooperation system work effectively for them, through better coordination among the myriad of United Nations agencies at the national level, while recognizing the normative function and unique mandate of specialized agencies such as PAHO. Partaking of the changes afoot, and with the guidance of the Governing Bodies, PAHO took numerous steps to improve its efficiency and effectiveness, among them a streamlining of its planning and programming system (AMPES), establishment of a formal institutional review of extrabudgetary projects, and involvement in a pilot program in Guatemala to evaluate the feasibility of coordinating UN country activities and to create decentralized PAHO/WHO “mini” offices to support local health projects. These reforms will result in even better delivery of cooperation in health with and among the countries of the Americas.

THE RESULTS

Budget and Finance

The Organization continuously reviews and reengineers its administrative processes, seeks to decentralize authority, and follows sound managerial practices—approaches that have resulted in PAHO's having among the lowest administrative service costs of all international organizations.

The trend in the Organization's regular budget over the past several biennia has been a near straightlining. Zero nominal growth increases in the regular budget have, in effect, resulted in reductions. The Organization has been able to deliver its program of technical cooperation to the Member Countries, despite these reductions, by carefully husbanding its resources and increasing efficiency.

The allocation of PAHO's regular budget directly to the countries has steadily trended upward, and more than four-fifths (83.2%) of PAHO's technical cooperation—in the form of country, multicountry, regional, and Pan American Center programs—is in support of its Member Countries.

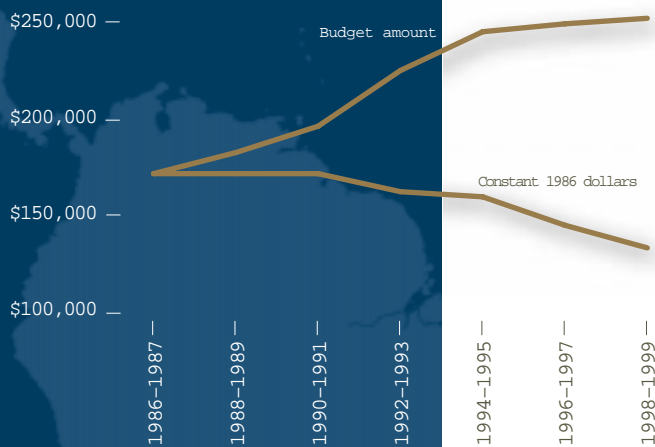
The lion's share of the budget—89%—targets the major strategic and programmatic areas, and some 42% of the total budget available to those areas comes from extrabudgetary sources—a testimony to the respect PAHO commands in the international community.

In recent years, the Organization has undertaken numerous efficiency and cost-saving measures to keep expenditures in line: a 4.7% reduction in the regular work force, across-the-board decreases in nonpost allocations, and reductions in overtime and travel costs.

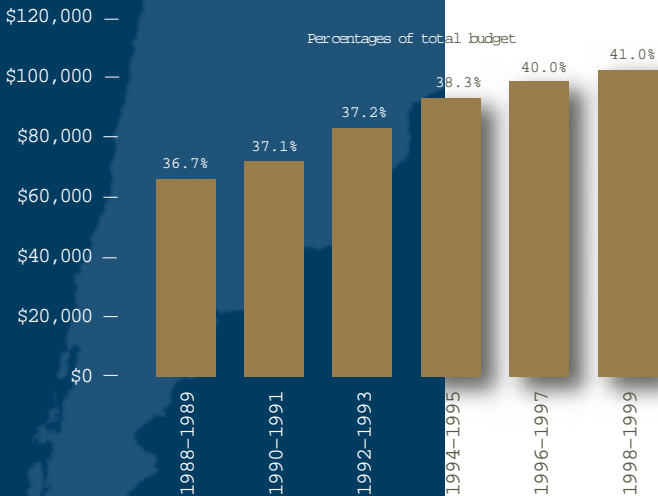
The quality and timeliness of financial reports to donors have improved, as have financial systems overall. A change in health insurance providers has resulted in savings in staff health costs of \$2.6 million during 1996–1997 alone, and a new prescription drug card program is saving an estimated \$100,000 per year.

Among treasury initiatives that strengthened the control over the Organization's financial assets and enhanced its return on those assets were cash management software

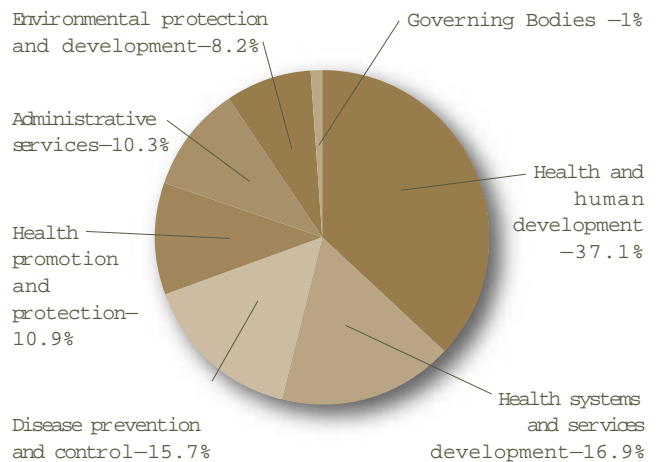
PAHO/WHO regular budget trends (in thousands US\$).



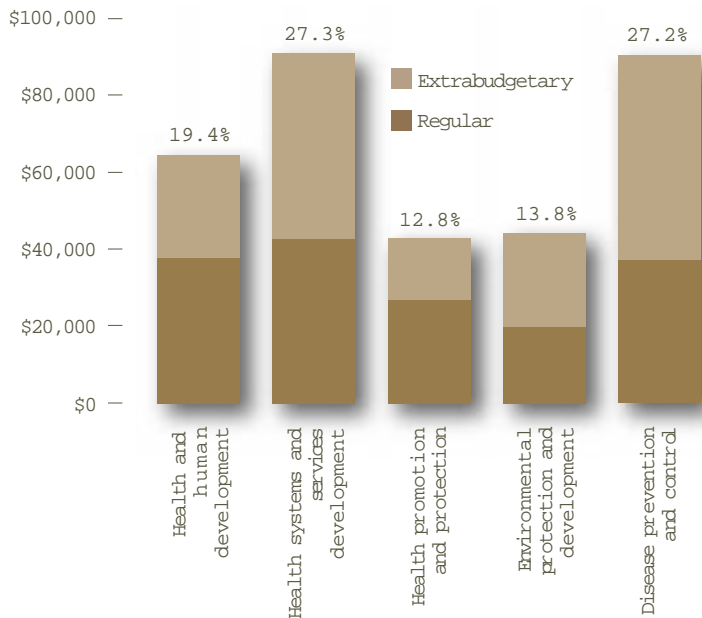
Allocation of the regular budget directly in support of the Member Countries (in thousands US\$).



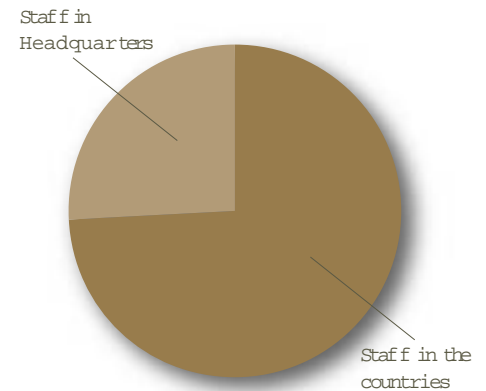
Current distribution of the PAHO/WHO regular budget by major areas of appropriation, showing individual percentages of total.



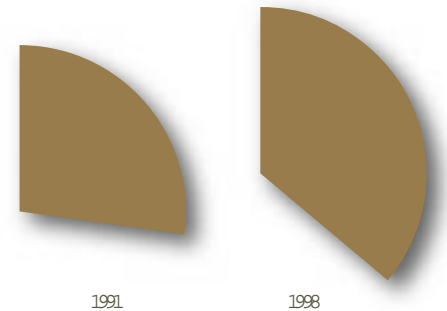
The budget of the Pan American Health Organization, 1996-1997, according to the five main areas of its work and to regular and extrabudgetary funding source (in thousands US\$).



Most of PAHO's staff—2,087 of 2,806 or 74%—work in the countries ...



The proportion of professionals in the Organization who are women is growing ...



PAHO has one of the best records among the United Nations agencies in hiring women. Today women hold 36% of all regular-fund professional posts, as compared to 27% in 1991. In the last four years, 44% of all new professional appointments have been women.

applications allowing the daily review of foreign bank account funding, overnight investment of excess funds resulting in \$150,000 per year in additional interest, and investments in higher-interest-rate commercial paper and U.S. federal agency paper.

Two out of three individuals now working for the Organization hold national contracts. In light of, and despite, real-term budgetary reductions, these contracts enable the Bureau to do more—at less cost—for the countries.

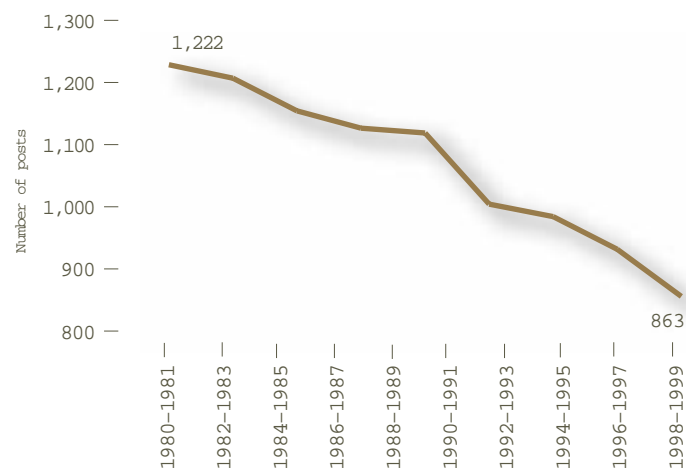
Personnel

The number of international civil servants employed by the Organization has dropped dramatically—from 1,222 in 1980-1981 to 863 in 1998-1999.

Yet PAHO has actually been able to reinforce its staffing—currently employing a total of 2,806 persons—by engaging nationals under a variety of contracts that are more flexible than those of the international civil service. This has been possible partly as a result of PAHO's decades-long work in developing the Region's human capital in the various disciplines of public health—through training, fellowships, seminars, workshops, and conferences. Today, the countries of the Americas have at their disposal a critical mass of well-prepared public health workers, talent which the Bureau itself is tapping for delivery of technical cooperation with the countries.

Other administrative innovations include standardizing personnel and hiring procedures, beginning development of an integrated personnel system, adopting a new personnel evaluation system, introducing a new induction program, and commencing work on a long-term staff development plan.

The trend in regular-funded posts.



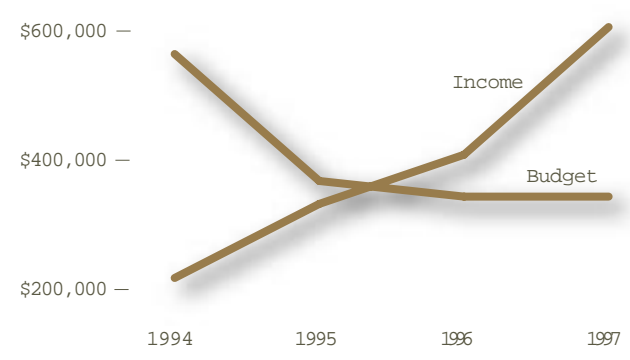


Corporate Information

To support its corporate functions, the Bureau manages a number of information systems: program planning, monitoring, and evaluation; personnel; budget and finance; and procurement. It also manages a communications network using the Internet that has made technical cooperation, and particularly the dissemination of information, more effective and efficient; has put in place an Intranet—a forum for information sharing among offices and staff throughout the Bureau; and has reduced internal communications costs by US\$100,000 per year.

In addition to enhancing the Organization's role as a leader in disseminating information in the Americas, PAHO's success in marketing its publications has made it possible, from 1994 to 1997, to reduce the funds allotted for distribution by more than one-third and to triple sales revenues.

Regular funds assigned to, and sales income generated by, marketing of PAHO publications (in US\$).



The buying power of the Expanded Program on Immunizations Revolving Fund increased significantly, enabling the Bureau to negotiate better deals with vaccine suppliers, which in turn resulted in major savings for national immunization campaigns. The cost of recombinant hepatitis B vaccine, for instance, dropped from US\$7 per dose to less than \$1 because of the Bureau's improved negotiating position.

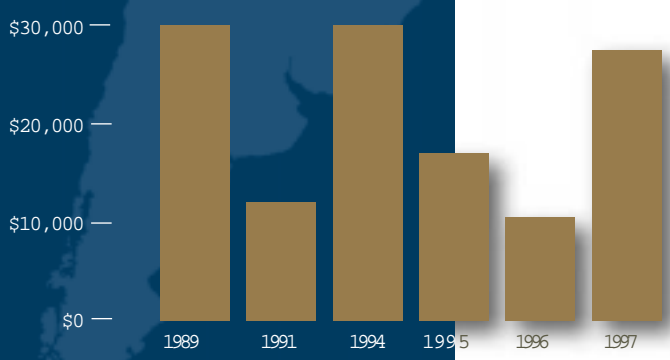
General Services

Modern management approaches have included computerized procurement and equipment tracking systems, a LAN-based help desk, a stockless supply warehouse, and advanced telephone technology. The procurement function evolved from that of solely purchasing goods and services for use by PAHO to also managing reimbursable procurements on behalf of the Organization's Member Governments.

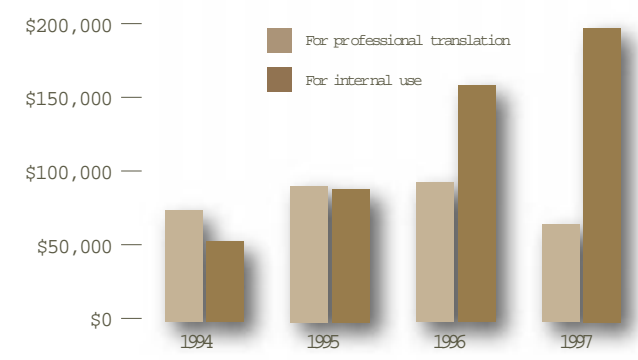
Conference services supported meetings of the Governing Bodies.

The PAHO machine translation systems produced over US\$100,000 in license, training, and support fees, while making it possible for PAHO translators to double the average output reported by other international organizations. ■

Income from licensing of PAHO's machine translation software (US\$).



PAHO cost savings made possible through use of machine translation (US\$).



BIREME	Latin American and Caribbean Center of Health Sciences Information (PAHO)
CAREC	Caribbean Epidemiology Center (PAHO)
CARICAD	Caribbean Center for Administrative Development
CARICOM	Caribbean Community
CDB	Caribbean Development Bank
CDC	Centers for Disease Control and Prevention (USA)
CEPIS	Pan American Center for Sanitary Engineering and Environmental Sciences (PAHO)
CFNI	Caribbean Food and Nutrition Institute (PAHO)
CIDA	Canadian International Development Agency
CLAD	Latin American Center for Development Administration
CLAP	Latin American Center for Perinatology and Human Development (PAHO)
ECLAC	Economic Commission for Latin America and the Caribbean
GTZ	German Agency for Technical Cooperation
IDB	Inter-American Development Bank
IDRC	International Development Research Center (Canada)
IICA	Inter-American Institute for Cooperation on Agriculture
ILPES	Latin American and Caribbean Institute for Economic and Social Planning
INCAP	Institute of Nutrition of Central America and Panama (PAHO)
INPPAZ	Pan American Institute for Food Protection and Zoonoses (PAHO)
MERCOSUR	Southern Cone Common Market
NAFTA	North American Free Trade Agreement
NIH	National Institutes of Health (USA)
OAS	Organization of American States
PAHEF	Pan American Health and Education Foundation
PAHO	Pan American Health Organization
PANAFTOSA	Pan American Center for Foot-and-Mouth Disease (PAHO)
PASB	Pan American Sanitary Bureau
UN	United Nations
UNAIDS	United Nations Program on AIDS
UNDP	United Nations Development Program
UNEP	United Nations Environment Program
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USMBHA	United States-Mexico Border Health Association
WHO	World Health Organization

MEMBER GOVERNMENTS

<i>Antigua and Barbuda</i>	<i>Guyana</i>
<i>Argentina</i>	<i>Haiti</i>
<i>Bahamas</i>	<i>Honduras</i>
<i>Barbados</i>	<i>Jamaica</i>
<i>Belize</i>	<i>Mexico</i>
<i>Bolivia</i>	<i>Nicaragua</i>
<i>Brazil</i>	<i>Panama</i>
<i>Canada</i>	<i>Paraguay</i>
<i>Chile</i>	<i>Peru</i>
<i>Colombia</i>	<i>Saint Kitts and Nevis</i>
<i>Costa Rica</i>	<i>Saint Lucia</i>
<i>Cuba</i>	<i>Saint Vincent and the Grenadines</i>
<i>Dominica</i>	<i>Suriname</i>
<i>Dominican Republic</i>	<i>Trinidad and Tobago</i>
<i>Ecuador</i>	<i>United States of America</i>
<i>El Salvador</i>	<i>Uruguay</i>
<i>Grenada</i>	<i>Venezuela</i>
<i>Guatemala</i>	

ASSOCIATE MEMBER

Puerto Rico

PARTICIPATING GOVERNMENTS

France

The Kingdom of the Netherlands

The United Kingdom of Great Britain and Northern Ireland

OBSERVERS

Portugal

Spain

Leading Pan American Health

Official Document No. 287

ISBN 92 75 17287 0

© Pan American Health Organization, 1998

Also available in Spanish:

Liderazgo en salud panamericana

Documento Oficial No. 287

ISBN 92 75 37287 X

© Organización Panamericana de la Salud, 1998

A full-text electronic version of this publication is available at www.paho.org.

Editorial production: PAHO Publications Program.

Design: Ultra Designs.

Photography: A. Waak/PAHO, pages 12, 13, 24, 27, 28, 30, 34, 38, 42, 44–47, 49, 52, 56–58, 60–63, 65, 66; A. Winder/PAHO, page 16; S. Jones/FPG International, page 18; Jamaican Board of Tourism, page 47.

Over the past several years, the Pan American Health Organization has worked in a world in which the only constant has been change. The freeing of trade and the ensuing globalization of national economies, the burgeoning of democracies, the emerging of technologies, the reshaping of demographic and epidemiological profiles, and the pushing toward social reforms...these factors have conditioned PAHO's vision of its role and the pursuit of its mission.

This situation is not new. Constant flux has characterized the history of public health in the Americas and of the Organization—for the most part, one and the same history. Today, poised on the cusp of a new millennium, PAHO is instituting major policy, managerial, and technical reforms aimed at clarifying priorities, redefining relations with stakeholders, measuring effectiveness, assuring accountability, and, through all these, bolstering international public health.

The Region of the Americas has scored major achievements in the area of health, as the result of the countries' collective will to tackle, together, their health challenges. This publication recounts recent progress the countries and the Organization have made in the areas of health and human development, disease prevention and control, health systems and services development, health promotion and protection, and environmental protection and development.



Pan American Health Organization
Pan American Sanitary Bureau, Regional Office of the
World Health Organization
www.paho.org