# The Search for EQUITY

*Pan American Health Organization*

Annual Report of the Director

**1995**

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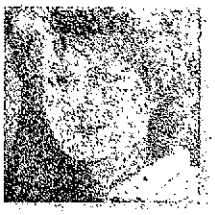

# The Search for EQUITY

*Pan American Health Organization*


PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau • Regional Office of
WORLD HEALTH ORGANIZATION
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Annual Report of the Director
**1995**

# MISSION OF THE PAN AMERICAN SANITARY BUREAU

The Pan American Sanitary Bureau is the Secretariat of the Pan American Health Organization (PAHO), 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.

# TO THE MEMBER COUNTRIES OF THE PAN AMERICAN HEALTH ORGANIZATION

In accordance with the Constitution of the Pan American Health Organization, I have the honor to submit the 1995 annual report on technical cooperation activities of the Pan American Sanitary Bureau, Regional Office of the World Health Organization. Within the context of the strategic and programmatic orientations for the 1995-1998 quadrennium, defined by the Governing Bodies of the Pan American Health Organization, the report analyzes the salient activities in the Organization's technical cooperation program during 1995.

The report is complemented by the *Interim Financial Report of the Director for the Year 1995*.

George A.O. Alleyne
*Director*

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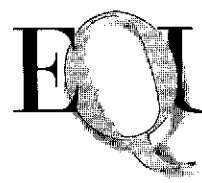
## The Search for EQUITY



***We have to be champions of the search for that equity and social justice that finds expression in Health for All.***

Such were my words on the day I became Director of the Pan American Sanitary Bureau in 1995. Since then, I have had time and cause to reflect on the meaning of that equity for us in the Bureau and for the countries of the Americas. Social justice and equality among all people are not new concepts: national constitutions speak to them and philosophers through the ages have put forward the appropriateness of adopting various means to ensure equality of opportunity. The preamble to the Universal Declaration of Human Rights says that, "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world." More recently, we have observed that those persons and institutions that take on some measure of responsibility for the development and general advancement of man have shifted their approach from one that focuses on means to one that focuses on ends. It became increasingly untenable to accept rapid economic growth without an attendant better distribution of wealth, and social equity gained respectability as an economic end.

I saw part of my responsibility as relating many of the philosophical concepts about equality and equity to the Pan American Health Organization's work in health. But, as soon as one tackles this task, one encounters the double problem of definition and measurement. After reflecting on the many varied, and often complex, approaches, I confess to having some sympathy with Karl Popper's view that the interminable "discussion of the meaning of words is not

only boring but harmful. The notion that we must define our terms before we can have a useful discussion is demonstrably incoherent. In this way of thinking precise knowledge does not depend on precise definition."

But I have had to skirt around that idea, since it is clear that policy discussions relating to equity must be based on some concept and definition. Indeed, we have seen entire national health services—such as the British—built upon an ideology that determines what is equitable and that seeks to correct the inequitable.

I prefer to express equity as implying fairness, but I acknowledge that one must go further, and realize that this characterization lacks enough content to serve as a template for empirical observation and inquiry. As a first approximation, then, I accept three possible interpretations that imply the translation of equity into manifestations of equality of access, equality of utilization, or equality of outcome.

Equality of access implies that anyone needing a given service can get it without having to pay more than any other person. Access and accessibility have been debated and discussed extensively. I believe that accessibility—which is really the potential for access—is related to those characteristics of the services that determine whether or not clients use them, as well as to the characteristics of the client population itself.

Equality of utilization would ensure that all clients having the same needs can use the services to the same extent. There should be no impediments of a social nature to such utilization.

Equality of outcome infers that any given service provision will result in the same health impact or outcome. The great debate about the inequality of outcome that persists despite a putative equality of access, probably stemmed from the Black Report on inequalities in health in Britain. The report showed that class differentials for mortality had held and even worsened, despite the fact that the national health service theoretically provided equal access to all. The report's conclusion stirred considerable research and discussion about the permanence of the meaning and relevance of class, and pointed to the limitations of class-based analyses in explaining health outcome inequality. It is possible that there are biological correlates of social gradients that result in different possibilities of becoming ill or dying from a particular disease. Much of this research has led to a thesis that maintains that absolute equality of health outcome, if health outcome is reflected in mortality, is almost impossible to achieve by external manipulation alone. It may, however, be possible to achieve equality of outcome in terms of satisfying perceived needs, provided that the services are appropriately structured.

Our colleagues in the World Health Organization's European Regional Office recently went to great lengths to define and measure equity, since it is a thread that weaves through many of the health targets their countries have set. Their working definition of equity in health is that, "ideally everyone should have a fair opportunity to attain their full potential, and, more pragmat-

ically, that no one should be disadvantaged from achieving this potential, if it can be avoided."

Another approach distinguishes between horizontal and vertical equity. Horizontal equity involves providing equal treatment for equal needs, whereas vertical equity involves providing unequal treatment for those who are unequal. The latter is probably the more relevant in our societies, which manifest marked differentials that translate into different social and economic levels within countries, as well as into injustices such as gender discrimination. What is clear is that no one supports a view of equity as being equal care for all or care that is solely determined on the basis of demand.

Equity as an ideal has been cited often in meetings of PAHO's Governing Bodies, and there have been numerous references to the fact that Health for All encompasses a moral commitment to reduce inequity in health as a manifestation of social injustice. Current efforts to renew the call for Health for All validate once again the timelessness of the principles of equity and social justice. And a concern for the gaps between rich and poor, and for the consequent disparity in health outcomes, was clearly expressed by the Director-General of the World Health Organization in the World Health Report for 1995.

The effort to help Member Countries attain the highest possible level of equity has been at the heart of PAHO's Strategic and Programmatic Orientations, and it is reflected in the structure and function of the Secretariat as well. These orientations, which were adopted by the XXVI Pan American Sanitary Conference in 1994, clearly state that the primary challenge facing the health sector over the quadrennium is overcoming inequity. Here I will allude to some of the main approaches developed in these orientations; many of the activities that flow from them will be covered in the report's main body.

In terms of health and human development, efforts are being directed toward demonstrating that health is a good indicator of human development and that it is firmly connected to the other components of that development; empirical evidence is being gathered to that end. We already know that a population's health is related to that population's economic situation. We propose that investing in health not only can help to boost economic growth, but that it also can help to even out income inequality. Preliminary data that show the correlation between measures of health and income inequality are already in. The poor's increased productivity, which ultimately will lead to a reduction in inequality, can be further advanced through improvements in health. By now, it also has been well established that the potential for reducing inequality is much greater in an economy that is growing.

Efforts to reduce inequities in health are a priority, and data are being sought to determine to what extent inequality in access or utilization of care is linked to ethnicity, gender, or race. Insofar as the health needs of certain groups are poorly addressed, and if one accepts that members of these groups become ill more frequently, vertical equity dictates that they must be treated differentially.

Before policies that promote equity can be effectively designed, inequity must be measured. However, inequity cannot be quantified through any single assessment. Rather, it must be demonstrated through the measurement of the human condition, of the utilization of a need for services, of the differentials in health outcomes, of avoidable mortality, and of the differential burden of disease. This is why I have so stressed the importance of the collection of data and its subsequent transformation into information and, ultimately, into knowledge.

The quest for equity is one of the driving forces behind the nearly universal preoccupation with health sector reform. And clearly, much of the concern with equity in health has centered on the health services. Although by now it is well-known that the health services are but minor contributors to the population's health, most health sector reform has targeted the health services.

Health sector reform rests on two main pillars: health service reorganization and health service financing. Almost every country has adopted an egalitarian stance with respect to the organization of services and has tried to distribute health care according to need, thereby ensuring that both vertical and horizontal equity are fulfilled. The prevailing approach regarding the financing of the services holds that, in order to attain equity, there should be two funding tracks: those services that are essentially public goods should be financed from the public purse, while more individualized services with low externalities should entertain private financing. To preserve equity, the State also should provide a minimum package of services to all citizens.

Although the health services have commanded most of the attention in reform proposals, there are equity implications for other determinants of the population's health. For example, healthy behavior in individuals and in communities will depend largely on the availability and accessibility of information. The dissemination of health-relevant information to the widest possible audience could make significant headway in breaking free from the inherently inequitable transaction between the typical health care provider and the recipient.

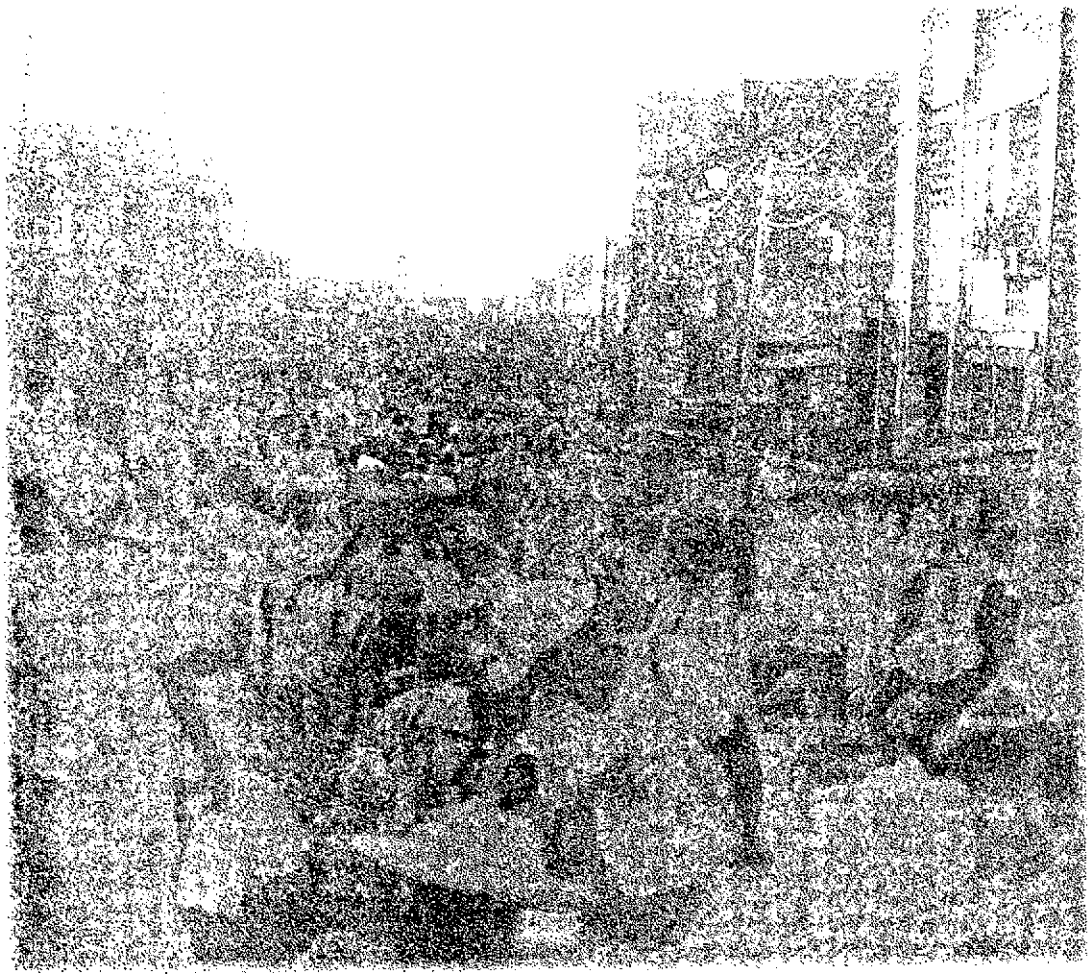
The 1986 Ottawa Charter for Health Promotion, which constitutes the first internationally accepted codification of health promotion concepts and practices, emphasizes that social justice and equity are fundamental prerequisites for health. Health promotion's major thrust has been, and will continue to be, the creation of favorable opportunities within communities, cities, schools, and factories, whereby citizens can mobilize to reduce the inequities that make for ill health.

Inequities in social and physical environmental conditions are the greatest contributors to ill health, and perhaps it is because many of these inequities have been so reduced that much attention can now be turned to other health problems. These improvements, of course, are relative; environmental conditions still vary widely among and within developing countries. The relative disregard for environmental conditions—which very recently has been dramatized by the reappearance of cholera—is due in part to the cost involved in correcting environmental problems and perhaps also because environmental services are public goods and, as such, lack a constituency willing to press for their improvement.

But, no matter how relevant to health and disease the search for equity has been demonstrated to be, the fundamental moral and ethical aspects of that search should not be overloooked. Earlier I referred to a simplistic concept of equity that was merely the equivalent of fairness and that was related to some notion of having the world's goods distributed more fairly. Should this more equitable distribution be left solely to selfless altruism, or should equity considerations be stressed more? The altruistic approach would have individuals perceiving some utility from providing health services to others, and the extent to which that happens would depend on the cost the giving individual was prepared to pay. But this approach is a rock on which health care reform can founder, because it is essentially a zero-sum game. There will be winners and there will be losers. Equity considerations in health care distribution, on the other hand, are taken beyond the sphere of individual preference and imply a concern for society as a whole.

But we must never underestimate the political difficulties in achieving equity in distribution. In general, governments make choices that maximize their possibilities of survival. And so, it is no accident that until recently so many election promises about health dealt with physical infrastructure and satisfying perceived needs for individual curative care.

I have referred often to the need for us to work toward a world that recognizes differences but eschews otherness, and I have postulated that there should be no otherness in health. The search for equity accepts the differences that are a fact of our existence, but seeks to put in place systems that recognize the essential humanity in all of us and the needs of that humanity. The Pan American Health Organization can be a forum for the discussion of ideas, such that we approach, if not consensus, at least an appreciation of these systems that will better the human condition. But as this report shows, our work in health can have practical implications for the search for social justice and for the new world as seen by Karl Popper when he wrote, "man has created new worlds—of language, of music, of poetry, of science; and the most important of these is the world of the moral demands for equality, for freedom, and for helping the weak."



# CHAPTER I

## *Health Situation Analysis*

*The number of the poor and dispossessed increases—the gap widens between those who never had it so good and those who wonder if they will ever have it at all....*
*It is to making the principle of "health for all" operational that our Organization must address itself. This is the work, this is the task—to hear and to heed the call of all who say, 'give us health in our time.' This is one course we must stay.*

George A. O. Alleyne
Address at His Installation as Director
31 January 1995

### DOCUMENTING INEQUITY

In addition to the many health problems that Latin American and Caribbean countries have traditionally faced, they now must cope with new challenges brought about by such health risks as the AIDS epidemic, increasing violence, environmental hazards, and new and re-emerging diseases. These changes are occurring in the context of political and economic reforms, the increasing decentralization of health services that is inherent to the health sector reform process and escalating costs.

In any society, health status is related to individual biological and social characteristics, economic and political organization, social structure, and cultural background, as well as demographic and macroecological processes, all of which must be considered in order to discern long-term trends of the health/disease process. Developing the capability to establish reliable information systems and to analyze health status measures will facilitate a more precise definition of sectoral priorities, improved programming, monitoring, and evaluation of health programs.

During 1995, the health situation of the Region's countries in large part resulted from complex economic and social adjustments that pushed segments of the population into deeper poverty. This situation, in turn, translated into great disparities in the health conditions of different countries and population groups: Latin American and Caribbean countries show some of the greatest social inequities in the world. These socioeconomic changes have sharply curtailed the ability of health institutions to adequately distribute equitable services to vul-

nerable segments of the population, bringing the problem of inequity and the search for a solution to it to the forefront.

For the Pan American Health Organization, the search for a way to ensure equity in the provision of and access to health care services represents one of the greatest challenges to its technical cooperation. Only by identifying gaps in equity and access can effective actions that target the populations at greatest risk be programmed and implemented. Acknowledging this critical need, the Director of the Pan American Sanitary Bureau assigned high priority to a work plan designed to improve the Organization's capability to describe, analyze, and interpret the health situation and trends of the Region's countries and to strengthen the capability of the countries themselves to analyze their health situation and target their interventions accordingly. Data gathered and studies and analyses conducted will supply invaluable information to political and strategic planning and management processes and to efforts to evaluate and redirect technical cooperation activities in the countries. These data also will inform technical cooperation activities directed at defining and formulating investment projects or special programs and effective disease prevention and control strategies. Further, the information will help mobilize financial resources, define research priorities, and provide data for periodic publications on monitoring the health situation and trends in the Region.

To this end, the Organization has been working to define a set of core data that can be used for health and trend assessment analyses. The data will be complemented with important bibliographic and background information that can contribute to better understand the health situation. A special effort is being made to select basic indicators disaggregated by major inequity characteristics such as gender, ethnicity, social class, race, and geographic distribution.

This chapter will review the health situation of countries in the Region of the Americas and provide documentation of the importance of addressing equity gaps in health as part of health sector reform processes. This review will utilize basic health and health policy indicators that the countries provided to PAHO's Technical Information System.

## METHODOLOGY

Various indicators of health conditions, resources, coverage, mortality, and morbidity were analyzed in order to highlight inequities among the countries. All the data analyzed were obtained from *Health Conditions in the Americas*[1] and "Health Situation in the Americas: Basic Indicators, 1995."[2]

Using discriminant analysis, 42 countries and other political units were classified in 5 groups, according to their per capita gross national product (GNP) (Table I-1). This indicator represents a reasonable approximation of the resources available to each country for satisfying the basic needs of its people. The minimum and maximum values within each per capita GNP range correspond to the lowest and highest values reported within each group.

The other indicators were analyzed by comparing the value of each country in a group with a calculated average for the group distribution. There were instances when the data was not available for all the countries within a group, as was the case with the income ratio of the highest 20% vs. the lowest 20% of the population, for which only 23 of the 42 countries had data. The percent of the gross domestic product (GDP) spent on health should not be analyzed independently from the GDP for each country. Any analysis of mortality data should consider the limitations inherent in this type of indicator; most importantly, data availability and quality (See Figure I-1.)





[1]. *Health Conditions in the Americas, 1994 edition.* Scientific Publication No. 549. Pan American Health Organization.
[2]. Health Situation in the Americas: Basic Indicators, 1995. Pan American Health Organization. PAHO/HDP/HDA/95.03.

**TABLE I-1.** Selected countries and other political units of the Region of the Americas, grouped by per capita GNP in US$, around 1993.

| Group | Country | Per capita GNP(US$) |
|---|---|---|
| I | Cayman Islands | 26,200 |
| | United States of America | 24,740 |
| | Canada | 20,555 |
| | Bermuda | 20,000 |
| | Aruba | 12,900 |
| | Bahamas | 11,420 |
| | British Virgin Islands | 10,600 |
| II | Netherlands Antilles | 7,800 |
| | Argentina | 7,220 |
| | Puerto Rico | 7,000 |
| | Antigua and Barbuda | 6,540 |
| | Barbados | 6,230 |
| | Anguilla | 5,930 |
| | Turks and Caicos Islands | 5,700 |
| III | Saint Kitts and Nevis | 4,410 |
| | Trinidad and Tobago | 3,830 |
| | Uruguay | 3,830 |
| | Mexico | 3,610 |
| | Saint Lucia | 3,380 |
| | Chile | 3,170 |
| | Brazil | 2,930 |
| | Venezuela | 2,840 |
| | Dominica | 2,720 |
| | Panama | 2,600 |
| | Belize | 2,450 |
| | Grenada | 2,380 |
| | Costa Rica | 2,150 |
| | Saint Vincent and the Grenadines | 2,120 |
| IV | Paraguay | 1,510 |
| | Peru | 1,490 |
| | Jamaica | 1,440 |
| | Colombia | 1,400 |
| | El Salvador | 1,320 |
| | Dominican Republic | 1,230 |
| | Ecuador | 1,200 |
| | Suriname | 1,180 |
| | Guatemala | 1,100 |
| V | Bolivia | 760 |
| | Honduras | 600 |
| | Guyana | 350 |
| | Nicaragua | 340 |
| | Haiti | 280 |

**Figure I-1.** Countries and other political units of the Americas, according to per capita gross national product, 1993.

## INEQUITIES IN THE POPULATION'S LIVING CONDITIONS

The grouping of countries by GNP was the first step in evaluating equity gaps in health; it is the initial approach in estimating the resources that are available for meeting the population's needs.

Table I-2 shows that 38.6% of the population of the Region of the Americas lives in the countries assigned to Group I, where the average per capita GNP is 3.4 times greater than for the countries in Group II and 48.3 times greater than that of the countries in Group V.

**TABLE I-2.** Total population (1995) and per capita GNP range and per capita GNP weighted average in US$ (around 1993) in the Region of the Americas, by groups of countries.[1]

| Group | Population (in thousands) | Per capita GNP (US$) | |
|---|---|---|---|
| | | Range | Weighted average |
| I | 293,155 | 26,200 to 10,600 | 24,304 |
| II | 38,810 | 7,800 to 5,700 | 7,193 |
| III | 300,261 | 4,410 to 2,120 | 3,142 |
| IV | 102,383 | 1,510 to 1,100 | 1,355 |
| V | 25,516 | 760 to 280 | 503 |

[1] Groups of countries from Table I-1.

In examining the income ratios of those in the wealthiest 20% and those in the poorest 20% of the population within each country, a skewed trend is observed—the poorest countries have the highest ratios and the richest countries, the lowest (Figure I-2).

According to data from "Health situation in the Americas: Basic Indicators, 1995," in Canada, for example, the wealthiest 20% of the population has an income that is seven times greater than that of the poorest 20%. In the United States, the ratio is nine. Yet, in groups III and IV there are countries such as Brazil with a ratio of 32, Guatemala with 31, Panama with 30, Honduras with 24, and Ecuador with a ratio of 20. When the average values of the incomes in the poorest quintile of the population in the poorest countries are compared with those in the wealthiest, the incomes in countries such as Guatemala and Honduras are 60 times lower than those in countries such as the United States and Canada.

If the change in per capita GDP between 1991 and 1993 is considered (see Figure I-3), the greatest growth is observed in group II and III countries: Argentina, 21.0%; Chile, 17.9%; and

**Figure I-2.** Income ratio (population with the highest 20%/population with the lowest 20%), average for each group of countries,[1] around 1990.

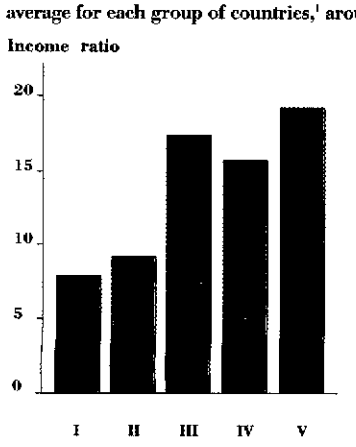
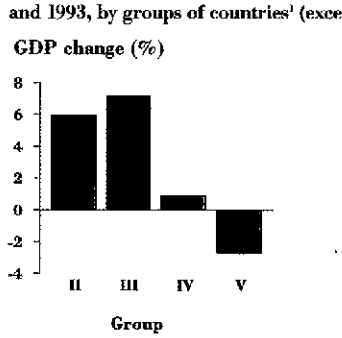



**Figure I-3.** Percentage change in per capita (GDP) in the Region of the Americas, between 1991 and 1993, by groups of countries[1] (except Group I).




[1] Groups of countries from Table I-1.

Panama, 17.4%. On the other hand, Group IV shows the smallest increase and Group V, the greatest decrease; these are the groups with countries that have lower GNPs (Haiti, -24.4%; Nicaragua, -11.0%; Suriname, -10.8%). By the same token, when group averages are compared, the poorer the country, the lower the growth (Group II, 6.15%; Group III, 7.57%; Group IV, 0.86%; and Group V, -2.94%).

## INEQUITIES IN THE DISTRIBUTION OF RESOURCES FOR HEALTH

Vast differences exist among the five groups of countries in terms of expenditures in health. For example, countries in Group I spend 6.2 times more than those in Group II and 80 times more than those in Group V (Figure I-4).

A disturbing trend is observed when the percentage of the GDP invested in health by the countries in each group is analyzed. Poorer countries tend to invest a lower percentage of their GDP (Figure I-5), and this trend tends to widen inequities in availability and accessibility of health care.

For purposes of this analysis, the availability of physicians per inhabitants is being used as a proxy indicator of the availability of medical care and the proportion of population living in rural areas as an indicator of accessibility. Figure I-6 shows the number of physicians per 10,000 inhabitants and the percentage of the population living in rural areas for each of the five groups of countries.

The data show that the availability of medical care decreases in the groups of countries where the per capita GNP is lower. On the contrary, the proportion of the population inhabiting rural areas is higher in the groups of countries with lower GNPs. Therefore, based on these two proxy indicators, both accessibility and availability decreases with lower GNPs.

In poorer countries, less money is available for health care. Concomitantly, one could say that the number of physicians per capita is lower and the problems associated with geographical access to health centers are greater.

## INEQUITIES IN THE HEALTH STATUS OF THE POPULATION

Inequities in the risk of becoming ill and dying prematurely correlate with inequities in the distribution of resources. This phenomenon can be seen in the infant mortality rates for countries in the Region, which range from 7 to 98 per 1,000 live births. Significant increases in this indicator are observed as important socioeconomic indicators decline (Figure I-7).

Infant mortality rates vary from country to country and within a given country. In Peru, for example, the city of Lima has an infant mortality rate of 50 per 1,000 live births, but some of the country's rural areas have rates as high as 140 infant deaths per 1,000 live births. In Panama, an indigenous infant is 3.5 times more likely to die than a non-indigenous infant. In Mexico City, the infant mortality rate ranges from 13.4 to 109.8 per 1,000 live births. The proportion of children with low birthweights tends to increase as poverty levels increase (Table I-3).

**TABLE I-3.** Percentage of newborns with low birthweight (<2,500 g) of total births in the Region of the Americas, by groups of countries,[1] 1990.

| Group | Percent of newborns with low birthweight (<2,500 g), 1990[2] |
|---|---|
| I | 8.7 |
| II | 8.0 |
| III | 10.9 |
| IV | 12.0 |
| V | 13.2 |

[1] Groups of countries from Table I-1.
[2] Average of percentages of countries in each group.

A similar situation occurs with the proportion of deaths due to acute diarrheal diseases among children under 5 years of age. Acute diarrheal diseases, long known to be preventable, kill more children in the countries with the lowest GNPs (Figure I-8).

**Figure I-4.** Per capita expenditure in health in the Region of the Americas, by groups of countries,[1] 1990 (in 1988 US$).

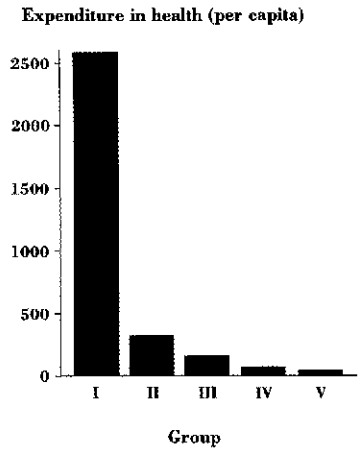



**Figure I-5.** Percent gross domestic product (GDP) allocated to health in the Region of the Americas, by groups of countries,1 1990.

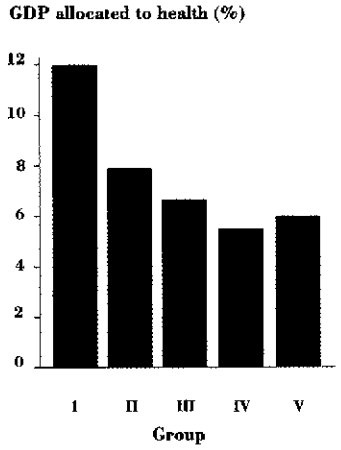



**Figure I-6.** Physicians per 10,000 inhabitants and percent population living in rural areas in the Region of the Americas, by groups of countries,[1] around 1992.

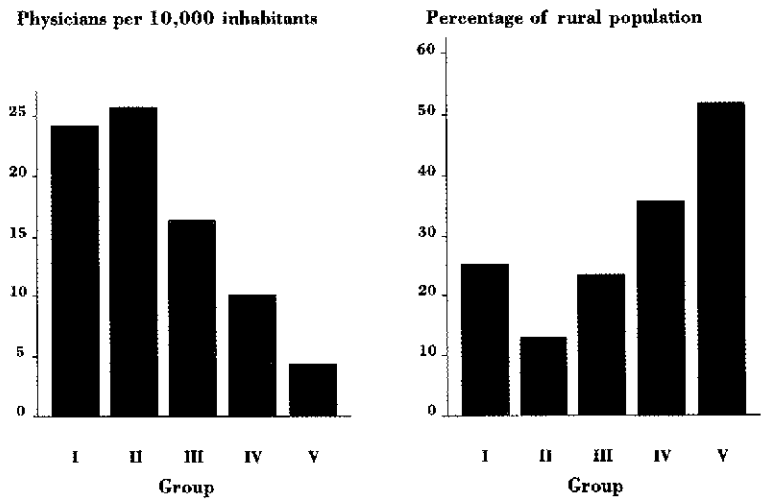



**Figure I-7.** Infant mortality rate per 1,000 live births in the Region of the Americas, by groups of countries,[1] 1994.

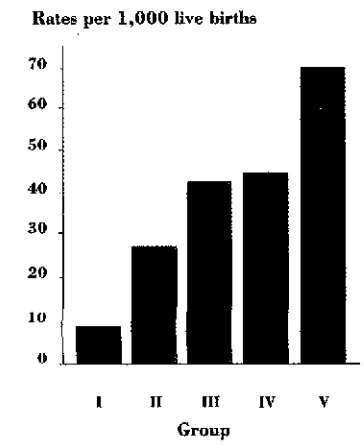
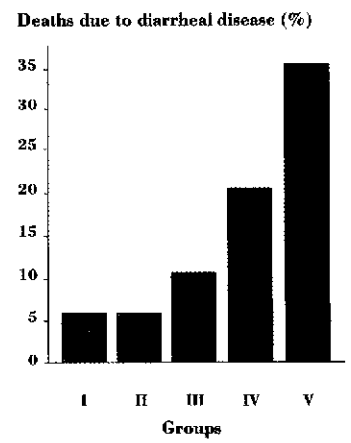



**Figure I-8.** Percentage of deaths from acute diarrheal disease in children under 5 years of age in the Region of the Americas, by groups of countries,[1] (data for latest year available between 1988 and 1993).




[1] Groups of countries from Table I-1.

The emergence of new infectious diseases or the resurgence of others thought to have been controlled by public health measures also have significantly affected the health conditions of the countries of the Region. Two dramatic examples of the latter are malaria and dengue. In the case of malaria, morbidity rates (as measured by annual parasite incidence rates) began to steadily rise in the mid-1970s, and have stabilized at rates that more than double the rates recorded two decades ago (Figure I-9). A similar trend can be observed in the resurgence of dengue and dengue hemorrhagic fever (Figure I-10).

Over the past four years, a cholera epidemic has swept through most of the Region's countries, leaving a toll of more than a million cases and nearly 10,000 deaths. This constitutes yet another example of a disease that had been virtually eliminated and then returned with a vengeance, ravaging the population's poorer and more disadvantaged segments. As shown previously, these infectious diseases tend to present with higher incidence, mortality, and case fatality rates in the countries with the lower GNPs.

Regarding tuberculosis, nine countries (representing 20% of the Region's population) present with incidence rates that reflect a serious situation for pulmonary tuberculosis, while eight countries (representing 67% of the population) present a less serious situation. An increase in the number of cases also is observed in these countries (Figure I-11).

The Region of the Americas contains great inequities in terms of who is predisposed to become ill or die prematurely. People living in the poorer and more deprived areas are at a much greater risk than those living in higher-income countries or regions.

## INEQUITIES IN ACCESSIBILITY TO THE HEALTH SERVICES

Even though every country in the Region is undergoing reform and adjustment processes, there are country-to-country differences in the stage of development of the health systems, especially in terms of accessibility and availability of health care resources.

The following indicators were used to assess the population's accessibility to health services: percentage of pregnant women receiving prenatal care and percentage of births attended by trained personnel. As shown in Table I-4, coverage is lower for both indicators in countries with GNPs. The differences in both indicators among the countries in groups IV and V are worth noting. When the percentages for prenatal care in the countries in Group V are compared, they show variations that range from 95% in Guyana to 38% in Bolivia. The percentage of births attended by trained personnel within group IV ranges from 23% in Guatemala to 90% in Suriname.

**TABLE I-4.** Percentage of pregnant women receiving prenatal care from trained personnel and percentage of live births attended by trained personnel, around 1990, average by groups of countries.[1]

| Group | Prenatal care (%) | Births attended by trained personnel (%) |
|---|---|---|
| I | 98.2 | 99.1 |
| II | 96.0 | 95.0 |
| III | 75.4 | 86.4 |
| IV | 56.8 | 45.5 |
| V | 58.4 | 40.5 |

[1] Groups of countries from Table I-1.

**Figure I-9.** Trend in malaria morbidity rates (annual parasite incidence) between 1970 and 1994 for 21 countries with transmission in the Region of the Americas.

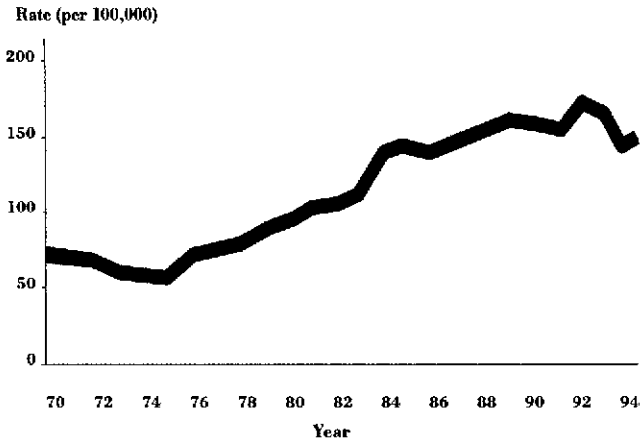



**Figure I-10.** Number of reported cases of dengue fever and dengue hemorrhagic fever in the Region of the Americas, by year, 1988 to 1994.

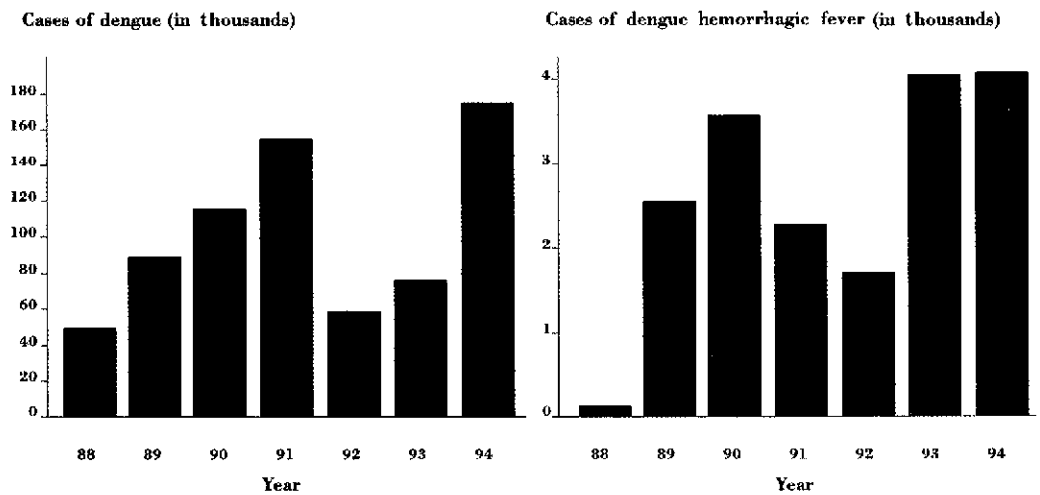
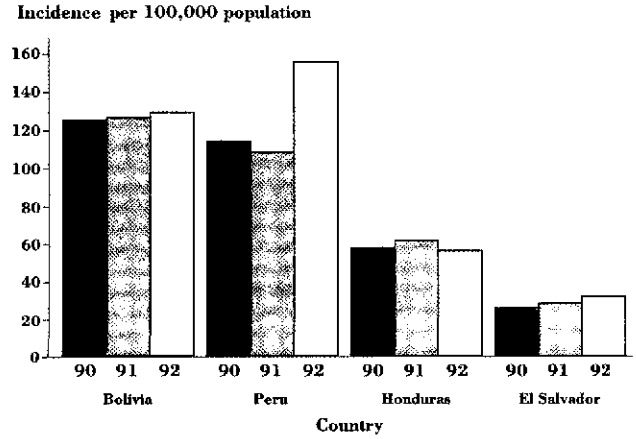



**Figure I-11.** Annual incidence rates of confirmed cases of pulmonary tuberculosis (per 100,000 population) in Bolivia, El Salvador, Honduras, and Peru, 1990, 1991, and 1992.




[1] Groups of countries from Table I-1.

## BRIDGING THE GAPS

The health situation analysis of the Region of the Americas in 1995 clearly documents the impact that the economic adjustments associated with the modernization of the state and the process of health reform have had on basic health indicators. Many countries are downsizing their governments. Their health systems are rapidly changing as a consequence of health sector reforms, and resources available to finance social sector programs, including important health activities, are being reduced. Given this, the health sector faces an enormous challenge if it is to implement social and health policies directed at reducing inequities without unacceptably sacrificing other policy goals. In every country, the health reform process aims at searching for equity, defined as accessibility to services by those who need them, regardless of geographic location, social status, or the type of ailment affecting them. While equity does not imply absolute equality, it does carry a sense of justice—and all health sector reform processes ultimately strive to attain justice in the delivery of services.

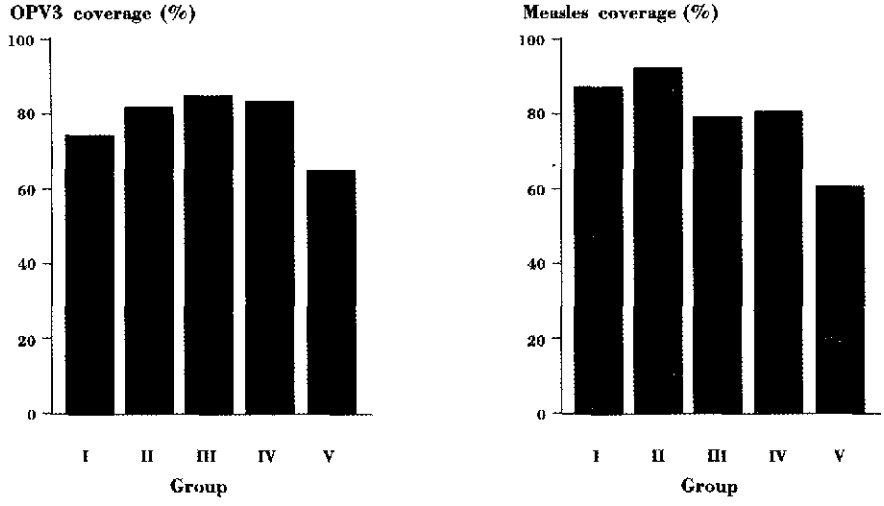
As a first step in the search for equity, indicators that will make it possible to evaluate and assess the population's health conditions must be identified. The need to show the impact of the international technical cooperation process grows. The principal criterion for evaluating technical cooperation programs in health should be their impact on the health of the population, and the most important indicators of impact should be linked to changes in the equity of the delivery of the health services.

The technical cooperation provided by an international agency specializing in health, such as PAHO, includes a wide spectrum of areas and projects that are determined by the countries' national priorities. Some health initiatives have easily quantifiable results, and the impact of PAHO's technical cooperation can be unequivocally demonstrated: for example, the projects associated with the goal of eradicating polio from the Region of the Americas. Without question, important improvements in the health of the population can be accomplished when targeted public health interventions such as these receive political and technical support and are undertaken with a common goal. Figure I-12 shows that, notwithstanding the vast differences in health status previously analyzed in the five groups of countries, OPV3 and measles vaccination coverages are relatively stable and do not vary significantly. The low case fatality rates that have been maintained during the cholera epidemic also represent an example of how control measures can be successfully derived as a result of concerted efforts directed at proper environmental management and prompt and adequate treatment. The recent outbreak of plague in Peru also showed the efficacy of control through sound environmental management.

Other health initiatives, however, involve technical cooperation projects designed to have an effect on national processes such as health sector reform, decentralization, and poverty alleviation. These areas of technical cooperation are characterized by their intersectoral nature (meaning that, at times, even the role of the health sector needs to be advocated), by being of interest to and influenced by a wide variety of actors, and by being sensitive to political processes. These projects, which fall within the more qualitative side of the spectrum, are the most difficult to evaluate. On the one hand, it is not easy to unequivocally establish causality and its direction; on the other, it is difficult to isolate the determinants of change and assign attribution to individual players.

Some memorable examples of efficient and effective interventions along this line are those that fall under the aegis of humanitarian assistance, whether in response to natural or man-made complex disasters, and those directed at health promotion, including healthy

**Figure I-12.** Oral polio vaccination coverage (OPV3) in children under 1 year of age and measles vaccination coverage in children under 5 years of age in the Region of the Americas, by groups of countries,[1] 1994.

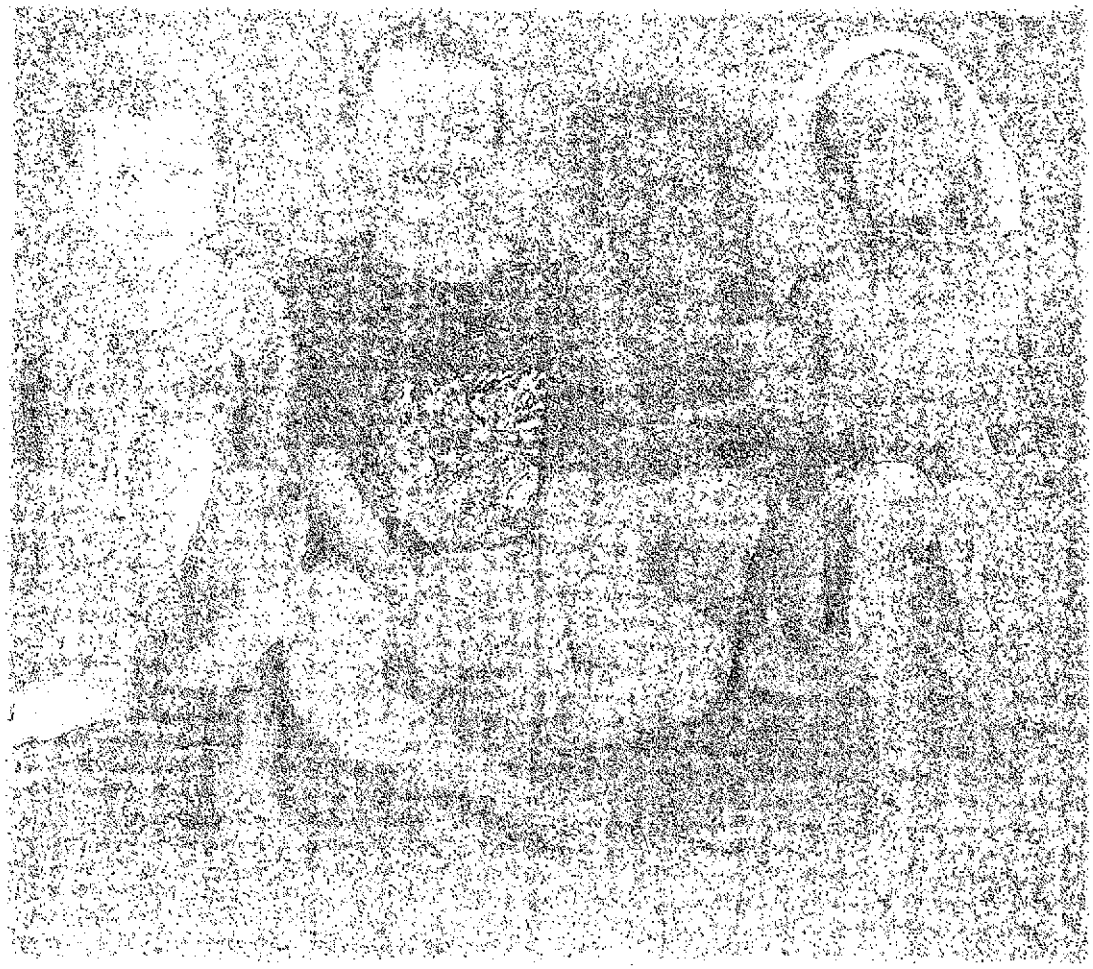



[1] Groups of countries from Table I-1.

lifestyles and the promotion of a healthy environment. The Ministers of Health of Central America devised the concept of health as a "bridge for peace" during the days in which that area was wracked by conflict. It has been well-documented that the ability to come together to discuss and plan health initiatives galvanized the peace process by raising the moral and ethical aspects of health and the preservation of life. There was a clear perception of the mutual self-interest that could be served by adopting common approaches to health problems. In addition, the willingness of the health sector to establish joint activities caught the imagination of the international community and led to a channeling of substantial resources to that area. We now need to mobilize the same energy and build a "bridge for equity."

In using the indicators shown in this chapter to describe and analyze the Region's health situation, the effect of multiple socioeconomic processes on the health status of populations becomes apparent. This kind of data-driven analysis facilitates the identification of important differences and gaps in health that exist in the Region. An understanding of the differential impact of various public and private sector interventions on the health and living conditions of the population also is paramount. However, the existing health conditions provide more than ample justification for the need to develop policies and programs that will help to bridge gaps in equity in health while searching for mechanisms to help to build a more equitable and sustainable health care delivery system.

The Organization is committed to work toward the consolidation of information systems in the Member Countries that will help document the impact of health interventions and also support the development of health policies that will lead us down the path to sustainable human development. When the countries work in collaboration with international technical agencies to address health problems, significant achievements can be accomplished for population groups at risk.



# CHAPTER II

## *Strategic & Programmatic Orientations*

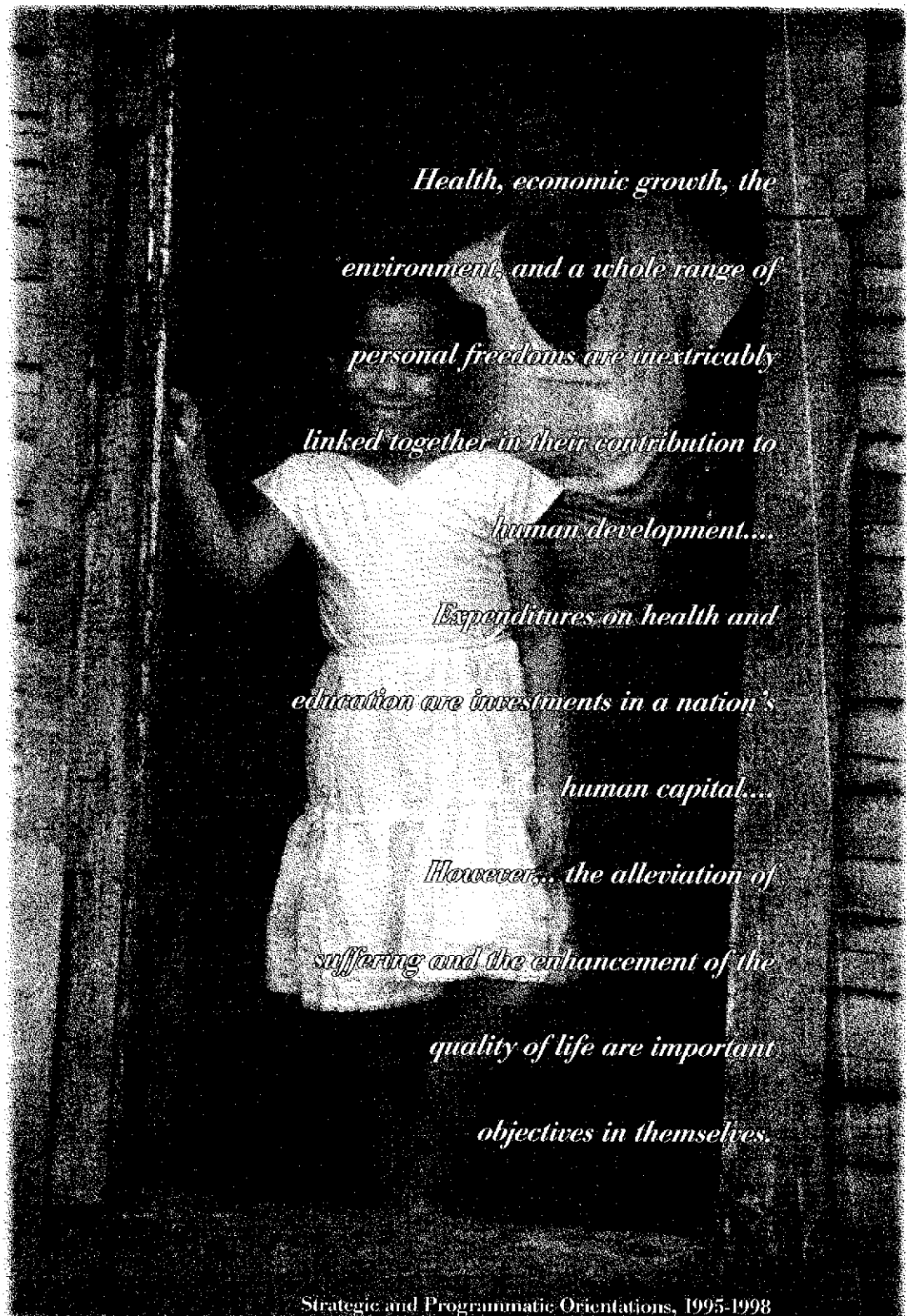
*We have to make our strategic and programmatic orientations a real living instrument of our work.... They constitute our programmatic points of reference.*

George A. O. Alleyne
Manager's Meeting
9 December 1995

This chapter reports on the major accomplishments of technical cooperation within each of the five Strategic and Programmatic Orientations approved by the Governing Bodies for 1995-1998.

The orientations chart the work of the Organization as it strives to eliminate inequities in access to and coverage of health services and in health conditions throughout the Region. Not only do they inform the planning and programming of the Organization's work, but they also are reflected in how the Bureau is structured. They guide the work of the Bureau in the short- and medium-term and suggest priority areas of action for Member Governments. Finally, while reflecting the particular reality of the Region of the Americas, they constitute the link with the Ninth General Program of Work of the World Health Organization.

The Organization is committed to evaluate its work in light of these orientations, as well as to review the validity of the orientations themselves over time and to assess progress in attaining the regional goals set forth in them. The *Annual Report* as a whole, and this chapter in particular, were prepared in fulfillment of these commitments.




Strategic and Programmatic Orientations, 1995-1998

# HEALTH in HUMAN DEVELOPMENT

## HEALTH SECTOR REFORM

Health sector reforms currently under way in the Americas reflect the different models and strategies the countries have adopted to achieve universal coverage with quality services and in consideration of national conditions. Health sector reform cannot follow a single blueprint throughout the Region: it is complex, and its implementation encompasses technical and managerial aspects, as well as political, economic, social, and cultural elements.

Regardless of country-to-country variations, health reform processes in the Region must all share certain guiding principles that echo tenets of overall State reform: the State must continue to have responsibility for setting overall health priorities, assuring care for the essential needs of all citizens, and reallocating scarce resources to address inequities that overburden the most disadvantaged population sectors.

The rising cost of health care services has driven most of the interest in and debate over health care reform. In Latin America and the Caribbean, some 6% of the GDP goes to health. In light of this, two issues have informed PAHO's technical cooperation regarding health sector reform: the health services themselves, and equitable access to them. Equality of access implies that everyone will pay equally for satisfying equal health needs. To attain this equity, the Organization's technical cooperation follows two broad tracks—organization of the health systems and services and their financing.

PAHO has particularly emphasized attaining gender equality within the health reform process. Throughout their lives, women become ill more often than men do, and social mores assign to them the duty of caring for others. These factors cause women to have specific health needs that must be identified and addressed, if health resources are to be distributed equitably across gender lines.

Of all WHO regions, the Americas seems to be the one most actively pursuing health sector reform. In fact, by mid-1995 nearly all of the Region's countries and territories were embarking upon reforms or considering some reform to their health systems and/or policies, according to reports submitted by PAHO's Member Governments to the Special Meeting on Health Sector Reform, held in Washington, D.C., on 29-30 September 1995. In addition to PAHO's central role in this process, other agencies such as IDB, the World Bank, and USAID also are actively involved.

For those reform processes that have been under way for some years, concrete results already can be seen; for those launched more recently, tangible change is yet to be seen. A few countries that already have attained acceptable coverage levels for their populations, continue to pursue reforms as a way to achieve greater sectoral efficiency and to preserve progress already made in terms of equity. For most countries, however, the reform process represents a search to overcome deep-seated inequities and inefficiencies in their health sectors.

Despite the vast variation in the countries' national health systems, certain reform approaches surface repeatedly. For example, decentralization, the establishment or expansion of health insurance, and adoption of cost-recovery schemes in the public sector are applied in half the countries or territories. At least one-third of the countries and territories are considering adopting approaches such as a basic package of health services, new forms of contracting, budgetary decentralization, the targeting of public expenditures, hospital autonomy, and selective privatization. One-sixth of the countries are adopting new drug policies. The Organization must understand and be able to operate within these differences and similarities as it strives to guide the health sector reform processes throughout the Region toward greater equity, efficiency, and effectiveness.

Through its Country Offices, PAHO has provided direct support for 26 national health sector reform processes in the Americas. This support has taken many forms, ranging from advocacy, technical assistance, seminars and forums for consensus-building, the development of health care models, the design of management systems and tools, the training of national personnel, dissemination of technical

information, and the sharing of information on national reform experiences. PAHO's cooperation also has sought to bring social security institutions into the reform process as active participants. In 1995, this objective was pursued in more than 10 countries, and it was targeted in subregional cooperation efforts such as those with the Central American Council of Social Security Institutions and the Andean Agreement on Social Security.

The Country Offices have provided the bulk of this cooperation, complemented by support from experts from the Secretariat or externally recruited. PAHO's permanent presence in Member Countries gives it some advantage compared to other cooperation agencies, but it also opens the Organization up to a near-constant demand for cooperation.

The interprogram missions for the analysis and programming of cooperation dealing with the reform process represented a special support for the national reform processes in 1995. During these missions, which were conducted in Bolivia, Chile, Colombia, the Dominican Republic, Ecuador, Venezuela, and the Caribbean countries, staff from the Secretariat and the Country Offices reviewed the health sector reform processes with the respective national authorities and counterparts. As a result of these missions, problems were identified and joint plans of action were drawn up to overcome them; these plans delineated each party's responsibility in the implementation of activities. Subsequent missions, involving internationally recognized external experts, were carried out to follow-up on points agreed upon with authorities from participating countries. The Director of the Pan American Sanitary Bureau participated in a meeting in Ecuador, with the President's cabinet members representing the social sector and the National Health Council. The meeting provided a forum for conducting a high-level review of the role of health in Ecuador's development process; this issue also was the key discussion point between the Director of the Bureau and the President of Ecuador.

Several high-level subregional seminars on reforms were held: in Costa Rica (in collaboration with the World Bank and IDB), Jamaica (in collaboration with the Caribbean Community [CARICOM]), in Guatemala (cosponsored by the Central American Council of Social Security Institutions), in Washington, D.C., (cosponsored by WHO for the poorest countries of the Region), and in Puerto Rico. Other national events also deserve mention, such as the forums held in Chile, the Dominican Republic, and Guatemala, which involved a broad representation of all interested political and social sectors.

Other workshops were designed to promote the sharing of reform experiences among the delegations of several countries. A meeting was held in Uruguay to discuss the most relevant experiences in the Region regarding new modalities of health service organization and management and managed health care. A book on the health systems of industrialized countries undergoing reform, which was prepared by Latin American investigators, was published. To facilitate the Regionwide dissemination of this information, two workshops were held in 1994, during which various Canadian experts shared their experiences with counterparts from the ministries of health and social security institutions of the Andean countries (La Paz, Bolivia) and Central America (Panama). In 1995, a third exercise of this type was conducted, involving a Canadian delegation and a group of Chilean counterparts.

Surprisingly, health sector reform receives limited attention in the regular curricula of public health and health administration programs offered throughout the Region. To counteract this, several activities specifically geared toward training personnel in various reform-related topics were conducted. Through the Inter-American Network on Health Economics and Financing (REDEFS), and with the support of the World Bank's Economic Development Institute, the British Overseas Development Administration (ODA), and the Canadian International Development Research Center (IDRC), more than 10 training workshops were held in this area. In partnership with the Inter-American Center for Social Security Studies (CIESS), a workshop was held to train ministerial advisers and legislators on legal aspects of the reform. An important meeting on the future of public hospitals in the Americas was held in Chile, which highlighted recent trends in hospital autonomy. In Central America, a workshop on human resources in health sector reform was offered.

REDEFS' work merits special coverage because the training it provides to participating national and international institutions and organizations is particularly far-reaching. Some 15 associations and national or subregional economic and financing

groups are affiliated, bringing the total membership to more than 500 individuals, mostly professionals, administrators, researchers, and educators interested in or having expertise in health economics and financing and who work in public or private, national or international institutions.

In recent years, this network, which is supported by PAHO, the Economic Development Institute (EDI)/World Bank, and CIESS, has successfully implemented a work program that is far more intense and diversified than the programs previously carried out by each agency acting on its own. REDEFS currently operates with resources from the World Bank, PAHO, ODA, IDRC, and other national sources mobilized by its affiliates. While the associations are becoming increasingly active in detecting and responding to national training needs, the agencies are changing their role, assuming a subsidiary function in support of the activities of the associations. This experience can be very useful for the establishment and operation of the Inter-American Network on health sector reform, whose creation was mandated by the Summit of the Americas. Given the paucity of adequately trained human resources, the network has provided invaluable support to the countries in an area where the Region is especially vulnerable.

A concerted effort has been devoted to elicit political support for national health sector reform processes. Six countries have established national commissions composed of representatives from the executive and legislative branches of government, the private sector, universities, and cooperation agencies, as well as health care providers and users. These commissions serve as forums where the various interest groups can build consensus about the reform, thus facilitating the preparation of proposals and the formulation of draft legislation to be submitted to the respective legislatures. External support groups for the national processes also have been created; these are comprised of representatives of the main technical and financial cooperation agencies working in the respective countries.

The Interagency Committee on Health Sector Reform, constituted by representatives from PAHO, the World Bank, IDB, the OAS, UNICEF, ECLAC, UNFPA, USAID, and the Government of Canada, prepared and held the Special Meeting on Health Sector Reform. The interagency committee was installed at the beginning of the year, after a meeting among the Director of PAHO, the President of the IDB, and the World Bank's Vice President for Latin America. PAHO serves as the Committee's Secretariat. Bearing in mind the terms of Resolution 17 of the Summit of the Americas, representatives from the other agencies were included to broaden the Committee's representation. In fact, the preparation for the Summit itself had involved coordination among these agencies with respect to health sector reform.

The Interagency Committee produced the reference document "Equitable Access to Basic Health Services: Toward a Regional Agenda for Health Sector Reform," which summarizes the determinants of health sector reform in the Americas and the scenario in which this process is unfolding; the frames of reference for the reform; the political dimensions and the problems faced by the national reform processes; and hemispheric cooperation in support of the reform, emphasizing interagency coordination, development of the Inter-American Network on health sector reform, and the monitoring of the national reform processes.

The special meeting brought together more than 400 representatives of national governments, parliaments, private institutions, NGOs, cooperation agencies, and research centers. Because the special meeting had such a broad representation of countries and interest groups, it ranks as the most important health sector reform event to date; it stands as an example of successful interagency coordination in support of the reform. In the course of the meeting, leaders and organizations interested in regional and national reform were identified; these individuals and institutions will be invaluable for follow-up activities in the near future.

Interagency coordination also made it possible to carry out other leadership development activities in support of health sector reform. Notable among them are the seminar on managed competition promoted by the World Bank (St. Michaels, Maryland); the aforementioned seminar on reform in Central America promoted by PAHO, the World Bank, and the IDB (San José, Costa Rica); and the stakeholders' meeting of the Regional Study on the Health Sector of the Caribbean planned by PAHO and IDB to be held in January 1996 (Christ Church, Barbados). Previous cooperation among PAHO, IDB, and the World Bank had already resulted in the 1994 meet-

ing of the Southern Cone and the Andean Area countries on health sector reform (Buenos Aires, Argentina).

Finally, PAHO and IDB, with the support of the World Bank, the Caribbean Development Bank (CDB), and CARICOM, have been carrying out activities dealing with the design and execution of the Regional Study on the Health Sector of the Caribbean. The study, which is being conducted with support from the authorities of the countries involved, will evaluate the sector's priority problems and the progress of national health sector reform process. In turn, this knowledge will foster the development of criteria for adapting national policies and external support.

## REGIONAL INTEGRATION INITIATIVES

Subregional and regional integration efforts could significantly accelerate progress toward attaining health sector reform objectives. PAHO has been following the NAFTA and MERCOSUR agreements, as well as the Andean, Central American, and Caribbean integration processes, with special attention to such areas as technology transfer, food and drug regulation, marketing of services, professional practice, access to health care, health and the environment, tourism, and occupational health. The following are highlights of the activities that have been promoted as part of this effort.

- In cooperation with the United Nations Conference on Trade and Development (UNCTAD), a study on international trade in health for Latin America and the Caribbean was carried out.
- An interprogrammatic advisory group was created to deal with the impact of trade liberalization on issues related to biologicals, medical devices/radiology, technology transfer, pharmaceuticals, laboratories, and research. The group will primarily examine the regulation of private-sector participation and the impact of the Agreement on Trade-Related Aspects of Intellectual Property that emerged from the Uruguay round of the General Agreement on Tariffs and Trade (GATT).
- Working with the Center for the Study and Research of Health Law of the School of Public Health of the University of São Paulo, the Organization coordinated research aimed at investigating the possible role that agencies such as the United States Food and Drug Administration (FDA) could play in collaborating with PAHO in working to develop a regulatory framework to deal with the globalization of the economy.
- Technical support was provided for the implementation of the Agreement on the Application of Sanitary and Phytosanitary Measures.
- The European integration process was examined in order to define common parameters with subregional and/or regional integration initiatives under way in the Americas.

Regarding MERCOSUR, since 1991 the Organization, through its Country Offices in Brazil, Paraguay, and Uruguay has been involved in analyzing standards applied to medical and pharmaceutical products, as well as health plans and legislation on occupational health.

Since 1992, the Organization has been carrying out NAFTA-related activities. These activities have sought to evaluate the impact that the agreement has had on issues such as the health conditions of special population groups, including tourists, retirees, and migrant workers; technology transfer; scientific development; professional practice; health sector reform; and human resources for health. Emphasis has been placed on ensuring that NAFTA and the other regional integration processes do not bypass concerns about equity and human dignity as they establish trade mechanisms.

The Organization also has been concerned with environmental issues and the preservation of healthy working environments. As a result of this, it supports initiatives carried out under NAFTA that are designed to review the legal framework already in place for guaranteeing safe working conditions, especially those that affect women's health and that deal with gender issues.

Working through the Field Office/U.S.-Mexico Border, the Organization also has been involved in an initiative that brought together an interdisciplinary network of researchers and educators under the consortium "Universities for a Healthier Border Environment." The group will evaluate the changes that have occurred and are expected to occur along the United States, Mexico, and Canada borders as a result of NAFTA. Of greatest concern

is the possibility that the agreement will increase pollution and, consequently, exacerbate environmentally-derived health problems that emerge from rapid economic and population growth. Although initially the target was conditions along the borders, there also is concern about ensuring that the trading partners' environmental and occupational laws and standards are upheld and that their health care systems are not compromised; any changes that come about as a result of the agreement should benefit all three countries.

In August 1995, the Organization and the Central American Integration System (SICA) signed a cooperation agreement whereby they agreed to collaborate with each other and with other agencies in activities related to the Central American Institutional Solidarity Force; the second SICA exhibit, "Integration and Sustainable Development;" and the strengthening of border health systems. This agreement consolidates the successful partnership between PAHO and SICA that since 1993 has carried out such technical cooperation activities as the Central American Nutrition and Food Safety Program and other activities within the "Friendly Borders Plan" executed within the framework of the Alliance for Sustainable Development.

Cooperation with CARICOM lead to a landmark achievement for the CARICOM Ministers of Health. PAHO prepared the background papers for and coordinated the special meeting of CARICOM Health Ministers to discuss the delivery of health services in the Caribbean. At a meeting in Montego Bay, Jamaica, in November 1995, the statement of the subregion's long-range view regarding health care was developed, and the Ministers agreed on several steps towards the rationalization and sharing of secondary and tertiary services; several projects are already being developed.

The health sector reform consultation meetings that the Caribbean Program Coordination office facilitated in several Eastern Caribbean countries were extremely important in preparing for the special meeting. These consultation meetings helped to ready the countries for the Montego Bay meeting, and facilitated the preparation of country reports on health sector reform that were presented at the special session on health sector reform during the XXXVIII Meeting of the Directing Council in 1995.

## POVERTY REDUCTION AND SOCIAL POLICY

As stated in the strategic and programmatic orientations for 1995-1998, the Organization has sought to strengthen the countries' capabilities to analyze and formulate health policies and plans that are part of and consistent with national strategies for human development. To reach this objective, PAHO mobilized a variety of actors who could influence the attainment of these policies at the national and regional levels.

Many have singled out poverty as the root cause of preventable disease and death in the Region, and even throughout the world. PAHO has aggressively searched for and identified strategies to reduce poverty. To this end, it sponsored studies on poverty reduction in Barbados, Belize, the Dominican Republic, Guyana, Jamaica, Mexico, Venezuela, and the Eastern Caribbean countries. PAHO published several papers on the findings of the studies. The papers were presented at the "Seminar on Poverty Reduction and Social Policy in the Caribbean: The Role of Health and Education" that was held in Trinidad and Tobago on March 20 to 24; the seminar was sponsored by PAHO, IDB, UNDP, the World Bank, the Caribbean Development Bank, and the Caribbean Community (CARICOM).

The seminar adhered to the commitments of the World Summit for Social Development, which was held earlier that month in Copenhagen, Denmark, and also addressed poverty and social policy. The cost-effectiveness of investments in human resources, education, and health were examined, because they are considered to be critical components of a poverty-reduction agenda for the Americas. The need to explore intersectoral strategies to reduce poverty also was stressed.

The seminar's 92 participants discussed how to define the poor and assess poverty and its causes. They also proposed policy priorities for poverty reduction and devised ways in which agencies could collaborate with one another to reduce poverty. As an outgrowth of the seminar, PAHO has planned several workshops and training sessions.

Some policy priorities assigned special significance to health and education policies within poverty reduction strategies; others addressed improvements to the decision-making process, capability-building at the central and local levels, the rational-

ization of data collection, the participation of NGOs and the private sector in planning and implementing poverty reduction, arriving at the appropriate mix of economic and social policy to increase equity, and the incorporation into policy formulation processes of lessons learned from the poor's coping strategies. PAHO was assigned follow-up responsibility for disseminating information on analysis and policy recommendations and for sensitizing target audiences regarding relevant options for poverty reduction.

PAHO has relied on a variety of strategies to execute its technical cooperation with the countries. Some—such as technical cooperation among countries—have been used, in one way or another, since the Organization's early days. This strategy promotes the establishment of networks among countries, so they can exchange experiences in similar fields and share technical expertise in dealing with a given problem. Another approach promotes subregional initiatives such as the Andean Cooperation in Health, the Caribbean Cooperation in Health, the Southern Cone Initiative, and the Central American Health Initiative as a way to intensify the countries' cooperation with one another.

WHO, working through PAHO, also has applied a special program of intensified cooperation with the least developed countries. Through this initiative, the Regional Office supports the Country Office so that it can channel its technical cooperation toward addressing poverty and its health consequences. This effort follows an approach that promotes wide-ranging capability-building tailored to each country's needs. In the Region of the Americas, Bolivia, Cuba, Guatemala, Guyana, and Haiti are involved in this intensified technical cooperation.

## BIOETHICS

As it stands today, bioethics has extended its reach to issues that go beyond clinical medicine and research, and it has come to embrace such issues as resource allocation, health care delivery, and use of environmental resources. In terms of bioethics, PAHO's Governing Bodies mandated that the Organization "cooperate with the Member Governments and their private and public entities in the conceptual, normative, and applied development of bioethics in its relation to health."

To fulfill this mandate, PAHO has endeavored to disseminate bioethics' principles through educational and training activities that deal with ethics pertaining to clinical issues, research, and public health, as well as through a well-grounded public outreach campaign. The Organization also publishes a bulletin that is distributed throughout the Region and has established a bibliographic collection that includes listings on organ transplant legislation, in-vitro fertilization, the human genome, and statements and codes issued by international bodies. PAHO also has actively pursued exchanges with sister institutions throughout the Region and worldwide, such as the UNESCO International Committee on Bioethics.

## SCIENCE AND TECHNOLOGY

The Organization has worked to incorporate health-related scientific and technological advances into the Region's development efforts, to integrate scientific production and distribution processes, and to promote research in areas that reflect the policy orientations for the quadrennium.

As the countries endeavor to fulfill those objectives, research leaders will be needed to investigate and document each country's health problems and the particular socioeconomic, political, and cultural contexts in which they occur. This research, in turn, can be used to guide policy-makers as they endeavor to improve conditions in their countries.

A PAHO-coordinated study reviewed 10,974 research projects carried out between 1987 and 1989 in Argentina, Brazil, Cuba, Mexico, and Venezuela. The percentage of projects devoted to public health research was low, ranging from 12% to 20%, and biomedical and clinical research clearly predominated. Further data show that an even lower proportion of public health research gets published. The same is true for articles on public health research published in regular periodicals.

In recognition of the importance of developing individual and institutional public health research capabilities, PAHO and Canada's International Development Research Center (IDRC), have set up a program offering public health research training grants. The initiative endeavors to train leaders in public health research by offering grantees an opportunity to acquire advanced training in this field, as well as the possibility to receive additional funding for the implementation of a research project. Given its focus on applied research and on the strengthening of research institutions as well as individuals, the initiative aims at enhancing the decision-making

process of the Region's countries, and, in so doing, improving the populations' health. Through the program, selected candidates receive a grant allowing them to spend one year at a leading research and/or academic institution outside their native country and are provided with technical assistance to develop a research protocol.

A complementary effort is designed to stimulate research on health systems and services, including studies on the health system itself or any of its components. This research is designed to generate knowledge that can contribute to redirect or reorganize the health system so as to attain equity, efficiency, and efficacy as quickly as possible.

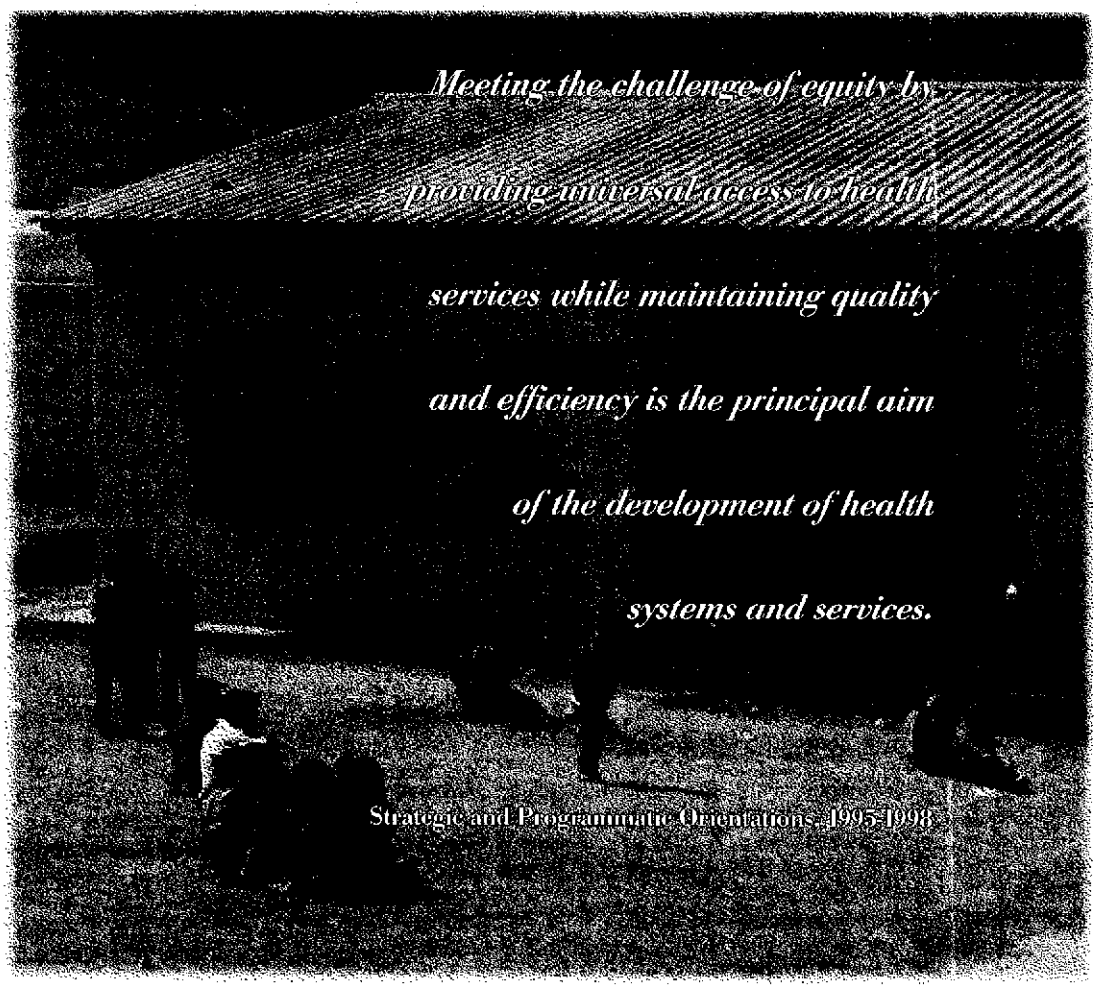
The Organization also launched a research competition inviting historians to present original research projects analyzing the Region's health reform efforts from a historical perspective. It is hoped that the research that emerges from this competition will stimulate a deeper analysis of the various political, technical, and social options that emerge within the health reform process.

In recognition of the importance of biotechnology for scientific-technological development and for solving health problems in the countries of the Region, PAHO, in conjunction with the National Institute of Health's John E. Fogarty International Center for Advanced Study in the Health Sciences, offers research training grants in biotechnology. This program provides Latin American and Caribbean researchers with the opportunity to train in the application of biotechnology methods and techniques, as well as the financial support to carry out research projects in selected areas. In addition, the program aims to strengthen research institutions and to promote technical cooperation among countries.

Enhancing the countries' capabilities to produce the necessary vaccines and biologicals to address the priority health problems also is viewed as a priority. To this end, PAHO has strengthened the partnership between governments and vaccine manufacturers in the Americas, in order to guarantee the quality of the vaccines used by the Member Governments in their regular immunization programs. This strategy addresses the great diversity found in the Region regarding policy and practices of vaccine production and quality control systems, and serves as another mechanism to enhance and harmonize the Regional System of Vaccines (SIREVA). While some countries have not yet established well-defined national control authorities to ensure that manufacturers follow established standards, vaccine-producing countries have already organized national quality control laboratories.

Efforts have been geared towards organizing overall national quality control authorities throughout the Region and national quality control laboratories in vaccine-producing countries, as well as towards gradually implementing a Regional Network of National Vaccine Quality Control Laboratories. By establishing a Regional Network among the eight vaccine-producing countries that house national quality control laboratories for vaccines, PAHO is helping to bring the countries of the Americas closer to harmonizing regulatory activities, control procedures, and methodologies, as well as to developing standard reference reagents. These initiatives have received the support of the United States' Food and Drug Administration (FDA) and USAID.

A technical advisory committee was established to monitor the network's activities. Emphasis is being placed on the development and standardization of regional reference reagents, starting with those required for the control of vaccines currently included in national immunization programs. The coordination of collaborative studies for each reference vaccine has been assigned to a specific quality control laboratory. Significant support for these objectives will be provided by the establishment of an electronic network. The network will link all member laboratories, facilitating the exchange of experiences and results on research and development related to vaccine production and quality control methods.


*Meeting the challenge of equity by providing universal access to health services while maintaining quality and efficiency is the principal aim of the development of health systems and services.*
Strategic and Programmatic Orientations, 1995-1998

# HEALTH SYSTEMS & SERVICES DEVELOPMENT

The Organization's cooperation in health sector reform has followed two courses: health sector financing and health services reorganization and transformation. The latter, which has been the reform's focus, is the object of technical cooperation as presented in this section.

As a key strategy in health sector reform, the countries have sought to sustain, and where possible to advance, decentralization measures and the development of local health systems. In the main, these efforts have aimed at achieving greater local-level decision-making by enhancing the community's participation through health promotion and prevention strategies and by relying on an intersectoral approach to decentralization. The latter approach has involved establishing coordination and links between the public and private sectors, encouraging greater participation of nongovernmental organizations, and establishing working relationships with other sectors whose policies affect the health of populations, such as water, sanitation, and education.

To deal with the effects of decentralization, the health sector reform process is addressing the need to have the central level—be it a ministry or a department of health—assume leadership responsibility. The central-level's duties have come under increased scrutiny, and are being adjusted to ensure that equity is upheld and that health care systems with a plurality of functions are coordinated. These functions include policy formulation and development, investment, regulation, standardization and control of activities, identification and selection of financing mechanisms, technology development, drug supply, staff development, and standards of professional practice.

If the health services are to achieve equity, they must be able to respond to the specific needs and problems of various population subgroups. Few would dispute the notion that clinical decision-making is influenced not only by scientific knowledge, but also by such factors as class, education, race, age, income, and gender, which are culture-specific.

Because the health services are responsible for minimizing impediments that different population subgroups may face in the course of fulfilling their health needs, ensuring that equity is attained across gender and ethnic lines becomes relevant to quality assessment research and management. PAHO has taken on the task of determining whether gender-related factors adversely affect the quality of care and, if they do, assessing how their influence works and how far it reaches.

## ORGANIZATION OF HEALTH SYSTEMS WITHIN HEALTH SECTOR REFORM

As a central objective, the reorganization of the health services seeks to develop more and better decision-making capabilities at the local level. To achieve this, management, organizational, and administrative skills must be enhanced, and the technical response capability of every service provided must be improved.

To support Member Governments as they endeavor to make the changes needed to achieve equity in access to efficient and quality services, the Organization has cooperated in developing the necessary leadership for conducting and managing the transformation of the health services. To this end, PAHO produced and disseminated technical documents on sectoral reform, sectoral analysis, strategic management, and quality of care designed to provide a frame of reference for decision-making. Several manuals on operational aspects of management also were prepared. In addition, a guide on how to analyze the level of development of local health systems in terms of decentralization and local development levels was prepared and used in 50 local health systems in two countries. This guide, which emphasizes strengthening managerial capabilities, productivity, and quality, has proven to be an invaluable tool for the countries in their efforts to develop local-level health services.

Quality indicators and standards for the health services were developed and disseminated through 2 regional, 4 subregional, and 27 national meetings. As these indicators and standards have become more widely known, they have led to the establishment of

a hospital accreditation process in 10 countries. The new edition of the Directory of Latin American Hospitals, which reports on 15,069 institutions also enhanced the countries' efforts to improve medical-care quality.

Nine national studies evaluated novel approaches for organizing and managing health institutions in the context of sectoral reform. Noteworthy among these were financial and institutional pluralism; the search for mechanisms to increase efficiency, including competitiveness, price controls, and cost recovery; changing patterns of contractual arrangements; alternative payment modalities; and shared services, within which managed care stood out as a useful mechanism for increasing quality and efficiency. Participants from Argentina, Canada, Chile, Colombia, Costa Rica, Mexico, Uruguay, and the United States of America analyzed the various approaches in a regional meeting held in Montevideo, Uruguay, in October 1995. The results of the meeting and an annotated bibliography will be used to develop a guide for contracting services in decentralized hospitals.

Training on strategic administration and management of public health policies that was conducted in Central America, the Dominican Republic, Puerto Rico, and elsewhere in the Caribbean and a regional course on health planning and management conducted with the support of the Government of Spain have significantly increased the availability of adequately trained resources. It is expected that those trained will help guide and execute the transformation of the Region's health systems that is needed to complement the modernization of the State and sectoral reform.

With the support of the Government of Italy, several projects known as SMALP—"Health, Environment, and Poverty Alleviation"—are being carried out in Argentina, Colombia, the Dominican Republic, and Peru; these projects aim at improving the health conditions of the most disadvantaged groups. Cooperation from the Government of Italy has made it possible to carry out human development projects for migrants in Central America, under the development program for displaced persons, refugees, and repatriates (PRODERE). Considerable external financial resources have been mobilized for the formulation and execution of four local development projects in El Salvador, Guatemala, Honduras, and Nicaragua and four SMALP projects in Brazil, Colombia, the Dominican Republic, and Peru. These projects focus on improving the health conditions and the environment of high-risk populations.

Declining socioeconomic circumstances and delays and reductions in social investments and in investments in basic infrastructures have further marginalized certain segments of the population and pushed them deeper into poverty. This, in turn, has led to the emergence of high-risk situations that make it more likely for violent epidemic outbreaks to occur. In fulfillment of a mandate issued at the First Ibero-American Summit of Heads of State held in 1992, the Organization formulated the "Plan for Investment in the Environment and Health" (PIAS). The plan seeks to address the vast deficit in the infrastructure of health care delivery, water supply, basic sanitation, and environmental protection and pollution control services in the Region of the Americas. The plan's greatest challenge involves strengthening the countries' ability to mobilize resources for investment in these areas. To this end, since 1993 the Organization has promoted functional coordination with multilateral and bilateral lending institutions in order to identify priority and timely environment-and-health analyses that hold promise for joint undertaking.

One such collaborative project is the Caribbean Regional Health Study. It was commissioned by the Consultative Group for Caribbean Economic Development; the group established a task force made up of PAHO and IDB to coordinate the research, using researchers from the University of the West Indies and the University of Toronto. The study will culminate in a regional report of the Caribbean health sector that will cover 16 countries. The report has two central objectives: to diagnose the health sector's leading problems, issues, trends, and challenges and to identify key measures and feasible policy alternatives, strategies, and actions needed to cope with the main obstacles and limitations to health sector development. A first draft has been distributed to the 16 ministers of health, and they discussed it at the special meeting on health sector reform held by the CARICOM Health Ministers in November.

The Organization also continued to support the project to strengthen and extend basic health service coverage in Ecuador (FASBASE), the project to strengthen health services in Peru, the pre-invest-

ment activities for strengthening the health system in the State of Minas Gerais, Brazil, and those for recovering the operational capacity of that country's health care network, as well as for institutional development of the ministries of health of Colombia, Nicaragua, and Uruguay.

Standards have been developed for incorporating rehabilitation services into local health systems. It is expected that these standards, which rely on community participation, will increase and improve health care for the disabled, who are a priority group in the quest for increased equity in the access to health services in the Region.

PAHO has assisted Barbados and Trinidad to establish community-based rehabilitation projects as a new component of primary care, and has helped Saint Lucia to revitalize its project. As part off this effort, PAHO provided guidelines, posters, videotapes, and public service announcements for a media campaign on disability; helped to upgrade NGO advocacy skills on behalf of the disabled; provided standardized data collection forms designed with the help of practitioners; and mobilized additional financial resources from an Italian NGO for two of the countries.

The Organization has shifted the orientation of its activities targeted to the maintenance of health facilities. The new orientation involves the organization of programs for the integrated management of technologies used to incorporate, operate, maintain, and renovate the physical plant infrastructure. This effort has been promoted through the establishment of the first regional engineering and maintenance network for the seven Central American countries and the creation of a second network covering the six countries that are part of the Andean Cooperation in Health Initiative.

## HUMAN RESOURCES DEVELOPMENT

The pursuit of quality and effectiveness has been at the heart of the changes that have been undertaken this year in the technical cooperation that PAHO provides to the governments and educational institutions in the field of human resources for health. In terms of the development of professional and technical human resources, and as part of educational reforms currently under way in most countries, mechanisms such as accreditation, certification and recertification, self-evaluation, and curricular innovation have been emphasized as ways to offset the problem of the overall deterioration in the quality of education. Training of health personnel in the context of health sector reforms is primarily directed at improving health care quality, effectiveness, and efficiency and at sustaining gains in the organization, operation, and management of the services. All investment and institutional development proposals that support reform processes contain important human resources development components.

During 1995, a permanent education methodology was updated and made available to the countries. Several nationals worked on drafting the proposal, which incorporates recent experiences and new methodological developments, taking advantage of recent multi-media and communications technologies. Activities to strengthen the countries' capabilities to offer in-service training and continuing education for health and education personnel in charge of training also were pursued as another way to support reform processes. PASCAP formulated a proposal to develop, validate, and implement staff performance evaluations in local health teams; this was applied widely in Central America and in the Dominican Republic and will be applied in other countries. Databases within the human resources bibliographic information network incorporated critical subjects dealing with sectoral reform; an Internet distance-education project was developed.

Since 1990, PAHO has been analyzing the theory and practice of public health in the Region of the Americas to define a cooperation plan with educational institutions offering public health programs in the Region. This plan was presented at the Interregional Meeting on the New Public Health, which was held by WHO in Geneva, Switzerland, from 27 to 30 November 1995 to consolidate the contributions of the different regions.

Significant efforts also were undertaken to establish or strengthen regulatory and accreditation mechanisms for nursing schools in support of subregional integration processes, such as the Subregional Tripartite Commission on Accreditation (Canada, Mexico, and the United States). The study of the basic characteristics of 48 graduate-level nursing education programs in Brazil, Canada, Chile, Colombia, Ecuador, the English-speaking Caribbean, Mexico, Panama, Peru, the United States, and Venezuela also is noteworthy.

## TECHNOLOGY AND ESSENTIAL DRUGS

During the year, the Organization undertook activities in information systems, drugs, diagnostic and imaging technology, and blood bank organization as ways to reinforce the health services' technology and infrastructure.

An information systems program established in 1995 within the Division of Health Systems and Services Development is charged with promoting, coordinating, and supporting information systems for managing the health sector, as well as with providing guidance on health information systems technology. This program allows the Secretariat to direct technical cooperation specifically toward systems and technology aimed at the day-to-day operation and management of clinics, hospitals, and direct care support services, particularly in terms of advancing information systems for the operation and management of district and local health services.

As a leading strategy in this effort, functional aspects of information systems and technology are used as a tool to operate and manage the health services, including for planning, programming, execution, and evaluation processes. The importance of medical and institutional record-keeping mechanisms, data-related processes, and standardization of data definitions also was stressed. This strategy is pursued chiefly by disseminating knowledge about information systems and technology opportunities, fostering the exchange of experiences, assisting in the selection of information systems and technology, and supporting the implementation of information systems directed to the operation and management of health services.

In order to enhance the countries' ability to generate useful management information from data gathered at the community health services level, the Organization has been engaged in a four-year project with Barbados and the countries of the Eastern Caribbean to improve information management systems for community health services. Applications were designed, developed, tested, and implemented; user education and training was pursued at every level; and health information units were established in each participating country. Several agencies also collaborated in the execution of this project, including the Caribbean Environmental Health Institute (CEHI), the Caribbean Community (CARICOM), the Organization for Eastern Caribbean States (OECS), USAID, French Cooperation, and the British Overseas Development Agency (ODA).

The Organization was instrumental in having the automated system for drug management (SIAMED) installed in Brazil, Colombia, Cuba, the Dominican Republic, Ecuador, Mexico, Nicaragua, and Venezuela. This software package was developed so that institutions and agencies that deal with pharmaceutical regulation could enhance their efficiency by having access to a low-cost system that could easily be tailored to local conditions.

The pharmaceutical sector has been directly affected by the countries' marked shift towards free-market economies. As a result, the Organization's cooperation has sought to ensure that commercial considerations do not override quality, safety, effectiveness, and availability criteria regarding pharmaceutical supplies. Support for the harmonization of drug regulation that has emerged from various subregional economic and trade integration initiatives has been a significant aspect of cooperation in this area.

Under the coordination of the Advisory Commission on Drugs of the Hipólito Unanue Agreement, and through the work of technical groups specifically developed to work on this issue, agreement was reached on the common requirements and on a standard registration application form for drug regulation. The standards of different pharmacological groups began to be reviewed, in order to standardize and define a foundation the countries could share. This exercise has laid the groundwork for implementing the Andean Drug Registry that was approved by the area's ministers of health. In Central America, the definition and official recognition of the national standards of good manufacturing practices were stressed as a way to reach a common groundwork that would be compatible with international standards. Work to prepare common standards for drug registration has continued in Central America. In both the Central American and the Andean subregions, PAHO's work entails mobilizing national resources, promoting cooperation among countries, and supporting the work of technical groups. During the year, considerable efforts were directed toward securing necessary resources to continue with these activities in the future. Within MERCOSUR, PAHO also provides

technical cooperation to the program for training pharmaceutical inspectors. A publication reporting on the current situation of the harmonization of drug regulation in each subregion was prepared.

In terms of radiological health, the dissemination of the "International Basic Safety Standards for Protection against Ionizing Radiation and for the Safety of Radiation Sources" had the most significant impact in the countries. This effort entailed reviewing national radiation legislation and regulations; teaching the subject in training courses, congresses, and conferences; and revising PAHO publications on the subject currently in progress for consistency with the standards. Recommendations regarding implementation were forwarded to the national authorities of Argentina, Colombia, Costa Rica, Cuba, the Dominican Republic, Honduras, Mexico, and Nicaragua. As a result, the Secretaries of Health of Mexico and of Honduras set up a radiological health unit. Regarding health services delivery, the leading achievements were the studies on how to upgrade diagnostic imaging services in Haiti and in the Eastern Caribbean and the initiation of a joint project with the International Atomic Energy Agency for improving radiotherapy in 17 Latin American countries; this project complements the 30-year-old postal dosimetry intercomparison program that verifies radiotherapy equipment calibration. This project will be coordinated with cancer programs, in order to make it an integral part of a comprehensive patient management approach that ranges from detection to treatment.

The ability of the services to detect agents in donated blood is critical to their efficiency in preventing infections transmitted through blood transfusions. The quality assurance of serology is a key aspect of the effort to prevent infections transmitted through blood transfusions and the operation of blood banks and blood-transfusion services. In this area, PAHO has directed its efforts at expanding the coverage and efficiency of serological testing of blood used for transfusions.

To this end, in 1995 the Organization set up a regional network of quality assurance for serology for the prevention of infections transmitted through transfusion. The Hemocenter in São Paulo, Brazil, is the network's hub. There, personnel from Colombia, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama have been trained in how to prepare panels for monitoring sera utilizing blood reagents. In addition, the first serology performance survey of the National Reference Blood Banks was conducted in the eight countries. All the countries have begun to establish national quality assurance systems for the serology of infections transmitted through blood transfusions, in which the National Reference Blood Banks will train local professionals and will conduct external performance evaluations of the serology in a country's blood banks.

## DISASTER PREPAREDNESS AND MITIGATION

Since 1960, natural disasters in Latin America and the Caribbean have killed 180,000 people and have caused approximately US$ 54 billion in property damages. The health sector has been particularly vulnerable: hurricanes "Gilbert" (Jamaica, 1988) and "Luis" and "Marilyn" (Antigua and Barbuda, Saint Kitts and Nevis, St. Maarten, and other islands; September 1995), as well as the earthquakes in Mexico (1985), El Salvador (1986), and Costa Rica and Panama (1991), devastated hospitals and health centers, precisely when they were most needed. The Economic Commission for Latin America and the Caribbean (ECLAC) estimates that between 1985 and 1988, the health sector lost roughly US$ 1.9 billion as a result of natural disasters.

There are some 15,000 hospitals in Latin America and the Caribbean, and up to half of them may be located in high-risk areas. Many of these facilities have no emergency plans or disaster mitigation programs, nor the appropriate infrastructure to withstand powerful earthquakes or hurricanes. The Organization is deeply concerned about the danger that this situation poses to the health of the populations and to the economic well-being of the countries. Consequently, as a way to save lives and ensure that the health services can continue to function in emergency situations, PAHO has worked with Member Countries and with international, regional, and subregional organizations in the adoption of regional and national policies to reduce the vulnerability of existing or planned hospitals to hurricanes, earthquakes, and other hazards.

In 1991, PAHO designed the Supply Management Project (SUMA), a tool specifically developed to help bring order and efficiency to the inventory, sorting, and distribution of emergency supplies in the aftermath of a disaster.

To date, some 1,300 people working in health, civil defense, the Red Cross, and other sectors have been trained to use SUMA in Latin America and the Caribbean. In May 1995, a SUMA demonstration was part of the "Tradewinds" exercise, a yearly activity in the Caribbean that simulates a multi-hazard disaster for training regional defense forces and emergency response agencies. And in September, in the wake of Hurricane Luis, SUMA was activated in Antigua, Saint Kitts and Nevis, St. Maarten, and Curaçao at the request of the respective governments.

PAHO's reputation and usefulness in disaster management has reached beyond the boundaries of the Region. In December, a joint mission involving the WHO Regional Office for Europe and PAHO went to Bosnia-Herzegovina. The mission evaluated the relief supply management system in use in the area at the time, proposed improvements, and explored the use of alternative methodologies. One of the main problems identified was the difficulty in exchanging information among the many agencies providing humanitarian assistance because their informational systems are not standardized.

Because information management lies at the heart of disaster management, PAHO is working to open the world of Internet and the World Wide Web to local disaster managers. This access provides a quick, inexpensive, and reliable way for these managers to communicate with experts from different institutions or countries and from a variety of sectors. As they do so, a mechanism for exchanging information is put in place, and a cadre of competent and contributing users who will utilize electronic disaster information networks to improve local disaster management is created.

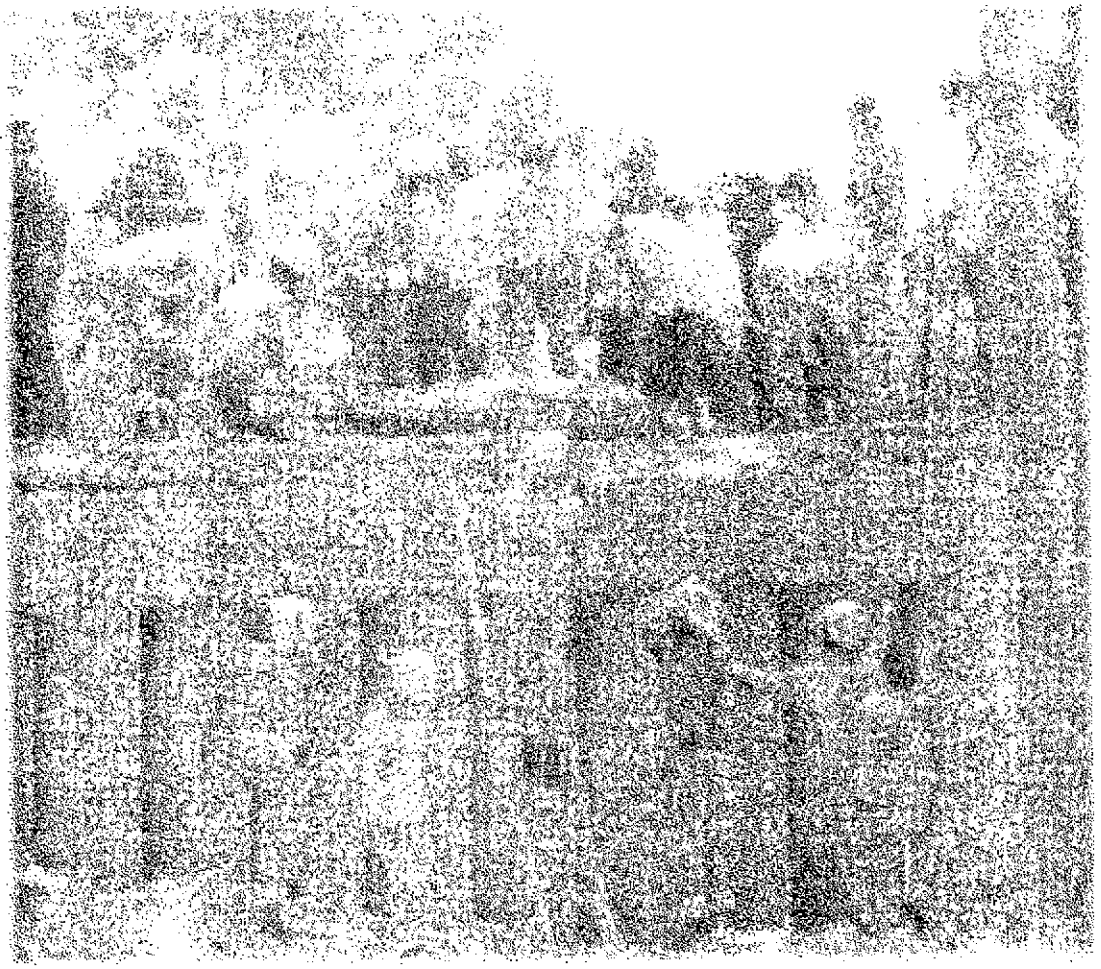
## ORAL HEALTH

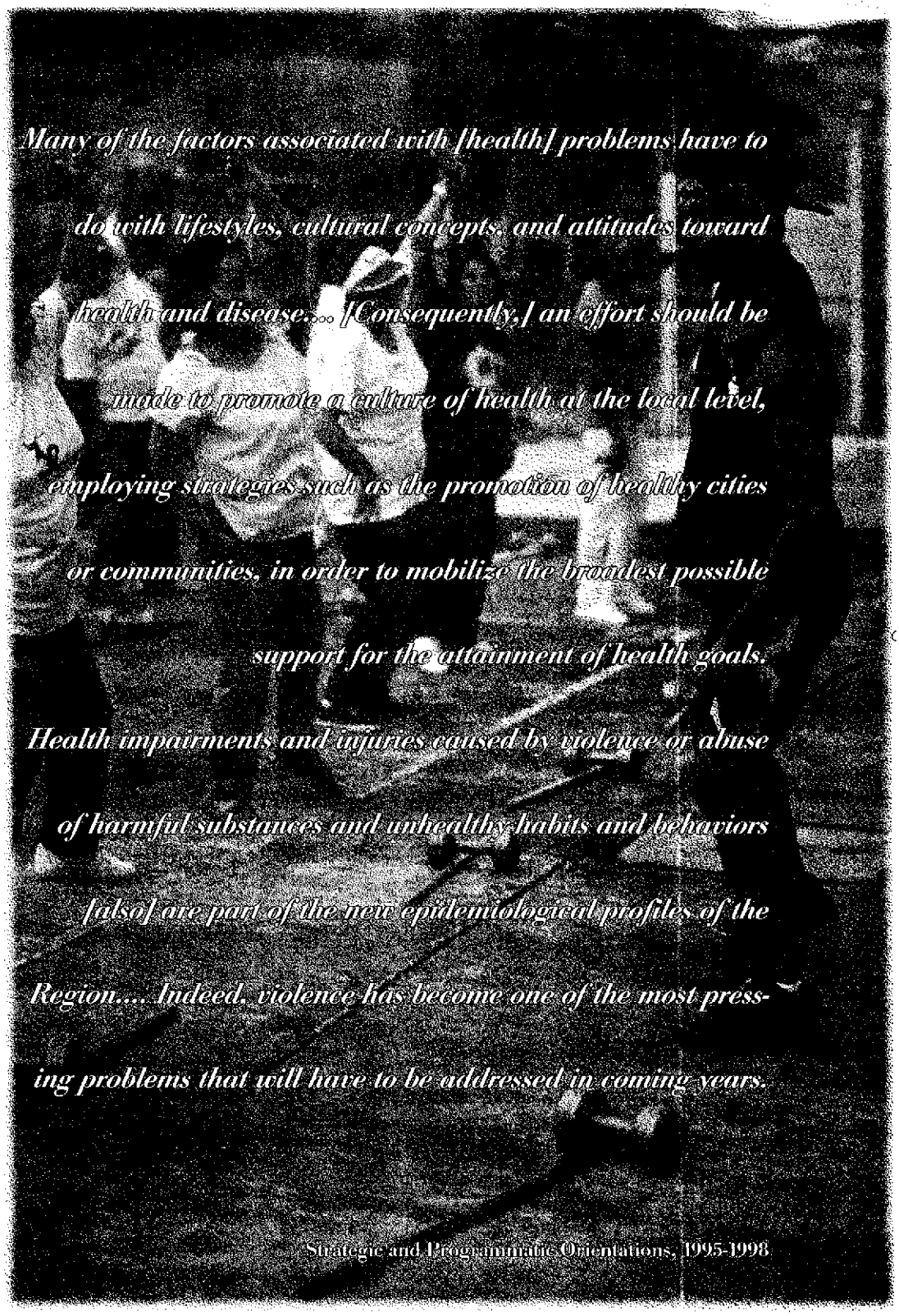
The Multi-annual Fluoridation Plan for the Region was implemented during 1995. The plan incorporates far-reaching interventions that are cost-effective and that have great potential for becoming self-sustaining in the short-term, such as the massive programs for salt and water fluoridation. These interventions are the leading strategies that will be used to reach WHO's Regional goal of an index under 3.0 caries, losses, or dental obturations per person by the year 2000.

An impact assessment conducted on Jamaica's national program for salt fluoridation revealed an overall caries reduction of more than 83%, with 86% of children under 6 years old reported to be free from caries. A similar evaluation is being carried out in Mexico.

Bolivia launched its national program for salt fluoridation, and Ecuador began to produce fluoridated salt. Epidemiological surveillance systems for fluoridation programs were developed in five countries, and national surveys of caries and periodontal disease prevalence and coverage of services were put in place in an additional five. Baseline studies of fluoride excretion in urine and fluoride concentration in water were completed in two countries. PAHO collaborated in designing the studies and in gathering and analyzing the data used in them.

Training dentists from the leading Andean and Central American dental schools also constituted a significant development in oral health. Training emphasized the incorporation of HIV/AIDS and hepatitis B in the university curriculum. More than 2,000 professionals were trained in 1995 on HIV/AIDS and more than 8,500 copies of a publication on the effects of HIV/AIDS on dentistry practice were distributed through the Region.





*Many of the factors associated with [health] problems have to do with lifestyles, cultural concepts, and attitudes toward health and disease.... [Consequently,] an effort should be made to promote a culture of health at the local level, employing strategies such as the promotion of healthy cities or communities, in order to mobilize the broadest possible support for the attainment of health goals.*

*Health impairments and injuries caused by violence or abuse of harmful substances and unhealthy habits and behaviors [also] are part of the new epidemiological profiles of the Region.... Indeed, violence has become one of the most pressing problems that will have to be addressed in coming years.*

Strategic and Programmatic Orientations, 1995-1998

# HEALTH PROMOTION & PROTECTION

As established in the Ottawa Charter, the Declaration of Santafé de Bogotá, and the Caribbean Charter, health promotion pursues the application of healthy public health policies, multisectoral action, and the reorientation of the health sector toward a new health paradigm. This paradigm should meet basic needs for sustainable human development– namely, food, nutrition, education, income, housing, water, and sanitation. It also should promote healthy lifestyles and create surroundings that foster health and human development.

Resolution XIV, adopted by the Directing Council at its XXXVII Meeting in September 1993, urged Member States to develop public policies aimed at strengthening health promotion, especially policies that involved intersectoral coordination and cooperation. It also called on the Governments to adopt programs and services designed to improve those conditions required for a healthy life and sustainable human development of individuals, families, and the community at large. The need to promote "healthy municipios" initiatives was particularly emphasized.

PAHO's technical cooperation in this area aims at promoting social development based on equity and every citizen's right to health and well-being and at strengthening the concept and the cultural value of health based on a healthy environment and fostered by the pursuit of healthy behaviors and lifestyles. Cooperation also aims at developing the health sector's capability to acknowledge and support health promotion and to assume leadership in carrying it out. Technical cooperation in this area promotes the health of the family and of the population, mental health, and the control of violence and of tobacco, alcohol, and drug abuse. It also encourages good dietary and nutrition practices. Health promotion activities are undertaken at several different levels– the municipio, the city, the community, the school, the health services, the workplace, and the family.

## THE "HEALTHY MUNICIPIOS" MOVEMENT

Through the "healthy municipios" strategy, the health sector can join forces with other social and economic sectors as they work toward attaining greater equity in health. The strategy also acts upon the true determining factors of health and transforms the individuals' living conditions.

In Latin America, the "healthy municipios" movement coincided with the development of health promotion, which has been tied to equity and to the rapidly spreading decentralization process. The development of local health systems also fueled the process. Local health systems are where decentralization, an intersectoral approach, and social participation naturally converge; they also contribute valuable methodologies and tools and help shore up the democratic process.

Experiences in "healthy municipios" have been diverse, given the social, economic, political, and cultural differences that exist from one country to another and within the same country. And yet, throughout the movement, initiatives have tended to spread rapidly on their own, and over time have begun to conform into networks. At the same time, the "healthy municipios" movement has helped to get priority health issues on the political agenda. In so doing, it has given the health sector an advantage for collaborating effectively with other sectors working to promote positive social and institutional changes and healthy public health policies. By the same token, the sector acts as a mediator between institutions and citizens through the contribution of its experience and resources. Finally, the "healthy municipios" movement fosters coordination and links among different localities, and makes it possible for effective models to proliferate. This, in turn, highlights common interests and situations that require mutual support or a joint approach.

As of 1995, "healthy municipios" movements were under way in Brazil, the Cayman Islands, Chile, Colombia, Costa Rica, Cuba, Mexico, Panama, Peru,

Trinidad and Tobago, and Venezuela. Chapter V presents country-by-country reports on specific technical cooperation accomplishments in 1995.

## "HEALTH PROMOTER SCHOOLS" INITIATIVE

This initiative is designed to develop knowledge and healthy practices and lifestyles in the schools through a participatory teaching-learning process about healthy environments. It emerged in the Americas as a result of a proposal adopted by 14 countries at the Consultative Meeting on Health Promotion and Education held at Heredia National University in Costa Rica in 1993. PAHO's regional strategy for developing and strengthening health promotion in the schools includes the establishment or upgrading of programs in health education, healthy surroundings and environments, and health and feeding programs in the schools as part of the "healthy municipios" movement. This movement and the school initiative are mutually beneficial: the former can locally identify and respond to the needs of the latter, and the latter can help to reduce risk factors to health and human development, such as students who drop out or who have to repeat grades.

There already are several successful experiences in which health promotion in the schools has been comprehensively applied. These include the project of health-generating schools in Buenos Aires, Argentina; the initiative of health promoter schools within the educational reform process and an interactive teaching-learning radio program in Bolivia; the Joint Education and Health Commission and the healthy university program in Costa Rica; the school health program in Mexico; and the school health and life skills project in Dominica, Saint Kitts and Nevis, and the British Virgin Islands. In addition, a survey of risk-related behavior in schoolchildren and adolescents is being conducted in Bolivia, Chile, Costa Rica, Cuba, Jamaica, and Mexico. This survey may be conducted elsewhere in the Region in the future.

## VIOLENCE AND HEALTH

Deaths from external causes (homicide, suicide, motor vehicle accidents, and other accidents) rank high among the causes of mortality in many countries of the Region, and they appear to be on the increase. An analysis of the main components of mortality from these causes shows that the rates of homicide in the Region have risen dramatically since the early 1980s.

Homicide and suicide obviously are the most extreme forms of violence, but there also are other forms of aggression against women, the elderly, and children that are yet to be fully studied. Domestic violence is often condoned in the Region by deeply rooted cultural patterns. Corporal punishment continues to be used in the schools, and a wall of silence goes up around sexual aggression against both women and children.

In light of this background, PAHO considers that it is extremely important to lay down clear and precise recommendations for the reporting of deaths from external causes. Thus, in cooperation with the United Nations program on urban affairs based in Quito, Ecuador, a workshop on the epidemiological surveillance of homicide and suicide was held in Cali, Colombia, on 2-5 May 1995. Representatives from nine countries attended the workshop, and advisory services were provided by CDC's National Center for Injury Prevention and Control. As a result of this workshop, a detailed register of mortality from external causes has been set up in Bogotá, Cali, Medellín, and other cities of Colombia, as well as in Rio de Janeiro and Campinas, Brazil. A similar system is also being set up in Caracas, Venezuela, and a seminar was held in Lima, Peru, for the purpose of disseminating the recommendations of the Cali workshop.

PAHO also cooperated with the University of Texas School of Public Health—which also serves as the WHO Collaborating Center on Health Promotion, Research, and Development—on the design of a multicenter study on cultural norms and attitudes toward violence. The study will make it possible to relate norms and attitudes to the rates of crime and violence in several cities. For the first time, there will be comparable data from several countries on victimization and attitudes toward various forms of domestic violence. The cities of Rio de Janeiro and Salvador, Brazil; Vancouver, Canada; Santiago, Chile; Bogotá, Cali, Medellín, and Barranquilla, Colombia; San José, Costa Rica; Havana, Cuba; San Salvador, El Salvador; and Caracas and Maracaibo, Venezuela; as well as the state of Texas in the United States of America currently participate in the study.

In Central America and some of the Andean Area countries, pilot studies are under way to test various intervention and prevention models dealing with domestic violence against women; these models are being applied mainly at the community level. Standardized protocols to measure the prevalence of child abuse are being disseminated for use in hospitals, and studies to determine the magnitude of the domestic violence problem have been initiated.

Several safe community initiatives have been implemented as a way to reduce violence of all kinds. Those in Argentina have been found to be the most advanced so far; some also are beginning to emerge in other Southern Cone countries. In Cali, Colombia, pioneering work is under way to promote community participation. The Development, Security, and Peace Project (DESEPAZ), a comprehensive effort that seeks to rehabilitate young gang members by weaning them away from violence and offering them incentives to work on development, security, and peace, is an example of this effort.

With support from IDB, a workshop was held in Caracas, Venezuela, in December 1955 to develop an instrument to measure the costs of violence. The data gathered with it will be instrumental in showing ministers of finance and planning how important it is for governments to invest in violence prevention.

## TOBACCO OR HEALTH

PAHO has assigned much importance to the health threat from tobacco use. Although smoking and other tobacco uses have been acknowledged to be complex, addictive disorders, it also is known that they can be controlled through preventive measures strategically introduced. In order to do this, leadership will have to be shared among a growing pool of human and institutional resources that have joined in the fight against tobacco use. These players come from various sectors and disciplines, including the legislative branch, the health and education sectors, scientific associations, and the mass media.

In 1995, PAHO's Interagency Regional Plan on Tobacco or Health was established, focusing on bringing together institutions from the United States of America that are working on the campaign against tobacco use, such as NIH's National Cancer Institute, CDC, and the American Cancer Society. Other participants include the Government of Canada (Health Canada), the International Union Against Cancer, and the Latin American Coordinating Committee for the Campaign Against Tobacco Use.

The above-mentioned organizations have supported a plan of action and they have delegated its coordination and assigned the executive secretariat to PAHO. The targets for action under the plan include promoting and strengthening anti-smoking alliances in the countries; developing knowledge and understanding of the issue; selectively disseminating printed and electronic information; mobilizing resources; developing educational and health promotion strategies for preventing and treating tobacco use; and, finally, taking maximum advantage of public communication to enlist public opinion in favor of tobacco-free lifestyles. PAHO's technical cooperation with the countries has been stepped up with a view to studying the epidemiological status of tobacco use. Resources also have been allocated for supporting local initiatives aimed at the prevention and control of the smoking habit.

## FAMILY AND POPULATION HEALTH

The new approach to family and population health allows the Organization to respond to several aspects and lines of action proposed at the World Summit for Children and the Fourth World Conference on Women. Moreover, in response to growing interest in the health of adolescents, in 1995 PAHO established a regional post to address adolescent issues and coordinate regional actions in this area. The Organization's new structure also reflects the important shift that has taken place at the international level toward expanding the concept of reproductive health. This concept now embraces sexuality; family planning; care during pregnancy, delivery, and the puerperium, as well as care of the newborn; sexually transmitted diseases, including HIV and AIDS; the prevention of gynecological cancer; and the prevention of sexual and domestic violence. Each component will be adapted to each country's available resources and to the level of development its services have achieved.

In 1995, PAHO participated in one of the most important political events in the Region regarding family and population health—namely, the Fifth Conference of Wives of Heads of State and of Government of the Americas, held in Asunción, Paraguay. The meeting gave priority to the reduction of maternal mortality and assigned to PAHO the

responsibility of coordinating technical cooperation on this subject in the countries. In preparation for the conference, a CDC advisory group was convened to evaluate and prepare a report on progress achieved under the Regional Plan for the Reduction of Maternal Mortality.

During the period covered by this report, a Regional Meeting of the Ibero-American Youth Organization also was held. At the meeting, PAHO was given responsibility for supporting and providing technical orientation on aspects related to the health of adolescents and young adults.

In terms of the evaluation of the targets set for mid-decade by the World Summit for Children, one of PAHO's most important contributions in 1995 was the preparation of a report on progress achieved in the Region's countries. The report was presented at a meeting convened by UNICEF in Antigua, Guatemala, with the participation of FAO, UNFPA, the ILO, UNDP, UNESCO, the World Bank, IDB, and USAID.

Another significant effort was the interagency initiative on mental health and the psychosocial development of children that was carried out with the cooperation of OAS, UNICEF, UNESCO, ECLAC, the Inter-American Children's Institute, the World Organization for Preschool Education, and the Latin American Pediatric Association. This group developed an interagency plan of action and gathered the Andean Area and Central American countries in an intersectoral meeting on the subject, at which the health, education, and judicial sectors participated.

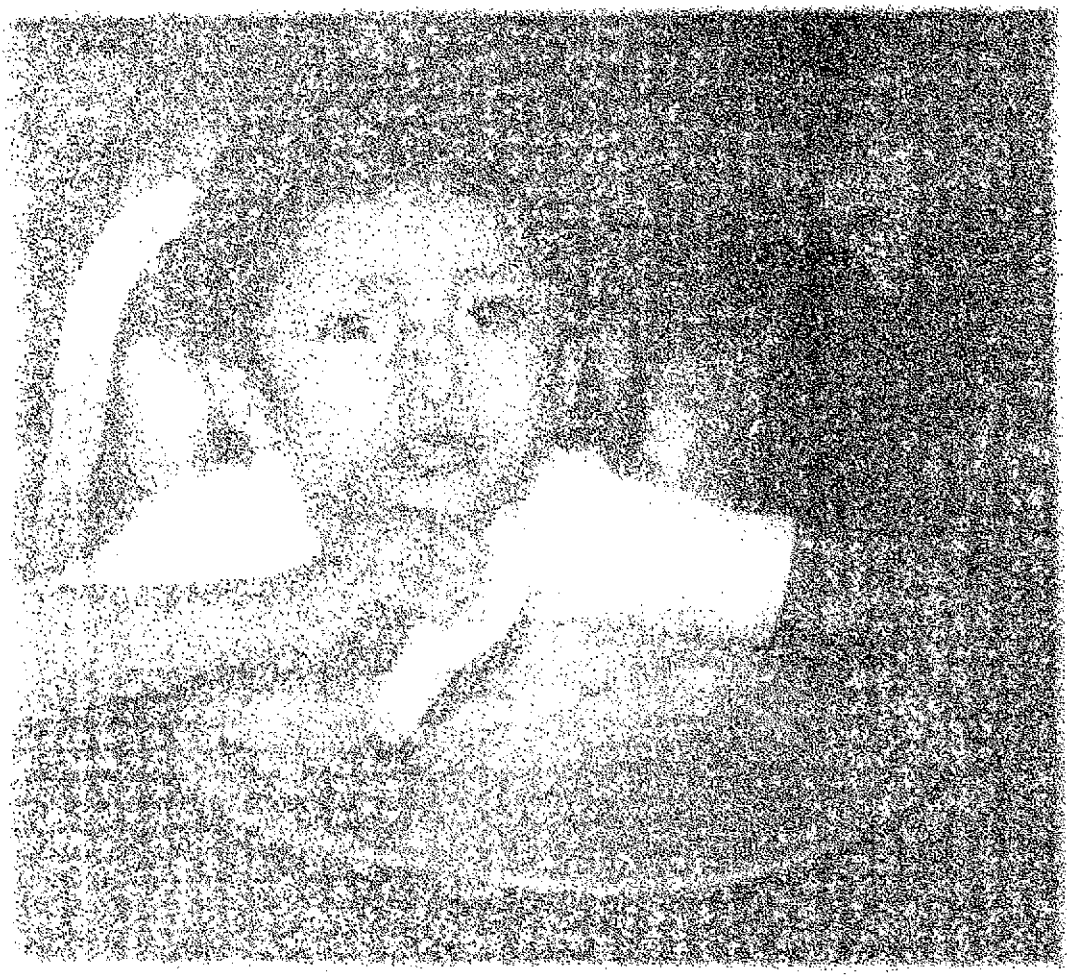
In 1995, financial resources were mobilized to carry out activities under seven interagency projects on family and population health. With support from UNFPA, work was carried out on projects to strengthen the management of reproductive health services and to improve the quality of maternal and child care, reproductive care in general, and the care of adolescents; to reduce maternal morbidity and mortality in the Region; and to upgrade the teaching of subjects related to reproductive health in the schools of health sciences. In addition, with cooperation from the Kellogg Foundation, progress was made under a project on comprehensive adolescent health, and, with support from the Government of the Netherlands, another project on the strengthening of maternal care in the local health services of Central America got under way.

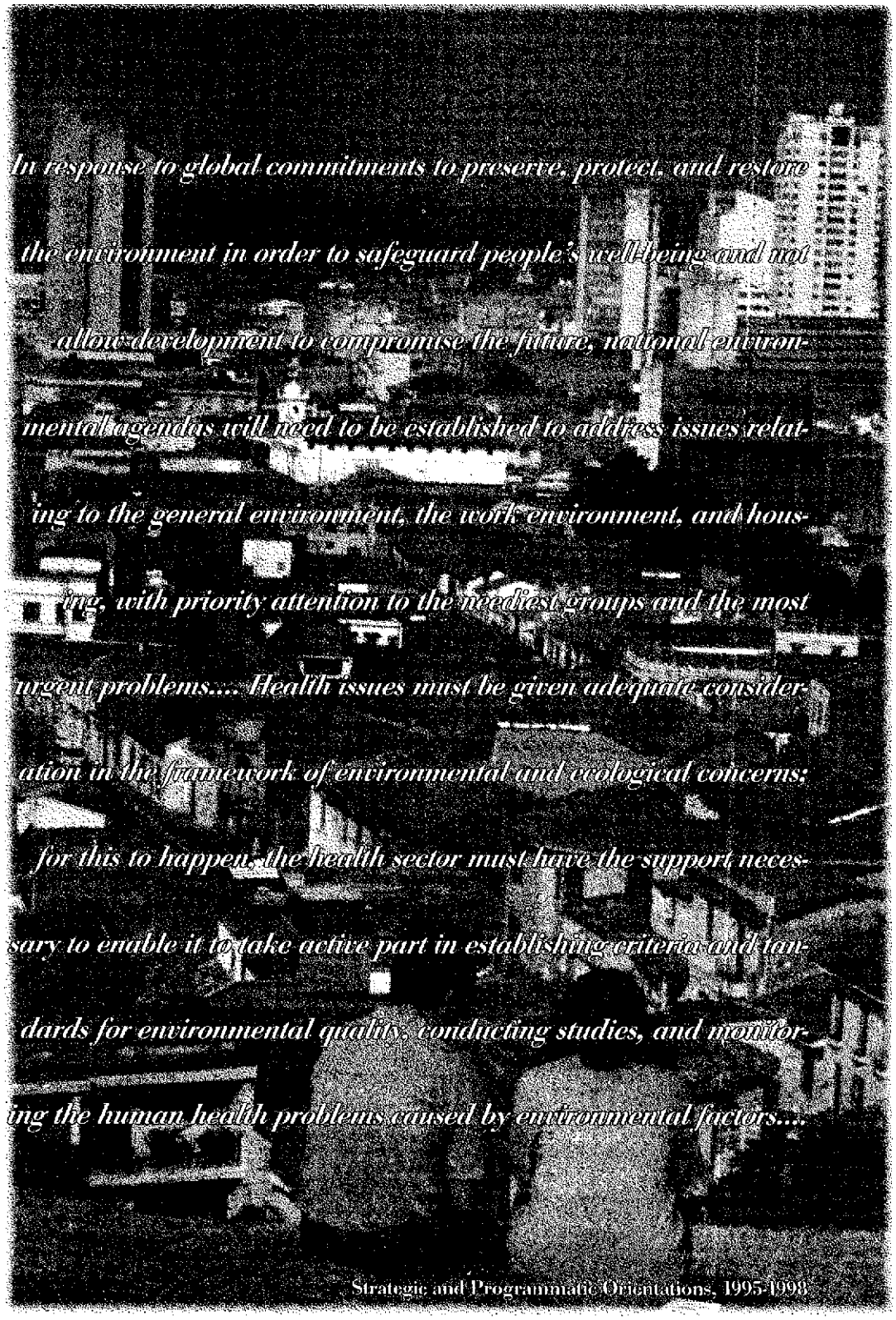
## FOOD AND NUTRITION

Good nutrition status and food availability are universal rights. This tenet guides the Organization's work and underlies the Regional Plan of Action in Food and Nutrition. In the current decade this principle has gained importance, given that high percentages of the population in the developing countries have only limited access to an adequate diet. In addition, broad sectors of the population suffer from nutritional deficiencies as a result of insufficient food, inadequate maternal and child health care, and poor access to health services, which in turn lead to the state of poverty in which they live. The plan of action relies on health promotion to combat the problems related to malnutrition and to promote a healthy diet throughout an individual's life. A comprehensive approach has been adopted for solving nutritional problems, using interventions aimed at the immediate and underlying causes and with a view to improving food security and nutrition. To this end, the Organization is working on aspects related to food security and the prevention and treatment of problems that lead to malnutrition, especially protein-energy malnutrition, micronutrient deficiencies, and obesity among the poor. Collaborative efforts also are under way to strengthen food and nutrition surveillance, as well as education and social communication, which are considered to be the foundation for bringing the actions together.

In 1995, as part of the regional plan for the control and elimination of micronutrient deficiencies, a strategy was formulated and a regional plan of action adopted for the control of anemia due to micronutrient deficiencies, especially of iron. Activities were carried out with Argentina, Belize, Costa Rica, Cuba, Ecuador, El Salvador, Guatemala, Paraguay, Peru, and Venezuela on the formulation and implementation of national nutrition plans, the control of micronutrient deficiencies, nutritional surveillance, the development of dietary guidelines for children under 6 years old, and the assessment of obesity problems among the poor.

As a way to further strategic alliances in support of food and nutrition programs in the countries, ties were strengthened with Cornell University, USAID, CIDA/Canada (on controlling anemia and iron deficiency), Opportunities for Micronutrient Inter-vention (OMNI), the Micronutrient Initiative (in which the World Bank, IDRC, and other agencies participate), the World Bank, and the International Life Science Institute (ILSI).




In response to global commitments to preserve, protect, and restore
the environment in order to safeguard people's well-being and not
allow development to compromise the future, national environ-
mental agendas will need to be established to address issues relat-
ing to the general environment, the work environment, and hous-
ing, with priority attention to the neediest groups and the most
urgent problems.... Health issues must be given adequate consider-
ation in the framework of environmental and ecological concerns;
for this to happen, the health sector must have the support neces-
sary to enable it to take active part in establishing criteria and tan-
dards for environmental quality, conducting studies, and monitor-
ing the human health problems caused by environmental factors....
Strategic and Programmatic Orientations, 1995-1998

# ENVIRONMENTAL PROTECTION & DEVELOPMENT

Latin American and Caribbean countries are living through a period of accelerated development which often has been associated with rapid urbanization and its attendant environmental degradation in both rural and urban areas. Environmental damage and its potential harm to the population's health is becoming critically important to government programs.

Health and development are intricately related—in fact, it can be said that a balanced development cannot be attained without a healthy population. As do all living creatures, human beings depend on their surrounding environment for their survival and, hence, for their health. If the environment can no longer provide the necessary quantity and quality of water, food, and shelter for the population living within it, either because resources are inadequate or poorly distributed, the health of that population begins to break down. And if, in addition to these deficiencies, countless risks and problems from exposure to hostile agents in the environment also assail the population, the damage to health is even greater.

An intersectoral effort is needed for positive changes to occur in the relationship between health and the environment. Improvements in public health must be tied to environmental and socioeconomic improvements in order to be able to have intersectoral activities that will guarantee sustainable development for the population in its communities.

Governments and international agencies have recognized the urgent need to implement the Declaration of Principles and Program 21 of the 1992 United Nations Conference on Environment and Development (UNCED-92), as well as the mandates emanating from the Ibero-American summits, the decisions taken at the subregional meetings of heads of state and government, and the plan of action agreed to at the Summit of the Americas in 1994. Participants at this last meeting proposed to guarantee sustainable development and to conserve natural resources for future generations.

In 1995, PAHO convened the Pan American Conference on Health and Environment in Sustainable Human Development to facilitate fulfillment of the commitments that the countries assumed in these forums. The conference was held at PAHO Headquarters in Washington, D.C., on October 1-3, 1995, and received support from other international agencies such as the World Bank, IDB, OAS, UNDP, and UNEP. Participants included 73 ministers and vice ministers of health, of environment, and of economy from the Governments of the Region. In addition, because it was an open event, representatives from other branches of government, academic institutions, business associations and trade unions, nongovernmental and volunteer organizations, and grass roots local organizations.

The conference was conceived mainly as a political event, designed to develop an understanding of the full scope and magnitude of the issues of health and environment, as well as social issues in general, including their mutual interaction and their contribution to sustainable human development. Thus, the conference was an ideal mechanism for fostering follow-up discussions throughout the Hemisphere as part of the process initiated by UNCED-92. It is hoped that this process will continue until the objectives embodied in the Declaration of Rio and Agenda 21 of the Rio Summit are attained. In addition, the conference attempted to strengthen and consolidate the participation and leadership of the health and environment sectors in the formulation, execution, and follow-up of national development policies. In this sense, it provided an important opportunity to reinforce and facilitate the coordination of external cooperation in support of national processes.

The conference's centerpiece was the "Pan American Charter on Health and Environment in Sustainable Human Development," a Hemisphere-wide declaration expressing the shared determination to move forward within the framework of equity, solidarity, social justice, and environmental preservation. In support of this initiative, a regional plan of action was drafted, which takes into account new trends in planning and will serve as a strategic guide for implementing the Pan American Charter as it is adapted to each country's national reality. In addition, the recommendations and proposals that emerged from the conference led to the preparation of a document on the opportunity for change under the banner of health and environment in sustainable human development. The conference helped

to reaffirm, facilitate, and consolidate national processes for incorporating health and environment into national development policies and plans so that development will be both human and sustainable–this is considered to be the conference's greatest contribution.

In 1993, the Organization put forth the Plan for Regional Investment in Environment and Health (PIAS), which was designed to generate investments to rehabilitate and expand the services and infrastructure that are necessary for a healthy environment. To this end, the plan aimed at improving national capabilities for conducting sectoral analyses to determine investment needs in environment and health and for developing investment projects. Reviews of the drinking water and sanitation and the solid waste sectors were carried out in 1995; as a result of this effort, projects were developed for the diagnosis and characterization of key aspects for sectoral development, sectoral policies were proposed, and investment programs and profiles of priority projects were developed. Table 1 summarizes these activities.

## WATER AND SANITATION

The discharge of untreated wastewater is a serious problem in every country, especially those with large cities. It is estimated that less than 10% of all wastewater is treated, and then only partially so. Municipal and industrial wastewater is the number one cause of surface water pollution.

In 1993, on the occasion of the congress of the Inter-American Association of Sanitary and Environmental

**TABLE II-1.** Results of sectoral analyses on drinking water and sanitation and solid waste coordinated by the Plan for Regional Investments in Environment and Health (PIAS), by country, 1995.

| COUNTRY | PARTICIPATING AGENCIES | ACCOMPLISHMENTS |
|---|---|---|
| **DRINKING WATER AND SANITATION** | | |
| Mexico | PAHO, IDB, UNICEF, CNA, IEA, SS | A sectoral analysis conducted in the State of Oaxaca resulted in the reorganization of the State Development Plan for the Drinking Water and Sanitation Sector. |
| Belize | PAHO, IDB, USAID, UNICEF | An investment plan was developed, which will guide work in the drinking water and sanitation sectors. |
| Cuba | PAHO | A meeting for potential donors from throughout the world was convened to enlist financial resources for investment, rehabilitation, expansion, and operational development projects in the sector that had been developed as a result of the sectoral analysis. |
| **SOLID WASTE** | | |
| Guatemala | PAHO, World Bank, IDB, UNICEF, USAID | The study led to the restructuring of a World Bank loan to 22 mid-sized cities and another IDB loan for improving the cleanup system in the capital. |
| Colombia | PAHO, World Bank | Based on the study's findings, a scheme was developed for reorganizing solid waste institutions and a master investment plan for the solid waste sector was prepared. As a result, authorities have requested a study of the drinking water and sanitation sector for 1996. |
| Uruguay | PAHO, GTZ, UNDP | The first investment program for development of the sector was prepared. |

Engineering (AIDIS), PAHO, that Association, and the Caribbean Water and Wastewater Association signed a declaration establishing the first Saturday in October as "Inter-American Water Day." The observance of this day has been used to promote such ideas as the importance of water for health, the role of citizens in the conservation and protection of water resources, and the need to step up the campaign against water pollution in order to reduce the frequency of water-borne diseases to communities. The observance also has been used to show how the campaign can be used as an opportunity for the various sectors involved to work together.

In 1995, 25 countries joined in observing "Inter-American Water Day." Millions of people, including schoolchildren, came together under the motto, "Water: A Heritage to Be Preserved;" information on health and the environment that had been prepared by PAHO and other concerned agencies in the Region was distributed during the celebration. Cabinet members and other high-level officials appeared in public or in the media to speak about policies and programs relating to water. The celebration also included contests in the schools, visits to water treatment plants, and public relations campaigns in the media. The publicity was aimed at adding to the public's understanding about the health benefits of safe water supply and the importance of conserving and protecting it for the future.

The cholera epidemic that swept through Latin America in 1991 called attention to serious problems in the quality of water and sanitation in the Region. PAHO supported various projects aimed at addressing these shortcomings. For example, in 1995 a pilot experiment in several Bolivian towns combined household water disinfection and safe storage practices. In light of the need for low-cost preventive measures that are effective and easy to apply and disseminate, PAHO, in cooperation with CDC, the Children's Health Project, and "Comunidad" [Community], a nongovernmental organization affiliated with the Bolivian Department of Health, developed a model that requires only the following three basic items:

- a narrow-necked plastic container with a cap and spigot, large enough to store 20 L of water, made in Bolivia;
- a disinfectant solution prepared locally, using an electric generator powered by a portable, salt-and-water operated battery. The solution is distributed to each home in 250 ml plastic containers; 2 ml, or a capful, of this solution is to be added to the drinking water stored in the 20 L container; and
- community education on the causes of diarrhea and the importance of preventing it, and how to use the water container and the disinfectant solution, emphasizing the importance of using the stored and treated water for drinking, cooking, hand-washing, and washing vegetables and eating and cooking utensils.

This model was successfully extended to several Bolivian localities, including an Aymará community in El Alto, whose water supply comes from shallow polluted wells. The population found the methodology proved extremely easy to use, and there has been a notable improvement in the quality of the drinking water. Another trial, carried out in the rural community of Huaricana, showed that the residents could produce a sodium hypochlorite solution locally. A third experiment in Bolivia—a field trial carried out in Montero—established the model's efficacy for reducing the incidence of diarrheal diseases. Preliminary results have shown that the families participating in the project were able to reduce their cases of diarrhea by more than 40%, compared with nonparticipating control families.

Given the success obtained in these trials, the models are likely to be implemented in other communities. The success of these trials may encourage other organizations or population groups interested in improving the quality of their water and sanitation to try the same approaches. In fact, they may prove to be very useful for similar communities in other developing countries and offer significant benefits for health—especially the health of children.

## SOLID WASTE

It is estimated that 370 million urban inhabitants in Latin America and the Caribbean produce 264,000 tons of trash and other solid waste each day; about 75% is collected. At the same time, there is growing concern about the increased content of toxic chemicals and cancerigenic, mutagenic, and teratogenic substances in urban solid waste.

Regarding the management of municipal solid waste, PAHO continued to provide technical advisory services on the design and operation of sanitary landfills and on upgrading the management of the institutions that provide this service. A manual also was published on the management of hospital waste, and various training activities were carried out, including a course on sanitary landfills, given jointly with the International Solid Waste Association (ISWA). This

course was held at PAHO Headquarters and was taught by 12 world-renowned experts who also constitute the ISWA working group on sanitary landfills. There were 60 participants from throughout Latin America, representing both public and private enterprises. For the first time, a registration fee was charged at a PAHO-sponsored event on water and sanitation; the money was used to cover the cost of the course.

## HEALTHY WORK ENVIRONMENTS

The economically active population represents between 38% and 66% of the general population in the Region. Given the essential contribution of workers to the countries' economic growth and to sustainable human development, their health has high priority.

Estimates indicate that 20% to 30% of the gross national product of the Region's countries goes toward defraying social and health costs of mortality and morbidity and toward paying for the permanent disability of workers.

PAHO technical cooperation in this area supported innovative activities and projects for identifying and reducing risks and hazardous working conditions. In collaboration with the Pan American Center for Human Ecology and Health, the PLAGSALUD component within the Environment and Health in the Central American Isthmus (MASICA) program was carried out. With this approach, and through greater involvement of the local health services, it has been possible to strengthen national capabilities for epidemiological surveillance as well as prevention and treatment of pesticide poisoning. Also of note was the project undertaken in cooperation with the Colombian Petroleum Enterprise which investigated the possible effects of exposure to aromatic hydrocarbons on the health of workers. This project made it possible to establish a political and technical alliance among workers, employers, and government personnel, which has set a valuable precedent. This kind of technical cooperation is being used as a model for other national-level actions.

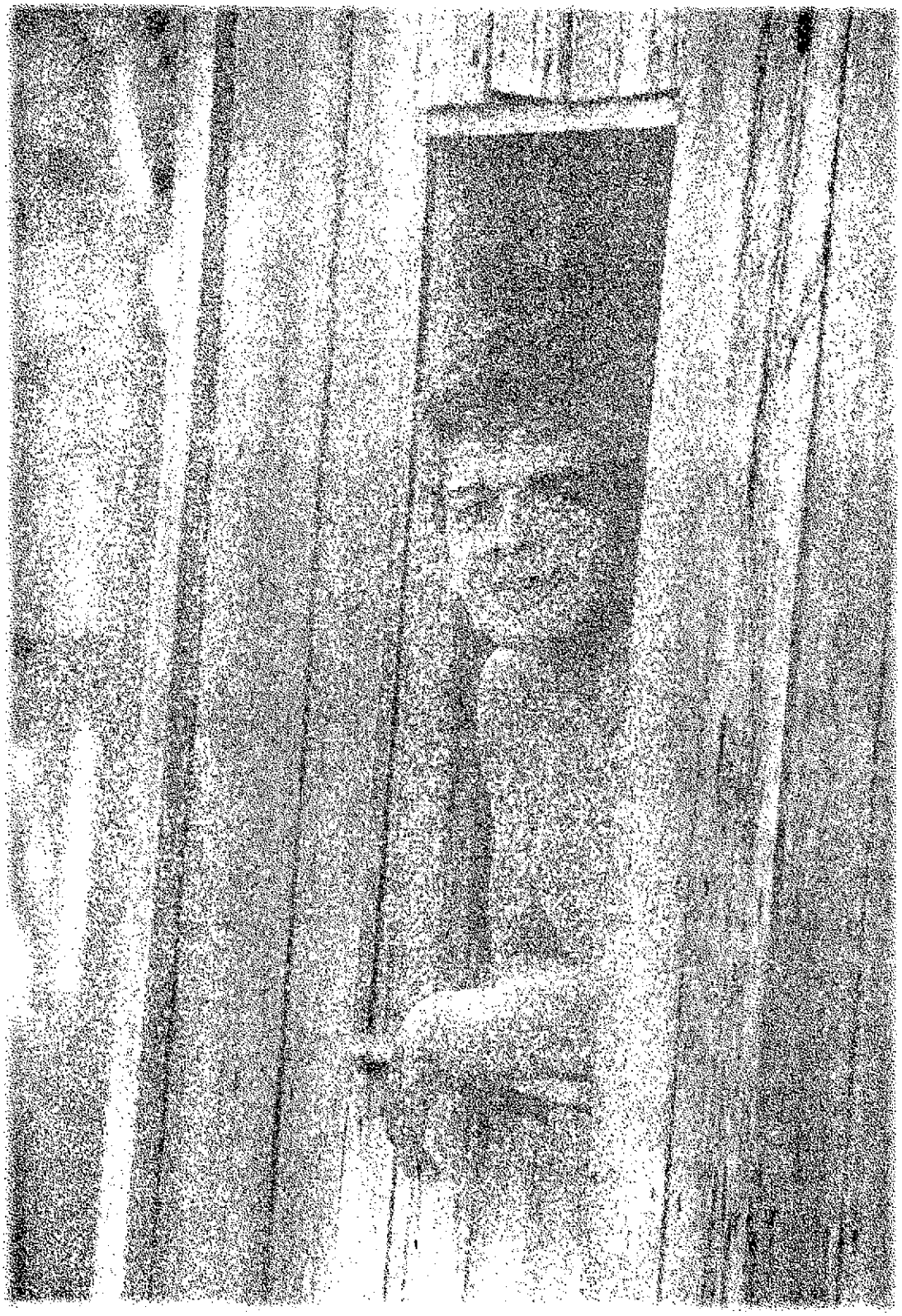
Cooperation also was channeled to an interinstitutional project in Argentina involving the ministries of Economy, of Labor, and of Social Security; suitable mechanisms were developed for modernizing the State in terms of work safety and the prevention of accidents and occupational diseases. In addition, with a view to supporting the Region's economic integration initiatives (NAFTA, the Andean Pact, CARICOM, MERCOSUR), multisectoral and multidisciplinary national and subregional activities are being promoted, which are aimed at addressing problems related to workers' health.

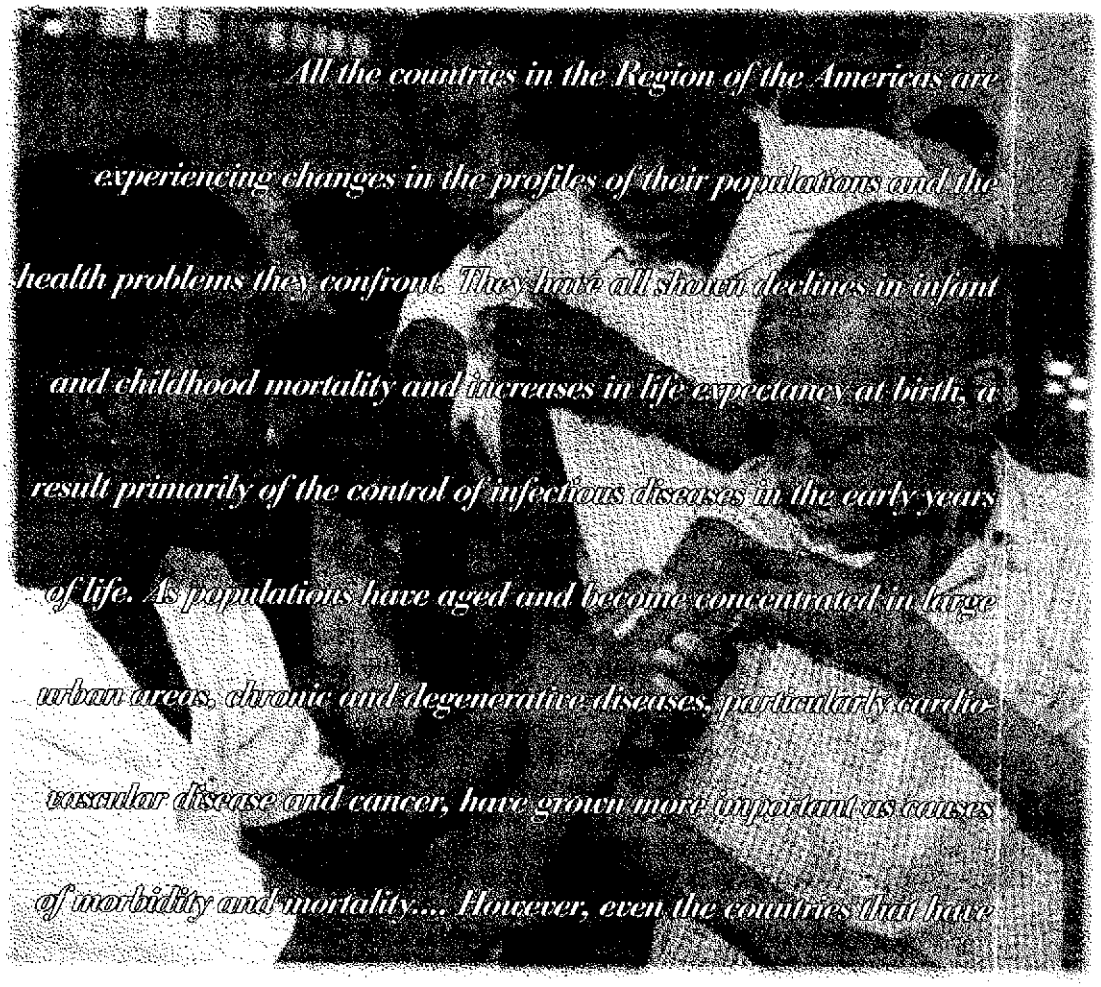
In Ecuador and Venezuela progress is being made in the development of pilot information systems on occupational health for the informal sector; these systems are being implemented in the local health services. In addition, innovative programs for occupational epidemiological surveillance are being applied in the steel and manufacturing industry in Venezuela and in the health services in Chile. In addition, an industrial risk prevention service was inaugurated in Bolivia. In 19 English-speaking Caribbean countries, working groups were formed to develop national workers' health plans which will be implemented in the next five, years. Some of these groups are multipartite and cooperate with the ministries of Health, Labor, Environment, and Social Security, as well as with the chambers of commerce, trade unions, universities, and other entities.

## HOUSING HYGIENE

Rural and marginal urban human settlements and precarious housing conditions contribute to the prevalence of certain vector-borne diseases and lead to social problems. Poor housing conditions also influence the deterioration of the quality of life.

In 1995, major progress was achieved in the activities that PAHO carries out to promote health in relation to housing. PAHO's interprogram and interdisciplinary work, particularly the efforts of its divisions of Disease Prevention and Control and of Health and Environment, deserve special mention. These divisions coordinate their regional and country-level activities, especially those dealing with the control of Chagas' disease. In addition, a network of health and housing centers has been created with support from the State University of New York/Buffalo—a WHO Collaborating Center. A second collaborating center was designated in Cuba, which is part of the above-mentioned network. The first meeting of coordinators of housing health centers, held in Mexico in October and attended by representatives from eight countries, is an event that also deserves mention.





*All the countries in the Region of the Americas are experiencing changes in the profiles of their populations and the health problems they confront. They have all shown declines in infant and childhood mortality and increases in life expectancy at birth, a result primarily of the control of infectious diseases in the early years of life. As populations have aged and become concentrated in large urban areas, chronic and degenerative diseases, particularly cardiovascular disease and cancer, have grown more important as causes of morbidity and mortality.... However, even the countries that have reduced infectious diseases must maintain programs capable of preventing their recurrence and dealing with new problems such as HIV/AIDS, hemorrhagic fevers, and hantavirus infections.*

Strategic and Programmatic Orientations, 1995-1998

# DISEASE PREVENTION & CONTROL

## PREVENTION AND CONTROL OF INFECTIOUS DISEASES IN CHILDREN

The Organization, in partnership with UNICEF, has developed a strategy for the integrated treatment of major childhood illnesses. This approach is considered to be the most effective intervention to date for reducing mortality and morbidity rates in children under 5 years old in developing countries.

### Vaccine-Preventable Diseases

Building upon the surveillance system established to track cases of acute flaccid paralysis as part of the effort to eradicate polio, the Region of the Americas receives weekly notifications from more than 22,000 reporting units on the occurrence of neonatal tetanus and suspected cases of measles. Activities related to polio eradication and measles elimination are described in the section on elimination and eradication of diseases.

The Region has attained the World Summit for Children's target for eliminating neonatal tetanus as a public health problem—yet another milestone achieved through PAHO's immunization programs. Efforts continue to identify high-risk areas and vaccinate all women of childbearing age with at least two doses of tetanus toxoid.

The logistical aspects of immunization programs have continued to be sustained and improved with the support of national governments, as well as bilateral and multilateral agencies, such as UNICEF, USAID, Japan's International Cooperation Agency, and the governments of Belgium, France, Luxembourg, and Spain.

### Diarrheal Diseases

Diarrheal diseases continue to rank among the first five causes of deaths in infants under 1 year old, and they are the first cause of death in children aged 1 to 4 years in many countries. In 1995, the number of diarrheal-disease episodes in children under five years old for 33 countries was estimated to be an average of 3.0 episodes per child per year in 33 countries.

To combat diarrheal diseases, PAHO has been working with the countries to strengthen national programs and activities and establish the strategies needed to reach the targets set by the World Summit for Children. During 1995, technical cooperation was geared towards implementing case management training methodologies in medical schools, testing a new long-distance education training course on cholera and diarrheal diseases, and strengthening the diarrheal disease training units. Working relationships and coordination with UNICEF, USAID, and nongovernmental and national organizations also were strengthened as a way to promote and support activities.

### Acute Respiratory Infections

Along with diarrheal diseases and malnutrition, acute respiratory infections (ARIs) are among the top three causes of death in children under 5 years old in developing countries. Pneumonia, the number one reason for deaths due to ARIs, is among the five main causes of death in children under 5 years old and among the three main causes of death in children between the ages of 1-4 years in most of the developing countries of the Americas. Community studies indicate that four to six yearly episodes per child occur, representing 40% to 60% of all consultations and 20% to 40% of all hospitalizations for children under 5 years old.

PAHO has played an important role in implementing the commitment made by the countries of the Region as part of the goals of the World Summit for Children, to reduce pneumonia deaths by 30% by the year 2000. To follow up on progress, the Organization has established a regional information data base on mortality due to pneumonia and other ARIs. Technical cooperation has focused on supporting the countries in establishing the training units to improve case management at the health services and community levels. There are approximately 120 units in operation as of now.

### Intestinal Helminth Infections

It is estimated that helminth infections (ascariasis; trichuriasis; hookworm infections, or uncinariasis; enterobiasis; strogyloidiasis; teniasis) affect between 20% and 30% of Latin America's general population, with prevalence rates as high as 60% to 80% in highly endemic areas. For years, efforts have been made to control these infections in Latin America, but improvements were short-lived, and as soon as measures were stopped, reinfection rates of parasites returned to initial levels. The burden of disease from intestinal helminths has been estimated at 2.4 disability-adjusted life years (DALYs) lost in millions, and the cost of infections by intestinal worms also has been calculated in terms of nutrients wasted as unabsorbed food. Intestinal helminth infections can be successfully controlled by programs that treat children periodically. If this course is followed, the intensity of helminth infections is reduced to levels that will cause little, if any, disease and the risk of reinfection is greatly reduced as well. Quantitative parasitological studies should be carried out to determine the parasitic burden in populations, so that follow-up studies to assess the impact of parasite reduction activities in the community can be carried out.

As a way to reduce morbidity caused by geohelminths, the Organization has promoted the implementation of a standard protocol for the elimination of intestinal parasites in children ("protocolo estandarizado para la eliminación de parásitos intestinales en niños"—PEPIN) in four Central American countries. The protocol considers interventions such as targeted chemotherapy coupled with improved health education and social communication practices, as well as the promotion of environmental sanitation. The intervention's effect is measured mainly by the concentration of eggs per gram of feces eliminated in a sentinel population after each treatment with mebendazole/albendazole. Upon five four-month treatments administered between October 1993 and February 1995 to 12 million preschoolers and school-age children in Mexico, a reduction of more than 90% of the worm burden was observed.

## EMERGING AND RE-EMERGING DISEASES

The epidemics caused by the Ebola virus in Zaire and the Hantaan virus in Argentina, Chile, and Paraguay pointed up both the countries' vulnerability to uncommon etiologic agents and the need to take swift and coordinated action.

In response to the needs raised by these epidemics, PAHO convened an international group of experts, who met in June 1995 to examine strategies for the prevention and control of new, emerging, and reemerging infectious diseases. As a result of this meeting, a regional plan of action was formulated to serve as the basis for establishing regional and subregional strategies to assist Member States as they devise approaches to cope with their specific problems. The plan proposed four goals, namely: (a) strengthen regional networks for the surveillance of infectious diseases in the Americas; (b) establish the national and regional infrastructure needed to establish early warning systems to alert people to the risk of infectious diseases and provide a rapid response through the strengthening of laboratories and multidisciplinary training programs; (c) promote applied research in the fields of rapid diagnosis, epidemiology, and disease prevention; (d) strengthen regional capacity to implement effective prevention and control strategies.

The Directing Council, at its XXXVIII Meeting in September 1995, examined and approved the plan.

PAHO has demonstrated the capability to provide rapid and efficient coordination of intersectoral resources and to promote community involvement in the timely control of epidemics of emerging and reemerging diseases.

### Cholera

Since its explosive onset in Peru in January 1991, the cholera epidemic has marched across Central and South America, affecting every country but Uruguay. Because cholera is under-reported and case definitions differ from country to country, cholera surveillance figures represent only a small fraction of the actual number of people infected. From 1991 to 1995, Latin American countries reported more than 1 million cases of cholera, including more than 11,000 deaths. In 1995, total reports of cholera cases declined, continuing a trend that has been observed each year since 1991. The overall cholera case fatality rate in Latin America, which has consistently held at 1% or lower since 1991, remained at 1% for the year as well. These data indicate that cholera case management continues to be effective in most of Latin America.

Annual cholera incidence rates for affected countries in the Western Hemisphere have decreased from a peak of 89 cases per 100,000 persons in 1991 to 19 cases per 100,000 population in 1995. The countries with cumulative cholera incidence rates greater than 20 per 100,000 persons are concentrated in a band extending from Mexico to the northern border of the Southern Cone countries. The Andean countries in South America, and Guatemala and Nicaragua in Central America had the highest cumulative incidence rates from 1991 through 1995. Cumulative incidence rates were lowest for Chile, Paraguay, and the United States.

Control measures implemented by the Organization in coordination with the countries and the international community, have led to this very encouraging downward trend. Since the beginning of the epidemic, the Organization has intensified prevention and control efforts for essential aspects of case management training, epidemiological surveillance, improvements in laboratory diagnostic capabilities, water and environmental sanitation, personal and domestic hygiene, health education, food safety, social mobilization, and public information. As of 1995, the PAHO/IDB technical cooperation program had provided support of more than US$ 3.8 million for projects in 15 countries. Nevertheless, and despite preventive measures and international support, the disease is likely to persist in many countries in endemic seasonal patterns, unless major improvements in water distribution, sewage treatment systems, hygiene education, and food safety are achieved and sustained.

## Plague

During 1995, PAHO mobilized a total of US$ 680,000 in financial resources from the European Community Humanitarian Office (ECHO) to strengthen plague prevention and control activities in Peru. These activities helped to significantly reduce the number of reported cases of the disease. In 1994, a total of 1,211 plague cases were reported from four departments (Cajamarca, La Libertad, Lambayeque, and Piura), with a case fatality rate of 4.5%, while in 1995, only 97 cases and 2 deaths were reported (case fatality rate of 2.1%).

In order to prevent rodent infestation of human dwellings and improve the economic income of small producers, 567 grain silos, each with a capacity of 200 kilograms, were constructed. Courses in the use and maintenance of the silos were given before they were turned over to the farmers.

Another measure taken to control the flea vector was insecticide treatment of 15,470 dwellings, which served to protect a population of 269,466 people in the four above-mentioned departments. In addition, studies were conducted to determine the risks of plague in the ports of Chimbote, Salaverry, and Santa Rosa and in the cities of Trujillo, Chiclayo, Cajamarca, and Lima. In the latter four cities, rodent and vector control actions also were undertaken to prevent plague.

With a view to involving the community in the prevention of plague, training was provided to 1,923 community health observers in various aspects of plague transmission, rodent and vector control, breeding of guinea pigs outside human dwellings, proper grain storage, and reporting and treatment of human cases of the disease. The reduction in plague incidence and mortality is in large part attributable to the participation of the community, which helped to structure a community-based epidemiological surveillance system and strengthen the delivery of timely treatment in primary health care services. Interinstitutional and intersectoral coordination also were major factors contributing to the success achieved in plague control activities.

## Leptospirosis

In late 1995, Nicaragua experienced an outbreak of febrile illness that affected 1,900 persons, with 200 hospitalizations and at least 30 deaths. Initially, the disease was suspected to be either dengue or dengue hemorrhagic fever or a disease caused by a viral agent associated with rodents. Teams of clinical physicians and epidemiologists from Cuba and Nicaragua, as well as from PAHO and the CDC, worked intensely for almost three weeks to identify the infectious agent causing the clinical symptoms. After numerous tests, leptospiral antigens were isolated in samples taken from patients. In November it was confirmed that the disease was leptospirosis. The outbreak was concentrated in the area of Achuapa and surrounding communities, some 65 miles from Managua.

The efforts of health personnel in the affected areas deserve recognition, since it was their timely and effective attention to patients that kept the case fatality

rate low. The ministries of health of El Salvador, Honduras, and Nicaragua also showed considerable solidarity, providing a responsible and effective response once the diagnosis had been confirmed, establishing lines of action for combating the epidemic and alerting their populations.

As a follow-up to these actions, the Nicaraguan Ministry of Health, in collaboration with PAHO, formulated strategies for rodent control, implemented public health education campaigns, and initiated a chemoprophylaxis regimen of doxycycline administered once weekly to protect the entire population at risk.

### Venezuelan Equine Encephalitis

In May 1995, an outbreak of Venezuelan equine encephalitis (VEE) occurred in the state of Falcón in northern Venezuela. From there the disease spread west and south, extending into the states of Carabobo, Cojedes, Guaricó, Lara, Yaracuy, and Zulia, where most of the cases were reported. In October of the same year, reports had been received of 11,390 human cases of a febrile illness resembling VEE, with 16 deaths from this cause. Of the total number of cases, 185 were confirmed to be VEE through isolation of the virus or a hemagglutination inhibition test.

In September, cases of VEE were reported in the communities of Mayapo, Manaure, and El Pájaro in the department of Guajira, Colombia, from where the outbreak spread southeast, reaching the Atlantic border of that department. The outbreak was contained in Guajira, thanks to timely control actions. Even so, 14,156 human cases of a disease consistent with VEE, with 1,258 hospitalizations and 26 deaths, were reported. Babies born to mothers who were infected during the epidemic are currently being studied for teratogenic sequelae.

The outbreaks in Venezuela and Colombia coincided with an increase in rainfall, which led to an increase in the vector population. Similar control actions were implemented in the two countries. In Venezuela 69.3% of the estimated equine population (horses, mules, and donkeys) in the areas in which outbreaks occurred were vaccinated (27.4% of the country), and in Colombia, 96% of the equine population in the affected areas (59.6% of the total equine population in the country). In addition, a quarantine was instituted in the affected states and insecticide was applied to control the vectors.

The Organization collaborated in controlling the epidemic and disseminating information to other countries to alert them to the situation. In particular, PAHO, working with the United States Army Medical Research Institute of Infectious Diseases, collaborated with Colombia to establish a diagnostic laboratory in the Animal Health Research Center under the Colombian Livestock Institute, organize an emergency plan for control and epidemiological surveillance, and conduct epidemiological studies of the factors associated with the epidemic.

### Dengue

During the 1995 meeting of the Directing Council, one of the issues that elicited greatest concern was dengue and dengue hemorrhagic fever, as more cases of these diseases had been reported during the year than in any year since 1981. Provisional data indicate that dengue cases totalled more than 244,000, and 6,666 of those cases were the hemorrhagic form of the disease. Deaths totalled 106. The most serious outbreaks occurred in Brazil, Venezuela, and in several Central American and Caribbean countries. Brazil reported almost half the cases. Serotypes 1 and 2 prevailed in that country. Venezuela reported 80% of the cases of hemorrhagic dengue. Serotypes 1, 2, and 4 predominated in Venezuela, while in Central America serotypes 1 and 3 were most common. The case fatality rate for the hemorrhagic cases was 1.6%.

In response to the grave problem the disease posed in Central America, PAHO formulated an emergency plan for the control of the dengue and dengue hemorrhagic fever epidemics in that subregion. The plan was presented to several donors, and funding was obtained from Norway and the United Kingdom. These funds were used to purchase insecticide and fumigation equipment, reagents, and laboratory supplies. Some resources also were used to organize workshops to provide training in diagnosis and treatment of the disease, insecticide use, equipment maintenance, and entomological evaluation. PAHO, working through the San Juan Laboratories, the CDC, and the Evandro Chagas Institute of Brazil, helped to strengthen quality control in 35 laboratories in 19 countries and supported training in diagnostic techniques. The Organization also provided support for an international course on dengue organized by the Pedro Kouri Institute in Havana, Cuba,

in which 49 persons from 12 countries participated. The course used the guidelines developed by PAHO that were published in *Dengue and Dengue Hemorrhagic Fever in the Americas: Guidelines for Prevention and Control.*

### Yellow Fever

As of epidemiologic week number 50 in 1995, a total of 492 cases of yellow fever had been reported from Peru, with 192 deaths (case fatality rate, almost 40%). This was the largest number of yellow fever cases ever reported in the history of the country. The resurgence of the disease affected at least seven departments. Several patients were hospitalized in cities infested with *Aedes aegypti*, which raises a serious risk for the urbanization of the arbovirus. The Organization has provided support in the form of technical advisory services through the PAHO/WHO Country Office in Peru, as well as external advisory services, supply of laboratory reagents, and purchasing of vaccines.

### AIDS and Other Sexually Transmitted Diseases

Despite some indications of relative success in curbing the spread of the AIDS epidemic, infection rates and deaths continue to rise worldwide. It is estimated that at least 6,000 to 10,000 new HIV infections appear each day, and that 60% to 70% of them occur in developing countries. Furthermore, AIDS and HIV are taking an ever-increasing toll among women and youth, especially in rural communities and in the poorest sectors of urban communities. In the past five years, AIDS became one of the five leading causes of death among individuals aged 25 to 44 in several countries.

During 1995, PAHO contributed to strengthen AIDS/HIV surveillance systems by training national professionals in sentinel surveillance methodologies and data analysis. This has resulted in the regular reporting to PAHO of AIDS cases and HIV sentinel studies by Member Countries. Data are used to produce a quarterly bulletin that is widely disseminated and serves as a tool for planning intercountry and subregional activities, as well as for mobilizing resources.

Managerial and administrative capabilities in the national programs were improved through subregional workshops in which participants from every country in the Region took part. Other sectors and NGOs had a hand in this training, thereby ensuring that there would be intersectoral participation in the planning and evaluation of activities. Several countries such as Argentina, Chile, Colombia, Ecuador, Honduras, Suriname, and Uruguay have already adapted the managerial training courses for national and local-level use.

The transition towards the United Nations Program on AIDS (UNAIDS) demanded special attention during most of 1995. Regional efforts led to the establishment of interagency "theme groups" on AIDS in every country where cosponsoring UN agencies were represented. Given their 12 years of providing uninterrupted technical cooperation on AIDS, the PAHO Country Offices are uniquely positioned to successfully launch UNAIDS in the Americas in 1996.

### Tuberculosis

Approximately 250,000 tuberculosis cases were reported in the Region in 1994, although it is estimated that another 150,000 cases went undiagnosed or unreported. More than 75,000 persons are believed to die due to the disease each year, and most cases and deaths occur among persons in their most productive years of life. In areas where the HIV epidemic is spreading rapidly, such as in parts of Brazil and Argentina, reported case rates have increased significantly in recent years. Other countries such as the Dominican Republic, Haiti, and Honduras face growing tuberculosis case loads attributable to HIV coinfection, but weaknesses in their reporting systems make it difficult to confirm trends. Many countries have conditions that are favorable to the emergence of drug-resistant strains, such as the United States has experienced over the last decade. Such conditions include the facts that many patients do not receive directly-observed therapy ("DOTS"); that other patients may get inadequate or unsafe regimens; that default rates are high; and that diagnostic delays may lead to unnecessary disease transmission. National surveys on resistance to anti-tuberculosis drugs are now being conducted in seven countries to determine the current nature of the problem. To increase cure rates and improve case-finding, PAHO is providing technical cooperation in all high-incidence countries to stimulate additional investments in control, including improved program norms, application of DOTS, laboratory networks, and program monitoring. Peru is among the countries already documenting dramatic and positive results.

### Malaria

In 1994 it was estimated that about 231 million people (30.3% of the Region's population) were living in areas in which conditions were favorable for the transmission of malaria. The risk of contracting malaria in the Americas varies by geographic region; however, in general, it is greater in the presence of certain ecological conditions, intense national and international migration, and exploitation of new territories. As a result of these changes, the risk of contracting malaria and the morbidity rate from the disease have increased in the Region. Between 1993 and 1994, malaria morbidity rose from 132.9 per 100,000 population to 145.9 per 100,000. In 1994, Brazil was the country in the Americas with the largest absolute number of cases, accounting for 50.6% of the Regional total. The countries of the Andean Area ranked second, with 29.4% of the total. However, the greatest risk of transmission was found in Guyana, French Guiana, and Suriname.

The process of epidemiological stratification is being gradually integrated with local health service activities in the areas of detection, diagnosis, and immediate treatment of malaria. As part of the Global Malaria Control Strategy, local service coverage is being extended with a view to reaching the majority of the population living in high-risk areas. The services will emphasize early diagnosis and immediate, complete treatment.

## ELIMINATION AND ERADICATION OF DISEASES

### Poliomyelitis

Subsequent to the 1994 certification by the International Commission for the Certification of Poliomyelitis Eradication (ICCPE) that poliomyelitis had been eradicated from the Americas, the Region has continued to maintain a rigorous surveillance system for cases of acute flaccid paralysis. Four years have elapsed since the last laboratory-confirmed case of wild poliovirus was detected in the Americas—since that last confirmed case occurred in Peru in 1991, more than 16,000 stool specimens have been examined from 9,000 acute flaccid paralysis cases in children under 15 years of age and their contacts.

PAHO's successful polio eradication strategy and the Organization's major role in strengthening the overall health infrastructure in the Americas have been extensively documented in the 1995 Taylor Commission Study. The eradication campaign used existing strategies in novel ways, which not only brought about the attainment of objectives that had been set, but also generated by-products that enhanced the health sector's capability to respond to new and emerging infectious diseases. The success of the polio initiative encouraged other programs to adopt interagency and intersectoral cooperation strategies, media strategies, information and epidemiological surveillance systems, and evaluation methods. Moreover, it fostered a culture of prevention among politicians, health workers, and community members. The involvement of high-level officials stimulated a broader participation on the part of government staff, nongovernmental organizations, and volunteer groups. National contributions towards Expanded Program on Immunization programs have steadily increased, further ensuring the sustainability of such programs within the delivery of routine health services. Equally important, the polio vaccination campaigns, which were used extensively throughout the polio eradication efforts, provided hard-to-reach population groups much needed access to vaccination programs.

### Measles

During the XXIV Pan American Sanitary Conference in September 1994, the Ministers of Health adopted a resolution that set the year 2000 as the regional target for eliminating measles. Measles elimination also was endorsed by the First Ladies of the Western Hemisphere at the "Fifth Conference of the Wives of Heads of State and of Government of the Americas," held in Asunción, Paraguay, in October 1995. At that meeting, the First Ladies pledged to work with the ministers of health, the Pan American Health Organization, and other international organizations on the campaign to eliminate measles transmission from the Americas by the year 2000 and to strengthen the surveillance of vaccine-preventable diseases. The "Measles Elimination Plan of Action" was approved by the XXXVIII Meeting of PAHO's Directing Council in September 1995. The plan calls for the achievement and maintenance of 95% measles coverage in all municipalities or districts in every country of the Region, with complementary vaccination campaigns aimed at preventing the accumulation of susceptible children among

preschoolers. Most countries in the Americas have adopted the PAHO recommended strategy of a one-time mass immunization campaign aimed at all individuals between the ages of nine months and 14 years of age, also known as the catch-up campaign.

Throughout 1995, approximately 4,500 confirmed cases were reported from the countries of the Americas, compared to 23,583 in 1994, with a provisional annual incidence rate of 0.48 cases per 100,000 population, which represents a 99% reduction from the incidence rate reported in 1980. Furthermore, there has been no single confirmed importation of measles from Latin America and the Caribbean into the United States in more than 12 months, another important indicator of the disease's control in those regions. Most Latin American and Caribbean countries already have implemented the catch-up campaign strategy, with excellent results. Current efforts target improvements in measles surveillance and in laboratory diagnosis.

It has been more than four years since a laboratory-confirmed case was reported by the English-speaking countries of the Caribbean. This achievement follows that subregion's commitment to conduct mass immunization campaigns covering more than 90% of all children between 9 months and 14 years of age, as well as the development of sensitive surveillance systems. Chile and Cuba have reported no cases of measles for the past 3 years.

To further strengthen national and regional surveillance efforts to eliminate measles, the current case classification and case investigation procedures are being revised. PAHO also is collaborating in training a cadre of virologists from laboratories in various countries, which are participating in the Measles Reference Laboratory Network. These laboratories will be working with assigned national laboratories and are expected to play a significant role in supporting countries in measles case investigations and surveillance aspects.

## Chagas' Disease

The annual meeting of the Intergovernmental Commission on Chagas' Disease was held in Asunción, Paraguay, under the Organization's sponsorship. The principal objective of the meeting was to examine activities undertaken in 1995. It was reported that the strategies used to control the disease had included spraying of residual-action insecticides, housing improvements, and community education. In addition, all the member countries of the Commission had agreed to standardize their control strategies and activities and the information system used to monitor the execution of activities. Common indicators for evaluating vector elimination efforts also were established.

According to the available information, during 1995 a total of 382,334 dwellings were sprayed in attack operations. Sustained application of the control strategies in Argentina, Brazil, and Chile has resulted in significant reductions in the infested geographic area and in vector densities in large areas. In Uruguay, transmission of the *T. cruzi* vector has been totally interrupted. Total combined investment during 1995 was more than US$ 40 million.

Vector elimination activities are evaluated periodically in the various countries by experts from other member countries of the Commission. PAHO supported several evaluation activities targeting Region IV in Chile and the states of São Paulo and Minas Gerais in Brazil. The Organization also has provided support for an evaluation of the quality of serology currently being used in national Chagas' reference centers.

## Rabies

During 1995, Costa Rica, Guyana, Panama, Suriname, Uruguay, and the countries of the English-speaking Caribbean remained free of canine-transmitted rabies. Chile completed its second year without any reports of human or canine cases and Ecuador achieved a 50% reduction in the number of animal cases. In El Salvador the number of human and canine cases continues to decline. However, in Colombia and Guatemala the numbers of both human and canine cases increased as a result of decreased epidemiological surveillance and a drop in canine vaccination coverage. In Belize, 15 cases of canine rabies were reported along the country's border with Guatemala, a situation which resulted in the exposure of 21 people. Thanks to prompt treatment, however, no deaths occurred. The vast majority of capital cities in the Region reported no rabies cases; exceptions were Guatemala City (Guatemala), La Paz (Bolivia), and San Salvador (El Salvador), which reported both human and canine cases.

Wildlife rabies, especially cases transmitted by vampire bats, is increasing in the Americas. Of the

human cases reported in the Region during 1995, 7.7% were caused by the bite of vampire bats. The groups currently at highest risk are indigenous populations, miners, explorers, and other persons who live or travel in wilderness ecosystems (ecotourists).

As part of the strategies for rabies elimination, PAHO continued to promote and support mass vaccination of dogs, and immunization campaigns were carried out in 16 countries. During 1995, the countries reported having administered 13.9 million doses of canine rabies vaccine, covering 58% of the estimated canine population in risk areas, although coverage levels varied from country to country.

Efforts to improve the care of persons exposed to rabies also continued. To this end, 29 workshops were held for 1,915 health workers from health centers in eight countries (Colombia, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Peru, and Paraguay). This training was reinforced through the distribution of guides on the care of exposed persons. These efforts have resulted in a significant reduction in human rabies cases.

The epidemiological surveillance system for rabies was extended to cover wildlife rabies. PAHO collaborated with five countries—Ecuador, Guyana, Paraguay, Peru, and Trinidad and Tobago—in developing studies to characterize areas at risk for the transmission of rabies by vampire bats. In addition, INPPAZ continued to process and analyze data from the regional epidemiological surveillance system for rabies, publishing the information in 52 weekly reports and in the bulletin on epidemiological surveillance of rabies for 1994.

### Foot-and-Mouth Disease

On 24 April 1995, immediately before the IX Inter-American Meeting, at the Ministerial Level, on Animal Health (RIMSA), the fifth meeting of the Hemispheric Committee for the Eradication of Foot-and-Mouth Disease was held with the participation of representatives of meat producers in the Region and of pertinent ministers. The President of Paraguay, Dr. Juan Carlos Wasmosi, chaired the meeting. The Committee examined the progress made under the Hemispheric Program for the Eradication of Foot-and-Mouth Disease and issued recommendations for future activities aimed at achieving the established goals and objectives. One of the major successes attained in the countries and regions covered by the Program has been the recognition of Uruguay as a country free of foot-and-mouth disease. The country has been disease-free with vaccination since 1993 and disease-free without vaccination since late 1995, and it has been more than five years since any cases of foot-and-mouth disease were detected. In northeastern Argentina, the area between the Uruguay and Paraná rivers has remained free of the disease for three years, and the entire country has been free of foci for more than two years. Central America, North America, French Guiana, Guyana, Suriname, the Caribbean, and the border region between Colombia and Panama also remained free of the disease.

As a result of this new disease-free situation, international markets have opened up to meat products from countries in which, until recently, foot-and-mouth disease had been considered endemic. Studies assessing the risk of introduction of the disease into importing countries were used as technical justification for allowing the meat products into the new markets.

PAHO, through PANAFTOSA, has played a prominent role in the progress achieved to date. It has been the reference institution which has continuously and systematically developed methodologies and instruments appropriate to the needs of each stage and country and for all matters related to the eradication of foot-and-mouth disease.

## NONCOMMUNICABLE DISEASES

Over the past two decades, noncommunicable diseases and injuries have come to rank as one of the leading causes of mortality and disability throughout the Region. They already have displaced communicable diseases and maternal and perinatal causes in several regions of the world. In the Americas, noncommunicable diseases are a leading cause of mortality in all age groups 15 years old and older. Moreover, it is estimated that by the year 2000, deaths from these diseases will outdistance those from communicable diseases threefold, increasing to fivefold by 2015.

In addition to continuing to pursue health promotion initiatives already under way, in 1995 the Organization launched a new program to support the development of noncommunicable disease programs throughout the Region, emphasizing cardiovascular disease, cervical cancer, diabetes, and injuries.

Stimulated by the success of similar initiatives in Europe and Canada, support activities for a com-

prehensive noncommunicable disease program—dubbed the "CARMEN" project—began in Valparaiso, Chile; similar projects are being explored in several other countries. ("CARMEN" stands for "Conjunto de Acciones para la Reducción Multifactorial de las Enfermedades No transmisibles.") While emphasizing cardiovascular disease prevention, the project also will serve to integrate other noncommunicable disease priorities such as diabetes, cervical cancer, and injury prevention. A regional network involving projects that deal with these diseases is under consideration.

## Cervical Cancer

Cervical cancer is the leading cancer site among Latin American and Caribbean women; it causes more than 25,000 premature deaths each year. The average age of onset for invasive cervical cancer is estimated at 38 years, a fact that unduly burdens families and communities—up to 90% of these cases could be prevented through early detection and treatment programs. The goal in all countries should be to implement cost-effective, population-based programs, with attention to quality in all aspects of screening. In an effort to benefit all women at risk for cervical cancer, the Organization is supporting technical improvements, ranging from the taking of smears to laboratory performance, as well as improvements in the access to service through systems of primary health care.

The Caribbean Program Coordinator's work in cooperating with the eastern Caribbean countries in their efforts to establish cervical cancer control programs is particularly noteworthy. On the one hand, based on findings of the Knowledge, Attitudes, Beliefs, and Practices (KABP) survey conducted in two countries, a comprehensive package of health and public education materials were designed and produced. Four radio and two television public service announcements were produced and disseminated, as well as a complementary set of posters, brochures, and pamphlets. All these materials emphasize prevention and early detection of cancer of the cervix. The project, which is crafted along a health promotion approach, seeks to improve and empower women by relying on a strategy that involves women's participation. Coupled with the cooperation provided for information systems in this area, the countries also have an infrastructure to launch national initiatives. This cooperation included the provision of data collection instruments, the software for the cervical cytology registry system developed at the Caribbean Program Coordination, and procurement of hardware for selected countries.

## Diabetes

Estimates for the Region place the number of people currently suffering from diabetes at approximately 28 million. This figure is projected to increase by more than 60% by the year 2010. The economic burden from the disease will parallel the increase in the case load. People with diabetes—given the disease's serious consequences such as blindness, amputations, and kidney failure—are high consumers of health care resources. However, steps can be taken now to reduce the impact and to contain the costs of an increased disease burden in the future. Some of these measures include risk factor reduction (eg., weight control), improved clinical management (eg., blood glucose monitoring), more efficient use of the health services (eg., ambulatory care), and patient education to improve self-care. The Organization is working with the International Diabetes Federation to launch, in 1996, a "Declaration of the Americas", a document that will set the stage for future program improvements.

# CHAPTER III

## *Evaluation of Technical Cooperation*

*At the end of the day, when we speak about the work of the Organization, we must realize that the work of the Secretariat will be small compared to what the countries [themselves] will do... with our help.*

George A. O. Alleyne
General Staff Meeting
6 October 1995

PAHO has four formal levels of evaluation of technical cooperation: the evaluation of the strategies for attaining the global and Regional goals of "health for all" calls for Member Governments to evaluate their implementation every six years; the evaluation of the strategic and programmatic orientations that the countries and the Secretariat establish every four years, calls for analyzing the implementation of health policies and plans at the national level and the attainment of the goals as defined by each country; the evaluation of the execution of the annual and the biennual program budgets every year and every two years, respectively; and, lastly, the joint evaluation of technical cooperation carried out in the countries by national authorities and Secretariat staff. These joint evaluation meetings, which is where both areas of operational analysis converge, is the focus of this chapter.

Upon adopting the managerial strategy for the optimum use of PAHO resources, PAHO's Member Governments endorsed the proposal that the Secretariat should establish a process whereby its staff and national authorities would jointly evaluate the Organization's technical cooperation at the country level. Member Governments further indicated that these joint evaluations should function as an extension of the annual review of technical cooperation that the country and PAHO conduct in preparing the annual and the biennial program budgets and that they should become yet another component in the ongoing dialogue that PAHO/WHO Country Representatives hold with national health authorities as part of the execution of the technical cooperation program.

PAHO has designed its own planning tool—the American Region Planning, Programming, Monitoring, and Evaluation System (AMPES)—to chart its work. The planning

exercise is the system's cornerstone. Using identified national health priorities as a starting point, national technical cooperation priorities are then identified; from the latter, national priorities for PAHO's technical cooperation are established. On the basis of these priorities, technical cooperation projects are formulated. Each project is designed to yield results that meet specific needs. These expected results and their indicators then become the parameters for evaluating the delivery of technical cooperation within each project. AMPES is critical to the joint evaluation process because it documents how technical cooperation is delivered.

In assessing PAHO's work in the countries, the joint evaluation process focuses on the efficiency, effectiveness, and impact of the Organization's technical cooperation. National authorities, working with PAHO staff, review the technical cooperation program for the previous two biennia and, in light of the country's current situation, set forth parameters for future technical cooperation. Thus, the joint evaluation serves to adapt PAHO's technical cooperation program to each country's priority health needs.

The joint evaluation should concentrate on assessing how technical cooperation has contributed to change health indicators, health care coverage for vulnerable groups, health service infrastructure, and the managerial process for national health development. It also should provide the Country Office with a forum for informing national authorities on PAHO's policies, strategies, structure, and managerial processes. The evaluation also should give PAHO/WHO Representatives an opportunity to strengthen intersectoral relationships, review the external cooperation environment, improve international technical cooperation in health, foster technical cooperation among countries, adjust the technical cooperation strategies to conform to political and social realities, and evaluate advances made towards the goal of "health for all." PAHO/WHO Representatives should emerge from the joint evaluation meetings armed with sufficient information to adapt technical cooperation in health so that it can better respond to needs in the countries. Finally, joint evaluation meetings should enlist the participation of the broadest possible representation of high-level officials from the health sector and partner sectors. This wide-ranging participation allows for better coordination and harmonization of efforts and a more efficient rationalization of resources.

The joint meetings are held, on an average, every four years, preferably at the beginning of a national political cycle. Within the Organization, reports on joint evaluation meetings in selected countries are presented to each meeting of the Subcommittee on Planning and Programming of the Executive Committee. During 1995, joint evaluation meetings were held in the Bahamas, Bolivia, El Salvador, Guatemala, Haiti, Panama, and Suriname. Reports on each of these seven meetings follow.

## BAHAMAS

PERIOD UNDER REVIEW: 1991-1995

PARTICIPANTS: Senior managers from program areas benefitting from PAHO technical cooperation and from the Ministry of Health and PAHO/Caribbean Program Coordination staff (57 participants).

Participants discussed a plan for devolving hospital administration away from the Ministry's central control, as a way to improve efficiency and contain costs. The Minister of Health stated that the joint review exercise helped the country to more clearly define a family care health package.

As a result of the exercise, senior and mid-level health officials were better able to understand Ministry programs that fell outside their particular spheres of responsibility and pointed out areas for interprogrammatic coordination. The meeting also led these officials to become more involved in the development and understanding of the 1996 programming cycle.

**Results of the Joint Evaluation Meeting**

| NATIONAL PRIORITIES FOR PAHO TECHNICAL COOPERATION | MAJOR ACCOMPLISHMENTS OF TECHNICAL COOPERATION |
|---|---|
| Infrastructure development | • Feasibility studies to determine the viability of local health systems in selected Family Islands were completed.<br>• The Management Information System was installed. |
| Strengthening operational capability of the Division of Environmental Health Services (DEHS) | • In-service management training for solid waste supervisors was provided with support from IDB.<br>• A proposal was developed for analyzing chlorine residual and bacterial contamination in the New Providence's public water supply.<br>• A pollution monitoring program for Nassau Harbor got under way. |
| Development of the Solid Waste Disposal Corporation (WASC) | • The waste classification study at Harrold Road Sanitary Landfill was completed.<br>• A ground water pollution and risk-assessment study was conducted.<br>• The legal groundwork for privatizing solid waste collection was carried out. |
| Maternal and child health (reduce maternal mortality and infant mortality; support EPI) | • The infant mortality reduction project was strengthened.<br>• Polio eradication was consolidated. |
| Development of the adolescent health program | • The adolescent health program was put in place.<br>• Teenagers received training in peer counseling and in coping with adolescent sexuality. |
| Promotion of lifestyle changes to reduce diabetes, hypertension, and obesity | • Guidelines on the management of diabetic foot were distributed. |
| Development of a nutrition policy | • The National Plan of Action for Nutrition was prepared and a timetable was approved. |
| Disaster preparedness and management | • Nationals were trained in SUMA methodology. |
| AIDS prevention and control (educational programs, surveillance, laboratory services) | • A national seroprevalence study was conducted.<br>• ELISA test kits were procured for and delivered to the Rand and Princess Margaret Hospital, in order to maintain a steady supply of HIV testing reagents; diagnostic equipment for opportunistic infections and gonorrhea also was provided.<br>• A media campaign was conducted to promote condom use and a reduction in the number of sexual partners.<br>• Lab technicians received training in HIV confirmation techniques. |

**Recommendations for future PAHO technical cooperation.**

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## BOLIVIA

PERIOD UNDER REVIEW: 1989-1995

PARTICIPANTS: Representatives from the Ministry of Human Development's four secretariats (Policies and Social Investment, Education, Sports and Culture, and Health); high-level officials from secretariats dealing with agribusiness gender, ethnic, and elderly issues; the country's Vice-President; members of Congress; and PAHO and WHO representatives (66 participants).

The joint evaluation meeting led to the strengthening of the links within the Ministry of Human Development and provided a new strategic framework for the next phase of the Intensified WHO Cooperation program. This intensified technical cooperation strategy focused on the development of local health systems and on health financing. The development of local health systems has become policy, and it has been incorporated into both the National Health Plan and the Popular Participation Law.

The joint evaluation meeting focused on analyzing the country's policy framework. PAHO's programmatic orientations were found to be compatible with major national policy items. Meeting participants concluded that the coordinating role of the Ministry of Human Development should be enhanced, in light of the need to monitor such issues as the effectiveness of decentralization and the operation of shared management, including community control over resource allocation. The importance of the Organization's support for the National School of Public Health was underscored.

## Results of the Joint Evaluation Meeting

| NATIONAL PRIORITIES FOR PAHO TECHNICAL COOPERATION | MAJOR ACCOMPLISHMENTS OF TECHNICAL COOPERATION |
|---|---|
| Development of human resources for health | • Integration of in-service training progressed.<br>• The Bolivian Health Sciences Information Network and the National Council of Health Sciences and Technology were established. |
| Health services development | • The implementation of primary health care moved forward.<br>• Coverage was extended.<br>• Gains were made in decentralization, regionalization, and community participation. |
| Communicable diseases | • Progress was attained in the Expanded Program on Immunization and in rabies and foot-and-mouth disease control.<br>• Interagency committees were organized in order to more efficiently obtain and use national and external cooperation resources.<br>• The organization of the National Health Information System and the Central Depository of Essential Supplies progressed. |
| Maternal and child health | There was a shift from maternal health to a comprehensive approach to women's health, an increase in children's growth and development interventions, and the incorporation of a reproductive health strategy. As a result, there have been reductions in the infant mortality rate, higher prenatal care and immunization coverages, reductions in iodine deficiency disorders, and the elimination of poliomyelitis. |

**Recommendations for future technical cooperation with PAHO**

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## EL SALVADOR

PERIOD UNDER REVIEW: 1992-1995

PARTICIPANTS: Representatives from 29 agencies of the central government, the municipalities, decentralized institutions, universities, nongovernmental organizations, PAHO, and other international cooperation agencies. (150 participants)

The technical cooperation provided during the evaluation period changed over time in terms of both approach and policy decisions. Up to the first quarter of 1994, resources were directed toward programs that dealt with the country's peace efforts, the strengthening of health programs geared to society's most vulnerable population segments, and to the development of mechanisms to improve management of the health services (i.e., budget, personnel administration, and management information systems). Thereafter, the cooperation emphasized comprehensive activities in support of institutional development in the sector's three main components: the Ministry of Public Health and Social Welfare, the Salvadorian Social Security Institute, and the National Association of Water Supply and Sewerage Systems. In terms of subregional efforts, the Organization paid special attention to the Central American Health Initiative and to activities designed to create better living conditions for the population and improve Central America's competitive position in the global economy.

## Results of the Joint Evaluation Meeting

| NATIONAL PRIORITIES FOR PAHO TECHNICAL COOPERATION | MAJOR ACCOMPLISHMENTS OF TECHNICAL COOPERATION |
|---|---|
| Support for the health planning process | • Institutional development efforts at the Ministry of Public Health and Social Welfare and at the Salvadorian Social Security Institute led to progress in the health sector reform process. |
| Strengthening the capability for epidemiological analysis | • Interinstitutional epidemiological teams established at the national and local levels are now ready to conduct research and outbreak control activities. |
| Coordination of external cooperation for the Plan for Regional Investment in the Environment and Health (PIAS), the Economic and Social Development Plan, the National Health Plan, and the Central American Integration Process. | • Extrabudgetary resources were mobilized to execute technical cooperation activities. |
| Coordination of activities to implement and follow-up summit resolutions with other countries and within subregional initiatives | • Legislative activities and efforts in safe blood handling, drug registries, and regulation of medical practice were carried out under the Central American Health Initiative and the Central American Economic Integration Initiative. |
| Promotion of behavioral changes aimed at healthy lifestyles within the context of development of local health systems | • The healthy municipalities and healthy schools initiatives progressed. |
| Increase the coverage and quality control of water supply and basic sanitation services | • A legislative framework for creating a national institution for the organization and management of the water supply and sewerage system got under way.<br>• The institutional capability to deal with basic sanitation problems was strengthened, coverage with safe water was increased, and the ability to adequately handle solid waste was improved. |
| Prevention and control of communicable diseases | • EPI vaccination coverage increased and the wild poliovirus eradication effort entered its consolidation phase.<br>• Gains were made in activities directed at the elimination of measles, neonatal tetanus, transmission of *T. cruzi* through blood transfusions, and leprosy. |

**Recommendations for future technical cooperation with PAHO**

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## GUATEMALA

PERIOD UNDER REVIEW: 1993-1995

PARTICIPANTS: Representatives of the Ministry of Health and Social Welfare; the Guatemalan Social Security Institute; universities; municipal governments; NGOs; agencies of the environment, nutrition, agriculture, and water and sanitation sectors (central, departmental and local levels); and PAHO and WHO representatives.(144 participants)

The Government assigned priority to health sector reform, mainly decentralization and the modernization of the State; priority also has been given to poverty reduction and processes to support the peace process. Guatemala is one of the Region's countries that receives Intensified WHO Cooperation; in this regard, the emphasis on poverty alleviation has led to the decentralization of the PAHO/WHO Country Office to some of the poorest areas. Overall, technical cooperation has been consistent with national priorities. An ongoing dialogue has been established with national health authorities, other cooperation agencies, NGOs, and civilian representatives, which has made cooperation in the country multisectorial and innovative.

## Results of the Joint Evaluation Meeting

| NATIONAL PRIORITIES FOR PAHO TECHNICAL COOPERATION | MAJOR ACCOMPLISHMENTS OF TECHNICAL COOPERATION |
|---|---|
| Strengthen decentralization processes to: increase coverage of basic services, reduce risk factors, transform the health model, and develop human resources in support of decentralization of the health sector. | • An agreement was signed by the Government of Guatemala and PAHO to support the Ministry of Public Health and Social Welfare's decentralization and the strengthening of local health systems.<br>• PAHO's technical cooperation was deconcentrated: offices were set up in the Quiché, Huehuetenango, Alta Verapaz, and Escuintla health areas and, in conjunction with the Division of Intensified WHO Cooperation staff, the Swedish International Development Agency, IDB, and the European Union, resources were mobilized to support the deconcentration effort.<br>• Municipal committees for cholera prevention and control and revised surveillance norms were developed. |
| Strengthen local programming, with special emphasis on interinstitutional and intersectorial coordination | • A proposal to reorganize the health care system was developed in support of health sector reform.<br>• The capability to carry out strategic planning and epidemiological surveillance was strengthened in NGOs in Huehuetenango.<br>• A database on health legislation was developed. |
| Strengthen the directing and coordinating role of the Ministry of Public Health and Social Welfare at both the national and local levels | • Water quality and surveillance programs were implemented in San Marcos, Retalhuleu, Sololá, Suchitepequez, Quetzaltenango, and Huehuetenango. |
| Broaden the scope of preventive and promotional programs and actions | • The creation of the National Epidemiological Commission got under way.<br>• A basic food package was developed. |
| Strengthen capacity for analysis of the health situation | • A surveillance program for drinking water services was implemented.<br>• Research was conducted on the migrant work force.<br>• Research on women's health was conducted in eight priority health areas.<br>• An assessment of the nutritional status of communities in Chiquimula, Quetzaltenango, and Huehuetenango was carried out. |

**Recommendations for future technical cooperation with PAHO.**

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## HAITI

PERIOD UNDER REVIEW: 1991-1995

PARTICIPANTS: Staff from the Ministry of Population and Public Health, PAHO, WHO, NGOs, the Association of Private Health Works, the Haitian Childhood Institute, the National Haitian Institute of Community Health, the National Association of Nurses, the metropolitan agency for drinking water distribution, and the national agency for drinking water distribution. (62 participants)

The joint evaluation represented the first formal meeting in three years between PAHO and Haiti's Ministry of Health authorities. Although there had been no dialogue between PAHO and the "de facto" government, the Organization was actively involved in humanitarian assistance through NGOs. The exercise served to inform the Constitutional Government about past activities, and, given that there had been no joint actions for three years, the main recommendations and conclusions of the 1991 evaluation were ratified as still valid. The meeting also was the first formal gathering where Ministry of Health personnel and NGOs sat down together to discuss programs and projects. Participants also included Intensified WHO Cooperation staff, who attended to assess the possibility of adding this program's support to PAHO's technical cooperation with the country. PAHO is shifting the focus of its technical cooperation from a humanitarian perspective to a strategy that supports the development of the public health system.

## Results of the Joint Evaluation Meeting

| NATIONAL PRIORITIES FOR PAHO TECHNICAL COOPERATION | MAJOR ACCOMPLISHMENTS OF TECHNICAL COOPERATION |
|---|---|
| Maternal and child health | • The approach for the integrated management of the child was developed. |
| Prevention and control of communicable diseases and epidemics | • Training was offered in management of diarrheal diseases and cholera, acute respiratory infections, diagnosis and treatment of malaria, and field epidemiology.<br>• A simplified epidemiological surveillance system was developed. |
| Water supply and sanitation services to villages and rural areas | • As part of the humanitarian assistance effort, water supply systems were maintained for villages and rural areas; this required the installation of systems for drinking water distribution. |
| Coordination of health activities with NGOs and other cooperation agencies | • NGOs and health institutions were identified as working partners for carrying out humanitarian assistance activities.<br>• Relying on coordinating mechanisms established with various partners and the Health Interagency Committee and its technical committees, and through the constant dialogue established with the Constitutional Government as of September 1993, the groundwork has been laid to implement the community health units that will function as the local health systems network. |
| Management of humanitarian fuel supply system | • A fuel supply program for humanitarian purposes (PAC-Humanitaire) was created. |
| Establishment of a system for the supply of essential drugs | • A supply system for essential drugs and medicines (PROMESS) was created. |

**Recommendations for future technical cooperation with PAHO.**

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## PANAMA

PERIOD UNDER REVIEW: 1994-1995

PARTICIPANTS: Representatives from the Ministry of Health, the Social Security Administration, the Ministry of Education, the University of Panama, the University of Santa María La Antigua, the Ministry of Economic Planning and Policy, the Social Emergency Fund, the Office of the First Lady, the National Aqueduct and Sewerage Institute, and the Institute of Renewable Natural Resources, as well as representatives from PAHO, IDB, and from other agencies of the United Nations system, including UNDP, UNICEF, UNFPA. (50 participants)

Programming focused on the formulation of mechanisms to improve technical cooperation by assigning resources to priority areas. Other UN and international agencies participated in the evaluation, and a special meeting between them and Ministry of Health officials was organized to better coordinate the international responses to Panama's needs.

In addition to the impressive degree of intersectoral mobilization accomplished during the meeting, cooperation targets were redefined, with priorities being assigned to local development and reform and modernization of the health sector. One of the main outcomes from the process was the consensus that medium- and long-term investment plans needed to be developed.

**Results of the Joint Evaluation Meeting**

| NATIONAL PRIORITIES FOR PAHO TECHNICAL COOPERATION | MAJOR ACCOMPLISHMENTS OF TECHNICAL COOPERATION |
|---|---|
| Combat social problems such as violence, child abuse, violence against women, accidents and injuries, alcoholism and drug addiction, and mental health problems | • A model for identifying, preventing, and acting on domestic violence was developed; this project is a joint undertaking of the seven Central American nations and includes a legislative component.<br>• The restructuring of the mental health services continued to progress; mental health week and mental health day were observed and various training activities were carried out, as were activities to improve mental health services.<br>• Activities for the prevention and reduction of tobacco consumption and drug addiction were carried out. |
| Perinatal mortality and morbidity | • Resources and physical equipment for infant-care services were improved.<br>• Personnel received training in the management of acute respiratory infections. |
| Teenage pregnancy | • Educational activities targeting high-school students and the community at large were carried out with UNFPA's collaboration; these activities were designed to work with pregnant teenagers and to prevent pregnancy, sexually transmitted diseases and AIDS, drug addiction, and accidents among teenagers. |

| NATIONAL PRIORITIES FOR PAHO TECHNICAL COOPERATION | MAJOR ACCOMPLISHMENTS OF TECHNICAL COOPERATION |
|---|---|
| STDs/AIDS | • Activities were conducted to increase the public's awareness and education about AIDS and to improve epidemiological surveillance and the level of care. |
| Malnutrition | • A five-year food and nutrition plan, and medium-term plans of action for the reduction of iodine deficiency, vitamin A deficiency, and iron deficiency were developed.<br>• Work on adopting universal iodinization and fluoridation of salt progressed.<br>• Nutritional guidelines were prepared and the national growth census was conducted and analyzed. |
| Tropical diseases (dengue and leishmaniasis) | • Malaria control efforts were enhanced through the subregional malaria project.<br>• Diagnostic assistance, the supply of biologicals, vector control measures, and training were provided during the dengue epidemic. |
| Tuberculosis | • New policies, plans, and norms were developed and existing ones were strengthened.<br>• The national tuberculosis program was evaluated. |
| Oral health | • Salt fluoridation and sodium fluoride rinses were adopted for the prevention of caries. |
| Environmental Health, especially air and water pollution and solid waste disposal. | • Working through MASICA, cholera prevention activities were strengthened, safer pesticide use was pursued through PLAGSALUD , basic sanitation was provided to the most deprived rural areas, the border environmental health initiative between Panama and Costa Rica moved forward, a comprehensive bibliography on water quality and PROACUA activities was developed, studies on the effects of specific contaminants were carried out, activities geared to the development of human resources in the area were conducted, and legislation was supported. |
| Organization of health services | • A proposal for modernizing the health sector was developed; it was complemented by the social development project "Municipios Siglo XXI."<br>• The Ministry of Health and the Social Security Fund jointly defined the basic principles of a National Health System.<br>• The capability for the planning, management, and operation of equipment maintenance was strengthened. The Government of the Netherlands and IDB provided external financing. |
| Human resource development | • As part of the project to develop education in health for Central America, capabilities to train public health personnel and to develop a research policy were strengthened. |

**Recommendations for future PAHO technical cooperation.**

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## SURINAME

PERIOD UNDER REVIEW: 1992-1995

PARTICIPANTS: Staff from the Bureau of Public Health (BOG); the Regional Health Services; the Medical Missions; the Central School for Nurses and Allied Professions; the Suriname Water Company; the ministries of Natural Resources, of Labor, and of Public Works; and PAHO. (33 participants)

Seven years had elapsed since the last joint evaluation meeting, and most of the nationals were new to the exercise. The meeting focused on strengthening the links with the process of programming technical cooperation with PAHO, including the establishment of priorities for future cooperation. Meeting participants expressed the clear need to establish a central coordinating body and to strengthen the Bureau of Public Health's management and infrastructure so it can improve its health services.

**Results of the Joint Evaluation Meeting**

| NATIONAL PRIORITIES FOR PAHO TECHNICAL COOPERATION | MAJOR ACCOMPLISHMENTS OF TECHNICAL COOPERATION |
|---|---|
| Health situation analysis | • The Bureau of Public Health's capability to analyze and disseminate information was strengthened, the infectious disease surveillance infrastructure was improved, and the national control program against nosocomial infections was enhanced. |
| Environmental health and sanitation | • Border activities in environmental health were carried out with Guyana.<br>• The cholera outbreak was brought under control within a year through the social communication program and the water disinfection program that was put in place after the 1991 outbreak.<br>• Activities dealing with community water supply and sanitation, solid waste management, pollution control, and worker's health were carried out. |
| Maternal and child health | • Active disease surveillance for EPI diseases was introduced in 1991; thanks to the program, no confirmed cases of the six vaccine-preventable diseases have been reported during the review period. |
| Communicable disease prevention and control | • The National AIDS program extended accessibility to HIV testing at different locations; this effort has led to more people being tested earlier, resulting in earlier detection. |

**Recommendations for future technical cooperation with PAHO.**

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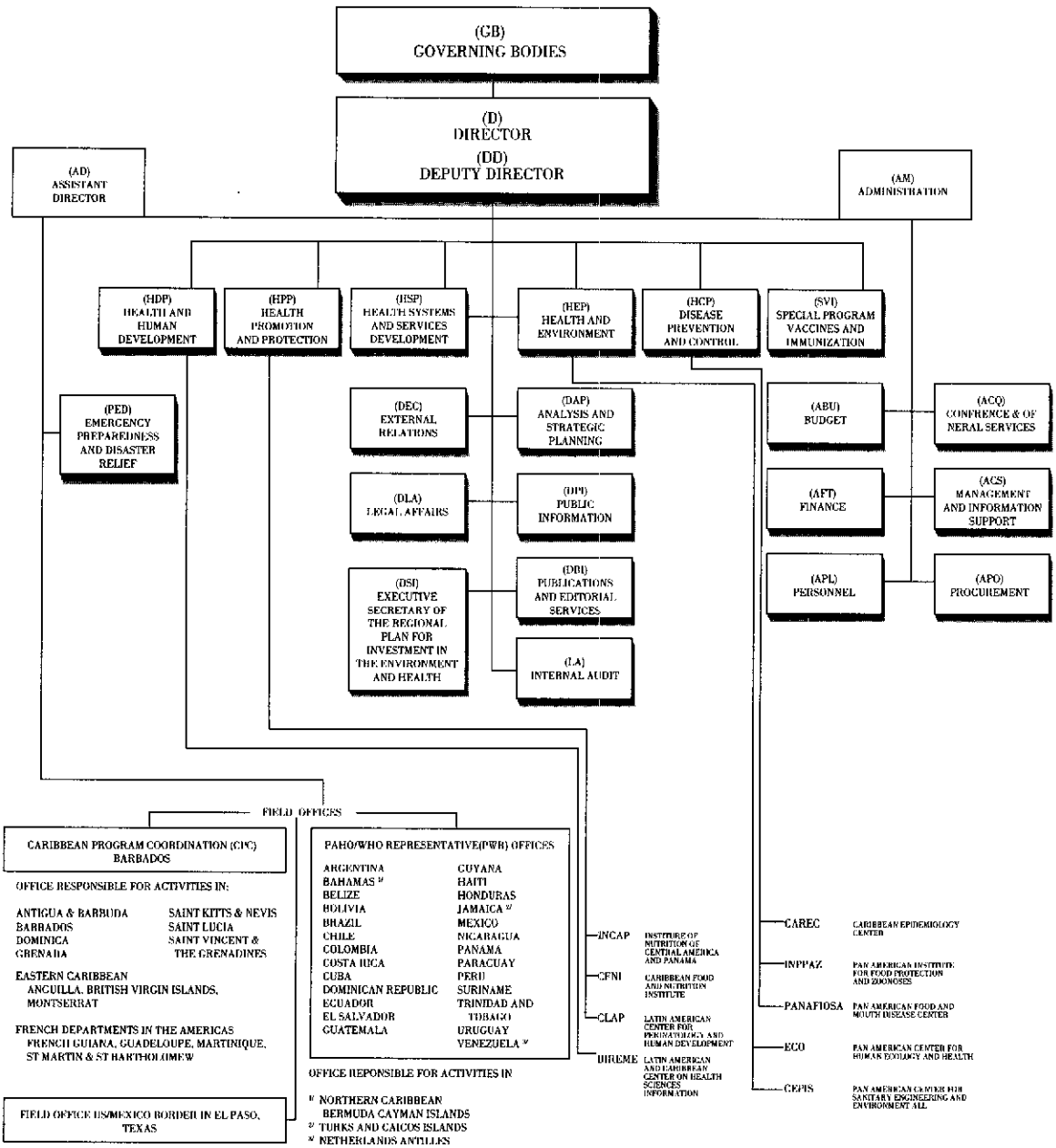
# PAHO Organizational Chart



# CHAPTER IV

## *Management & Administration*

*In this new wave of hemispheric solidarity, the Pan American Sanitary Bureau is willing and able to play its role as it has done before. Its presence in our countries, the capacity of its human and organizational resources, the nature or its basic principles give it a unique capability to contribute to a new America.*

George A. O. Alleyne
Address at His Installation as Director
31 January 1995

Dr. George A. O. Alleyne, the new Director of the Pan American Sanitary Bureau (PASB), assumed office in February 1995. The centerpiece of his administrative goals involved ensuring that all parts of the Organization—the center, as well as the periphery—work together in a manner that allows for diversity while maintaining congruence and uniformity; to that end, mechanisms of due process were put in place. The principal elements of this process include a thorough knowledge of local conditions, effective two-way communication, the involvement of Country Representatives in policy- and decision-making, and the development of effective means of program coordination, both at the point of technical cooperation with the countries and among the senior levels of the Organization.

The first step taken by the Director was to engage the staff in a participatory exercise to redefine the Organization's mission. The exercise demonstrated what participation can accomplish and how much richer the results are than when they emerge from one individual. The renewed mission of the Pan American Sanitary Bureau emphasizes the importance of cooperating technically with the Member Countries and stimulating 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.

In 1995, PAHO/WHO initiated a consultation process at the Regional and national levels to renew the commitment to achieve the goal of "health for all," taking account of the possible consequences of global trends that are affecting and will affect the health of the population of the Americas. These efforts are geared toward building a new vision of health based on equity, solidarity, and sustainability and on renewing the value of health as an essential ele-

ment of human development. The response intends to support national and Regional efforts to meet the challenges in health in the next century. The topic of renewing "health for all" has been discussed in national fora, subregional meetings, and during technical discussions within the Organization itself. A regional conference, "Future Trends and Renewing the Call for Health for All," which will be sponsored by the Ministry of Health of Uruguay, the Pan American Health Organization, the World Health Organization, and the International Health Futures Network, is being planned for mid-1996. The main thrust of the effort has been to address the restatement and validation of the goal, and the process is referred to as "Renewing the Call for Health for All." There also have been efforts aimed at revisiting the concept of technical cooperation in health. To this end, the Organization has been engaged in an assessment of technical cooperation principles and experience, with the expectation that shared experience will strengthen PAHO's effectiveness in carrying out its constitutionally-mandated function. The constitutional mandate calls for PAHO/WHO to provide technical cooperation in health as a primary function and product, concurrently with its role as the authority in international health matters.

Historical changes have challenged the uniqueness of this function over the past 50 years. Whereas traditional technical assistance focused on the instruments being delivered (consultancies, supplies and equipment, fellowships, courses, seminars, grants, etc.), the new mode of technical cooperation introduces a more dynamic set of issues related to the fulfillment of specific aims or functions. This orientation is based on country needs, on indigenous potential, and on a flow of expertise and resources that will lead to outcomes that are better adjusted to local situations.

The evolution of international health within the context of complex socio-political and economic factors, the development of the countries themselves, and the proliferation of organizations and agencies that are involved in technical cooperation in health have made it necessary to re-examine how best to support health development in the Region. With financial support from the Carnegie Corporation, PAHO/WHO convened the seminar "Rethinking International Technical Cooperation in Health," in which distinguished participants, including a select group from Member States from other WHO Regions and collaborating official and nongovernmental organizations, shared their experiences in technical cooperation for health.

The Strategic and Programmatic Orientations (SPOs) for 1995-1998 that were approved during the XXIV Pan American Sanitary Conference, provide the framework for the Organization's health action in the Americas during the quadrennium and represent an adjustment of WHO's Ninth General Program of Work to the Region's particular situation. They define the principal challenges for the Organization during the period as the persisting inequity in the access to health services by the population and the response to the health conditions that are derived from these social inequities. Since the SPOs are meant to be the basis for action, the Secretariat has begun a process to evaluate the response of the countries. Eight countries participated in the definition of indicators and methodology for evaluation of the orientations during 1995.

Because structure should follow function and enhance managerial capacity and product delivery, and considering the SPOs and WHO's Classified List of Programs and Ninth General Program of Work, changes were made in the Secretariat's organizational structure, effective 1 March 1995. The Secretariat comprises five Technical Divisions (Health in Human Development, Health Systems and Services Development, Health Promotion and Protection,

Environmental Protection and Development, and Disease Prevention and Control); an Office of Administration that provides administrative support to field offices and Headquarters; the Office of the Director, which includes the Office of the Deputy Director with six staff offices (Analysis and Strategic Planning, External Relations, Legal Affairs, the Executive Secretariat of the Regional Plan for Investment in the Environment and Health, Public Information, and Publications and Editorial Services); and the Office of the Assistant Director, which provides the operational coordination of the PAHO/WHO Country Representative Offices, the Caribbean Program Coordination, and the Field Office/U.S.-Mexico Border located in El Paso, Texas, as well as supervision of the Emergency Preparedness and Disaster Relief Program. In addition, a Special Program of Vaccines and Immunization was established to promote activities in the prevention of vaccine-preventable diseases and in the development of new vaccines. The Divisions coordinate the activities of the Pan American Centers whose work falls within their purview. (See PAHO's organizational chart on page 68.)

Special efforts have been made to "flatten" the Organization, increase the transparency of the decision-making process, and enhance staff participation through various mechanisms that promote information-sharing, such as technical discussions, networking around specific subjects, and electronic bulletin boards. To function in the best possible way, these various mechanisms must rely on information: an effective programming system and a proper flow. PAHO needs information for its internal functions—its "corporate needs"—and to execute technical cooperation. The effective management and use of information is essential for PAHO's functions and operations, including those of the Secretariat and those of the Member Governments. The restructuring of the Secretariat is designed to emphasize information use and to enhance the Organization's management of information. Information gathering and management systems are needed for both internal and external functions.

Corporate administrative systems support operations in budget and finance, procurement, and personnel. For the execution of technical cooperation, PAHO has established a set of core data about the countries which is managed at the level of the countries. The Organization also has concentrated on cooperating with the countries in the development of the information needed to manage the health services. Finally, attention also has been placed on those information needs that have to do with the Organization's image with various audiences through its publications, the "information highway," and the media.

In keeping with its tradition since the early 1920s, during 1995 PAHO published an array of publications covering a range of topics of importance to the countries of the Americas (see Table IV-1 for a list of the year's publications). Original articles on health and human resource development also continued to appear in the monthly *Boletín de la Oficina Sanitaria Panamericana*, the quarterly *Bulletin of the Pan American Health Organization*, and *Educación Médica y Salud*. In response to the growing interest in electronic media, PAHO issued its first compact disk, "Health Conditions of the Americas."

To assure that its publications reach the widest possible audience, the Organization set up its first 56 Publications Centers in 9 countries. These centers—mostly existing libraries and documentation centers—make PAHO's books and journals available to those who otherwise might not have access to them. To extend the reach of its information even farther, PAHO has capitalized on the Internet. It enhanced its text-based gopher service and launched English and Spanish versions of a media-rich, interactive World Wide Web service, offering users information about the Organization and its products and services, including PAHO's scientific and

technical resources, information on natural disasters and emergencies, and health country profiles. By mid-December, over 14,000 user sessions were logged on the PAHO Headquarters Web site.

Several PAHO Country Offices and Centers also took an active role on the Internet, launching their Web sites and gophers. This enabled the Organization to move closer towards its objective of building an Internet-based Wide Area Network to support internal communications and information flow and to provide an interactive tool for disseminating information to the countries of the Hemisphere. The Organization significantly reduced the costs of electronic mail communications by substituting international telephone calls with Internet transmissions, thus optimizing the financial benefits from Internet use.

**Table IV-1. Publications Issued by PAHO's Editorial Service in 1995.**

| SERIAL NO. | TITLE |
|---|---|
| | SCIENTIFIC PUBLICATIONS |
| 548 | Dengue y dengue hemorrágico en las Américas: guías para su prevención y control |
| 552 | La salud del adolescente y del joven |
| 554 | Clasificación estadística internacional de enfermedades y problemas relacionados con la salud (3 vols) |
| 556 | Health Statistics from the Americas. 1995 Edition |
| 556 | Estadísticas de salud de las Américas. Edición de 1995 |
| | OFFICIAL DOCUMENTS |
| 269 | Strategic and Programmatic Orientations 1995-1998 |
| 269 | Orientaciones estratégicas y programáticas 1995-1998 |
| 271 | Annual Report of the Director, 1994 |
| 271 | Informe Anual del Director, 1994 |
| | TECHNICAL PAPERS |
| 40 | Guía práctica para la erradicación de la poliomielitis. Segunda edición |
| 42 | Biology, Disease Relationship, and Control of *Aedes albopictus* |
| 42 | Biología, relaciones con enfermedades y control de *Aedes albopictus* |
| 43 | Biology and Ecology of *Anopheles albimanus Wiedmann* in Central America |
| | COMMUNICATING FOR HEALTH SERIES |
| 6 | La salud de los adolescentes y los jóvenes en las Américas: escribiendo el futuro |
| 7 | La salud de los niños en las Américas: un compromiso con nuestro futuro |
| 8 | Salud sexual y reproductiva |
| | PERIODICALS |
| | Bulletin of the Pan American Health Organization (quarterly) |
| | Boletín de la Oficina Sanitaria Panamericana (monthly) |
| | Educación médica y salud (quarterly) |

Based on the policies established by the Governing Bodies, PAHO collaborates with its 38 Member Governments in the planning, implementation, and evaluation of technical cooperation activities through the PAHO/WHO Country Offices, the Caribbean Program Coordinator, and the Field Office/U.S.-Mexico Border in El Paso Texas. The Country Offices discharge political, administrative, and technical functions. Whereas the first two devolve principally on the

managers of the Country Offices—the PAHO/WHO Representatives—the latter represent how technical cooperation is directed at satisfying needs based on the identification of national health priorities. These needs for technical cooperation with PAHO/WHO have been selected from a broader set of needs for technical cooperation for the country.

The Secretariat's various parts operate according to basic principles that guide its overall functioning. These principles are coherent with the mission of the Organization and include the basic areas of work, as defined by the Governing Bodies of PAHO and WHO. It is these Governing Bodies or, rather, the countries themselves collectively or individually, which establish the areas where the Organization must direct its technical cooperation. There is but one program of technical cooperation of the Secretariat; there is no one part of the Organization which controls the acquisition of information or the generation of knowledge.

The Secretariat delivers its technical cooperation through the Country Offices and through the Regional Programs. The Country Office is the final common pathway for all technical cooperation directed towards satisfying those priorities for cooperation that have been based on the identification of national health priorities. Technical cooperation needs to address those priorities, and needs which PAHO can address must be identified. The Regional Programs represent the collection of resources at Headquarters and the Pan American Centers, as well as the country-based staff. They translate the mandates of the Governing Bodies into the programs of technical cooperation that the Secretariat offers, promote technical cooperation directed towards problems that the countries can best address collectively, and support the countries in carrying out those activities within the areas identified as important. The American Region Planning, Programming, Monitoring, and Evaluation System (AMPES) is the central management system that the Organization uses to plan, program, monitor and evaluate technical cooperation in the short-, medium-, and long-term.

AMPES serves both administrative and technical functions in the management of information regarding the program of technical cooperation. Significant progress was made in increasing the efficiency and the effectiveness of programming and evaluation through the utilization of AMPES. Progress also was achieved in strengthening the linkage between the formulation of projects and the Organization's policy orientations, as well as with the national priorities of Member Governments. A modified methodology for the programming of AMPES was approved to ensure its smooth integration with the new Strategic and Programmatic Orientations and with WHO's Ninth General Program of Work.

In order to better respond to the needs of Member Governments in the delivery of technical cooperation, administrative processes have been improved to reinforce coordination and communication between Headquarters and the Country Offices. To accomplish this, a focal point was established within the Office of Administration to reinforce support to activities in the Country Offices. The focal point provides guidance in the preparation of the administrative development plans of the PAHO/WHO Country Representatives, examines requirements, answers questions on administrative matters, promotes effective administrative policies, implements procedures and establishes management controls. As a way to provide the best possible assistance to field operations, specific needs in some duty stations were addressed, both in terms of identifying deficiencies in operations and in recommending corrections and solutions where problems exist. Special attention was given to the requirements for adequate and qualified staff in the Country Offices as well as proper separation of duties and definition of assigned responsibilities.

The Secretariat undertook several efforts to ensure that a gender perspective is incorporated into the work and the life of the Organization. In particular, it designed and conducted workshops at Headquarters and at the Country Offices to assist professionals in seeing how health and development initiatives could gain by incorporating the gender perspective into their planning. (See Figure IV-1 for the percentage change of women holding professional posts between 1985 and 1995.)

In recent years, PAHO/WHO has endeavored to establish a performance evaluation approach that incorporates institutional and individual responsibility for assessing the relevance, effectiveness, efficiency, and impact of the Organization's activities within the context of the policies established by the Governing Bodies. This year, an new evaluation instrument was developed; it will be reviewed by staff and implemented on a trial basis during 1996. This exercise aims at developing, in the most participatory manner possible, a management tool that will allow for the improvement of staff performance on the basis of work objectives.

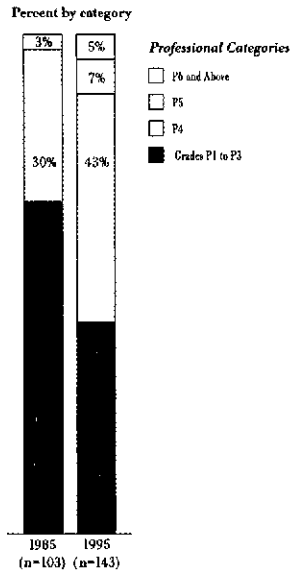
PAHO has a unique information tool in its trademarked machine translation software. The Organization has been using SPANAM® (Spanish into English) and ENGSPAN® (English into Spanish) to translate official documents and scientific and technical manuscripts since 1989. This software has yielded a 30%-50% gain in efficiency in the translation unit, producing significant cost savings. The software is installed in the local area network at Headquarters, where it can be accessed by staff in some 20 other technical and administrative units. The system's dictionaries include PAHO and WHO terminology culled from the more than 22 million words that have been translated through the system.

The machine translation system is available to the centers and field offices that have high translation outputs. So far, the software has been installed at CEPIS, INCAP, ECO, the PAHO/WHO Field Office/U.S.-Mexico Border in El Paso, Texas, and at the PAHO/WHO Country Office in Paraguay. License agreements have been signed with the Ministry of Health of Costa Rica and the National Center of Medical Science Information of Cuba. Since 1987, it has been licensed to five outside public and nonprofit organizations in the United States, Latin America, and Europe for a fee. The license fee includes basic training and technical support, and the revenues received are used to help defray development costs. PAHO's system is widely known outside the Organization, and PAHO is considered to be a pioneer in English-to-Spanish and Spanish-to-English machine translation.

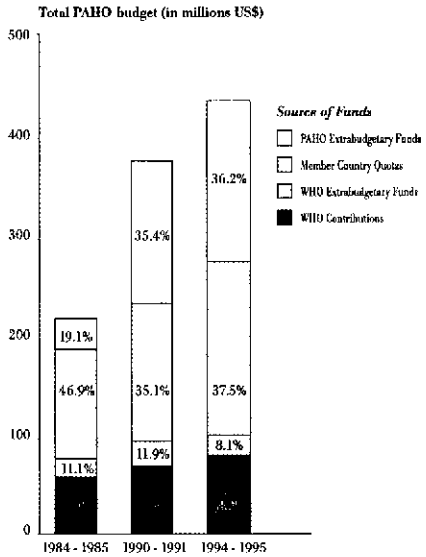
PAHO provides a Reimbursable Procurement Program to Member Governments, pursuant to Resolution XXIX of the V Meeting of the Directing Council in 1951. With this Program, PAHO's Procurement Department makes its procurement services available to Member Governments to purchase health program items unobtainable or difficult to procure in their respective countries. These services are also made available to any nonprofit agency or institution under the jurisdiction of the Minister or Director of Health of a Member Country or whose program is sanctioned by the Minister or Director of Health.

Of total procurement carried out by the Procurement Department at Headquarters in Washington, D.C., totalling US$ 40.6 million in 1995, some $6.6 million was purchased as part of the Reimbursable Procurement Program; in addition, more than $20 million of vaccines and syringes was purchased under the EPI Revolving Fund set up for the Expanded Program on Immunization. The Revolving Fund is essentially reimbursable procurement operating under a somewhat different mechanism. Aside from vaccines and syringes, the Program mainly purchased pharmaceutical drugs, laboratory reagents and biologicals, and hospital and lab-

**FigureIV-1.** Percent Distribution of Women Holding Professional Posts P1 and Above, by Grades, Pan American Sanitary Bureau 1985 and 1995.



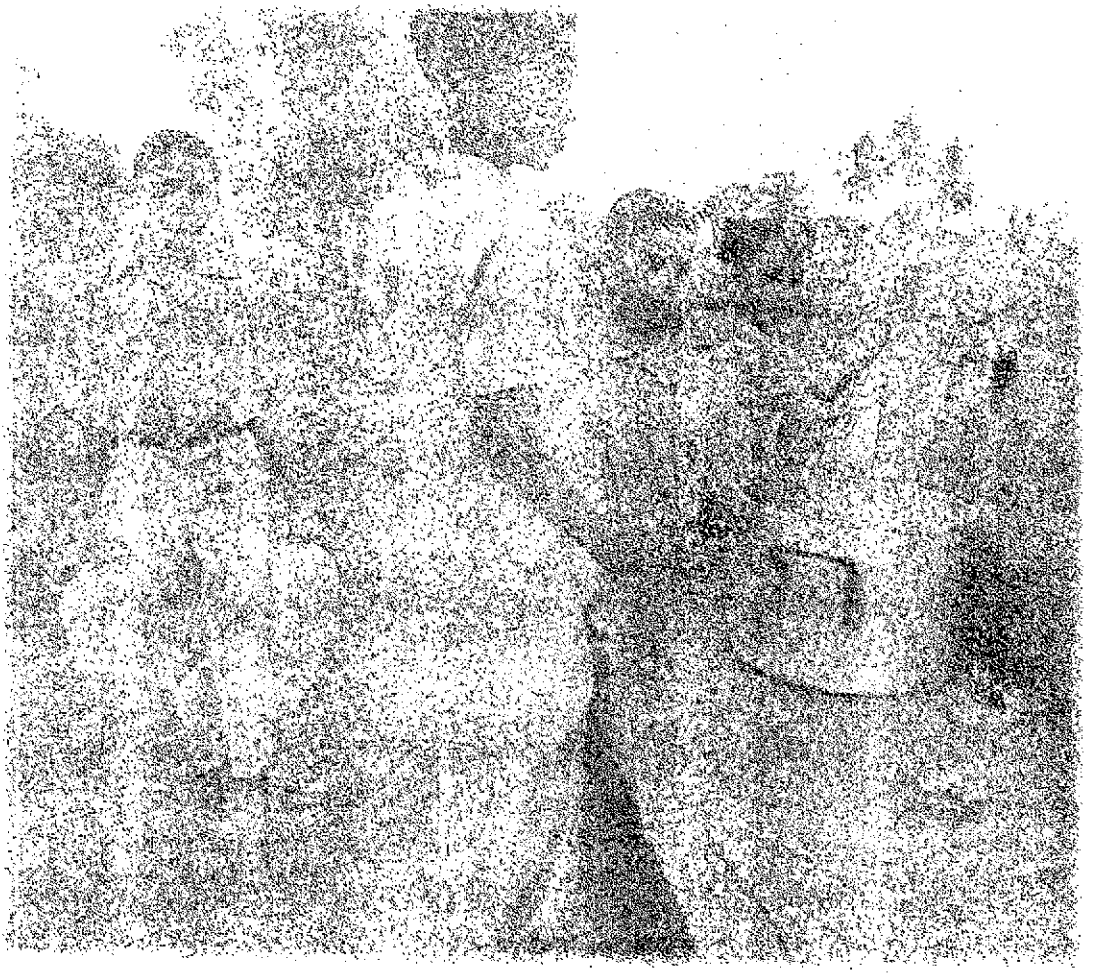

**FigureIV-2.** Pan American Health Organization, Biennial Operating Budget, 1984-1985, 1990-1991, 1994-1995, by Source of Funds.




oratory equipment and supplies. Some computers, office equipment, and vehicles in support of health programs in Member Countries were also purchased as part of the Program.

The Directing Council of PAHO held its XXXVIII Meeting in September of 1995 and passed 14 Resolutions, including resolutions to adopt new principles to govern official relations between PAHO and national and inter-American non-governmental organizations (CD38.R5), eliminate measles from the Americas by the year 2000 (CD38.R6), approve the plan of action to eliminate congenital syphilis from the Region by the year 2000 (CD38.R8), reiterate the commitment to collaborate with the newly established UNAIDS program and continue to cooperate with the countries in their efforts to prevent and control the AIDS epidemic (CD39.R10), implement the goals and objectives of the Regional Plan of Action for the control and prevention of new, emerging, and re-emerging diseases (CD38.R12), and continue to support the health sector reform process in the Region of the Americas (CD38.R14).

During the Meeting, the Council also approved the budget for the 1996-1997 biennium, with the dissent of only one Member Government. The approval of the budget indicates that Member Governments support the Organization's work and are committed to having it continue to grow. In fact, despite financial and political difficulties experienced by most of the Region's countries, 1995 was a record year in terms of the number of countries who paid their quotas. For example, Haiti, its enormous economic problems notwithstanding, is current with its quota payments to the Organization. And the Government of Paraguay went so far as to pass a congressional resolution increasing the amount of its contribution to PAHO. Nevertheless, the Organization is still faced with serious shortfalls due to de facto reductions presented by some of the major contributors and a reduction in the WHO portion of the PAHO budget. (See Figure IV-2 for the source of funds of PAHO's biennial operating budget for 1984-1985, 1990-1991, and 1994-1995.)



# CHAPTER V

## *Major Accomplishments of Technical Cooperation at the Country Level*

*Our structure, our presence in all countries and our access to many points of influence in our countries is one of our greatest assets.*

George A. O. Alleyne
Manager's Meeting
9 December 1995

This chapter summarizes the major accomplishments of PAHO's technical cooperation at the country level during 1995. Viewed as a whole, these highlights depict the scope of technical cooperation activities that the Organization conducts in its Member Countries.

The major accomplishments reported here were selected by the Country Office staff. Selection criteria were remarkably uniform from country to country. They basically fall within the following six broad areas:

- a program's successful demonstration of the benefits of intersectoral, interprogrammatic, interinstitutional, inter-Regional, or intercountry cooperation;
- a program's clear benefit to the population's health or to the health delivery system;
- a program's contribution to national institutional development through the dissemination of knowledge or the enhancement of national capabilities;
- an activity's impact on national health policies, including on health sector reform efforts in the countries;
- the effective mobilization of financial, human, technical, or political resources; and,
- the accomplishment's congruence with the strategic and programmatic orientations of the Organization and/or its mission.

## ANTIGUA AND BARBUDA

◦ PAHO's Caribbean Disaster Response Team, located at the Office of the Caribbean Program Coordinator in Barbados, provided the first damage assessment of health care facilities in Antigua and Barbuda in the aftermath of hurricanes Luis and Marilyn. The Organization's Supply Management (SUMA) Team went into operation, and eight nationals were trained in its application. PAHO mobilized funding from the European Community Humanitarian Office (ECHO) to repair the three government hospitals and provide emergency water treatment materials and vector control equipment. The close work among the Government, PAHO, and the European Community Humanitarian Office resulted in an effective and timely reconstruction project that quickly reestablished the severely disrupted health services.

◦ A two-day retreat for senior staff from various sectors of the Ministry of Health and Home Affairs was held in preparation for the joint country review conducted between the Government and PAHO to review the Organization's technical cooperation in the country. The retreat offered personnel an opportunity to identify elements of Antigua's health policy; reach consensus on priority health programs; and discuss infrastructure problems, offering recommendations for program improvements to address them. The retreat also allowed Ministry of Health and Home Affairs staff to come together as a team for the first time in years for purposes of program review and joint planning.

◦ An intersectoral workshop on drinking water, pollution risk assessment, and quality monitoring was held for representatives from the Ministries of Health and of Agriculture and the Water Department. Participants agreed to work together in a multisectoral project to survey potential threats to the quality of major public water sources, establish a monitoring program for freshwater and drinking water resources, and recommend ways to reduce pollution risks to freshwater and drinking water resources. This integrated approach will allow all sectors involved in managing the water supply, each of which has a distinct and separate role to play, to work together effectively to maintain water supply and quality.

◦ Twenty-seven doctors and nurses were trained in the use of the pantograph for managing labor and delivery of high-risk pregnancies. By training both doctors and nurses in the use of this technology, labor and delivery care of high-risk pregnancies will be strengthened, leading to the overall improvement of services provided. This, in turn, will help reduce perinatal mortality and morbidity.

◦ A public health inspector received training in meat and poultry inspection through the one-month course offered at the University of the West Indies in Jamaica. This course was designed specifically to address Caribbean issues. As a result, it has proven to be more cost-effective than similar courses taught outside the Caribbean. This training will contribute toward the development of the integrated food protection program and a better application of the hazard analysis and critical control point approach.

## ARGENTINA

◦ Following the formation of the National Advisory Commission on Epidemiology, a methodological guide for analyzing the health situation by population groups and risk areas was prepared. This methodology has now been applied in all the provinces. Priorities for human resource training in epidemiology also have been established. This exercise has revitalized relations between the Organization and training centers and national epidemiology institutes. Training of epidemiologists responsible for program management or teaching has been emphasized.

◦ As part of the development of the health information and telecommunications network, the computer system at the PAHO/WHO Country Office in Argentina was linked to the Internet. This connection has made it possible to provide national and international communities with access to the first file transfer protocol (FTP) service, in addition to specialized servers, gophers, and World Wide Web sites in the health sciences in Argentina and direct access to bibliographic databases. Currently, 120 institutions are directly connected to the system and

230 institutions are indirectly connected through distribution nodes.

° The Government decided to update the institutional framework that governs the functioning of labor markets in the health field, which are increasingly dependent on and competitive with one another. The introduction of new technologies also makes them subject to constant change. PAHO technical cooperation in this area contributed to the formulation of sectoral policies and basic documents. This material was provided to the country to serve as a basis for the discussions of the Permanent Advisory Committee on the Occupational Hazards Law, which were aimed at establishing new legislation. The activities were of a multidisciplinary and multisectoral nature (they included the health, labor, and economic sectors) and they involved several agencies (the International Labor Organization also participated).

° The Pan American Environmental Waste Management Network (REPAMAR) was created in the framework of the Regional Plan on Management of Hazardous Waste. A national network, the Argentine Environmental Waste Management Network (REMAR), was formed with the involvement of the private, governmental, community, and university sectors. Both networks rely on modern concepts of waste minimization and contaminant-to-resource relationship. A proposal for the organization of a waste exchange also is being developed. The German Technical Cooperation Agency (GTZ) provided financial and technical support. In addition, maximum advantage was taken of existing resources, in particular the Pan American Network for Information and Documentation in Sanitary Engineering and Environmental Sciences (REPIDISCA). A user assistance center was created with resources from REMAR and REPIDISCA at the headquarters of the Inter-American Association of Sanitary and Environmental Sciences.

° With a view to compiling a body of data to serve as the basis for planning health sector reform, the Ministry of Health, with support from PAHO, has given priority to a national survey of health institutions; the last survey of this type was conducted in 1980. In the 1995 survey, data were collected systematically from public, private, and social assistance institutions throughout the country. Modern computer technology was used to collect and evaluate the information from various sources. The new survey was organized so as to permit both countrywide data and provincial statistics to be analyzed. As a result, the country now has an up-to-date database with information on its physical health resources, which serves as a basis for sectoral and extrasectoral planning.

## BAHAMAS

° Two projects stand out as examples of the benefits to be derived from intersectoral cooperation and from incorporating management structures in projects. The first was the community-based rehabilitation project funded by the Government of Italy through the Caribbean Cooperation in Health initiative. The project provided training for 19 volunteer nurses, teachers, social workers, and community members from Long Island. These volunteers, along with trainers and other staff from the Ministries of Health and Environment, of Education, and of Social Services and with additional funds provided by the Crippled Children's Committee (an NGO), worked to improve the lives of several disabled children and adults on that island. Based on this effort's success, plans are already under way to duplicate the initiative elsewhere.

Training received by the nurse coordinator of the adolescent health program considerably strengthened this program. The nurse coordinator was instrumental in organizing a workshop to discuss strategies to deal with adolescent problems identified by the Commission on Youth, and it brought together representatives from the Ministries of Health, of Education, and of Social Services; the Commission of Youth; the Police; the Church; an NGO dealing with family planning and other nongovernmental organizations; and a group of adolescents. The workshop served as a catalyst, leading some agencies to reactivate their activities and others, including some schools, to begin programs to address adolescent problems. Because of this effort, there is greater awareness of what resources are available in the various agencies, and those resources are already being used and shared more efficiently.

• Health education staff was trained in the development of health promotion strategies to support health programs; the training emphasized the fact that programs should not carry out health promotion in isolation from other aspects of their operations. In addition, approximately 20 health workers and 3 media workers received training in public communication for health. These activities complement the initiative begun by the Ministry of Health and Environment to increase the public's awareness of priority health issues through the use of the electronic media.

• PAHO's cooperation in health sector reform followed three channels: providing technical expertise for planning the hospital devolution process and identifying an adequate organizational structure for the devolved hospital corporation; assisting the Ministry of Health and Environment in preparing for the shift to a decentralized government by sensitizing selected communities to the concept of local health systems; and facilitating the conduct of the health sector study and offering political and senior governmental officials the opportunity to attend regional and subregional meetings on health sector reform.

## BARBADOS

• Regarding the development of health services, PAHO's technical cooperation targeted improvements in the billing system and in the management of the medical aid scheme. A health information unit was established to support the computerized financial management system and the computerization of all information systems. In conjunction, computers were provided to the radiology service, where an information system is now operational.

• Ten fellowships were awarded in hazardous material management, microbacteriology, public health administration, psychiatric social work, public health nursing, advanced nursing management, and radiography.

• As part of the Ministry of Health's overall management improvement program, PAHO provided assistance for introducing a new approach for the psychiatric hospital. The Organization helped to design and implement the Psychiatric Hospital's inpatient census, a tool that has more clearly determined the needs of the Hospital and of the community mental health services. Strategies for integrating mental health into primary health care were recommended, and administrative needs for the Psychiatric Hospital and the community mental health services were identified. The Ministry of Health is now prepared to develop a project for improving the management of its psychiatric hospital and strengthening the linkages with the community mental health program.

• PAHO intensified its cooperation to help revitalize the National AIDS Committee. A comprehensive multi-media campaign involving radio and television stations and newspapers was launched, and a two-hour session on "AIDS in the workplace" was conducted at the Erdiston Teacher Training College for approximately 75 primary and secondary school principals. In addition, PAHO, in collaboration with the national AIDS program, designed and carried out an "AIDS in the workplace" workshop for key representatives from private sector companies. These persons, who included members of the mass media and a labor union, as well as management and human resource development personnel from private enterprises, were trained to facilitate the development of AIDS prevention and support programs within their respective workplaces.

## BELIZE

• During 1995, PAHO provided technical cooperation for the formulation of the National Health Plan for the 1996-2000 period, which has been approved in principle by the Cabinet and is expected to go into effect in 1996. The Ministry of Health spearheaded the drafting of the plan, but the process was multisectoral and also involved the private sector. The plan has helped to steer health sector reform efforts, inasmuch as it sets goals and outlines possible responses to future changes, such as the Ministry of Health's reorganization. It also lays the foundation for a health policy, which the country has not had up to now. The major changes proposed under the plan include a shift from a curative approach to one that emphasizes prevention and

health promotion, as well as a transition from a vertical and centralized model to a decentralized and participatory model. It also provides for a reorganization of the Ministry of Health.

• As a way to facilitate implementation of the National Health Plan and improve the managerial capacity of the Ministry of Health, the Organization provided support for the establishment of a planning unit. During 1995, the functions and organizational structure of the unit were defined and the equipment needed for it to begin operating in 1996 was acquired.

• PAHO supported activities for the control of communicable diseases, especially rabies and measles. Belize experienced an epidemic of rabies in August 1995—the first since 1989—in the areas of Benque Viejo, located on the border with Guatemala, and Corozal, on the border with Mexico. A total of 48 persons were exposed, but thanks to quick intervention the epidemic was brought under control and no human deaths occurred. Mass vaccination of dogs and cats was initiated in 1995 and will continue in 1996.

In October 1995, along with other English-speaking Caribbean countries, Belize launched a national campaign to eliminate measles. This activity received support from several specialized agencies of the United Nations as part of the observance of that institution's 50th anniversary.

• In the framework of the Regional Plan for Investment in the Environment and Health (PIAS), PAHO/WHO's Country Office in Belize coordinated an assessment of national water and sanitation resources, involving several sectors in the country and collaboration from UNICEF, IDB, USAID, and PAHO. As a result of this effort, an investment plan was formulated to guide the actions of the sector. The plan will go into effect in 1996.

• The Ministry of Health and PAHO signed an agreement under which their documentation centers have been consolidated and the National Health Library has been established within the new Belize City Hospital. The centers were consolidated in 1995 and the library will open its doors in 1996. The new institution will make its resources available to the general public and will help to improve the dissemination of health information in the capital and elsewhere in the country.

• With regard to technical cooperation among countries, during 1995 Belize stepped up its participation in two subregional health initiatives—the Central American Health Initiative and the Caribbean Cooperation in Health—and in the trinational health initiative with Guatemala and Mexico. Several projects within the framework of technical cooperation among countries were planned and executed as part of these initiatives, mainly with support from Cuba, Guatemala, and Mexico.

## BOLIVIA

• Health conditions have improved appreciably, as evidenced by the significant decline in infant mortality that has come about mainly as a result of the elimination or reduction of vaccine-preventable diseases. Citizen participation, continuous political support, and interagency coordination helped to bring this about.

• The enactment of the law on popular participation ensured that national general treasury resources would be redistributed to all the municipios in the country. This devolution will further social development and will give grassroots organizations control over the use of resources, significantly contributing toward greater equity and increasing local investment in health. The new legislation will foster participatory planning in the country. The Ministry of Human Development, established in response to the crisis caused by the country's external debt and the introduction of structural adjustment measures, has made it possible to adopt an intersectoral approach that views health as a product of complex historical, political, and socioeconomic processes.

• The country's population has significantly more access to primary care services. In addition, mechanisms for the deconcentration and regionalization of services have been implemented in the context of local health system development, and a program of essential drugs has been established. The strengthening of information systems, coupled with an analysis of the findings of surveys and studies, has

yielded a more accurate picture of the country's health situation. The dissemination and administration of knowledge also has improved as a result of the decentralization of information resources through the creation of health documentation networks and the use of modern communications technology.

## BRAZIL

• The Organization, working with the Ministry of Health, formulated a proposal for establishing a health situation information system in Brazil. The system, set up as an integrated network of basic data and situation assessments, would serve two principal purposes: development of a set of selected core indicators and preparation of current and prospective situation reports. This system also would provide information for conducting analyses pertaining to the formulation and evaluation of health-related public policies and activities.

• PAHO also collaborated in the development of methodologies to facilitate the establishment of government policies aimed at organizing and promoting primary health care through a family health program. These mechanisms are territorialization, rapid assessment methods, geographic information systems, local participation in planning and programming, and cost studies.

• Particularly noteworthy in the context of the healthy cities and healthy municipios initiative are the efforts of Campinas and other communities in the states of Paraná, Ceará, and Bahia, where the principles of health promotion and healthy communities have been put into practice. In addition, methodologies have been developed for participatory planning, promotion of intersectoral collaboration, and the establishment of quality-of-life indicators. A comprehensive child and adolescent health care component also has been established.

• The Pan American Conference on Health and the Environment in Sustainable Human Development made it possible for Brazil for the first time to achieve coordination among the various sectors involved in health and environmental issues. This work aimed at developing a proposal for action in this area. As a result of these activities, the Ministry of Health assumed responsibility for coordinating the national process of implementing the adopted plan of action. Throughout this process, government institutions dealing with health, education, foreign affairs, labor, sanitation, mining, and energy have participated significantly, and civil society, represented by nongovernmental organizations, also was actively involved.

• PAHO supported the country in formulating human resource policies as part of the Ministry of Health's Multi-Year Plan of Action. Initial steps were taken to set an agenda of priorities in the area of human resources for managers of the Unified Health System; the national program of health management training was enhanced; a program for institutional development of mid-level technical training schools was implemented; and the national training program for human resource specialists was strengthened.

## BRITISH DEPENDENT TERRITORIES

### Anguilla

• Anguilla was declared a disaster area following Hurricane Luis. PAHO's Caribbean Disaster Response Team responded quickly and coordinated efforts with the British Development Division to assist Anguilla in the assessment phase. Supplies were provided during the island's reconstruction phase.

• Regarding the development of health services, 102 fellowship/months were awarded in Anguilla in general nursing, post-basic pediatric nursing, health services, public health inspection, psychiatric nursing, and hospital infection control. The development of human resources in these fields is critical, if the health services are to maintain acceptable standards of health care delivery.

• To improve vector control, a public health inspector received training in meat and poultry inspection at the one-month course given at the University of the West Indies in Jamaica. PAHO, with certification of the University of the West Indies, developed the course content specifically to address Caribbean needs. This training will strengthen the integrated food protection program and the applica-

tion of the hazard analysis and critical control point approach; its cost-effectiveness and relevance will allow many more persons to be trained in this area than were in the past.

• The manual on ARI/asthma that PAHO developed for the Caribbean was introduced to health personnel in Anguilla, and training in the manual's use was conducted with the participation of private-sector physicians. This manual was adopted by the Ministry of Health as the standard for the management of asthma at the hospital and community levels, and it will help Anguilla reduce one of the leading causes of morbidity.

### Bermuda

• Fellowships were awarded in areas such as HIV/AIDS, midwifery, nursing, epidemiology, neonatal care, and medical records. Training of health staff in hazard analysis and critical control point system methodology also was provided with support from the Organization. In terms of disaster management, a workshop was conducted for nurses and community workers.

### British Virgin Islands

• A plan of action on health and the environment was developed after a high-level consultation involving participants from the health sector and other sectors; the plan of action was used as background information at the Pan American Conference on Health and Environment in Sustainable Human Development held at PAHO Headquarters in Washington, D.C., in October. The plan of action was submitted to and approved as a policy document by the Executive Council of the Government of British Virgin Islands, which is the highest political Governing Body.

• The evaluation of the health sector's adjustment plan, jointly carried out by PAHO and the British Development Division, showed that among the British-dependent territories, the British Virgin Islands has taken the lead in implementing the reform plan.

• A seminar on the effects of AIDS/STDs on health and development was well-received by decision-makers from various government sectors. The seminar increased awareness of the effects that AIDS/STDs have had on development in each sector, and decision-makers were able to identify areas for their involvement.

• A workshop to standardize and improve management of ARI/asthma was conducted for 30 nurses and doctors from hospital and community services. The use of PAHO's manual on management of ARI/asthma in the Caribbean has been accepted as the standard treatment for ARI/asthma in the British Virgin Islands' public and private sectors.

• A public health inspector received training at the meat and poultry inspection course jointly developed by PAHO and the University of the West Indies, and offered at the latter institution in Jamaica.

### Cayman Islands

• A team of dental health experts from Jamaica and the United States conducted an oral health survey in the Cayman Islands.

• Fellowships were provided in HIV/AIDS, midwifery and nursing, epidemiology, neonatal care, and medical records.

• PAHO provided support for the establishment of inspection procedures and guidelines for pharmaceutical services in the primary care setting at the district level.

### Montserrat

• During the year, Montserrat faced volcanic eruptions and hurricanes, which stressed the inhabitants and taxed the island's health services. PAHO's Caribbean Disaster Response Team responded quickly and efficiently during the assessment phase, and continued to provide support from July to December during the evacuation phase, setting up a casualty unit on the north, assessing an alternative evacuation site in Antigua, and mobilizing funds from the European Union in the amount of ECU 100,000 for relief support. Working with CAREC, mechanisms were put in place to monitor health conditions in evacuation areas. Health personnel was made available to nationals working on relief operations, and courses were organized to help victims cope with traumatic stress.

• Thirteen fellowship/months were awarded to two nationals to pursue education at the University of the West Indies. One attended a 12-month bachelor of science program in nursing; in Montserrat, where senior nurses with a degree are few, the bachelor of science degree is an important component of human resources development. The other took part in the a one-month meat and poultry inspection course offered at the University of the West Indies.

### Turks and Caicos Islands

• Training focused on the development and strengthening of the technical and administrative staff of Grand Turk Hospital. Training areas included quality improvement as a management tool, updating midwifery skills, training at a geriatric facility, parasitology, and radiography.

• A greater understanding of the causes and social and economic costs of HIV infection has come about through the proper functioning of the Family Island AIDS secretariat subcommittees, the sustained educational efforts aimed at youths and the creole community, ongoing public education campaigns, and sensitization of political and administrative officials. Cooperation has helped to maintain a high level of public and governmental awareness of the consequences of HIV infection for the Turks and Caicos.

## CANADA

• The Organization worked closely with Canada's Department of Health (Health Canada) to facilitate the provision of health expertise from the Department itself and from other Canadian health sector professionals, including provincial ministries of health and NGOs. Health Canada provided expertise to PAHO programs on health issues such as tuberculosis control, health of indigenous peoples, and disease surveillance.

• Health Canada cooperated in preparing and carrying out PAHO's Conference on Health Sector Reform. The Organization and Health Canada also worked together on the Pan American Conference on Health and Environment in Sustainable Human Development and in preparation of the Pan American Charter on Health and the Environment in Sustainable Human Development, which included the presentation of a paper on federal-provincial collaboration on environmental issues ("National Accord on Health and the Environment, Where we Live, Work, and Play").

• Most of PAHO's cooperation in the country involved support of the Canadian Society for International Health (CSIH) in its role as the Organization's technical representative in Canada. The following activities highlight the Society's work on behalf of the Organization's programs in the Americas:

In November, CSIH organized a major conference, "Health Reform Around the World: Towards Equity and Sustainability," which dealt with one of PAHO's priorities. CSIH also hosted a one-day forum to explore the potential for strengthening cooperation in health between Canada and NGOs from Latin America and the Caribbean.

The Society arranged visits for Latin American delegations, particularly for a group from Chile that traveled to several Canadian cities. CSIH served as host to PAHO residents in international health while they stayed in Ottawa, promoted the resident program, and administered the PAHO fellowships program in Canada. The Society participated in the health sector reform forum held in Puerto Rico, and it provided information on the Canadian health system at workshops held throughout the Region.

PAHO publications were promoted by offering special discounts to CSIH members and by increasing the Organization's visibility through information displays and at fora across Canada. A World Wide Web home page was established, fostering links between health and development groups in Canada and those in Latin America and the Caribbean. CSIH continued to promote awareness of "World Health Day," "World No Tobacco Day," and "World AIDS Day" in Canada and to recruit the participation of relevant groups in these activities.

• PAHO's cooperation supported the establishment of nursing services in several Latin American countries and in the Bahamas in collaboration with Toronto's Mount Sinai Hospital. PAHO also facilitated the collaboration of the Douglas Hospital at McGill University (Montreal) in training Guyana health workers in community-based mental health programs.

## CHILE

• In early 1995, an evaluation was conducted of the national program for household elimination of *Triatoma infestans*, focusing on its impact in Region IV of the country. The evaluation led to the preparation of a document that will serve as the basis for a five-year campaign to eliminate the vector.

During the second half of the year, work began on the development of the country's basic epidemiological profile. In addition, a national seminar was conducted to evaluate the measles elimination program and discuss strategies for keeping the country free of this disease. A decision was taken to launch a mass revaccination campaign in April 1996, in order to ensure that there are no remaining susceptibles in Chile. To that end, a serologic survey was conducted among a representative national sample of the population of children under the age of 1, schoolchildren, and women of childbearing age. Given the results of the survey, it was decided to administer only the measles vaccine, since the high immunity rates among women of childbearing age did not justify use of the rubella vaccine.

• The Organization has actively participated in bringing innovation to the services, and it has cooperated in the country's scientific production. PAHO also collaborated in a project to address multiple risk factors for communicable diseases, the development of an integrated mass communication project, and a study of the clinical management of diabetes. A proposal for a nursing strategy also was formulated, which evenly incorporated the contributions of the Ministry of Health, the College of Nurses, and the Chilean Association of Schools of Nursing.

• With a view to strengthening Chile's presence in international public health, a forum-panel discussion on "Health in the Chilean Development Process" was organized. This event was intended to stimulate internal democratic dialogue on crucial health sector reform issues and to show the historical evolution of public health in Chile, from the creation of the National Health Service and the reform of the 1980s to the present.

• PAHO and the Government of Chile, represented by the Ministries of Health and of Planning, signed an agreement for the development of a rural sanitation project; this project aims at conducting a preinvestment analysis that will lead to a proposed methodology for identifying and evaluating rural sanitation projects for remote populations. The project will also make it possible to incorporate the health sector in the national investment process, which, in turn, will open up the possibility of providing sanitation services to more than one million low-income Chileans.

• Successful negotiations with the Ministry of Public Works culminated in direct activities with the health services to improve the services themselves and strengthen the areas of epidemiology and environmental health. PAHO's support has helped the Antofagasta health service to establish a computerized system for monitoring levels of arsenic, a natural pollutant in the area.

## COLOMBIA

• As a way to support health sector reform, the Organization has emphasized adoption of the principles of universalization and expansion of equitable coverage and equitable access to health services; improvement of the quality of care; and efficiency in the use of the sector's institutional, human, and technological resources. The Organization collaborated with the Ministry of Health, the Social Security Institute, and other health sector institutions in formulating and executing a broad-based national program for the development of family medicine, which constitutes the fundamental strategy for reorganizing and rationalizing the primary care level. A collaborative effort was initiated, which aimed at analyzing external technical and financial cooperation as away to support health reform.

° PAHO also provided support for activities to address the epidemic of equine encephalitis. The Organization collaborated in confirming the diagnosis; sending samples of human, equine, and mosquito sera; providing vaccines to immunize laboratory and field personnel; supplying reagents for diagnosis; analyzing vaccine strains (genomic and antigenic); and conducting epidemiological surveillance. PAHO also financed an entomological study in the department of Guajira and participated in negotiating and making arrangements for the importation of 400,000 doses of the vaccine against the disease donated by the United States of America.

• As part of a project for occupational health in the petroleum industry, a specific technical cooperation agreement was finalized in coordination with the Petroleum Workers Union and the Colombian Petroleum Enterprise to carry out a study on occupational health in the aromatic hydrocarbon plants of the Barranca Bermeja Industrial Complex.

• The Organization also collaborated in the establishment of a doctoral program in public health with emphasis on epidemiology. As part of this effort, the curricula of master's degree programs were revised and updated and priority areas for research were identified. The national capability to conduct health situation analyses was strengthened, as was research aimed at gaining a better understanding of the factors that determine health and the magnitude of the country's most frequent health problems.

° Under the special program on immunization, vaccination against measles, mumps, and rubella was stepped up from October through December 1995. During this period, 1,686,448 children aged 1-3 years old were immunized (74% coverage). Several factors—including the success of the polio eradication campaign, the degree of interagency and intersectoral coordination achieved, and the reduction of measles transmission by 99% between 1984 and 1995—have led the country to establish new goals with regard to vaccine-preventable diseases. These include elimination of measles by the year 2000, control of hepatitis B and congenital rubella, and intensified surveillance of bacterial meningitis. The objective of the latter activity is to assess the feasibility of introducing new vaccines into the program.

° In 1995, the Ministry of Health revised the healthy communities strategy with a view to implementing health promotion at the local level. This effort involved the exchange of experiences and the dissemination of information from communities that have accumulated experience in social participation and intersectoral collaboration. In keeping with the country's legal framework, which provides for decentralization, future plans call for the establishment of networks of healthy communities in the departments; these networks would facilitate the sharing of information on projects associated with the strategy.

## COSTA RICA

• The Ministry of Health and the Costa Rican Water Supply and Sewerage Institute are carrying out a project to provide basic sanitation services in rural areas, funded exclusively by national resources channeled through PAHO. This project is expected to solve the basic sanitation deficit by ensuring that the rural population has access to drinking water supply and sanitary elimination of excreta. The innovative technological solutions being applied under the project may prove useful for other similar projects in the subregion.

The PLAGSALUD project, which is part of the program on Environment and Health in the Central American Isthmus (MASICA), primarily aims at improving the national epidemiological surveillance system, particularly the surveillance of pesticide poisonings, and carrying out educational activities and other interventions to reduce the risk of such poisonings. The most noteworthy activities have concerned the use and handling of pesticides, which are imported into Costa Rica in great quantities and can harm workers' health. The project also seeks to reduce the high level of underreporting of acute pesticide poisoning cases and train medical and paramedical personnel to treat them.

• Of particular note in the context of health services development and health reform is the project to modernize the Costa Rican Social Security Fund (CCSS), which has recently introduced a new health

care model. In this process, the Organization supported the definition of functions and standards for the primary care level—or basic comprehensive health care teams—and area support teams. PAHO also collaborated in defining and analyzing the functions of the first 20 areas established as a result of the joint efforts of the Ministry of Health and CCSS. The Organization also supported a study that enabled CCSS to accurately determine the situation of second- and third-level services, which account for more than 50% of the Fund's expenditures. The study also made it possible to choose the best option for managing the development of the sector; improving the quality of services; and channeling investment in infrastructure, equipment, and human resources.

• During 1995, Costa Rica succeeded in substantially reducing the transmission of dengue. The number of reported cases fell from 14,000 in 1994 to slightly more than 5,000 in 1995. Only one case of dengue hemorrhagic fever was reported and no deaths from the disease occurred. These results were achieved thanks to the coordinated efforts of the Ministry of Health and CCSS, as well as other government sectors, municipal governments, schools, and community organizations, in addition to broad social participation. National resources were used for these efforts; external cooperation also was mobilized. In particular, resources for the vector control project were provided by the Government of Sweden and administered by PAHO.

• With a view to improving adolescent health, activities aimed at this population group were incorporated expressly into the new health care model. The responsibilities of primary care personnel were defined and standards for adolescent care were developed and published. In addition, through the National Commission on Adolescent Care, projects aimed at young people who live in marginal urban areas were formulated and approved. National funds were used for this purpose. Four books dealing with various aspects of adolescence and young adulthood were published and distributed.

• Another noteworthy project is the healthy cantons project. Its objective, and that of the Network of Healthy Cantons, is to promote greater well-being and a higher level of development to the population. Support has been provided for the Ministry of Health in its activities in the area of health promotion, which have been incorporated into the national strategy for sustainable development, and a commitment has been obtained from national health authorities to incorporate the project among their priorities. Healthy canton initiatives have been initiated in various regions of the country.

## CUBA

• A sectoral study of drinking water supply and sanitation was completed during 1995: based on its findings, it was estimated that approximately 30% of drinking water supply and sanitation systems need renovation. Subsequently, an international meeting with potential donors was held with a view to securing financing for investment, rehabilitation, expansion, and operational development projects in the water sector. As a result of the meeting and other efforts at mobilizing international support, projects already have been negotiated with various countries and cooperation agencies, including the UNICEF committees in the Netherlands, Spain, and the United Kingdom; the Spanish and Italian cooperation agencies; and PAHO. Total financing mobilized thus far amounts to US$ 2.6 million.

• During the period covered by this report, the Cuban network of healthy communities, comprising 27 entities, was formed. The "Healthy Communities Network Declaration," signed in Cienfuegos in December 1994, served as the basis for formation of the network. PAHO has provided scientific, technical, methodological, and financial support, which enhanced the support provided in these areas by municipal governments; the Ministry of Public Health; the Legislative Commission on Health, the Environment, and Sports; and community organizations. The Cuban Network has incorporated healthy public policies, social communication, leadership training, information dissemination, intersectoral action, resource mobilization, and exchange of experiences into its strategies.

• Resource mobilization and technical cooperation among countries increased markedly during

1995. This growth was seen particularly in the area of donations from the nongovernmental organization Global Links, which contributed drugs, medical equipment, and other supplies for the National Health System. Rotary International contributed essential vaccines to ensure that national immunization campaigns could be carried out. In addition, during the period, negotiations for a contribution from Italy for the province of Guantánamo were finalized. That support will commence in early 1996.

• In November 1995, an interagency meeting of the United Nations System was held in the framework of the fifth Seminar on Primary Health Care. This meeting was organized by the Ministry of Public Health in coordination with the ministries of Foreign Affairs, Foreign Investment and Cooperation, Economy and Planning, and Finance and Prices. Of the international agencies that participated (UNDP, PAHO, WHO, UNICEF, and UNFPA), some were represented by their highest-level officials, including the Director of PAHO. During the meeting, a progress report on the sectoral analysis currently being undertaken was presented. The analysis forms the basis for the health reform efforts under way in the country.

## DOMINICA

• Through a collaborative effort between national authorities and PAHO, a high-level meeting was held to prepare a background paper and a national plan of action; the latter was presented at the Pan American Conference on Health and Environment in Sustainable Human Development, held in Washington, D.C. The Minister of Health, as well as policy-makers from government agencies representing areas such as tourism, finance, and planning for health and the environment in sustainable development participated.

• As a way to improve solid waste management, 20 nationals were trained in rural composting; subsequently, a pilot project for background composting was started in five schools with PAHO support. An intersectoral approach has been used in the project's implementation, which augurs well for its success. The project will be used as a model for similar projects that may be implemented in other Caribbean countries.

• Some 91 fellowship/months were awarded in post-basic pediatrics, operating room techniques, water monitoring, advanced nursing education, public sector management, and physiotherapy. PAHO's fellowship program plays a critical role in Dominica's efforts to improve the efficiency of its primary care system and upgrade its technical services.

• With PAHO's and CAREC's collaboration, Dominica successfully controlled its dengue fever epidemic in 1995. CAREC procured larvicides and helped to improve surveillance.

• PAHO collaborated with the Ministry of Health in its efforts to upgrade child health services. The Organization helped to develop a screening program for the early detection of developmental delays. In addition, health and education personnel were trained in the use of a manual that identifies developmental milestones and outlines managerial procedures and referral mechanisms. This combined approach is expected to both increase early detection and improve the outcome of conditions that result from developmental delays.

## DOMINICAN REPUBLIC

• PAHO mobilized technical experts to support the debate on health sector reform, and it participated in various forums and provided financial and technical resources for the reform process, one of the outcomes of which is the General Law on Health currently being considered by the national senate. Progress also was made in the process of accrediting health establishments. To this end, information was collected from 20% of the country's public and private hospitals. With a view to creating health area systems, four multidisciplinary and interinstitutional working groups with broad community participation were formed in three health regions and eight health service areas. Among the participants in these groups are the Ministry of Public Health and Social Welfare, universities, and nongovernmental organizations.

A program for quality control of domestically produced drugs was developed and implemented. This process entailed the establishment of manufacturing standards for the Dominican Republic and their application in all national pharmaceutical laboratories.

• Support was provided for strengthening technical and administrative aspects of the Expanded Program on Immunization, and basic inputs, including biologicals, were supplied. For the first time in the country's history, there were no confirmed cases of measles, although surveillance activities were stepped up, as were reporting of laboratory test results and active case-finding in public and private establishments.

• A system for the surveillance of febrile illnesses was put in place with a view to increasing the disease surveillance capacity of the network of hospital establishments (sentinel posts), which daily report suspected cases of malaria, dengue, and measles, three of the most important acute pathologies. In addition, on a weekly basis they report the total number of patients and the number of those who had a febrile illness. Although this network is still being consolidated, it has already proven to be a useful tool for the detection and monitoring of outbreaks of dengue, meningococcal diseases, malaria, and measles.

Regarding dengue control activities, laboratory personnel were trained to isolate and type the virus. The Organization provided cooperation to strengthen a laboratory's technical capacity for conducting serological diagnosis of dengue and collaborated in establishing the National Institutional Commission for the Prevention and Control of Dengue and revising the national plan.

• The National Food and Nutrition Plan was formulated with the participation of the various national sectors and in close coordination with other international agencies. This Plan has been approved at the highest political level. As part of its implementation, a national micronutrient survey was conducted, salt iodization activities continued, and a commitment was obtained from high-level political leaders and commercial manufacturers for the formulation of a plan to fortify sugar with vitamin A.

• Considerable progress has been made under national initiatives on the health of mothers, children, and adolescents, one of the objectives of which is to reduce maternal mortality. A national plan of action was formulated, and the national committee established for this purpose was strengthened. Regional and provincial committees also were formed, and an intersectoral group including representatives of international agencies was created.

Advances have been made toward incorporating a gender perspective into health program activities. In addition, a comprehensive health care program for adolescents has been developed and services have been established at the various levels of care. Intersectoral activities also have been initiated through the creation of a committee that has the authority to set policies on issues relating to adolescents and young people. As a result of these initiatives, various primary and secondary schools and universities, as well as formal and informal groups working in the health field, have incorporated comprehensive adolescent health into their conceptual and operational frameworks.

## ECUADOR

• During the year, the process of health sector reform was promoted and articulated with a view to strengthening the National Health Council. To this end, the Organization provided advisory services to the country's principal health institutions under the leadership of the Ministry of Public Health. The National Health Council worked to achieve consensus and made significant progress in developing lines and a plan of action for a consolidated and integrated health sector reform project. The resulting document was presented at the special session on health reform held during the XXXVIII Meeting of the Directing Council of PAHO. The Organization has provided ongoing advisory support to the National Health Council and has coordinated the work of the Interagency Commission on Health Sector Reform, which was formed in September. The Commission was initially composed of IDB, the World Bank, USAID, and PAHO; subsequently, UNICEF and UNFPA became members.

• New opportunities were found for health advocacy in various social and institutional settings, both public and private, as well as at national and international levels. The most noteworthy success in this regard involved an official visit to the country by

the Director of PAHO, who discussed health's ranking in the political, economic, and social contexts with the country's president and vice-president and with members of the economic and social cabinets. As a result, relations among the Ministry of Public Health and Social Welfare and the National Congress, the Ecuadorian Social Security Institute, and various health services and institutions were strengthened. In addition, contacts with several businesses and with various nongovernmental and indigenous organizations were enhanced.

• Working with the Ministry of Health and the World Bank, PAHO conducted an in-depth revision of its participation in the project to strengthen and expand basic health services (FASBASE). This strategic project has received considerable financing and is expected to make a substantial contribution to the development of local health services between now and the year 2000. Joint programming was undertaken and opportunities for technical cooperation were identified in the areas of nutrition; control of dengue, malaria, and cholera; development of local managerial capacity; improvement and accreditation of the quality of services; drugs; salt fluoridation; and institutional development, with emphasis on automated information systems.

• The political commitment to eradicate foot-and-mouth disease was reaffirmed, and epidemiological surveillance was strengthened with the establishment of a master's degree program in epidemiology at the Catholic University of Ecuador. Training was provided for establishing sentinel posts for epidemiological surveillance of HIV and improving information systems; training also was provided in alternative techniques for the control of communicable diseases. Participation on the epidemiological emergency committees of the Ministry of Public Health was enhanced through the formulation of specific plans of action for the control of cholera, yellow fever, and Venezuelan equine encephalitis. The involvement of the network of laboratories in disease control programs also was strengthened, especially in the case of the programs on HIV, cholera, tuberculosis, leishmaniasis, and dengue. Substantial support was given to the binational projects "Health, a Bridge to Peace" and "Healthy Borders," whose purpose has been to foster peace between the peoples of Peru and Ecuador after the military conflicts that erupted at the beginning of the year.

• To support the Ministry of Public Health in the integrated program to control micronutrient deficiencies, PAHO obtained financing for the development of an integrated proposal for the control of iron and vitamin A deficiencies. The negotiations and mobilization of support carried out in connection with this proposal were extremely successful: in addition to PAHO and the Ministry, several government institutions, including some from the Ministry of Agriculture and the Ministry of Commerce and Industry, and representatives of private industry (wheat and sugar mills) participated in the effort. Interest was also expressed and financial support was obtained from various international agencies, including UNICEF, Opportunities for Micronutrient Intervention (OMNI)/USAID, the International Life Sciences Institute (ILSI), the World Bank, and the Belgian national cooperation agency.

## EL SALVADOR

• During the period of armed conflict, El Salvador received substantial economic support from the international community. Subsequently, that support declined markedly, although the country continued to need economic and technical cooperation, especially in the social sectors. As a result, the mobilization of external resources has been a priority for PAHO's technical cooperation.

• The country, with support from the Organization, has encouraged efforts to increase efficiency in the use of resources, an undertaking that calls for the development of new managerial approaches, strategic management of information, and institutional analysis and development. The effects of internal resource mobilization are demonstrable—increased efficiency in the accessibility and quality of services provided for the neediest segments of the population.

• The current administration has given priority to the modernization of the State and

reform of the health sector. Both IDB and the World Bank are involved in the process, for which financing in excess of US$ 100 million was expected. The Organization pursued a strategy of support based on the following elements: guidance for change and interagency coordination, ongoing processes of decentralized local development, and coordinated work with the three principal institutions of the sector (Salvadorian Social Security Institute, the agency responsible for water supply, and the Ministry of Public Health and Social Welfare). A noteworthy example of this modality of cooperation is the Organization's collaboration with the Salvadorian Social Security Institute, which has rapidly increased the number of its beneficiaries, thereby enhancing equity in health care coverage and financing. The Institute has adopted a new social approach to the delivery of services and has established a basic basket of services, which are provided to the entire population in the Institute's area of influence through clinics located in high-risk urban communities. The Institute is also extending its coverage to the rural population through agreements developed with agroindustrial cooperatives, and it has entered into discussions with the country's principal businesses to explore the extension of comprehensive health care into the work environment. It is also actively working on various aspects of institutional development.

• The Organization's cooperation in the area of communicable diseases has contributed to the adoption of a modern approach to control strategies that entails, in particular, promotion of intersectoral participation and technical and operational decentralization of surveillance and control activities. The effort to control the epidemic of dengue and dengue hemorrhagic fever is a concrete example of this collaboration between the country and the Organization. Although 126 cases and 4 deaths occurred early in the epidemic, entomological indexes were reduced from more than 80% to 19%. PAHO's international efforts to secure financing ensured that critical control activities could continue.

## FRENCH DEPARTMENTS IN THE AMERICAS

### French Guiana, Guadeloupe, and Martinique

• PAHO's cooperation has helped to increase and improve cooperation between the French-speaking and English-speaking Caribbean. The Organization focused on the project to establish programs for the prevention and control of cancer of the cervix. The pathologist at La Meynard Hospital continued to function as a major training resource in cytotechnology, and two experts participated in two workshops that resulted in guidelines for establishing cancer registries.

## GRENADA

• The new Government has slated health sector reform as one of its top priorities and has stated its intention to modify the hospital's management. To support these efforts, PAHO facilitated the participation of a national team in the meeting on health sector reform held in Jamaica in November.

• A total of 31.5 fellowship/months were awarded in health services management, advanced nursing education, inspection of meat and other foods, and prevention and control of alcoholism.

• A broad representation of high-level officials from the health sector and other sectors participated in a consultation on health and the environment. A background paper was prepared, as was a plan of action. The latter was presented at the Pan American Conference on Health and Environment in Sustainable Human Development, held in Washington, D.C., and now constitutes a policy document approved by the Cabinet.

• Women in Grenada continue to enroll late in prenatal care programs. In response, PAHO worked with health personnel and a focus group to develop a communication strategy using health promotion and the media. A program to increase the number of women who seek care in the first trimester of pregnancy was planned as a complement. This health promotion approach involving the media as a strategy for maternal and child health will be evaluated for possible use in other countries.

• Health promotion continues to be viewed as a priority. A two-day multisectoral conference on health promotion was held in March to increase the awareness and understanding of principles, strategies, and general implications outlined in the Caribbean Charter on Health Promotion. The meeting was attended by 20 participants from the health, finance, education, and community development sectors, as well as from leading NGOs. Participants relied on prepared guidelines on health promotion to share perspectives on current initiatives and issues and to identify possible approaches for implementing the Charter. This is an important phase in the country's effort to reorient its resources toward health promotion.

## GUATEMALA

• As part of the process of health sector reform, the country signed agreements for three projects, for which US$ 57.5 million in loans from IDB and donations from the European Union and the Swedish International Development Authority (SIDA) were obtained. These resources will make it possible to expand the coverage and improve the quality of health services, increase public spending on health, improve managerial and administrative efficiency in the services, and address both the demand for health services and some of the determinants and risk factors associated with that demand. PAHO, in addition to providing advisory services for the overall process, is the executing agency for the project financed by SIDA, which aims at improving health surveillance and planning, with emphasis on the populations of migrant workers and indigenous women.

• An initial proposal was developed for restructuring the water and sanitation subsector, with a view to expanding the coverage and improving the quality and efficiency of the services. The Organization played a catalyzing role in the formulation of the proposal, which also involved the IDB, UNICEF, and USAID.

• In terms of health sector reform, an initial proposal was developed for training human resources at the community, auxiliary, technical, professional, and postgraduate levels. The University of San Carlos established a master's degree program in public health.

• The country also has progressed in the decentralization of health activities. For example, 21 local health systems were strengthened through the establishment of four decentralized technical cooperation offices in Huehuetanango, Quiché, Alta Verapaz, and Escuintla. With regard to the local health management information system, the first module of the computer program was finalized and is currently in use in all of the country's health areas and in some hospitals. This system is the result of joint efforts and resource mobilization by the Ministry of Health, USAID, and PAHO.

## GUYANA

• A revised, community-based curriculum for the School of Medicine at the University of Guyana was completed through a collaborative effort involving professional staff from the Faculty of Health Sciences, and the Ministry of Health, as well as other local and foreign specialists. As a result, general objectives, a curriculum, and course outlines were developed. The program has been designed to address the country's specific needs. Although for many years Guyana produced its own medical personnel, conditions in the country led many of them to leave, eventually diminishing the quality of care. To counter this situation, the Organization has channeled efforts toward developing sustainable, local-level programs.

• PAHO was instrumental in the conduct of research for the two-year campaign culminating in the Medical Termination of Pregnancy Act that was approved by the National Assembly in May. This is only the second such pieces of legislation in the Region and the first in South America. Among its unique features is the commitment to preserve the dignity and sanctity of life by reducing the number of abortions; it also seeks the involvement of male partners in pre- and post-abortion counseling.

• The number of properly trained environmental health officers is very low. To increase their ranks, 14 environmental health assistants have been trained and are now working to support environmental health officers in the country's regions and municipalities. Environmental health officers routinely visit dwellings within their districts to observe and report on their environmental health status; they also dis-

cuss any unsatisfactory conditions with the occupants and monitor improvements.

• The care offered by the perinatal services at the referral center, Public Hospital Georgetown, and at other national and regional hospitals was improved as a way to reduce the level of morbidity and mortality associated with these services. Specifically, the knowledge and skills of medical and nursing personnel in perinatal care were strengthened. Technical assistance also was provided for upgrading the facilities and management of the perinatal services at Public Hospital Georgetown.

• Several activities in food and nutrition strengthened the country's capacity to monitor food quality and increase the public's awareness of food safety. Highlights included carrying out training programs to improve the analytical capacity in food microbiology and chemistry at the Government Analyst Laboratory, initiating the consultative process to develop a national food safety plan, and increasing the awareness of managers of food factories of their role in maintaining food safety standards.

## HAITI

• The Organization contributed to develop a new national health policy based on equity, decentralization, and community participation. PAHO also helped to coordinate donor efforts in the health sector during implementation of the emergency economic recovery program. PAHO served as the Coordination Committee's Secretariat, and was charged with follow up and reporting on behalf of the Ministry of Health.

• PAHO, working with NGOs and the Ministry of Health, designed a new training course for traditional birth attendants. Between May and December, 523 trainers were trained, which will have clear benefits in the country, where 80% of births take place at home and are assisted by traditional birth attendants.

• The Organization issued training materials for physicians, nurses, and auxiliaries on the use of essential drugs. The materials will become part of the new academic curricula in the school of nursing and the school of medicine, and they will also be used for continuing education purposes.

• PAHO provided support for the launching of a project to restore the State University Hospital's maternity ward.

## HONDURAS

• The Ministry of Public Health is strengthening decentralized management at the local levels. The involvement of civil society in this effort is manifested through local governments, municipios, and their development committees.

• Institutional work in the health field has been more firmly established through a project to increase access, which aims at enhancing equity in the delivery of services to the population, carrying out an internal restructuring of the Ministry of Health, and achieving greater efficiency and effectiveness in the planning of health services and activities through health situation analyses.

• Gradual progress is being made toward acknowledging and applying a gender approach to health care. In addition, there has been significant growth in the community's participation in health activities carried out at the local level in the framework of specific projects, such as the Expanded Program on Immunization and cholera and dengue control.

• The Central American Health Initiative has contributed to the establishment of excellent interagency and international coordination.

• In the area of human resources, the Organization has provided ongoing cooperation, including support for the master's degree program in public health. PAHO also has contributed to the development of a scientific community in the health field through the publication of scientific works, the network of documentation centers, electronic mail, and the dissemination of journals and bulletins.

## JAMAICA

• As part of the effort to prevent and control the dengue epidemic, the Organization provided technical assistance, supplies, and equipment and collaborated in the implementation of research to assess the efficacy of aerial spraying. One-hundred new latrines, two public sanitary conveniences in St.

Mary, and three sanitary conveniences in Kingston were completed with support from the project funded by the Government of Italy.

• PAHO, the Ministry of Health, and Alkali Ltd., a private company, implemented a salt fluoridation program. A survey to assess its impact showed that Jamaica had the lowest prevalence and incidence of caries of any country in the Region.

• Eighteen engineers from Cuba helped to examine the biomedical maintenance program. They assessed the available biomedical equipment and made some repairs.

• Regarding the expanded program on immunization, PAHO supported the launching of a media campaign to promote the need for immunization against measles. The campaign included television messages and the distribution of educational materials; high immunization coverage rates can be traced its success.

• Seminars, workshops, and fellowships were provided in health information, epidemiology, public communication, and health services management.

## MEXICO

• With support from the Organization and utilizing national resources, 30 instructors from Mexico, Central America, and the Caribbean were trained to use the *International Statistical Classification of Diseases and Related Health Problems,* Tenth Revision (ICD-10). The 10 Mexican instructors who participated have already offered a first national course, which served to train 50 coders. Having personnel trained in how to use the ICD-10 helps to ensure that disease classification is standardized in the country's institutions, improves the quality and timeliness of mortality and morbidity data, and enhances health situation analysis.

• In the area of health systems and services development, Mexico carried out several activities under the Regional Plan for Investment in the Environment and Health. A sectoral study and health investment plan were consolidated in Chihuahua and an analysis of the drinking water supply and sanitation sector was undertaken in Oaxaca. In addition, a rapid situation assessment of hazardous and urban solid waste was conducted, an analysis of the investment program was carried out, and the National Ecology Institute was strengthened.

To support the strategy for extending health service coverage, the Organization helped to disseminate the package of basic health services and facilitated discussions about it in all health jurisdictions.

A system of public health instruction was consolidated with the inclusion of all the education programs in this discipline. Through this system, the organization, continuing development, and evaluation of the quality of public health instruction and of the human resources trained are standardized.

• With regard to health promotion and protection, the comprehensive approach to reproductive health that was agreed on at the International Conference on Population and Development has been adopted and is being applied in programs in the areas of perinatal health, family planning, comprehensive health care for adolescents, prevention and control of cervical and breast cancer, treatment for infertility, climacteric and menopause, and prevention of AIDS and other sexually transmitted diseases. In the framework of the Mexico-Belize-Guatemala trinational health agreement, comprehensive health care for women has been included among the joint activities carried out along the borders shared by the three countries.

• During 1995, the healthy communities movement was consolidated nationwide. PAHO played a key role in incorporating approximately 100 communities into a national network. These communities have agreed (through the Monterrey Agreement) to carry out multisectoral projects and establish healthy public policies at the local level.

• Strengthening of cooperation between the health and environment sectors led to the creation of the National Technical Committee for Sustainable Development and Health. The Committee's purpose is to establish an ongoing process of consensus-building aimed at ensuring that health and environmental concerns are addressed in all development plans and programs. The basis for this coordinated effort is a cooperation agreement signed between the Ministry of Health and the Ministry of Environment, Natural Resources, and Fisheries.

• Regarding disease prevention and control, malaria morbidity has been reduced to fewer than

10,000 cases. Ivermectin was administered to 98% of the population diagnosed with onchocerciasis. The Organization's technical cooperation in the case of both diseases was directed toward maintaining the operational capacity of the control programs at the health jurisdiction level. The National Commission for AIDS Prevention and Control (CONASIDA) completed the design and testing of an intervention for specialized HIV prevention educators. These educators included teachers, health workers, professionals from nongovernmental organizations, and others. This is the first structured intervention of this type for the prevention of HIV infection in Mexico. The work with educators is expected to have a multiplying effect and thereby increase the dissemination of information. In addition, the groundwork has been laid for more systematic interventions in the area of formal and informal education.

## NETHERLANDS ANTILLES AND ARUBA

• After the data from the Curaçao National Health Survey had been analyzed, PAHO provided support for the establishment of a national program of essential health research in the Netherlands Antilles. In addition, it collaborated in the formulation of health policies and plans and in the development of a proposal for reducing inequities and improving the overall health situation. To this end, the Organization also supported the development of an epidemiology unit in Aruba.

• When Hurricane Luis struck, PAHO was the first technical cooperation agency to respond and assist in mitigating the disaster's consequences. The Organization collaborated in reestablishing communications and enlisting aid from the Government of Venezuela for the Island of St. Martin.

• With support from the Latin American Center for Perinatology and Human Development, a perinatal information system is being established, and some 2,000 prenatal and postnatal records already have been analyzed.

• Workshops were held in Aruba and Curaçao for media executives and journalists. These events were designed to initiate a health promotion program to be coordinated by the health services, with the participation of members of the media and citizen organizations. The programs on AIDS, Human Resources, and Maternal and Child Health participated in the workshops, as did all the nongovernmental organizations working in the areas of health, the environment, labor, and education.

• PAHO technical cooperation helped to establish and launch the activities of the Intrainstitutional Commission on Accreditation of Services, an early step in developing the health reform proposal.

## NICARAGUA

• During 1995, Nicaragua successfully eliminated neonatal tetanus as a public health problem in the country. The incidence of this disease, which had been one of the leading causes of perinatal death, has been reduced to below 1 per 1,000 live births. This achievement has enabled the country to meet one of the goals of the World Summit for Children. The vaccination of women of childbearing age is part of regular activities carried out, including national health days. The strategy's effectiveness is reflected in the large number of doses administered and in the reduction of cases and deaths from neonatal tetanus. In addition, efforts to eliminate this disease have contributed to the overall development of the immunization program and to the strengthening of local health services.

• With a view to developing and strengthening the capacity of the Ministry of Health to formulate policies, standards, and plans in the framework of decentralization and health reform, a series of activities has been carried out to improve the efficiency and raise the quality of the services provided by the institution. The entry into force of the country's new health policy has helped to facilitate decentralization of the system, development of the primary and hospital care network, improvement of the quality of care, and institutional and managerial strengthening. The leading achievements in sector development thus far include the formulation, approval, and publication of standards and manuals; the formulation and approval of the National Quality Assurance Program; and the proposal of a national policy on essential drugs.

• An Internet node has been created for the country's health sector. Its main objective is to establish a communications and data network linking the institutions at the central and local levels. To date, 11 of the country's 17 comprehensive local health systems (SILAIS) are connected to the system. The program areas that have derived the greatest benefit from this technology are epidemiological surveillance, information systems, libraries, administrative systems, and teaching and research. National authorities believe that the use of this tool will help to resolve long-standing problems of communication, timeliness, and reliability, and will also reduce operating costs. In addition, it is expected to be a useful instrument for distance education programs.

• The Organization collaborated in formulating and submitting to the Ministry of Health a methodological proposal for differentiating morbidity data by sex and incorporating sex-disaggregated data into a health situation analysis research project. The project, a descriptive, cross-sectional study entitled "Health Situation Analysis According to Living Conditions," employed a gender approach at the local level and was carried out in the municipio of Diriamba (within the Carazo SILAIS). It comprised two phases: the first, a retrospective phase, involved a review of files; in the second phase, information was gathered through a survey that included a structured interview. Data collection and analysis were carried out by an interdisciplinary team comprising health personnel and community workers from the neighborhoods in which the study was conducted.

• The most important achievements under the project to support health sector decentralization in six SILAIS were related to the effort to expand the coverage of the existing health units in the area. The mechanisms employed for this purpose have been the supply of basic inputs and periodic visits by mobile health care and community training teams, which provide regular services in hard-to-reach communities.

## PANAMA

• The Organization collaborated extensively with health authorities and the Office of the First Lady in order to organize and consolidate the first phase of the initiative "Municipios of the 21st Century: Toward Sustainable Human Development." PAHO provided assistance for meetings aimed at raising awareness and launching the initiative in 13 municipios. The Organization also contributed to the development of a portfolio of projects in the municipios, utilizing the logical framework methodology, and it helped disseminate information about the initiative domestically and abroad. PAHO's support in obtaining additional funding for the development of the program in the country has helped to strengthen intersectoral coordination, interprogram integration, and the development of comprehensive local health systems, which will help to support and enhance the initiative.

• The Government's general policy on social development and economic growth encompasses provisions relating to the reform of the State, including the health sector. PAHO mobilized resources for a project aimed at channeling specific technical cooperation and generating an intrainstitutional movement. The project culminated in the preparation of a document that describes the Ministry of Health's position on health reform. This document provided the basis for the development of the fundamental principles of the National Health System, whose proposed functions for the sector include leadership and management, health care delivery, and financing.

• Since 1994, PAHO technical cooperation in Panama has focused on improvements to the efficiency of the health services provided by both the Ministry of Health and the Panamanian Social Security Fund. To this end, an effort has been made to construct a new paradigm that will fundamentally change the way in which services are delivered; the technological foundation for this change is the Local Management Information System (LOMIS). This innovative process has placed PAHO in a prominent place in the delivery of technical cooperation, inasmuch as it has prompted a change in the cultural values of health personnel and led to more efficient utilization of managerial and technological resources. The process of health sector reform and modernization has thus been brought to the operational level.

• In the area of environmental health, an evaluation of the exposure to toxic substances began to be

conducted as part of the PLAGSALUD project, a component of the Environment and Health in the Central American Isthmus (MASICA) program. In addition, a system for local epidemiological surveillance of acute pesticide poisoning has been established in the district of Bugaba, Chiriquí, and a national interdisciplinary advisory group on the issue has been created. A database of national literature on the subject also has been developed, and a national assessment of pesticide use and its health consequences has been undertaken. Through the national advisory group a proposal has been formulated for the second phase of the PLAGSALUD project; a sum of US$ 791,000 has been tentatively allocated to cover the next four years.

• The first joint evaluation of PAHO technical cooperation in Panama was conducted during 1995. The evaluation pointed up the high degree of intersectoral mobilization that had been achieved. The lines of cooperation that give priority to local development as an essential element of the national program also were redefined. In addition, it was agreed that it was of utmost importance to undertake a reform and modernization of the health sector and of other institutions and organizations related to the sector, including universities and agencies such as PAHO. As a complement to the foregoing activities, it was decided that a medium- and long-term plan of investment should be formulated and that the plan should address human resource and scientific-technical concerns as well as financial issues.

## PARAGUAY

• In terms of eradication and elimination of diseases, in September 1995 the country marked its first anniversary free from any reported clinical cases of foot-and-mouth disease; this situation continues to hold. National authorities acknowledge that the success obtained thus far and the rapid progress toward eradication achieved through the program to control foot-and-mouth disease is due in large measure to the fact that in 1992 Paraguay became a party to the Agreement for the Eradication of Foot-and-Mouth Disease in the River Plate Basin. This agreement has been coordinated by PAHO through PANAFTOSA. In 1995, legislation pertaining to foot-and-mouth disease eradication was enacted in Paraguay.

• The program to eliminate *Triatoma infestans* was implemented in Paraguay for the first time in 1995. The targets for household spraying coverage set for the year were exceeded. This program came about in response to the country's high prevalence of infection and household infestation. Its continuity has been assured with the approval of a budget of US$ 2 million for 1996. The program, which is being carried out in the framework of the Southern Cone Health Initiative (INCOSUR), is an outgrowth of the Intergovernmental Commission on Chagas' Disease, which was created in 1991 and for which PAHO serves as the secretariat.

Paraguay served as the secretariat pro tempore of INCOSUR during the 1993-1995 period, which was marked by dynamic cooperation among countries, especially in terms of border health. PAHO/WHO's Country Office in Paraguay provided direct support for INCOSUR, coordinating activities among the countries, publishing six issues of the *Boletín del INCOSUR* [Bulletin of INCOSUR], and compiling and publishing the basic documents that have guided the Initiative since its creation in 1986. This collaboration culminated with the support provided by the Organization for the fifth Meeting of Ministers of Health of the Southern Cone, which was held in Asunción in November 1995.

• In 1995, the National Health Institute, with the cooperation of PAHO, organized a course for specialized training in public health. Twenty-six health professionals completed the one-year course.

• As a result of the advocacy and direct technical cooperation activities initiated in June 1994, during 1995 a national law on drugs was drafted and is currently being considered by the health commission of the national senate.

• In the framework of sustainable development as proposed by the 1992 United Nations Conference on Environment and Development, Paraguay decided to formulate and execute the National Environmental Sanitation Plan (PLANASAM). PAHO provided technical advice and support for the coordination of PLANASAM's preparatory activities. The work of formulating the plan also served as preparation for the Pan American Conference on Health and the Environment in Sustainable Human Development, organized by PAHO and held at the Organization's Headquarters in October 1995.

## PERU

• During 1995, a document outlining the country's health policy for the 1995-2000 period was drafted and published, following a consensus-building process. As part of this process, documents were drawn up and several meetings and forums were held, involving a broad range of participants from all health sector institutions. In this framework, significant progress was also made in relation to health sector reform. PAHO provided valuable support for the preparation of various studies and documents and the organization of seminars and workshops aimed at establishing the basis for health sector reform in the country.

• The Organization also collaborated to sustain Peru's level of epidemiological surveillance of acute flaccid paralysis, which has enabled the country to obtain information on the five indicators established by the International Certification Commission on Poliomyelitis Eradication. PAHO also provided support for a national house-to-house vaccination campaign aimed at immunizing all children under the age of 5 years old against measles. A national vaccination coverage level of over 90% was achieved as a result of this effort.

• Effective coordination between regional health authorities and the community in plague prevention and control activities resulted in a drop in the number of reported cases from 1,122 in 1994 to 97 in 1995. In addition, health services were improved through the establishment of a network of diagnostic laboratories, the strengthening of epidemiological surveillance and information systems, the extension of coverage to the most remote areas, and strengthening of political commitment. Social participation also has been crucial, as have economic and social improvements in communities as a consequence of sales of crops stored in small silos.

• The quality of the country's health services has improved, partly as a result of the preparation of a hospital accreditation manual and a methodological guide for the study of hospital vulnerability. The new regulations for health sector hospitals are nearing completion. These mechanisms will help to assure the quality of hospital services and will raise technical capacity so that hospital decentralization can move forward.

• PAHO collaborated in the analysis and formulation of the National Food and Nutrition Plan, a multisectoral approach that involves the agriculture, fishing, education, economic, and health sectors. The Organization also provided support for the regional councils on food and nutrition of Arequipa, San Martín, La Libertad, Puno, Chavín, and Tacna, all of which are decentralized, multisectoral bodies engaged in formulating regional nutrition plans.

## PUERTO RICO

• Regarding health systems development, PAHO collaborated with Puerto Rican authorities in organizing a forum on leadership in health sector reform processes, held in San Juan in June 1995. The event was attended by health sector authorities and professionals from 25 countries of the Americas, including nine ministers and three vice-ministers of health, three directors of social security institutes, and a representative of the Spanish Government. The forum afforded the opportunity to exchange experiences and resulted in the San Juan Declaration on Health Sector Reform, which emphasizes the concept of equity as the foremost goal of all health reform efforts.

• The Department of Health and the School of Medical Sciences also received collaboration from PAHO to reorient the training of Department personnel toward health protection and promotion and to implement new managerial tools to be used in the sector's reform. In addition, the Organization collaborated in various health research activities undertaken by the School of Medical Sciences, which also participated in technical cooperation activities among countries, involving cooperation with authorities from Haiti to develop a training project in nursing; PAHO coordinated this cooperation.

• The Organization's technical cooperation program in Puerto Rico supported several activities in the area of bioethics, including some with the PAHO Regional Program on Bioethics. Among its collaboration in various other activities, PAHO helped to facilitate dialogue between officials and professionals from Puerto Rico with authorities from elsewhere in the Region.

## SAINT KITTS AND NEVIS

• Eighty-seven fellowship/months were provided in community health, public health nursing, diagnostic radiotherapy, and medical laboratory technology.

• PAHO collaborated with the Ministry of Health in assessing the feasibility for a hospital and the decision to proceed with the first construction phase; a detailed feasibility study of the project's second phase is under way.

• Two workshops held in June trained doctors and nurses in the management of ARI/asthma, using the protocol specifically developed for the Caribbean.

• Thirteen nationals from a wide range of sectors, including the Ministry of Health, the Department of Tourism, and several NGOs, were trained in hazard analysis critical control point (HAACP) methodology. The training promoted the establishment of a National Food Protection Committee and a foodborne disease surveillance system.

• The development of health services was supported through close work with members of the new administration on health and development issues and the promotion of their participation in meetings of the Governing Bodies and in special meetings on health and environment and on health sector reform.

## SAINT LUCIA

• The Organization's technical cooperation focused on human resources development, since this is one of the country's highest priorities. During 1995, 96 fellowship/months were awarded in post-basic psychiatric nursing, bachelor of science in nursing, pharmacy, laboratory, leadership and management for nursing, and meat and poultry inspection. As external resources available for personnel development have diminished, PAHO's fellowships have played an increasingly important role. The introduction of cost-sharing among the Government, PAHO, and the fellows has increased the number of fellowships that can be awarded to nationals.

• A high-level consultation chaired by the Minister of Health was held to prepare for the Pan American Conference on Health and the Environment in Sustainable Human Development. A background paper and plan of action were prepared, and the latter was presented to the Ministerial Cabinet of Saint Lucia for approval as a policy.

• With the collaboration of CAREC, 15 nationals were trained in-country in basic epidemiology. This highly successful program was the first attempt at strengthening the capabilities of several health personnel at the local level in disease surveillance. The collaboration between PAHO and CAREC demonstrated how resources can be used efficiently and cost-effectively.

• Strategies for an integrated approach to perinatal care were developed, including training sessions for public sector doctors, hospital and community nurses, private doctors, and NGOs. This approach encompassed prenatal, delivery, and post-partum care, as well as follow-up of children, thereby integrating obstetrics with pediatrics into a continuum of care. This integrated approach was seen as a priority.

## SAINT VINCENT AND THE GRENADINES

• The provision of fellowships was an important priority in the Organization's technical cooperation. Fifty-seven fellowship/months were awarded in radiology science, operating theater techniques, psychiatric nursing, and cytology screening. This training helped to fill critical human resource shortages in secondary-level services. The fellowship program supported the human resources development plan within the country's overall health plan.

• An IDB-funded project on community health information systems was highly successful; eight of the health modules are fully operational.

• With CAREC's support, a training program to improve the management skills of key personnel from the AIDS/STD program was carried out, and training was provided to focal points on how to incorporate monitoring and evaluation as part of project implementation. This effort improved the program's delivery.

• Hospital and community-service doctors and nurses were trained in the management of asthma. The Ministry of Health has assigned priority to this training, as a way to counteract the steady increase in the number of children presenting with ARI/asthma.

## SURINAME

• Delegations from Guyana have come to Suriname and worked in immunization and in workers' health. In addition, technical cooperation activities in human resource training and hospital management systems were jointly carried out by the Academic

Hospital of Paramaribo and the Queen Elizabeth Hospital of Bridgetown.

• Plans have been drawn and activities have been carried out to improve health service information systems at the health district and health center levels. The Regional Health Services began to be reorganized in 1995. In support of this effort, management, financial systems, the computerization of systems, transportation and communication, physical infrastructure rehabilitation, personnel training, community participation, and systems of drug control and management were strengthened.

• A comprehensive health education plan of action was developed, which includes technical support for the Bureau of Public Health's recently restructured health education unit. Other considerations in the plan involve the incorporation by the health sector's various units of key concepts and methodologies required for disease prevention and control, strengthening the Ministry of Education's curriculum development unit, and support for teacher training and training in medical technology and chemical analyses.

• A set of water quality standards was developed. Efforts were directed at strengthening the reorganization of the Bureau of Public Health's Environmental Division, improving solid waste management in Paramaribo and at the international airport, and improving the disposal of septic tank and pit latrine sludges in Paramaribo. PAHO also assisted the Ministry of Labor in establishing its occupational health and safety database. Surveys were conducted to assess the country's lead utilization levels and pesticide use in the rice fields.

• The Organization supported Suriname's Malaria Control Program in its efforts to intensify activities, particularly at the local level. Emphasis was placed on case detection and treatment and on spraying for vector control in high-risk logging and gold-mining areas. Support also was directed to the preparation of manuals and for training clinicians in the application of case management protocols. The preparation and submission of a national plan for the control of cholera led to the mobilization of US$ 54,700 to control cholera in Marowijne District. The National AIDS Program has made HIV testing more accessible at different locations; as knowledge about the test has spread, more people are being tested earlier. To improve accessibility and effectiveness of HIV/AIDS/STD services, the National AIDS Program has decentralized its services.

## TRINIDAD AND TOBAGO

• PAHO, in collaboration with CARICOM, the Caribbean Development Bank, IDB, UNDP, and the World Bank, organized the subregional conference, "The Reduction of Poverty: The Role of Health and Education," which was held in Port of Spain, Trinidad, on March 20-24. Participants discussed issues such as improving the decision-making process in resource allocation, defining the role of the State, improving ways to assess poverty, and establishing an appropriate mix between economic and social policies.

• More than 300 representatives from service organizations, government agencies, NGOs, and the private sector participated in a two-day national consultation on health, environment, and development that was held in Port of Spain, Trinidad, on July 4-5. The consultation's final report was disseminated to the national authorities and was presented to the Pan American Conference on Health and Environment in Sustainable Human Development, which was held in Washington, D.C., in 1995.

• The long-awaited drug formulary for the public sector was completed under a joint project between Trinidad and Tobago and Barbados. Several hundred copies of the formulary were disseminated to the Ministry of Health to promote and facilitate rational drug use and strengthen the management of their drug supplies.

• As part of its health sector reform program, the Ministry of Health has created a Quality Management Directorate at its central headquarters. During 1995, PAHO supported several quality management workshops for staff at different managerial levels in the Ministry of Health and in the Regional Health Authorities, in order to sensitize them to the issue and to discuss quality assurance policies. An accreditation pilot project was concluded in four hospitals, and some hospitals already have begun to develop quality assurance activities.

• About 80 participants from various ministries attended a PAHO-sponsored workshop held to discuss

women, health, and development issues. Participants discussed issues, achievements, and challenges relating to women in health and development and identified strategies to cope with the challenges. They also underscored the need to collaborate with NGOs and identified government policies and programs required to move forward.

## UNITED STATES OF AMERICA

• Promoting health initiatives along the United States-Mexico border was the major emphasis of technical cooperation during 1995. The work of the border binational health councils was supported through grants and through the U.S.-Mexico Border Health Association; other efforts were directed at environmental health activities involving agencies from the United States and Mexico.

• PAHO's cooperation with the United States also facilitated technical support activities provided by the United States Centers for Disease Control and Prevention to the Peruvian Social Security Institute. With PAHO support, experts from the United States National Institutes of Health and the Food and Drug Administration cooperated with Chile regarding nursing legislation.

• The Organization facilitated the exchange of experiences between NGOs from the Boston area with counterparts in Jamaica. Boston residents associated with the "Healthy Boston" initiative studied Jamaica's experience in the prevention of teenage pregnancy and violence prevention, and in micro-enterprise development. The Boston group members hope to apply some of the insights from the Jamaican experience to community and neighborhood initiatives in their area.

• A total of eleven fellowships in health issues were provided to United States citizens to support the study of methods that can improve health care delivery and research in the United States. Areas of international study included toxicology, pediatrics, occupational health, midwifery, public health planning, and dental public health.

## URUGUAY

• Concerns over quality control, quality assurance, and overall quality rose to primary importance for health care providers, users, and sector leaders. During 1995, for the first time in the country's history, various activities dealing with quality were carried out with health care personnel. These activities culminated in the preparation of a manual on quality assurance and accreditation of public and private hospitals, which represented an important initial step in the process of improving the quality of medical care in Uruguay. The group that worked on the manual included representatives of the Ministry of Public Health, the State Health Service Administration, the School of Medicine, PAHO, the Association of Collective Medical Care Institutions, the Mutual Aid Union of Uruguay, the Medical Federation of the Interior, the Uruguayan College of Nurses, and the National Nursing Institute.

• A system of laboratory surveillance for meningitis was established, and the necessary reagents for strain identification (monoclonal antibodies and multilocular enzymes) were obtained. The results of this work have given health authorities a solid basis for making policy decisions on meningitis vaccination, and have enabled them to enlist the support of both the population and the scientific community.

• With the National Sectoral Study on Solid Waste, coordinated by PAHO, the first situation assessment was undertaken and a proposal for development of the sector was formulated. This exercise involved the Ministry of Housing and Environment; the Ministry of Public Health; municipal governments, education sector agencies, and nongovernmental organizations. The Organization's direct involvement led to effective intersectoral and interagency coordination. The process culminated in a definition of how to restructure the sector, in a decision to strengthen the normative role of the National Office of Environmental Affairs, and a decision to incorporate new technologies at the municipal level.

• An interministerial commission composed of representatives of the Ministry of Public Health and the Ministry of Livestock-Raising, Agriculture, and Fisheries was established to carry out surveillance, control, and studies with regard to zoonoses. PAHO serves as technical secretariat for the commission. The PAHO/WHO Country Office also participated in the planning and coordination of activities that have given continuity and increased the coverage of activities aimed at interrupting vector transmission of Chagas' disease.

• The communication sciences program offered by the University of the Republic of Uruguay was officially included in the PAHO/UNESCO project on education in communication for health promotion at the undergraduate level.

## VENEZUELA

• Following studies conducted in Venezuela on the connection between living conditions and health, 15 communities have been incorporated into the healthy communities initiative; 170 projects have been developed with full community participation. Many of these projects are already being executed, funding is being sought for others, and several have been funded and will be initiated in the near future. The participation of various sectors, civil society organizations, and the Social Investment Fund has been obtained, and several bilateral cooperation agencies have been invited to take part. Two state networks of healthy communities have been formed in addition to the Venezuelan National Network of Healthy Communities, which publishes a bulletin describing the experiences of these entities.

• As part of the process of health sector reform at both the central and state levels, PAHO has contributed to the development of plans of action. Discussions began on a draft general law on health, and support was provided for the reorganization and restructuring of the central level of the Ministry of Health and Welfare. The Organization, working with members of the services and the universities, has focused on the role of human resources in health sector reform: the theory and practice of public health has been strengthened in 14 departments of preventive medicine at the undergraduate and graduate levels; support has been provided for the process of strengthening the integration of teaching, service, and community; and 20 schools have implemented projects of quality management in education.

• PAHO collaborated in managing the Project for the Control of Endemic Diseases undertaken by the Ministry of Health and Welfare and finalized a proposal for a technical cooperation agreement between the Organization and the Government of Venezuela. In addition, PAHO is to chair the focus group recently established under the new AIDS program, which also includes the World Bank, UNESCO, UNDP, UNICEF, the European Union, and nongovernmental organizations.

The Organization also played an important role in promoting intersectoral action and active international cooperation during the epidemic of Venezuelan equine encephalitis. As a result, the outbreak was rapidly controlled and the disease did not spread throughout the country.

• In the area of emergency preparedness and disaster relief, risk maps have been prepared for the prevention and mitigation of natural disasters in the country's central-northern coastal region. A project for hospital disaster mitigation also has been implemented in the states of Sucre and Carabobo.

• With regard to environmental pollution, a national survey of solid waste services has been conducted and the country has been incorporated into the GEMS-Air project on atmospheric pollution. Another national survey on drinking water quality was carried out, and emergency plans for drinking water systems were formulated.

## FIELD OFFICE/U.S.-MEXICO BORDER

• In 1995, representatives of the federal governments of Mexico and the United States met with PAHO officials to formulate a new strategy for the Organization's Field Office located in the city of El Paso, Texas. The strategy is aimed at facilitating PAHO's role in promoting and coordinating binational activities to benefit health along the border.

• The "Border Cities Project" promotes the development of binational activities that acknowledge and address health needs of the populations in the sister cities along the border. The new strategy assigned greater priority to this line of cooperation and created a project coordinator post.

• As in previous years, the annual meeting of the United States-Mexico Border Association was held. This meeting brings together several hundred members from both countries in a border city to examine a program of political, technical, and social activities aimed at analyzing and reorienting joint actions. To strengthen the binational health committees, the Organization sponsored and provided support for periodic meetings of their members. A binational workshop to discuss a document on health profiles of the sister cities also was organized.

# Acronyms and Corresponding Agencies or Programs

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|---|---|
| AIDIS | Inter-American Association of Sanitary and Environmental Sciences |
| AMPES | American Region Planning, Programming, Monitoring, and Evaluation System (PAHO) |
| BIREME | Latin American and Caribbean Center on Health Sciences Information |
| CAREC | Caribbean Epidemiology Center (PAHO) |
| CARICOM | Caribbean Community |
| 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 |
| CIDES | Inter-American Center for Economic and Social Development (OAS) |
| CLACSO | Latin American Council for Social Sciences |
| CLAP | Latin American Center for Perinatology and Human Development (PAHO) |
| COSALFA | South American Foot-and-Mouth Disease Control Commission |
| DANIDA | Danish International Development Assistance |
| ECLAC | Economic Commission for Latin America and the Caribbean |
| ECO | Pan American Center for Human Ecology and Health (PAHO) |
| EDI | Economic Development Institute (World Bank) |
| EPI | Expanded Program on Immunization |
| EU | European Union |
| FAO | Food and Agriculture Organization |
| FINNIDA | Finnish International Development Agency |
| FLACSO | Latin American School of Social Sciences |
| GTZ | German Agency for Technical Cooperation |
| IAEA | International Atomic Energy Agency |
| IBRD | International Bank for Reconstruction and Development (World Bank) |
| 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) |
| LACRIP | Latin American Cancer Research Information Project |
| NIH | National Institutes of Health (USA) |
| NORAD | Norwegian Agency for Development Corporation |
| OAS | Organization of American States |
| PAHEF | Pan American Health and Education Foundation |
| PAHO | Pan American Health Organization |
| PANAFTOSA | Pan American Foot-and-Mouth Disease |
| PASB | Pan American Sanitary Bureau |
| RORIAN | Regional Operational Network of Food and Nutrition Institutions |
| SELA | Latin American Economic System |
| SIDA | Swedish International Development Agency |
| SIREVA | Regional System of Vaccines (PAHO) |
| SUMA | Supply Management Project in the Aftermath of Disasters (PAHO) |
| UN | United Nations |
| UNDP | United Nations Development Program |
| UNEP | United Nations Environment Program |
| UNESCO | United Nations Educational, Scientific, and Cultural Organization |
| UNFDAC | United Nations Population Fund |
| UNHCR | United Nations High Commissioner for Refugees |
| UNICEF | United Nations Children's Fund |
| UNIFEM | United Nations Development Fund for Women |
| USAID | United States Agency for International Development |
| WFP | World Food Program |
| WHO | World Health Organization |


**Pan American Health Organization**
**Pan American Sanitary Bureau, Regional Office of the World Health Organization**