



PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION



51st DIRECTING COUNCIL
63rd SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 26-30 September 2011

Provisional Agenda Item 3.2

CD51/3 (Eng.)
26 August 2011
ORIGINAL: ENGLISH

**ANNUAL REPORT OF THE DIRECTOR
OF THE PAN AMERICAN SANITARY BUREAU**

Health and the Millennium Development Goals: From Commitment to Action

CONTENTS

	<i>Page</i>
From the Director	3
Introduction	4
Chapter I. Regional Progress on the Health-Related MDGs	10
Chapter II. From Goals to Results	23
Chapter III. Lessons and Challenges	62
Acronyms and Abbreviations	67

From the Director

To the Member States:

In accordance with the provisions of the Constitution of the Pan American Health Organization, I have the honor to present the 2010–2011 annual report on the work of the Pan American Sanitary Bureau, Regional Office for the Americas of the World Health Organization. The report highlights the Bureau's major work in providing technical cooperation during this period within the framework of the 2008–2012 Strategic Plan of the Pan American Health Organization, defined by its Governing Bodies.

Mirta Roses Periago
Director

Health and the Millennium Development Goals: From Commitment to Action

“The Millennium Development Goals are the most ambitious endeavor ever pursued against human deprivation and the first to place health at the center of development. They give us an unparalleled opportunity to improve health and equity by mobilizing coordinated multisectoral action to fight disease and improve the social determinants of health.”

*Dr. Mirta Roses Periago
Director, Pan American Sanitary Bureau
Pan American Health Organization*

Introduction

1. For countries in the Americas and around the world, the United Nations Millennium Development Goals (MDGs) have proven to be both challenging and catalytic, which was the intent of the 189 heads of government who endorsed the Millennium Declaration at the dawn of the 21st century. In signing on to the MDGs, leaders of low- and middle-income countries pledged to significantly step up efforts to reduce poverty and improve quality of life for their most vulnerable people, while representatives of high-income countries promised to increase support for their efforts. Together these leaders expressed an unprecedented new global commitment to “making the right to development a reality for everyone and to freeing the entire human race from want”.

2. For Latin America and the Caribbean, the MDG call to action has resonated with a regional development agenda focused on reducing poverty and the gaps between rich and poor that have made the Americas the most unequal region in the world. Mandates from the Summit of the Americas meetings, the general assemblies of the Organization of American States (OAS), the Pan American Health Organization (PAHO) Directing Council meetings, and other regional forums have repeatedly urged policies and programs aimed at reducing inequity and improving living conditions for the poor.

3. The Region’s political leaders reiterated their commitment to the MDGs at the 2003 International Conference on the MDGs in Latin America and the Caribbean, held in Brasilia, and at the Summits of the Americas in Monterrey in 2004, Mar del Plata in 2005, and Port of Spain in 2009. The 2003 Brasilia Declaration, in particular, was a strong call to action that lay out in considerable detail the responsibilities of states, legislators, civil society, and the international community in advancing the MDGs. The Region was well represented at both the 2005 and 2010 MDG review summits, and United Nations (UN) agencies active in the Americas all contributed to the 2005 and

2010 MDG progress reports, under the coordination of the UN Economic Commission for Latin American and the Caribbean (ECLAC).

PAHO Mandates Supporting the MDGs, 2000-2010

- Regional Strategy for Maternal Mortality and Morbidity Reduction (CSP26.R13), 26th Pan American Sanitary Conference, 2002.
- Millennium Development Goals and Health Targets (CD45.R3), 45th Directing Council, 2004.
- Access to Medicines (CD45.R7), 45th Directing Council, 2004.
- Scaling-Up of Treatment within a Comprehensive Response to HIV/AIDS (CD45.R10), 45th Directing Council, 2004.
- Malaria and the Internationally Agreed-Upon Development Goals, Including Those Contained in the Millennium Declaration (CD46/R13), 46th Directing Council, 2005.
- Regional Strategic Plan for HIV/AIDS/STI, 2006-2015, of the Pan American Health Organization (CD46.R15), 46th Directing Council, 2005.
- Regional Strategy for the Control of Tuberculosis for 2005-2015 (CD46.R12), 46th Council, 2005.
- PAHO Gender Equality Policy (CD46.R16), 46th Directing Council, 2005.
- Regional Strategy and Plan of Action on Nutrition in Health and Development 2006-2015 (CD47.R8), 47th Directing Council, 2006.
- Regional Strategy for Sustaining National Immunization Programs in the Americas (CD47.R10), 47th Directing Council, 2006.
- Neonatal Health in the Context of Maternal, Newborn and Child Health for the Attainment of the Millennium Development Goals of the United Nations Millennium Declaration (CD47.R19) 47th Directing Council, 2006.
- Health of the Indigenous Peoples in the Americas (CD47.R18), 47th Directing Council, 2006.
- Strategic Alliance for Attainment of the Millennium Development Goals (CD47/INF/2), 47th Directing Council, 2006.
- Health Agenda for the Americas, 2008-2017, presented by the Ministers of Health of the Americas in Panama City, 2007.
- Faces, Voices and Places: A Community-Based Response to the Millennium Development Goals (CSP27/14), 27th Pan American Sanitary Conference, 2007.
- Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care (CD48.R4, Rev. 1), 48th Directing Council, 2008.
- Regional Strategy for Improving Adolescent and Youth Health, 48th Directing Council, 2008.

- Plan of Action for Implementing the Gender Equality Policy (CD49.R12), 49th Directing Council, 2009.
- Family and Community Health (CD49.R13), 49th Directing Council, 2009.
- Integrated Health Services Delivery Networks Based on Primary Health Care (CD49.R22), 49th Directing Council, 2009.
- Strategy and Plan of Action for the Reduction of Chronic Malnutrition (CD50.R11), 50th Directing Council, 2010.
- Strategy and Plan of Action for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis (CD50.R12), 50th Directing Council, 2010.

4. The MDGs assign a central role to health. Three of the eight goals (4, 5 and 6) address specific health challenges, while two other goals (1 and 8) and at least three other targets are inextricably linked with health (see Box 2). This reflects the broad 21st-century consensus that health is both an outcome of and an essential input for social and economic development. Indeed, the MDG framework shows that health status and life expectancy have become proxy indicators for a well-functioning society.

5. Though the MDG framework does not include every current global health priority—chronic diseases are a notable omission—the health goals address major contributors to the burden of illness among the world’s most vulnerable populations. Equally important, the other goals address the major social determinants of health status and health inequalities, reinforcing an approach promoted by both the World Health Organization (WHO) and PAHO. With this focus, the MDGs have opened up unprecedented opportunities for promoting action and investments in health and its social determinants at the local, national, regional, and global levels.

The Millennium Development Goals

1. Eradicate Extreme Poverty and Hunger

- Halve, between 1990 and 2015, the proportion of people living in extreme poverty
- Achieve full and productive employment and decent work for all, including women and young people
- Halve, between 1990 and 2015, the proportion of people who suffer from hunger

2. Achieve Universal Primary Education

- Ensure that, by 2015, boys and girls everywhere are able to complete a primary education

3. Promote Gender Equality and Empower Women

- Eliminate gender disparity in primary and secondary education by 2005 and at all levels by 2015

4. Reduce Child Mortality

- Reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate

5. Improve Maternal Health

- Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio
- Achieve universal access to reproductive health

6. Combat HIV/AIDS, Malaria, and Other Diseases

- Halt and begin to reverse the spread of HIV/AIDS
- Achieve universal access to treatment for those who need it
- Halt and begin to reverse the incidence of malaria and other major diseases

7. Ensure Environmental Sustainability

- Integrate sustainability into policies and programs and reverse the loss of environmental resources
- Reduce significantly the rate of loss of biodiversity
- Halve, by 2015, the proportion of the population without sustainable access to safe drinking water and sanitation
- Significantly improve the lives of at least 100 million slum dwellers by 2020

8. Develop a Global Partnership for Development

- Develop further an open, rule-based, predictable and nondiscriminatory trading and financial system
- Address the special needs of the least-developed countries
- Address the special needs of landlocked developing countries and small island developing states
- Deal comprehensively with the debt problem of developing countries
- In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries
- In cooperation with the private sector, make available the benefits of new technologies, especially information and communications

6. While PAHO/WHO's efforts to advance the MDGs started shortly after the Millennium Declaration, the overarching framework for this work was established in 2004 at PAHO's 45th Directing Council, when the Region's health leaders made the MDGs a top priority and pledged to strengthen political commitment at all levels of government (CD45.R3).

7. At that moment, no country in the Americas seemed likely to reach all the MDG targets, according to the report "Millennium Development Goals and Health Targets," which was prepared by PAHO's Secretariat in anticipation of the 2005 UN General Assembly and which formed the basis for the 2004 Directing Council resolution. As a whole the Region was not progressing sufficiently to achieve the targets for infant and maternal mortality, nor was it on track to halt and reverse the spread of HIV by 2015. The prospects for controlling and reversing malaria and tuberculosis and for meeting the targets on access to water, sanitation, and essential drugs were unclear. To accelerate progress, the study urged a "Pan American approach" in which governments, civil society, the private sector, and international organizations would work together through new partnerships and with increased development assistance to advance the MDGs.

8. In response to the report, the ministers committed to a series of actions in their countries and internationally, aimed at accelerating MDG progress. These included promoting intersectoral partnerships, intensifying action on national health development and social protection, improving measurement and monitoring of MDG progress, and promoting greater civil society involvement in efforts to advance the MDGs. The ministers called on PAHO's Secretariat to support their efforts and to mainstream the MDG health priorities in all its technical cooperation programs, focusing special attention on countries and population groups with the greatest needs.

9. These commitments to accelerating progress on the health-related MDGs were reinforced by the Health Agenda for the Americas 2008-2017, launched by the Region's ministers of health prior to the opening of the OAS General Assembly in **Panama** in 2007. The new regional agenda was aligned with the MDGs both explicitly and in its focus on the social determinants of health and expanded social protection with the aim of reducing inequities between and within countries.

10. PAHO/WHO member countries followed up on these commitments by incorporating the MDGs into their national health and development planning processes, by developing new initiatives, and by strengthening efforts in such areas as child and maternal mortality that were already oriented toward the MDGs. These efforts found strong support from the international donor community, particularly Spain's MDG Achievement Fund, from PAHO's Secretariat, and from other UN partners.

11. PAHO/WHO technical cooperation in support of its member countries' efforts in this area has included both ongoing programs and special initiatives explicitly focused on

the MDGs. The former include actions to improve infant and young child nutrition, reduce child and maternal mortality, control HIV and other infections, promote access to safe drinking water and sanitation, strengthen and reorganize health systems, and expand social protection in health. The latter include technical cooperation focusing on four main areas: (a) strengthening the evidence base for and monitoring progress toward the achievement of the MDGs, (b) advocacy and consensus building, (c) development and implementation of regional MDG plans and strategies, and (d) mobilizing alliances and resources. To advance the MDGs at the local level, PAHO/WHO also developed the “Faces, Voices, and Places of the MDGs” initiative, an integrated, intersectoral, and multipartner effort that engages the Region’s most vulnerable communities to address gaps in MDG progress that are concealed behind national averages.

12. All these efforts have contributed to significant MDG progress in the Americas over the past several years. In contrast to 2004, the Region as a whole is today on track to meet most of the MDG health targets, including those on hunger, child mortality, and water and sanitation. Among the greatest gains have been reductions in child malnutrition, expanded access to water and sanitation, and declines in incidence and mortality from malaria and tuberculosis. Assessing progress in some areas—especially maternal mortality—is difficult because of data problems. But only the goal of halting and reversing the HIV epidemic by 2015 appears to remain well out of the Region’s reach, despite major advances in expanding treatment and prevention of HIV.

13. At the same time, most of this progress has been uneven across and especially within countries. A few countries remain behind schedule and are unlikely to meet targets for which the Region as a whole is on track. But in virtually all the countries in the Region there are vulnerable communities and population groups that have benefitted little or not at all from MDG progress at the national level. The need to focus especially on these groups has been a tenet of PAHO/WHO’s efforts to advance the MDGs and is one of the key lessons learned from the Region’s experiences in this area.

14. Other lessons—presented in detail in Chapter 3 of this report—include the need to adapt targets and indicators to ensure they are meaningful in the regional context, the urgency of building human capital at the local level, and the importance of incorporating climate change and sustainability issues into the regional development agenda. It will be important to apply all these lessons to consolidate gains and accelerate MDG progress in the years remaining before 2015 as well as to ensure sustainable progress in the years beyond.

Chapter I. Regional Progress on the Health-Related MDGs

15. The prominence of health in the MDG framework reflects widespread recognition of the strong links between health and socioeconomic development and the need to reduce inequities in both to achieve sustained progress in the world.

16. Health has consequences for entire economies and societies through the direct economic costs of illness and disabilities as well as through its impact on individual development, productivity, and creativity. At the same time, social determinants such as poverty, educational levels, discrimination, and other forms of social exclusion all impact health throughout the course of life through such variables as prenatal and childhood nutrition, living and workplace conditions, health knowledge and behaviors, and access to health goods and services. Therefore, progress on all the MDGs is needed, to some degree, to facilitate and sustain progress in health outcomes, creating social cohesion and building stronger citizenship for every person.

17. While Chapter 2 of this report will highlight PAHO/WHO technical cooperation in relation to nearly all the MDGs, this chapter focuses on the status of progress in the Americas on those Millennium goals and targets that are most directly related to health: MDG-1 target C, MDG-4, MDG-5, MDG-6, MDG-7 targets C and D, and MDG-8 target E.

MDG-1: Eradicate Extreme Poverty and Hunger

MDG-1 Hunger Target and Indicators

Target C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger

Indicators:

- Prevalence of underweight children under 5
- Proportion of population below minimum level of dietary energy consumption.

18. More than half of Latin American and Caribbean countries and territories for which data are available seem to be on track at the national level to achieve the official MDG targets on hunger, according to the 2010 ECLAC report *Achieving the MDGs with Equality in Latin America and the Caribbean: Progress and Challenges*. These targets focus on minimum calorie requirements, defined as 1,800 kcal per day per person in the Americas, and child malnutrition defined as low weight-for-age (underweight).

19. Eight countries and territories have already attained the target on minimum calorie requirements: **Cuba, Guyana, Jamaica, Netherlands Antilles, Nicaragua, Peru, Saint Vincent and the Grenadines, and Uruguay**. Eight more countries appear set to

achieve that target: **Bahamas, Brazil, Chile, Colombia, Costa Rica, Ecuador, Honduras, and Suriname** (ECLAC/FAO).

20. In contrast, seven countries have made less progress than needed to meet the minimum calorie target by 2015: **Argentina, Bolivia (Plurinational State of), Dominican Republic, Haiti, Panama, Paraguay, and Trinidad and Tobago**. Seven others have made no progress or are less able to meet their populations' minimum nutrition needs now than 20 years ago: **El Salvador, Grenada, Guatemala, Mexico, Saint Lucia, Saint Kitts and Nevis, and Venezuela (Bolivarian Republic of)** (ECLAC/FAO).

21. It is important to note that in several countries that have made progress, 20% or more of their populations still consumes less than the minimum calorie needs. These include **Bolivia** (23%), **Dominican Republic** (21%), **Haiti** (58%), and **Nicaragua** (21%), as well as the Caribbean subregion as a whole (23%) (ECLAC/FAO).

22. In contrast, six countries have less than 5% of their populations consuming less than their minimum calorie needs: **Argentina, Chile, Costa Rica, Cuba, Mexico, and Uruguay** (ECLAC/FAO).

23. According to the available data on child malnutrition (low weight-for-age), Latin America and the Caribbean as a whole have reduced this indicator by 20% more than would be needed to meet the MDG target by 2015.

24. However, progress varies significantly across countries. Twelve countries are ahead of schedule: **Bolivia, Brazil, Chile, Dominican Republic, Ecuador, Guatemala, Guyana, Honduras, Mexico, Nicaragua, Peru, and Venezuela**. **Belize** and **Jamaica** have progressed since 1990, but less than what is needed to meet the target by 2015. **Argentina, Costa Rica, and Uruguay** have rates of child malnutrition of less than 5% (2005), making it very likely they will reduce it to below 2% by 2015, effectively eradicating malnutrition (ECLAC/WHO/UNICEF).

25. Measures of malnutrition that are equally or more meaningful in the regional context than the official MDG indicators are also worth examining to assess progress toward eradicating hunger. Levels of acute malnutrition, defined as low weight-for-height, have been stable in most of the Region over the past two decades. But the problem has re-emerged in several countries—including **Bolivia, Guatemala, Haiti, and Honduras**—with high case-fatality rates when not properly treated.

26. Moreover, chronic malnutrition, measured as low height-for-age (stunting), continues to be a serious health problem in the Region, affecting an estimated 9 million children and contributing significantly to child mortality. Throughout Latin America and

the Caribbean, the prevalence of stunting is significantly higher than the prevalence of underweight. Here too, however, the trend is mostly positive: in all countries for which representative data are available, rates of stunting have declined in recent years. Six countries in Latin America—**Brazil, Colombia, the Dominican Republic, El Salvador, Mexico, and Nicaragua**—are on track to reduce stunting by half by 2015, while **Bolivia, Costa Rica, and Haiti** are within 3 percentage points of being on track. Stunting remains most serious in Central America and the Andean countries, affecting half of Guatemalans and a quarter to a third of Bolivians, Ecuadorans, Haitians, Hondurans, and Peruvians.

27. Micronutrient deficiencies—in iron, vitamin A, and iodine, for example—are also significant nutritional problems in the Region, though they are not MDG indicators. The prevalence of anemia in young children has declined very little, from 34% to 33% over 10-12 years, in 16 countries for which there are trend data. Among non-pregnant women of childbearing age, anemia declined only slightly, from 21% to 20% during a similar period. The trend is better among pregnant women: anemia prevalence in this group declined from 43% to 28% in 15 countries over 10 years. Improvements have also been seen in iodine deficiency disorders. Data are not available to assess progress in vitamin A deficiency.

28. While MDG hunger data have not been compiled for the **United States and Canada**, indicators show that in 2007, 0.8% of U.S. households with children had one or more of those children experiencing “very low food security,” that is, with irregular meals and food intake below levels considered adequate by caregivers (USDA). In 2007-2008, 2.7% of Canadian households were “severely food insecure,” that is, with reduced food intake and disrupted eating patterns because of insufficient money for food (CCHS/Health Canada).

MDG-4 Reduce Child Mortality

MDG-4 Child Mortality Target and Indicators

Target A: Reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate.

Indicators:

- Under-5 mortality rate
- Under-1 mortality rate
- Proportion of 1-year-olds immunized against measles

29. The countries of the Americas have made significant progress in reducing both infant (under-1) and child (under-5) mortality. In **Canada** and the **United States of America**, where baseline rates were already low, recent changes have been small. Infant mortality declined 4% in **Canada** between 2001 and 2006 (from 5.2 to 5.0 per 1,000 live

births). In the **United States** during the same period, infant mortality declined 7.4% (from 6.8 to 6.7 per 1,000).

30. As of 2009, Latin America and the Caribbean had the lowest infant mortality rate of any developing region, at 19 per 1,000 live births, as well as the fastest rate of decline (55%) since 1990. To attain the MDG target on reducing infant mortality by 2015, countries needed by 2009 to have achieved a reduction of at least 50.2% since 1990, meaning that the Region is generally on track to achieve MDG-4.

31. This progress reflects a number of factors. They include expanded access to and improvements in critical primary healthcare interventions, such as immunization, support for breastfeeding, well-child care, and oral rehydration therapy for diarrheal diseases, as well as expansion of basic services for potable water and sanitation. Other important factors include higher educational levels, especially among women, lower fertility rates, and reductions in poverty levels.

32. These regional averages, however, mask major differences between countries. In addition to **Canada** and the **United States**, several countries and territories—including **Chile, Costa Rica, Cuba, and Uruguay** in Latin America; and **Anguilla, Guadeloupe, French Guiana, and Martinique** in the Caribbean—have achieved infant mortality rates of 10 per 1,000 or lower, comparable or better than in many developed countries. In contrast, **Bolivia** and **Haiti** have rates as much as eight times higher, between 50 and 80 deaths per 1,000 live births. **Guyana, Suriname, and Trinidad and Tobago** have rates between 20 and 40 per 1,000, by various estimates.

33. There are also important disparities in infant mortality within the Region's countries. In the **United States**, infant mortality is nearly twice as high among babies born to non-Hispanic black women as the national average—13 vs. 6.7 per 1,000 live births—and the rate among those born to Puerto Rican women is 44% higher than among non-Hispanic white women (CDC, 2006). In Latin America, estimates of deaths among children born to women aged 25 to 39 vary strikingly across small administrative divisions in a number of countries, ranging from less than 3% to over 25% in different areas of **Mexico, Guatemala, Nicaragua, and Panama** (CELADE, 2000). Disparities also exist between urban and peri-urban areas of major metropolitan areas, and between indigenous or ethnic groups and the general population, although the gaps are much larger in some countries than in others.

34. As for child (under-5) mortality, Latin America and the Caribbean as a whole saw a decline of 79.1% between 1991 and 2009, and nearly all the countries had declines well over 50%, sufficient to achieve the target reductions by 2015 (CELADE and UN Population Division). As with infant mortality, however, actual rates continue to vary widely across countries and territories, ranging from more than 50 per 1,000 live births in

Haiti, Bolivia, and Guyana to fewer than 10 per 1,000 in **Chile, Cuba, and Guadeloupe**.

MDG-5 Improve Maternal Health

MDG-5 Maternal Health Targets and Indicators

Target A: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Indicator

- Proportion of births attended by skilled health personnel

Target B: Achieve, by 2015, universal access to reproductive health

Indicators

- Contraceptive prevalence rate
- Adolescent birth rate
- Antenatal care coverage
- Unmet need for family planning

35. Maternal mortality varies dramatically across the countries of the Americas, from fewer than 50 deaths per 100,000 live births in **Argentina, Canada, Chile, Costa Rica, Cuba, the United States, and Uruguay** to a high of 630 deaths per 100,000 births in **Haiti**. In the Caribbean, the three countries with the highest maternal mortality are **Suriname** (184.3 deaths per 100,000 live births in 2007), **Guyana** (112.5 deaths in 2007), and **Jamaica** (95 deaths in 2001-2003) (PAHO Basic Indicators).

36. According to PAHO/WHO data, maternal mortality declined 40% in the Americas between 1990 and 2008, from 140 to 84 deaths per 100,000 live births. However, progress on this indicator is difficult to monitor because of data quality and coverage problems. Some countries have improved their reporting of maternal deaths, which can mask actual improvements in maternal mortality. Other countries are believed to undercount maternal deaths by as much as 50%. While the available data show that 15 countries in the Region experienced declines between 1990 and 2008, many did not, and most of the countries are unlikely to meet the MDG target by 2015.

37. Meanwhile, recent estimates suggest there are just over 10,000 maternal deaths in the Americas each year, many of them preventable through common interventions.

38. Major contributors to maternal mortality include direct obstetric causes such as hypertensive disorders (preeclampsia and eclampsia), hemorrhage, abortion, and sepsis and other infections following childbirth. Indirect causes include infections such as HIV

and vector-transmitted diseases, such as malaria, which are contributing factors to maternal deaths.

39. Among the factors most closely related to maternal illness and deaths is the absence of skilled health personnel during delivery. The United Nations General Assembly in 1999 established a threshold of 90% of births with professional attention as a target for 2015. A number of countries in the Region—including **Bolivia, Guatemala, Haiti, and Peru**—lag far behind on this indicator; **Honduras, Nicaragua, and Paraguay** are also behind, though to a lesser degree (ECLAC). However, skilled attendance at birth alone cannot guarantee reductions in maternal mortality; equally important are the effectiveness and quality of care, along with delays in seeking more specialized medical attention.

40. The target of universal access to reproductive health was added to MDG-5 in 2005, reflecting concerns that this is essential to improving maternal health and reducing maternal deaths. The indicators for this target are contraceptive prevalence, adolescent birth rate, prenatal care coverage, and unmet need for family planning.

41. Overall, prenatal care coverage is relatively high in Latin America and the Caribbean, with more than three in four women having four or more prenatal visits in seven of 11 countries reporting data for this indicator (ECLAC). However, access to both prenatal care and assisted childbirth is much lower in rural areas and among indigenous and Afro-descendant populations.

42. As for adolescent fertility, births to women ages 15 to 19 remain high in Latin America and the Caribbean; they have only declined 7.2% since 1990 (ECLAC). Sub-Saharan Africa is the only region that has had a smaller decline in adolescent fertility (5.7%) during this period.

43. Unwanted pregnancies are believed to contribute to about one-fourth of maternal deaths (UN MDG Report 2007). In a number of countries in Latin America, contraceptive use among women of childbearing age remains low, although the gap between rural and urban areas has narrowed in most countries for which data are available (ECLAC). In addition, the majority of countries have reduced the unmet demand for family planning and narrowed gaps in access between different social sectors (ECLAC). Yet much progress remains to be made before every person in the Region has access to comprehensive and good-quality sexual and reproductive health services.

MDG-6: Combat HIV/AIDS, Malaria, and Other Diseases

MDG-6 HIV/AIDS Targets and Indicators

Target A: Halt and begin to reverse the spread of HIV/AIDS by 2015

Indicators:

- HIV prevalence among population aged 15-24 years
- Condom use at last high-risk sex
- Proportion of population ages 15-24 years with comprehensive correct knowledge of HIV/AIDS
- Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years

Target B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it.

Indicator:

- Proportion of population with advanced HIV infection with access to antiretroviral drugs

44. The HIV epidemic has had different impacts on different subregions of the Americas. With nearly 1% of adults (15 to 49) infected, the Caribbean has the highest HIV prevalence of any region of the world other than sub-Saharan Africa. In North, Central, and South America prevalence is estimated at 0.5% (UNAIDS).

45. Recent trends in new infections also vary by subregion. Between 2001 and 2009, new infections in the Caribbean declined 15% (from 20,000 to 17,000) and in Central and South America, 7% (from 99,000 to 92,000), while during the same period, new cases increased 6% in North America (from 66,000 to 70,000). Region-wide, this added up to a 3% decline in new cases over the period.

46. Changes in mortality have varied considerably across the Americas. In the **United States** and **Canada**, deaths from AIDS decreased dramatically following the introduction of highly active antiretroviral therapy (HAART). The number of deaths attributable to HIV in **Canada** decreased 76% from 1995 to 1999 and 16% from 2000 to 2006, the last year for which data are available (PHAC). The age-adjusted HIV death rate in the **United States** decreased 28% from 1995 to 1996, 46% from 1996 to 1997, and 18% from 1997 to 1998. After 1998, the annual decrease ranged from 3% to 8% (CDC). Nevertheless, AIDS remains one of the leading causes of death among people 25 to 44 years old in the **United States**, particularly among those who are black/African American or Hispanic.

47. In Latin America, several countries—including **Argentina**, **Brazil**, **Chile** and **Costa Rica**—have significantly reduced HIV/AIDS mortality through expanded access

to antiretroviral treatment (ART). In others—including **Colombia, Ecuador, and Venezuela**—HIV mortality remains stable or has increased.

48. The groups most affected by the epidemic in the Americas continue to be men who have sex with men, injecting drug users, and sex workers. The proportion of women with HIV has stabilized at about 34% of all people living with HIV in Latin America and 48% of people with HIV in the Caribbean (UNAIDS/PAHO/UNICEF).

49. In terms of condom use, studies show that more men (69%) than women (40%) who have had more than one sexual partner during the previous 12 months report using condoms. In Latin America and the Caribbean only three countries have reported that condoms are available to adolescents in school (UNAIDS/WHO). Studies also show increasing use of condoms among sex workers and their clients, but gaps in prevention efforts remain, particularly among men who have sex with men and injecting drug users (UNAIDS/WHO).

50. Knowledge of HIV transmission and prevention also varies widely across the Region's countries. Estimates of the proportion of young women aged 15 to 24 with comprehensive correct knowledge about HIV vary from 9% in **Guatemala** to 89% in **Argentina**, while the proportion of young men with such knowledge ranges from 10% in **Guatemala** to 82.3% in **Argentina** (UNAIDS/WHO). In the Caribbean, the percentage of all young people with comprehensive correct knowledge was below 60% in 2007, ranging from a high of 56% in **Trinidad and Tobago** to a low of 5.2% in **Aruba** (UNDP/MND Belize).

51. As for progress toward universal access to treatment for HIV, as of 2009, 50% of people in Latin America and the Caribbean who needed ART were receiving it, the highest level among low- and middle-income WHO regions. Coverage was higher for women (55%) than for men (49%) and even higher (58%) among children under age 15 who need ART. However, estimated coverage for children in the Caribbean was only 29%, compared with 68% of children in Latin America. The percentage of pregnant women living with HIV and receiving ART to prevent mother-to-child transmission of HIV increased from 19% in 2004 to 54% in 2009, with slightly higher coverage in the Caribbean (59%) than in Latin American countries (53%).

52. As with other MDG indicators, there are significant differences across countries in levels of ART coverage. **Cuba** and **Guyana** are currently the only countries in Latin America and the Caribbean that have achieved 80% coverage, the benchmark for "universal access" to ART (WHO, 2009). Seven other countries—**Argentina, Brazil, Chile, Costa Rica, El Salvador, Mexico, and Suriname**—had between 50% and 80% coverage as of 2009. Others had less than 50% coverage or lacked the data needed to estimate coverage levels.

53. **Argentina, Brazil, Ecuador, Guyana, and Jamaica** are among only 11 developing countries worldwide that have reached the target of 80% coverage with ART to prevent mother-to-child HIV transmission. Half of the 14 developing countries worldwide that have reached 80% ART coverage for children are in the Region: **Argentina, Brazil, Guyana, Jamaica, Panama, Paraguay, and Uruguay.**

54. Assessing trends in ART coverage in Latin America and the Caribbean over the past decade is difficult because of data problems and changes in WHO criteria for who needs therapy and when. At the global level, WHO's 2010 recommendation to change the CD4 cell count threshold for initiating ART resulted in an increase of 45% in the total number of people estimated to be in need of ART in 2009 in low- and middle-income countries.

55. Easier to compare is the absolute number of people needing ART and having access to it over time. In Latin America and the Caribbean, this number grew from 192,000 in 2002 to 478,000 in 2009, for an increase of 149%. (Comparable data are not available on ART coverage in **Canada** and the **United States.**)

MDG-6 Malaria and TB Targets and Indicators

Target C: Halt and begin to reverse the incidence of malaria and other major diseases by 2015

Indicators:

- Incidence and death rates associated with malaria
- Proportion of children under 5 sleeping under insecticide-treated bed nets
- Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs
- Incidence, prevalence and death rates associated with tuberculosis
- Proportion of tuberculosis cases detected and cured under directly observed treatment short course

56. In the Americas, malaria remains endemic in the majority of countries (all except **Canada, Chile, the United States, Uruguay,** and the Caribbean Islands other than **Hispaniola**).¹ In the 21 endemic countries, coordinated control and treatment efforts have contributed to a 52% reduction in total malaria cases since 2000 and a 69% decline in deaths. Incidence decreased in 18 countries between 2000 and 2009, and in nine of these—**Argentina, Belize, Costa Rica, Ecuador, El Salvador, Guatemala, Nicaragua, Paraguay, and Suriname**—the decrease was more than 75%, effectively attaining the MDG target for malaria.

¹ Non-endemic countries in the Americas have recently reported to PAHO/WHO an average of 1,825 cases of malaria (imported and introduced) each year, most of them in the United States (1,414) and Canada (385).

57. Four other countries—**Bolivia, Brazil, Honduras, and Mexico**—saw decreases of between 50 percent and 75 percent in malaria incidence. **Venezuela, the Dominican Republic, and Haiti** saw increases in malaria between 2000 and 2009, however, the trend since 2005 has been downward in all endemic countries except **Haiti**.

58. Much of this progress is due to successful efforts to monitor the development of resistance to malaria drugs and to adjust treatment regimens accordingly (these efforts are described in more detail in Chapter 2). For example, after changing its treatment policy in 2004 based on drug effectiveness studies, **Suriname** saw an 82%% reduction in malaria cases over the next four years. Similar trends have been seen in **Bolivia, Brazil, Colombia, Ecuador, and Peru**.

59. Tuberculosis incidence has been declining in the Region of the Americas since the 1980s, according to WHO data, and the decline accelerated following the widespread implementation of the directly observed treatment - short course (DOTS) strategy in the mid-1990s. According to WHO estimates, the Americas reduced TB prevalence from 97 cases per 100,000 inhabitants in 1990 to 38 per 100,000 in 2009 (a decrease of 60%) and the number of TB deaths from 8 per 100,000 in 1990 to 2 per 100,000 in 2008 (a 75% decline). Since both represent declines of more than 50%, the Region as a whole has already attained the target of having halted and begun to reverse the incidence of TB.

60. Progress among individual countries, however, has been uneven. **Chile, Costa Rica, and Cuba**—along with **Canada** and the **United States**—have implemented TB elimination plans that have reduced incidence to less than 10 per 100,000 inhabitants, thus effectively achieving the MDG targets for TB. Fourteen other countries saw declines of over 50% in TB prevalence and mortality between 1990 and 2009, while 10 countries saw only modest declines. Six countries—**Antigua and Barbuda, Belize, Jamaica, Paraguay, Suriname, and Trinidad and Tobago**—had increases in incidence or deaths, or both, and are unlikely to meet the MDG target by 2015. Several of these countries have concurrent epidemics of HIV, and indeed co-infection with TB and HIV is a major challenge to overcome, along with multidrug-resistant TB (MDR-TB) and TB in marginalized populations in hard-to-reach areas. While all countries in Latin America focus some effort on diagnosis and treatment of TB in marginalized populations, their efforts generally fall short of what is needed to meet the Stop TB Partnership target of treating at least 85% of cases.

MDG-7: Ensure Environmental Sustainability

MDG-7 Water and Sanitation Targets and Indicators

Target C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

Indicators:

- Proportion of population using an improved drinking water source
- Proportion of population using an improved sanitation facility

61. Access to water and sanitation, along with shelter, has been established as a human right and as essential for ensuring a basic quality standard for people's living environments, which in turn are among the main social determinants of health.

62. The Region of the Americas has significantly expanded access to drinking water and sanitation since 1990 and is well within reach of the respective MDG targets. The proportion of the population without improved drinking water declined from about 16% to 9% between the early 1990s and the mid-2000s, a 44% reduction over approximately one decade. The proportion of people without improved sanitation facilities declined from 32% to 22% during the same period, for a reduction of just over 30% over 10 years (ECLAC). This pace of progress is more than sufficient to reach the 50% reductions needed by 2015.

63. Progress has also been made in reducing the gaps in access between urban and rural residents. The percentage of urban residents with access to improved drinking water increased from 95% in 1990 to 97% in 2008, while the proportion of rural dwellers increased from 63% to 80%. Nonetheless, in 2008, some 40 million people in the Region still lacked access to improved sources of drinking water, and some 115 million people were without improved sanitation facilities (WHO/UNICEF), leaving room for considerable progress even after the MDGs are met.

MDG-8: Develop a Global Partnership for Development

MDG-8 Target and Indicator on Access to Essential Drugs

Target E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries

Indicator:

- Proportion of population with access to affordable essential drugs on a sustainable basis

Access to affordable medicines

64. Data on access to medicines are not widely available in the Americas, making it difficult to assess MDG progress in this area. A recent PAHO/WHO study in **Guatemala, Honduras, and Nicaragua** found that, on average, 80% of households had access to medicines for common health conditions, including acute and chronic diseases and pregnancy. Out-of-pocket expenditures on medicines averaged 58% of total household health expenditures.

65. In terms of total national spending on pharmaceutical products, PAHO/WHO estimates based on 2008 data from 21 countries suggest that 78% is out-of-pocket expenditures by private households, while 22% is by public institutions. This situation contrasts sharply with WHO recommendations on health system financing, which say that direct household payments should be no more than 15-20% of total health expenditures to prevent significant numbers of households experiencing financial catastrophe.

66. Major obstacles to expanding access to essential medicines and public health goods include scarce resources; inadequate financing systems; and inadequate capacity for product assessment, regulation and supply management, including forecasting, programming, and planning. In addition, many countries lack the regulatory capacity needed for rapid registration of new generic drugs, and few provide incentives for the development of generic markets or promote the rational use of generic drugs. Moreover, lack of transparency in prescribing and dispensing practices often means that consumers pay more out-of-pocket than necessary to access essential drugs.

67. An important area of progress in access to essential medicines in Latin America and the Caribbean is the growing use of the PAHO Strategic Fund and the PAHO Revolving Fund for the Purchase of Vaccines, Syringes, and Related Supplies (see also Chapter 2). Both funds have helped lower the costs of medicines and supplies for PAHO/WHO member countries by providing technical cooperation in supply planning and management, consolidating purchases, and negotiating prices directly with pharmaceutical manufacturers.

Regional partnerships

68. Although the Region of the Americas has seen a decline in its share of official development assistance, it has produced or participated in a wealth of alliances, partnerships, and joint initiatives that promote equitable development and health. Regional initiatives formed specifically to promote the MDGs include the Newborn

Health Alliance for Latin America and the Caribbean², the Regional Inter-Agency Task Force for Maternal Mortality Reduction³ (GTR), the Safe Motherhood Initiative⁴, and the Pan American Alliance for Nutrition and Development⁵.

69. These and similar alliances among UN agencies and other organizations active in the Region have increased visibility and political commitment, created synergies, and reduced overlap and duplication of efforts among actors working toward similar goals. They have also helped the Region's lower- and middle-income countries as well as small-island developing states access resources from major international funding sources, including the Global Alliance for Vaccines and Immunization (GAVI), Spain's MDG Achievement Fund, and the Global Fund to fight AIDS, Malaria and Tuberculosis.

² Members include PAHO/WHO, the United Nations Children's Fund (UNICEF), the US Agency for International Development (USAID), ACCESS, BASICS, CORE Group, Plan USA, University Research Co./Center for Human Services (URC/CHS), Save the Children/Saving Newborn Lives, the Latin American Association of Pediatrics (ALAPE), the International Confederation of Midwives (ICM), and the Latin American Federation of Societies of Obstetrics and Gynecology (FLASOG).

³ Members include PAHO/WHO, UNICEF, the UN Population Fund (UNFPA), USAID, the World Bank, the Inter-American Development Bank (IDB), the Population Council, Family Care International (FCI), the Latin American Federation of Societies of Obstetrics and Gynecology (FLASOG), the Pan-American Federation of Nursing Professionals (FEPPEN), and the International Confederation of Midwives (ICM).

⁴ Members include the members of the Regional Inter-Agency Task Force for Maternal Mortality Reduction (GTR) as well as the Organization of American States (OAS) and the La Caixa Foundation of Spain.

⁵ Members include PAHO/WHO, the UN Development Program (UNDP), UNICEF, ECLAC, UNFPA, the International Labor Organization (ILO), the World Food Program (WFP), the UN Office on Drugs and Crime (UNDOC), the UN Joint Program on HIV/AIDS (UNAIDS), the UN Development Fund for Women (UNIFEM), and the UN Office for Project Services (UNOPS).

Chapter II. From Goals to Results

MDG-1: Eradicate Hunger

70. As indicated in Chapter I, more than half of Latin American and Caribbean countries and territories appear to be on track at the national level to achieve the official MDG targets for hunger. Yet progress varies across and within countries. Moreover, acute malnutrition has re-emerged as a problem in several countries, and scant reductions have been achieved in micronutrient deficiencies.

71. Since 2006, PAHO/WHO has provided technical cooperation in this area within the framework of the Regional Strategy and Plan of Action on Nutrition in Health and Development 2006-2015 (CD47.R8, 2006), the Global Strategy for Infant and Young Child Feeding (WHO/UNICEF, 2003), and the International Code of Marketing of Breast-milk Substitutes (WHO, 1981). In 2010, PAHO's 50th Directing Council approved the Strategy and Plan of Action for the Reduction of Chronic Malnutrition (CD50.R11), with the intent of strengthening activities proposed in the 2006 regional strategy through an integrated, intersectoral approach that addresses the social determinants of chronic malnutrition and incorporates proven interventions into primary health care. PAHO/WHO promoted this new strategy throughout 2010-2011 and supported its implementation in nine member countries: **Belize, the Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua, Panama, Paraguay, and Peru.**

72. One of the key elements of the new strategy is its endorsement of the Pan American Alliance for Nutrition and Development (PAND). Established in 2008 by the UN Regional Directors Team (UNDG-LAC), PAND facilitates inter-agency cooperation on evidence-based, interprogrammatic, and multisector interventions to tackle the multiple causes of malnutrition.

Technical Cooperation in Nutrition in Bolivia and El Salvador

PAHO/WHO supported two major nutrition initiatives during 2010-2011 that exemplify the multisector, multi-agency approach promoted by PAND. Both initiatives were financed by Spain's MDG Achievement Fund and contributed to advancing MDG-1 as well as MDG-4.

The first, in **Bolivia**, is a three-year (2010-2012) program involving nine government ministries, 22 municipal governments, and six UN agencies, including PAHO/WHO. It seeks to build local capacity for food security and nutrition in the departments of Cochabamba and Chuquisaca and supports the country's multisector Zero Malnutrition program. Beneficiaries include some 321,000 families living in 360 communities.

The program works with community organizations, women's groups, students and teachers, volunteer health aides, health workers, and local authorities, with interventions focused on health education for pregnant women, promotion of complementary feeding for nursing infants,

and integrated management of childhood diseases for children under age 5 (IMCI strategy). It also includes measures to increase food self-sufficiency and improve water sources and sanitation.

Since its launch in 2010, the program has trained nearly 1,000 women leaders on best practices in health, nutrition, and food safety and some 730 community health aides on the 10 nutrition-related Key Practices of Family and Community IMCI. The community health aides provide health and nutrition education for about 11,000 families; they also monitor their health and nutrition status and refer those who need attention to the proper health facilities.

The program also has provided training in health and nutrition for 600 primary school teachers and includes a “healthy schools” component that mobilizes students and teachers to help ensure safe drinking water in schools. These efforts, together with monitoring of water sources by departmental Environmental Sanitation Units, are aimed at reducing the incidence of diarrheal diseases.

The second initiative, in **El Salvador**, supports the implementation of a new national policy on food and nutritional security and included the roll-out of the National Council on Food and Nutritional Security (CONASAN). During 2010-2011, PAHO/WHO provided support for the program at the national level by helping update information on the food and nutrition situation in El Salvador and through technical cooperation on micronutrient fortification of foods (vitamin A, iron, folic acid, and B complex).

In addition, the Organization supported the Regional Forum on Food and Nutritional Security (FOROSAN), whose members include the Center for Breastfeeding Support (CALMA), the National Center for Agricultural and Forestry Technology (CENTA), the Universidad del Oriente (UNIVO), the UN Food and Agriculture Organization (FAO), and the INTERVIDA Foundation.

At the municipal level, support was provided to inter-institutional planning boards led by mayors and including representatives of the Ministry of Health, local schools, NGOs, and churches. To facilitate joint analysis and planning by the boards, PAHO/WHO helped carry out a baseline study of the prevalence of global, acute, and chronic malnutrition and anemia among boys and girls under 5 years old in the three municipalities.

PAHO/WHO also helped train and equip 14 new Community-based Family Health Teams (ECOs), responsible for monitoring and providing primary healthcare services for 600 families each, as well as three additional ECOs that provide more specialized pediatric, gynecological, psychological, and surgical care.

These efforts are coordinated by CONASAN and supported by **El Salvador**’s Ministries of Health, Education, and Agriculture, the Secretariat for Social Inclusion, the Technical Secretariat of the Presidency, UNIVO, and other UN agencies including UNICEF, WFP, FAO, and UNDP.

73. To promote the PAND approach elsewhere in the Region, PAHO/WHO organized meetings with health and other government authorities, civil society

organizations, and international NGOs in countries including **Argentina, Bolivia, Guatemala, Panama, Paraguay, and Peru.**

74. A number of other initiatives on food and nutritional security and child malnutrition were also supported. These included micronutrient supplementation and food fortification in 11 countries (**Belize, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Panama, and Peru**), the construction of a national database of children suffering from acute malnutrition in **Guatemala**, and a national survey of target populations in **Nicaragua**.

75. The Caribbean Food and Nutrition Institute (CFNI) developed and promoted a new Regional Protocol for the Detection, Prevention, and Treatment of Anemia in Maternal and Child Health Clinics in the Caribbean. It takes into account the high prevalence of anemia in some countries of the subregion as well as current programs, recent research, and international recommendations on anemia in pregnant women and young children in the maternal and child health clinical setting. The protocol emphasizes screening, supplementation, and the use of iron-rich and fortified foods as well as public health measures such as control of malarial and other parasites. It includes procedures for diagnosis and assessment as well as detection, prevention, and management of anemia at various life stages, particularly vulnerable periods such as pregnancy, post-partum, infancy, and early childhood.

76. In **Cuba**, the focus was on strengthening surveillance, prevention, and care of pregnant women and children under 5 years with anemia and the design of a nutritional surveillance of anemia component for the country's Maternal-Child Health Observatories. In **Bolivia**, the Organization supported a program to detect and treat anemia in pregnant women, nursing babies, children under 5, and school-age children. Technical cooperation was also provided to incorporate anemia prevention into **Haiti's** Free Obstetric Care (SOG) program.

77. A number of efforts took place to advance MDG-1 within the framework of the Faces, Voices, and Places (FVP) initiative. In **Brazil's** countryside, for example, it helped revitalize the Association of Producers of Olinda-Amparo and implement a program to cultivate medicinal plants. FVP also supported the country's Health in Schools Program with nutritional evaluations and orientation for children and teens in 20 schools.

78. In the El Chaco region of **Argentina, Bolivia and Paraguay**, FVP supported training for small farmers and livestock producers; organized women producers of fruits and vegetables, bread, and crafts; and promoted food gardens in schools to improve child nutrition.

79. In **Cuba**, the Institute of Veterinary Medicine and local authorities implemented a “productive municipalities” strategy aimed at improving food and nutritional security. The strategy, implemented on a pilot basis in four municipal districts, supports families engaged in farming and animal husbandry and includes a new model for providing veterinary care.

Small Grants Advance MDG-1 in the Caribbean

The Caribbean Food and Nutrition Institute (CFNI), PAHO/WHO’s technical center in **Jamaica**, has established a small grants program that advances food and nutrition security while reducing poverty among members of vulnerable groups. It recognizes the links between poverty, nutrition, and health and empowers low-income people to overcome the conditions that lead to and prolong poverty through productive activities.

During 2010, the program made grants of US\$10,000 to \$12,000 to six community-based groups in **St. Kitts and Nevis** to support income-generating projects that primarily benefit former sugar workers who were displaced following the closure of the country’s sugar industry in 2005. The projects included a 90-acre peanut plantation, broiler hen and rabbit meat producers, a small agro-processor, and a revolving fund for the purchase of new equipment for sustainable fishing to replace older fishing equipment.

In addition to grants, the program provides training and technical assistance, facilitates membership arrangements and collective investment funds, and promotes networking and information sharing among the beneficiaries.

80. Other nutrition-related technical cooperation included evaluations by CFNI of school feeding programs in **Jamaica, St. Vincent and the Grenadines, and Trinidad and Tobago** and technical assistance to develop and publish food service manuals and cycle menus for use in schools. In addition, the Organization provided support for breastfeeding promotion, “baby-friendly hospitals,” and the new WHO Child Growth Standards, described in more detail under MDG-4 below.

MDG-3: Promote Gender Equality and Empower Women

81. Gender remains a key social determinant in the Americas, not only of socioeconomic inequality but also of health status and prospects. PAHO/WHO work in this area seeks to increase gender equality in health as a matter of social justice but also addresses the differences between the health needs and risks of men and women, boys and girls to improve the coverage, effectiveness, efficiency, and impact of health interventions.

82. The framework for technical cooperation in this area is the 2005 PAHO Gender Equality Policy (CD46/12) and the 2009 Regional Plan of Action for Implementing the

Gender Equality Policy. These guide PAHO/WHO's technical cooperation in its member countries as well as its own human resources management, strategic planning, monitoring, and evaluation.

83. The Organization supported the development and implementation of gender equality plans in **Bolivia, Guatemala, Nicaragua, Paraguay, and Suriname**. Letters of agreement were signed with the Council of Ministers for Women in Central America (COMMCA) and the Council of Ministers of Health of Central America (COMISCA) to mainstream gender in the Central American Integration System (SICA).

84. In the Andean Region, a participatory process for defining key indicators on gender and health led to a proposal to include them as part of the social indicators used by the Andean Community.

85. In **Nicaragua**, the Organization supported the design and initial implementation of a project on gender and chronic disease that addresses the legal and social barriers to girls' participation in sports and physical activity, to improve their well-being and decrease their risks for obesity and chronic disease.

86. In other technical cooperation in this area, gender-equality guidelines were used to review a proposal to the Global Fund by RedTransSex, a South American network of sex workers, and a proposal and interview guide to study gender aspects of multidrug resistant TB (MDR-TB) were finalized in **Peru**.

87. The Organization collaborated on several publications in this area that were launched during 2010-2011, including *Profile on Gender and Health in the Andean Subregion*, *Profile on Gender and Health for the Republic of Panama*, *Health of Men and Women in Central America and the Dominican Republic*, and a statistical brochure on gender, health, and development in **Costa Rica**. In addition, the Organization launched a new virtual course on gender and health with a focus on human rights and cultural diversity, which is now available through the Virtual Public Health Campus.

88. In March 2011, during an event marking International Women's Day, PAHO/WHO honored the winners of the 4th annual "Best Practices that Incorporate the Perspective of Gender Equality in Health" contest, which focused on HIV prevention, care, and treatment. The winners were an **Argentine** initiative that promotes sexual and reproductive health and prevention of HIV in adolescents from marginal neighborhoods, and an initiative from **Trinidad and Tobago** that provides counseling and treatment for couples with only one member who is HIV-positive.

89. As part of its Gender, Diversity, and Human Rights program, the Organization also promoted the health and human rights of indigenous peoples. This work included

technical support for the Andean Intercultural Plan on Indigenous Health and the Andean Intercultural Plan on Afro-descendants, as well as a technical cooperation between countries (TCC) project between **Colombia** and **Brazil** to promote health among the Rom people.

90. In coordination with ECLAC's Latin American and Caribbean Demographic Center (CELADE) and UNFPA, PAHO/WHO collaborated with experts on indigenous and Afro-descendant affairs from ministries of health and civil society to develop a first draft of a recommendation to include ethnic/racial identification into health statistics, based on experiences in the Americas.

91. In May 2011, the Organization chaired the Inter-Agency Support Group on Indigenous Peoples' Issues during the 10th session of the UN Permanent Forum on Indigenous Issues in New York and helped organize a side event on noncommunicable diseases in indigenous communities.

92. A new CD and a written guide to the United Nations Declaration on the Rights of Indigenous Peoples and ILO Convention 169 for civil society organizations, governments, UN agencies, and other stakeholders were also launched.

MDG-4: Reduce Child Mortality

93. As noted in Chapter 1, Latin America and the Caribbean have the lowest infant mortality of any developing region as well as the fastest rate of decline in this indicator since 1990. But while the Region as a whole is on track to achieve MDG-4, progress has been uneven across and within countries. Technical cooperation in this area focused on consolidating gains already achieved and accelerating progress in countries and population groups that are lagging behind.

94. Much of the work in this area is aimed at reducing neonatal mortality, that is, deaths within the first 28 days of life, which currently accounts for some 60% of mortality among children under 1 year of age in the Region. The Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care (CD48/7), approved in 2008 by PAHO's 48th Directing Council, addresses care throughout the life cycle, including adolescence, preconception, pregnancy, childbirth, and childhood, not only in health clinics and hospitals but also in the home and the community.

95. A central focus of the strategy is care provided during the critical hours after childbirth, when a baby's survival depends in large part on the skilled attendant who cares for both mother and child. The action plan stresses well-known cost-effective interventions, including IMCI interventions, as well as investments to strengthen health

systems, with special attention to training and deployment of health professionals, including doctors, midwives, and nurses.

96. Based on the regional strategy, technical cooperation to member countries sought to develop and implement neonatal health plans. In **Brazil, Bolivia, the Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua, and Peru**, the Organization helped incorporate evidenced-based neonatal interventions into norms and procedures for maternal and child care. In **Guyana**, it helped implement a course on “Essential Care of the Newborn” and developed a neonatal nursing care curriculum as part of the Magnet Hospital project.

97. A WHO-recommended methodology was used in the development of neonatal and child health profiles for six countries: **Ecuador, the Dominican Republic, Guatemala, Honduras, Nicaragua, and Panama**. The profiles utilized data disaggregated by geographical area (departments or provinces and municipalities) to provide a baseline for monitoring MDG progress and for planning and prioritizing activities and investments aimed at reducing neonatal, infant, child, and maternal mortality at the subnational and local levels.

98. A regional training module on monitoring, supervision, and evaluation of neonatal health in hospitals and other health facilities was developed, with six countries currently using the instrument to improve neonatal services: **Bolivia, the Dominican Republic, Ecuador, Guatemala, Nicaragua, and Panama**.

Improving Quality of Data for the MDG Indicators

PAHO/WHO provided technical cooperation during 2010-2011 to help Member States improve the quality and timeliness of the data they generate to monitor progress toward achieving the MDGs.

A special emphasis of this work has been updating time series data on infant and maternal mortality within the regional Basic Indicators, which includes data from all 48 countries and territories in the Americas. As of mid-2011, most countries had updated their time series data for indicators of MDGs 4 and 5.

CLAP/WR has used this data to identify vulnerable women and children and to develop focused interventions for advancing MDGs 4 and 5. To disseminate the data further, a virtual space was created within the Regional Observatory of Health, where visitors can discuss the MDG indicators and exchange analytical approaches.

The Eastern Caribbean Countries (ECC) office in **Barbados** hosted a workshop in which health officials from **Anguilla, Antigua and Barbuda, Barbados, the British Virgin Islands, Dominica, Grenada, Montserrat, St. Lucia, St. Vincent and the Grenadines, and St. Kitts**

and Nevis reviewed their own time series data for MDGs 4, 5, and 6 and learned how to critically evaluate the quality of health information. As a result of the workshop, nine participating countries—**Anguilla, Antigua and Barbuda, Barbados, Dominica, Grenada, Montserrat, St Lucia, St Vincent and the Grenadines, and St Kitts and Nevis**—have carried out evaluations of their health information systems using tools from the Health Metrics Network (Red Métrica de Salud) and PRISM (Performance of Routine Information System Management).

99. At the regional level, the Organization strengthened coordination with other agencies working on child health through monthly meetings of the Latin America and Caribbean Newborn Health Alliance, whose members also include UNICEF, USAID, Save the Children, Plan International, the CORE Group, the Latin American Pediatrics Association (ALAPE), the Pan American Federation of Nursing Professionals (FEPPEN), and the Latin American Federation of Obstetrics and Gynecology Societies (FLASOG).

100. To better coordinate child health efforts among different international agencies, academic institutions, and NGOs working in the same country, the Organization helped establish “national inter-agency alliances” for child health in six countries: **Bolivia, the Dominican Republic, El Salvador, Guatemala, Nicaragua, and Peru**. Similar alliances are expected to be established in another six countries by the end of 2011: **Colombia, Ecuador, Guyana, Honduras, Panama, and Paraguay**.

IMCI Alliance in Guatemala

Guatemala is one of a dozen countries where inter-agency alliances to improve child health and survival were established. The framework for the alliance’s work is the IMCI strategy. The Organization and other alliance members—including the Ministry of Public Health, UNICEF, Save the Children, ILO, USAID, and the Church of Jesus Christ of Latter-day Saints—supported a number of activities during 2010-2011 to implement IMCI in Guatemala’s public health system.

The contributions in this area included support for the development of a National Strategy and Plan on Neonatal Health, training for health workers and managers, acquisition of pediatric medical equipment, and the adaptation of IMCI guidelines and manuals for the Guatemalan context. The latter covered areas including evidence-based neonatal interventions, monitoring of early child development, protocols for prevention and treatment of child abuse, and IMCI in the contexts of nursing, nutrition, pandemic influenza, and HIV care.

101. An important focus of IMCI-related technical cooperation was monitoring of early child development as part of routine primary health care. PAHO/WHO developed a generic regional instrument that was being used in eight countries: **Argentina, Brazil, Chile, the Dominican Republic, Guatemala, Nicaragua, Paraguay, and Peru**.

102. The Organization also promoted the incorporation of IMCI into pediatrics curricula in medical schools, with a focus on students in their final year, who typically are required to serve for several months in rural or vulnerable communities. At least nine countries were using IMCI in medical education: **Argentina, Brazil, Bolivia, the Dominican Republic, Ecuador, Guatemala, Nicaragua, Peru, and Uruguay.**

103. Similarly, IMCI content was incorporated into nursing curricula in 10 countries: **Argentina, Chile, Cuba, the Dominican Republic, El Salvador, Guatemala, Nicaragua, Panama, Peru, and Uruguay.**

104. In addition, distance-learning tools were disseminated to allow countries to train larger numbers of health personnel in evidence-based interventions.

105. Efforts in the area of nutrition also contributed to improving child health, including the promotion of the WHO Child Growth Standards and the introduction of measurement of height in a number of countries that previously did not use this indicator. **Colombia, Ecuador, Haiti, Honduras, Nicaragua, and Suriname** were among countries whose health systems adopted and implemented the new standards.

106. Promotion of breastfeeding was advocated as the single most effective intervention for increasing child survival. This included support for “baby-friendly hospitals”—that is, hospitals that promote practices consistent with optimal breastfeeding of infants—in **Bolivia, Costa Rica, the Dominican Republic, Ecuador, Honduras, Panama, and Paraguay.**

107. In addition, the Organization supported the establishment and promotion of milk banks in countries including **Costa Rica, Cuba, the Dominican Republic, and Nicaragua**, as well as in **Guatemala**, where new milk banks were established in hospitals in areas with high rates of acute malnutrition. PAHO/WHO also supported monitoring of the Code of Marketing of Breast-milk Substitutes in **Ecuador, Panama, and Peru** and published a 30-year retrospective on the code in Latin American countries, which summarized important legislative actions and the current status of the code in each country.

108. A key focus of technical cooperation on MDG-4 was monitoring and surveillance of childhood diseases and mortality. Examples included support for auditing of infant mortality at the subnational level in **Costa Rica**, capacity-building for surveillance of cholera and other diarrheal diseases in the **Bahamas**, and a system for continuous monitoring of children’s health in daycare centers, preschools, and primary schools in **Montserrat.**

Immunization

109. The Organization's continuing support for immunization in its member countries is fundamental to successful efforts to reduce child mortality. In 2011, Vaccination Week in the Americas celebrated its ninth anniversary, with 43 countries and territories of the Americas participating, reaching 41 million children and adults with vaccines against common childhood diseases as well as other infectious diseases.

110. As a result of global outreach efforts, parallel vaccination weeks were held simultaneously in 2011 in four other regions besides the Americas: Europe, the Eastern Mediterranean, Africa, and the Western Pacific, with a total of more than 180 countries and territories participating in vaccination week events. By mid-2011, planning was under way for a proposed global vaccination week in 2012, which would coincide with the 10th anniversary of Vaccination Week in the Americas.

111. Important immunization support was provided through the Revolving Fund for Vaccine Procurement, the ProVac Initiative, and training and technical assistance in all aspects of immunization, from procurement and cold chain maintenance to surveillance and the identification and targeting of priority population groups.

112. In **Colombia**, for example, the Organization supported a review of vaccination coverage by cohorts since 2002 and helped estimate the accumulation of susceptible populations. On the basis of that review, **Colombia** carried out an immunization effort in 2010 that targeted all children ages 1 to 8—more than 6 million children—with measles and rubella vaccine.

113. Similarly, activities in the **Bahamas** and **Turks and Caicos** included training for immunization personnel, technical advice and guidance to national surveillance committees, and logistical support for procurement and shipment of vaccines.

114. The Revolving Fund for Vaccine Procurement provided vital support for countries' immunization efforts. During 2010 and the first half of 2011, the fund purchased nearly US\$723 million in vaccines, syringes, and cold chain supplies on behalf of 40 countries and territories: **Anguilla, Antigua, Argentina, Aruba, Bahamas, Barbados, Belize, Bermuda, Bolivia, Brazil, Cayman Islands, Chile, Colombia, Costa Rica, Cuba, Curaçao, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Honduras, Jamaica, Montserrat, Nicaragua, Panama, Paraguay, Peru, St. Kitts and Nevis, St. Lucia, St. Maarten, St. Vincent, Suriname, Trinidad and Tobago, Turks and Caicos, Uruguay, Venezuela, and the British Virgin Islands.**

115. The ProVac Initiative, financed by the Bill & Melinda Gates Foundation, continued to help countries gather and analyze evidence for decision-making on the

introduction of new vaccines. ProVac carried out activities in **Argentina, Bolivia, Ecuador, Guatemala, Jamaica, Nicaragua, and Paraguay**. This included advocacy for evidence-based decision-making on vaccine introduction, training for multidisciplinary national teams in data collection and economic analysis, and guidance in planning the effective introduction of new vaccines when warranted by the evidence.

116. ProVac also supported the activities of its six Centers of Excellence, housed in academic institutions in **Argentina, Brazil, Colombia, and Mexico**. Their work included developing tools and methodologies to help countries perform national-level economic analyses concerning both new vaccine introduction and broader immunization policy.

117. PAHO/WHO continued its close collaboration with the GAVI Alliance, which provides financing for vaccines in priority countries. In 2010-2011, GAVI financed rotavirus vaccines for **Bolivia, Guyana, Honduras, and Nicaragua** and pneumococcal vaccines for **Guyana, Honduras, and Nicaragua**. For its part, PAHO/WHO implemented a one-year moratorium during 2010 on the purchase of 10-valent pneumococcal vaccine (PCV10) to support GAVI's Advanced Market Commitment (AMC) for pneumococcal vaccines, which seeks to accelerate access to these vaccines by GAVI-eligible countries.

118. As a result of all these efforts, 13 countries and territories introduced new childhood vaccines into their immunization programs during 2010-2011. These included rotavirus vaccine in **Guatemala, Guyana, and Paraguay** and pneumococcal conjugate vaccine (PCV7) in **Aruba, Brazil, Chile, Colombia, Curaçao, Ecuador, El Salvador, Guyana, Honduras, Nicaragua, and Panama**. In addition, **Peru** introduced the human papilloma virus (HPV) vaccine in early 2011.

New Vaccination Plan in Haiti

Substantial support was provided to Haiti's Ministry of Public Health and Population in developing a new plan that seeks to ensure immunization against the country's most prevalent childhood diseases for at least 90% of children under age 1 by 2015. The plan was developed to re-establish and expand routine vaccination in **Haiti**, which was interrupted by the 2010 earthquake.

The plan aims to increase immunization coverage from 60% to 90% of children under 1; keep Haiti free of polio, measles, and rubella; eliminate maternal and neonatal tetanus by 2015; introduce new rotavirus and pneumococcal vaccines, and the pentavalent vaccine against diphtheria, pertussis (whooping cough), tetanus, hepatitis B and *Haemophilus influenzae* type b (Hib); and improve immunization surveillance for the early detection of vaccine-preventable outbreaks.

In May 2011, Haitian health authorities presented the new plan to a group of international partners convened by PAHO/WHO, who have expressed interest in providing support ranging

from financial backing to training for healthcare workers. The partners include UNICEF, the Canadian International Development Agency (CIDA), the GAVI Alliance, Project Hope, USAID, the U.S. Centers for Disease Control and Prevention (CDC), the Ministry of Health of Brazil, the American Academy of Pediatrics, Children's Hospital Denver, the Maimonides Medical Center in Brooklyn, the Minnesota Department of Health, and the University of Chicago Medical Center.

A series of meetings and teleconferences took place with leading international immunization experts to examine the feasibility of cholera vaccination in **Haiti**. The Organization conveyed the group's provisional recommendations to Haiti's Ministry of Public Health in early 2011 and continued to organize discussions among group members into late 2011.

119. The process of verifying the Region's elimination of measles, rubella, and congenital rubella syndrome (CRS)—important areas of progress toward MDG-4—continued during this period. The last endemic case of measles in the Americas was reported in 2002, and the last case of rubella in 2009. The Region's countries have set the goal of verifying the elimination of these diseases by the end of 2012.

120. During 2010, the Organization convened the first meeting of an international expert committee to oversee the verification process and then supported national-level verification commissions in gathering and analyzing data on these diseases in their own countries. In March 2011, the presidents of national-level commissions met with members of the international expert committee to discuss verification efforts so far and the work that remains to complete the process.

121. In June 2011, a meeting of a special working group was held to assess the situation of mumps in the Americas and to make suggestions for improving control and response strategies based on country experiences. The group's recommendations were endorsed during the 19th meeting of the Technical Advisory Group (TAG) on Vaccine Preventable Diseases, held in July 2011 in Buenos Aires.

122. The Organization also supported the implementation of effective and timely strategies to handle rumors and events supposedly attributable to vaccination and immunization (ESAVI), with the objective of maintaining public trust in vaccines and immunization programs.

123. Technical cooperation in this area also included support for countries' efforts to develop and improve national electronic nominal immunization registries. A workshop in Bogotá, **Colombia**, in February 2011 brought experts from more than 20 countries together with representatives of partner agencies including UNICEF, PATH, CDC, the Sustainable Sciences Institute, and the Latin American Open Source Health Informatics Group. An outcome was the creation of a community of practice, through which

workshop participants and other experts in this field can share problems, lessons learned, and best practices.

MDG-5: Improve Maternal Health

124. As discussed in Chapter 1, maternal mortality declined some 40% from 1990 to 2008 in the Americas as a whole, but not all countries shared in those gains, and current indicators vary dramatically across different countries. Continuous work with member countries was undertaken to improve maternal health within the framework of the 2002 Regional Strategy for Maternal Mortality and Morbidity Reduction (CSP26.R13), the 2008 Regional Strategy for Improving Adolescent and Youth Health (CD48.R5), and the 2008 Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care (CD48.R4).

125. An important complement to the regional framework was the launch in 2010 of the Safe Motherhood Initiative, a call for the countries of the Americas to redouble their efforts to achieve MDG-5. In addition, during 2010-2011 PAHO/WHO and its technical center in this field, the Latin American Center for Perinatology, Women and Reproductive Health (CLAP/WR), developed the new Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity, for presentation to the 51st PAHO Directing Council in September 2011.

126. The Safe Motherhood Initiative—which is also supported by the Regional Inter-Agency Task Force for Maternal Mortality Reduction⁶ (GTR), the OAS, and Spain's La Caixa Foundation—was the centerpiece of advocacy efforts for MDG-5 during 2010-2011. The initiative seeks to mobilize political will to spur action in countries to accelerate reductions in maternal mortality. It emphasizes universal access to comprehensive reproductive health services; improvements in the quality of prenatal, childbirth, and postpartum care; measures to reduce unsafe abortions and severe maternal illnesses; improvements in information systems; empowerment of women; and the participation of fathers and men as well as communities in protecting and promoting maternal health.

127. Following the regional launch during the 50th PAHO Directing Council in September 2010, the Safe Motherhood Initiative was launched at the national level in 15 countries: **Argentina, Bolivia, Brazil, Colombia, the Dominican Republic,**

⁶ GTR members include PAHO/WHO, UNICEF, UNFPA, UNIFEM, UNOPS, UNESCO, ECLAC, USAID, Family Care International, the Population Council, the Inter-American Development Bank (IDB), the International Federation of Gynecology and Obstetrics (FIGO) and its Latin American arm FLASOG, and the International Confederation of Midwives (ICM). Associate members include UNHCR, UNDP, ILO, UNEP, UNAIDS, OCHA, FAO, UNHCHR, and the World Bank. Funding is provided by members and the Spanish Agency for International Development Cooperation (AECID).

Ecuador, El Salvador, Guatemala, Guyana, Honduras, Nicaragua, Panama, Peru, Suriname, and Uruguay. Additional launches were planned in late 2011 for **Mexico and Paraguay.**

128. A special photo exhibit by Spanish photojournalist Bru Rovira, sponsored by La Caixa Foundation was displayed in Washington, D.C., and during country launches in **Argentina, the Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Nicaragua, and Suriname.** In addition, two contests were organized in 2011, one to illustrate the rights of mothers and newborns in the Americas to attain the highest possible standard of health and the other to recognize best practices in reducing maternal mortality.

129. At the country level, technical cooperation ranged from protocols and training on obstetric care to support for surveillance, reorientation of health services, and advocacy for the rights of users to comprehensive and high-quality sexual and reproductive health care.

130. A key focus of interest was expanding access to and improving health services within the continuum of care, from pre-pregnancy through childbirth and post-partum.

131. In **Colombia**, gynecologists, general practitioners, and nurses received training on comprehensive care of pregnant women with a focus on obstetric hemorrhage, hypertensive disorders, and sepsis, which account for 60%-70% of maternal deaths and illnesses. Between 2009 and mid-2011, workshops had provided training for some 400 participants from health facilities identified as needing quality-of-care improvements.

132. **Argentina's** Ministry of Health implemented a national strategic plan to reduce maternal and child mortality and developed a strategy to regionalize perinatal health services, which was subsequently implemented in the province of Buenos Aires. Similarly, in **Costa Rica**, the Ministry of Health strengthened planning at the regional and local levels in the country's South region, to improve survival among mothers and children under 5.

133. In **Ecuador**, the Organization continued to support implementation of the Plan for Accelerated Reduction of Maternal and Neonatal Deaths, launched in 2008 with UNFPA and nongovernmental partners. The plan stresses informed access to contraception, particularly to prevent adolescent pregnancies; the organization of intra- and inter-institutional networks for Essential Obstetric and Neonatal Care (CONE); epidemiological surveillance; improved quality of care; and mechanisms to increase demand for services using a rights- and equity-based approach.

Integrated Health Service Delivery Networks

An important cross-cutting effort to advance the MDGs and improve health equity in member countries is the Integrated Health Service Delivery Networks based on Primary Health Care (IHSDNs) Initiative. IHSDNs address the fragmentation of health services in many countries, which creates costly inefficiencies and negatively impacts patient outcomes. The initiative promotes instead equitable, comprehensive, integrated, and continuous health services delivered through networks of organizations that are willing to be held accountable for clinical and economic outcomes and the health status of the populations they serve.

New guidelines were developed to support the implementation of IHSDNs in six areas: general orientations for implementation, governance, information systems, human resources development, clinical coordination mechanisms, and strengthening of the first level of care.

At the country level, the Organization supported IHSDNs in **Brazil, Chile, Colombia, Panama, Suriname, Trinidad and Tobago, and Venezuela**. In **Colombia**, the Ministries of Health and Social Protection mobilized a consortium of 13 universities to carry out a National Initiative for Human Resources Development in Primary Health Care and Integrated Health Service Networks. Launched in June 2011, the initiative aims to provide education and training in the principles, values, and practices of primary health care and integrated health service networks for students of medicine and public health, as well as for practicing health professionals.

134. **El Salvador** launched the National Strategic Plan for the Reduction of Maternal and Neonatal Mortality, updated guides on family planning and care within the life cycle, and developed a Sexual and Reproductive Health Policy. As part of these efforts, PAHO/WHO partnered with the Ministry of Health, Enfants du Monde, and the Concertación Educativa de **El Salvador** to implement the Program to Empower Women, Families and Communities (MIFC), which develops capacities in individuals and communities that lead to greater demand for and better-quality health services.

135. **Venezuela** initiated the development and implementation of a new Plan for Accelerated Reduction of Maternal Mortality, including updated protocols on routine and emergency obstetric and neonatal care, equipment, and human resources training.

136. The Ministry of Health of **Chile** reviewed the child and maternal health programs undertaken the previous decade and developed strategic proposals in these areas for inclusion in the country's National Health Plan 2011-2020.

137. In **Cuba**, efforts focused on improving the quality of pregnancy, childbirth, and post-partum care through training for health providers and help with developing and adapting healthcare guidelines and methodologies. These efforts were instrumental in strengthening Cuba's network of "maternity homes" and converting them into "maternal-child homes." The Organization also supported pandemic H1N1 influenza vaccination of pregnant women and at-risk children through a mobilization plan, human resources

training, a social communication campaign, and an epidemiological study to evaluate the safety and efficacy of the vaccine in pregnant women.

138. In **Guyana**, the Organization helped carry out a Make Pregnancy Safer project financed by WHO, the European Community, and the African, Caribbean and Pacific Group of States (ACP). Activities in 2010-2011 included training in emergency obstetric and neonatal care and advanced labor and risk management (ALARM) for 60 health professionals in collaboration with the Society of Obstetricians and Gynaecologists of **Canada**. It also included training in neonatal resuscitation (“Helping Babies Breathe”) for midwives and other health professionals in collaboration with the Church of Jesus Christ of Latter-day Saints. **Guyana** was also supported in developing national strategic plans for maternal, neonatal, child, and adolescent and youth health for 2011-2015.

139. In the **Dominican Republic**, the Organization partnered with the Ministry of Health, the Office of the First Lady, the Dominican Medical Association, and CLAP/WR to hold the First International Symposium on the Humanization of Maternal-Child Care in Santo Domingo in January 2011. Some 600 participants attended the symposium, including health authorities, medical faculty and other academicians, representatives of national medical and scientific associations, and private health providers. The symposium led to wider recognition of sexual and reproductive rights and helped produce a consensus among different actors on the need to improve the quality of healthcare services.

140. Technical cooperation was also provided to the **Dominican Republic** for a national survey on women’s perceptions of obstetric and neonatal health services in the public sector, which included questions to assess women’s knowledge of their sexual and reproductive rights and the extent of violations of those rights in maternity health services. The results will be used to design a new strategy to raise awareness in the area of gender equality and respect for women’s rights.

Free Obstetric Care in Haiti

Haiti’s Free Obstetric Care (SOG) program is a ground-breaking effort to reduce maternal mortality by offering all pregnant women free access to quality health services. The program’s second phase began in July 2010 and included an increase in the number of participating health facilities from 42 to 63, and an expansion of the minimum package of health services to include emergency obstetric care, neonatal services, prevention of vertical transmission of HIV, and prevention and care of gender-based violence. Thanks to the program, more than 60,000 pregnant women and their newborns had access to skilled care during 2010-2011.

PAHO/WHO has helped mobilized US\$9 million for the implementation of SOG, including funds from CIDA, the World Bank, and the European Union. In September 2010, an additional US\$20 million were pledged to help integrate SOG with Haiti’s Free Child Care (SIG) project over the next two years.

141. Special efforts were made to improve sexual and reproductive health services using an approach that emphasizes the rights of women and youths to access to comprehensive, quality services that include family planning services.

142. In **Ecuador**, the Organization helped develop a new National Intersectoral Strategy for Family Planning (ENIPLA), which aims to guarantee access to sexual and reproductive health information, counseling, and services, based on constitutional norms. The strategy was developed with support from UNFPA and with the collaboration of the Ministry of Public Health, the Ministry of Education, the Ministry of Economic and Social Inclusion, scientific and non-governmental organizations, and civil society groups.

143. In **Argentina**, UNICEF, UNFPA and PAHO/WHO partnered to provide technical and financial support for a new Observatory in Sexual and Reproductive Health, which will produce information and knowledge on the promotion of sexual and reproductive health from a human rights perspective. Members of the observatory include the Center for Studies in the State and Society, the Rosarino Center for Perinatal Studies, and the National Academy of Medicine.

144. An inter-agency technical team on sexual and reproductive health was organized in **Honduras** to develop a common agenda and harmonize efforts among different international agencies working on these issues. It also helped the Ministry of Health update norms and procedures related to family planning, menopause, and infertility; maternal and neonatal care within the continuum of care; and post-abortion care. In partnership with Honduras's Gynecology and Obstetrics Society, protocols were developed for managing obstetric complications and discussions on post-abortion care were promoted.

145. At the request of **Argentina**, **Honduras**, and **Peru**, the Organization's human rights team presented technical opinions to national courts on the right to access emergency oral contraception as a strategy for reducing maternal mortality.

146. In **Venezuela**, policies and strategies on adolescent health were implemented, including norms on the provision of comprehensive sexual and reproductive health services, including access to contraception. Similarly, **Ecuador** developed new norms on comprehensive adolescent health care to make health services "friendlier" to adolescent girls. These efforts were part of the implementation of the National Plan to Prevent Adolescent Pregnancies and were financed by the Spanish Agency for International Development Cooperation (AECID).

147. A partnership with the Catholic University of **Chile** provided distance training in adolescent health—including adolescent pregnancy—for health professionals from **Chile** and other Latin American countries.

148. In **Suriname**, cooperation focused on the introduction of the Joint Action Plan for Women's and Children's Health at the Ministry of Health and its incorporation into the Family and Community Health program. PAHO also supported the introduction of the WHO Family Planning Decision Making Tool through training and pilot implementation, as well as the development of an MDG project proposal on maternal health for **Suriname** as a member of ACP.

149. The Organization backed efforts in several countries to reduce maternal mortality in indigenous communities. This included technical and financial support for community-based maternal-health projects in Machachi and Latacunga, **Ecuador**, and in Wiwili, Jinotega, **Nicaragua**. A series of workshops on sexual and reproductive health was organized in **Argentina** in conjunction with the Indigenous Communication Network, an indigenous women's organization, while a partnership with UNFPA helped refurbish the Maternity Waiting Home for Amerindian Women in **Guyana**.

150. Surveillance and information systems are another important focus of efforts to advance MDG-5. During 2010-2011, CLAP/WR provided technical cooperation to strengthen surveillance of maternal mortality in countries including **Colombia**, **Ecuador**, **El Salvador**, **Honduras**, and **Mexico**. In **Honduras** and **Mexico**, this included training and consultations with staff responsible for health information and surveillance to support active case-finding of deceased mothers and children under 5 and improved data analysis.

151. The Organization also provided support for the implementation of CLAP/WR's Perinatal Information System (SIP), a software system that collects information on pregnant women and babies in the health services, assesses the outcomes of the care they receive, and helps identify common problems and priority areas for improving care. During the period, SIP was implemented or strengthened in the **Dominican Republic**, **El Salvador**, **Guyana**, and **Honduras**. In the **Dominican Republic**, CLAP/WR and USAID helped to reactivate SIP in public maternity hospitals.

152. CLAP/WR also contributed to the creation of a new Central American Network of Perinatal Information Systems (which also includes the **Dominican Republic**) and supported the development of a related TCC project involving **El Salvador**, **Honduras**, **Nicaragua**, and **Panama**.

153. The Ministry of Social Protection of **Colombia**, in partnership with CLAP/WR and CDC, implemented a web-based surveillance system for maternal mortality, begun in 2008. By mid-2011, the system had been validated in 40 health facilities and in both departmental and municipal health departments. The system has provided complete and timely information on the causes and risk factors for maternal mortality and has helped health officials identify interventions needed to prevent maternal deaths.

154. **Venezuela** updated maternal mortality information systems, developed new methodologies for improving the quality of data, and promoted the use of tools of the Health Metrics Network (Red Métrica de Salud).

155. In addition, CLAP/WR partnered in 2010-2011 with ECLAC, as a member of the GTR, to develop a guide for health teams on how to interpret and utilize existing information on maternal mortality, including WHO estimates, data from articles in peer-reviewed journals, and official data reported by ministries of health in the Region. USAID is providing financial support for the project.

MDG-6: Combat HIV/AIDS, Malaria, and other Diseases

156. As indicated in Chapter 1, new HIV infections in Latin America and the Caribbean have begun to stabilize, although prevalence remains high in the Caribbean, at 1% of adults. It is unlikely the Americas as a whole will meet the MDG of halting and reversing the spread of HIV by 2015. However, most countries in the Region continue to make steady progress in promoting HIV prevention and improving and expanding treatment and care.

157. The key frameworks for technical cooperation in this area are Scaling-Up of Treatment within a Comprehensive Response to HIV/AIDS (CD45.11), the Regional Strategic Plan for HIV/AIDS/STI 2006-2015 (CD46.R15), and the 2010 Strategy and Plan of Action for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis (CD50/15). Within these frameworks, the Organization supported efforts to improve health services for people with HIV, increase testing and counseling, expand access to antiretroviral treatment (ART), monitor and prevent drug resistance to ART, strengthen surveillance, and promote prevention, particularly among high-risk and vulnerable groups. PAHO/WHO provided technical cooperation in these areas at the regional, country, and community levels, in close coordination with ministries of health and other partners.

158. Much of the work on HIV during the period was carried out in conjunction with other UN and international agencies. Examples include collaboration with UNFPA on prevention and care for female sex workers and with the United Nations Educational, Scientific and Cultural Organization (UNESCO) on comprehensive sex education and promotion of sexual health. UNAIDS provided coordinating support for all these efforts as well as for inter-agency cooperation to advance universal access to ART.

159. An important development in 2010 was the launch of the Strategy and Plan of Action for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis, approved by PAHO's 50th Directing Council. It seeks to eliminate mother-to-child transmission of HIV and syphilis as a public health problem in the Americas by

2015, through prevention and control interventions for prenatal, sexual, and reproductive health; improvement of health services; increased collaboration with other agencies and sectors and with the community; improved data collection and analysis; and research.

160. Following the launch of the strategy, technical support focused on the implementation of its provisions, in partnership with UNICEF and in coordination with other agencies including UNAIDS, CDC, the Pan Caribbean Partnership against HIV and AIDS (PANCAP), the International Planned Parenthood Federation (IPPF), the Inter-American Development Bank (IDB), and the World Bank.

161. As part of this work, national strategies were developed and implemented in countries including **Colombia, Guatemala, Guyana, Haiti, Honduras, Panama, and Venezuela**. In **Panama**, for example, PAHO/WHO partnered with UNICEF and the National Commission for Prevention of Mother-to-Child Transmission of HIV and Syphilis to design and implement a plan that focuses on increased HIV screening for pregnant women and better follow-up of detected cases, as well as improvements in epidemiological surveillance and information systems, and prevention efforts, including communication for behavior change.

162. In **Colombia**, the Organization partnered with the Ministry of Social Protection, the National Institute of Health, and the Colombian Association of Comprehensive Medical Companies (ACEMI) to develop a similar national plan. The partners then worked with private and public health institutions in Barranquilla, Bogotá, Cali, and Medellín to improve the quality of prenatal care, increase detection and improve reporting of HIV and gestational and congenital syphilis, and properly classify stages of syphilis to facilitate timely and appropriate treatment.

163. The implementation of similar national strategies in **Guatemala, Nicaragua, and Venezuela** was supported through training as well as the development and dissemination of guidelines and protocols on treatment and prevention of mother-to-child transmission of HIV and syphilis.

164. Among the most important HIV-related initiatives was a series of evaluations of health systems' capacities to provide comprehensive sexual and reproductive care, including prevention of HIV and sexually transmitted infections (STIs) in young people. The evaluations used a participatory approach, involving ministry of health staff from HIV programs, staff responsible for planning and management of health services, and representatives of partner agencies including UNAIDS and the **United States** President's Emergency Plan for AIDS Relief (PEPFAR).

165. Evaluations were carried out in **Jamaica, Paraguay, and Trinidad and Tobago**. The exercises were designed to identify gaps in ART coverage, assess the cost-effectiveness of interventions, and evaluate sustainability, resulting in recommendations

for use in strategic and operational planning. Overall, the results of the evaluations reinforced the premise that efforts to address priority health problems (“vertical” approaches) must go hand in hand with efforts to strengthen health systems.

166. A number of training initiatives helped improve services for people with HIV. These included training in voluntary counseling and testing, peer education, and social marketing of condoms in **Turks and Caicos** and, in **Guyana**, training for 141 health professionals in Integrated Management of Adolescent and Adult Illnesses (IMAI) and a regional workshop to train people with HIV to become “expert patient trainers.”

167. The Organization also developed or deployed a number of new training tools for HIV-related capacity-building. One such tool, designed to improve the skills and practices of health workers who care for men who have sex with men, was used in workshops in **Guatemala**, **Mexico**, and **Peru** and on the **U.S.-Mexico** border during 2010; similar workshops are planned for Central America, the Andean Region, the Southern Cone, and **Puerto Rico** during 2011. A new tool for peer training of female sex workers on HIV and STI prevention and violence was first used in a workshop held in May 2011 for participants from throughout Central America.

168. Other technical cooperation on HIV focused on vulnerable groups, particularly young people, and on high-risk groups who remain at the center of the Region’s HIV epidemic, including men who have sex with men and other sexually diverse people, and sex workers. In **Argentina**, UNAIDS, UNFPA, UNDP, and PAHO/WHO worked in five hospitals to improve access to testing, counseling, and comprehensive care for men who have sex with men and transgender people. Similar efforts in **Venezuela** focused on identifying vulnerabilities of these groups to HIV, promoting their human rights, and improving the quality of services they receive. In **Honduras**, the Organization supported a project that trained and deployed youth communicators to promote prevention among young people using vehicles known as “HIV Preve-mobiles”.

169. The Arica-Parinacota region of **Chile** has the highest HIV incidence and prevalence in the country. UN agencies partnered to carry out a situation analysis of HIV in the region and studies of seroprevalence in men who have sex with men and female sex workers, as well as to support second-generation HIV/AIDS surveillance and promote HIV-related cooperation between Arica and Tacna, across the border in **Peru**.

170. In the **Bahamas** and **Honduras**, the Organization supported leadership training and advocacy for men who have sex with men and transgender people, emphasizing a human rights approach. Support was also provided for capacity-building on human rights in relation to HIV, sexual and reproductive health, mental health, indigenous people, and youths in **Barbados**, **Bolivia**, **El Salvador**, **Guatemala**, **Mexico**, **Panama**, and **Trinidad and Tobago**.

171. In **Guatemala**, technical cooperation was provided to the national congress to reform laws related to HIV.

172. An important focus of technical cooperation related to HIV was improving and expanding access to ART for people who need it. This work included the development of treatment standards and guidelines in **El Salvador, Guyana, and Haiti** and technical support and training for the organization and operation of 32 ART-dispensing centers in **Nicaragua**. In **Honduras**, the Organization partnered with Aidstar One (USAID's global HIV/AIDS project) to organize a national consultation on improving coverage and testing for HIV.

173. Critical support for expanding ART coverage was provided by the Regional Revolving Fund for Strategic Public Health Supplies, known as the PAHO Strategic Fund (see also MDG-8 below). Between June 2010 and June 2011, nine countries acquired US\$16.1 million worth of antiretroviral medications through the fund, enough treatment for approximately 30,000 patients. Thanks to the fund's ability to pool demand and negotiate with manufacturers, participating countries paid the reduced price of US\$178 for first-line treatment combinations and US\$621 for second-line combinations (AZT+3TC+Lop/r). Two countries—**Ecuador** and **Paraguay**—purchased third-line ART through the fund during this period.

174. Also pivotal in this area was support for surveillance of ART drug resistance in countries including **Guyana, Honduras, Nicaragua, and Venezuela**. This support helped **Guyana** become the first country in Latin America and the Caribbean to establish HIV drug-resistance monitoring based on WHO guidelines.

175. Technical cooperation to improve epidemiological surveillance of HIV, STIs, and other infectious diseases was provided in **Argentina, the Bahamas, Guyana, Nicaragua, Suriname, Turks and Caicos, and Venezuela**. In **Nicaragua**, this work included improvements in reporting of HIV and congenital and gestational syphilis in health establishments to correct under-reporting cases. The country also improved HIV surveillance data through disaggregation by sex, age, and vulnerable population group (pregnant women, adolescents, and sexually diverse people).

176. In **Argentina**, the Organization partnered with UNICEF to support a study on prevalence of HIV and syphilis in pregnant women that provided a baseline for monitoring elimination efforts within the regional framework.

177. A number of research efforts related to HIV were carried out, including an analysis of the impact of homophobic harassment on risk taking and health among young men who have sex (or presumably have sex) with men and a study of women recently

infected with HIV, the findings of which will be used to develop new prevention strategies.

178. At the country level, the Organization supported a study in **Venezuela** on the status of access to ART among children with HIV and research in the **Bahamas** on HIV knowledge, attitudes, practices, and beliefs among 15- to 17-year-olds, the findings of which will inform policymaking and program development. In addition, the Organization hosted a meeting of public health experts to examine evidence on blood-borne and sexually transmitted infections among drug users in Latin America and the Caribbean.

179. Finally, CFNI in **Jamaica** promoted nutrition as an important aspect of HIV care and treatment through a special algorithm that reflects current knowledge of the effects of nutrition on the immune system and on patient adherence to medication. The algorithm was adapted for the Caribbean and incorporated into special toolkits for use by healthcare workers. This work supports the shift in the Region from vertical care for people with HIV to a more decentralized model common in the treatment of other chronic diseases.

Malaria

180. As noted in Chapter I, the incidence of malaria has declined over the past decade in 18 of 21 endemic countries in the Americas, and in nine countries, the decline was more than 75%, effectively attaining the MDG-6 target. Nevertheless, some 17 million people in the Region continue to live in high-risk zones.

181. The Organization continued supporting country efforts to prevent and control malaria within the framework of the Regional Strategic Plan for Malaria in the Americas 2006-2010, while also developing a new Strategy and Plan of Action for Malaria to present to the 51st Directing Council in September/October 2011.

182. Efforts in this area focused on integrated vector management, diagnosis and treatment, health systems strengthening and capacity-building in surveillance and early detection of outbreaks in both high-risk areas and areas where the risk has declined. The Organization partnered with USAID to support the work of the Amazon Network for the Surveillance of Antimalarial Drug Resistance and the Amazon Malaria Initiative (RAVREDA/AMI) in **Bolivia, Brazil, Colombia, Ecuador, Guyana, Peru, Suriname, and Venezuela.**

183. In **Brazil**, technical cooperation included support for improvements in surveillance of antimalarial resistance, access and use of antimalarial drugs, quality of drugs, quality of and access to diagnosis, entomology and integral vector control, epidemiological surveillance, and information systems. Specific activities included an evaluation of the introduction of pesticide-treated bed nets in the states of Amazonas and

Acre, support for procurement of anti-malarial drugs, and implementation of quality control mechanisms for these drugs, in partnership with the National Malaria Program and the Federal University of Minas Gerais. Much of this work was carried out in partnership with USAID, CDC, the Foundation for Tropical Medicine of Amazonas, and the Evandro Chagas Institute.

184. In **Ecuador**, the Organization supported activities related to RAVREDA that included monitoring of resistance to anti-malarial drugs and insecticides, norms for using mosquito nets, and updated treatment guidelines as well as maintenance of the malaria information system to ensure the availability of data needed to control the diseases at the low levels of prevalence already achieved.

185. In **Jamaica**, support was provided to prepare a national policy and action plan for integrated vector control of malaria and for pilot studies in Kingston and Portmore to show how solid waste and partially treated wastewater contribute to the creation of mosquito breeding sites. The studies were followed up with advocacy for integrated vector control at the local level. In addition, the Organization prepared a concept paper on minimizing the use of pesticides that affect the environment and health and alternative biological methods that use plants with repellent and pesticide properties. The paper was submitted to the Ministry of Health and presented to the Environmental Health Fund, which is considering funding a related pilot project.

186. **Guyana** improved its regional health authorities' capacities to control outbreaks through training for microscopists and the heads of malaria "mini-laboratories," monitoring of resistance to anti-malarial treatments, and the establishment of two sentinel sites for monitoring of drug quality. A new operational manual for the management of malaria medicines and supplies was also developed.

187. In **Haiti**, support was continued to the National Malaria Program and for the implementation of Haiti's 2008 National Plan for Malaria Control. The Organization purchased malaria drugs and supplies for the program, including 20,000 pesticide-impregnated mosquito nets for hospitals in malaria-affected areas. It also worked with the National Public Health Laboratory to improve epidemiological, entomological, and parasitological surveillance.

188. **Honduras** implemented a malaria information and surveillance system and carried out a study on the management and availability of antimalarial drugs in the public and private sectors. In the Mosquitia region, the Organization supported the implementation of a plan for comprehensive malaria control in the municipality of Wampusirpi, Gracias a Dios, through a health survey, mass diagnosis and treatment, distribution of insecticide-treated bed nets, education of families, and entomological analysis.

189. The Organization's Caribbean Epidemiology Center (CAREC) continued to monitor reports of malaria from its 23 member countries and territories. Just four countries reported indigenous cases during 2010-2011, 95% of them from **Guyana**. CAREC also monitored undifferentiated fever (UF), a proxy for infections including malaria, dengue, and leptospirosis, and issued alerts when the reported number of cases exceeded expected numbers. Additionally, CAREC provided training on outbreak investigation, hosted a workshop on data analysis for laboratory staff from eight countries and territories, and organized a meeting of national epidemiologists and laboratory directors to discuss data reporting and other surveillance and laboratory issues related to malaria.

190. In non-endemic countries of the Caribbean, including the **Bahamas** and **Turks and Caicos**, PAHO/WHO supported the maintenance of surveillance capacities, procurement of rapid diagnostic test kits and medicines, and capacity-building in vector control and response.

191. The fourth annual "Malaria Champions of the Americas" contest was held in 2010, with winning entries from **Suriname**, **Brazil**, and **Colombia**. The top winner was Suriname's National Malaria Board, which oversees efforts that have virtually eliminated malaria from most of the country's interior. The second honor went to Brazil's Foundation for Health Surveillance of the Amazon for its efforts in integrated prevention and control of malaria in the state of Amazonas. Third place went to the Administrative Department of Health and Social Security of Chocó (DASALUD-Chocó) in **Colombia**, whose efforts have helped reduce the incidence of malaria in Chocó by more than half. The winners were honored at a celebration of the 2010 Malaria Day in the Americas.

Tuberculosis

192. As highlighted in Chapter 1, the Americas as a whole have already begun to reverse the spread of TB, but progress among individual countries has been uneven. Technical cooperation in this area was provided within the framework of the Regional Strategy for the Control of Tuberculosis for 2005-2015 (CD46.R12), which seeks to advance MDG-6 by applying the WHO Stop-TB program. The strategy emphasizes expansion of directly observed treatment – short course (DOTS), measures to address TB drug resistance, and coordination of efforts to address co-infections with HIV and TB.

193. Technical cooperation in this area focused on ensuring universal access for patients with TB/HIV co-infections to ART and preventive treatment, strengthening laboratory capacity by introducing rapid diagnostic tests for resistant TB, and improvements in inter-programmatic and community-based collaboration to address the social determinants of TB, particularly in poor and marginalized populations. Other support included the promotion of communication and social mobilization strategies to

address stigma and discrimination of TB and to raise public and political awareness of the importance of combating TB.

194. In **Brazil**, PAHO/WHO partnered with USAID to provide support for the National TB Program, including strengthening operational capacity, implementing recommendations from a 2009 PAHO/WHO-supported evaluation, and expanding the Stop TB strategy in 12 municipalities in Rio de Janeiro and in Manaus, Amazonas. The Organization also supported the advocacy and social mobilization efforts of the Brazilian Alliance to Stop TB, helped implement a distance-learning program on TB for health personnel at the state and municipal levels, and carried out a study of TB prevalence among people with diabetes in São Paulo and Bahia states.

195. Ecuador's efforts in this area included the development of a new project to strengthen TB control, with a focus on areas of high prevalence, and a plan to provide monthly bonuses to patients with MDR-TB to reduce the number of patients who stop taking medication. **Ecuador** also revised and improved its TB information system and strengthened its regulation of sales of anti-TB medications. In addition, PAHO/WHO supported the work of a technical mission from the University of Massachusetts to evaluate Ecuador's network of diagnostic laboratories and to make recommendations for future technical cooperation in this area.

196. External evaluations of existing TB programs in **Costa Rica** and **Colombia** produced recommendations for strengthening human resources management and collaborative actions between HIV and TB programs, and for improving the management of childhood TB, DOTS implementation, and case follow-up.

197. Technical cooperation provided to the National TB Program of **El Salvador** helped the Ministry of Health submit a proposal that was approved during Round 9 of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

198. In **Haiti**, the Organization supported the reconstruction of a TB sanatorium that was damaged in the 2010 earthquake and helped train its staff in the new WHO guidelines for treatment of TB. Additional support was provided for the National TB Program through a partnership with CDC, USAID, Family Health International, Grace Children's Hospital, GHESKIO, and Partners in Health.

199. **Mexico** developed, produced, and distributed a new Guide for the Care of Persons with Drug-Resistant Tuberculosis in all 32 states to help standardize the management of resistant-TB patients throughout the country. The Ministry of Health of **Honduras** implemented a national system for information and monitoring of MDR-TB, with data on sex and age disaggregated by individual and locality.

200. In **Nicaragua**, the Organization provided TB-related technical cooperation and support to the Ministry of Health in partnership with the medical faculties of the National Autonomous University of Nicaragua, the Ministry of Education, the Ministry of Interior, the Nicaraguan Social Security Institute, and the National Army's Military Medical Corps. Specific activities included technical and financial support for the development and implementation of a new Protocol for Multidrug-Resistant TB and for funding proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

201. Technical cooperation to improve coordination of TB and HIV efforts was provided to a number of countries. **Guyana** rolled out a new IMAI program and strengthened implementation of DOTS to improve care for people with HIV/TB co-infections. **Venezuela** developed strategic plans to address TB/HIV co-infections through improved surveillance, increased coordination and joint action between TB and HIV programs at the national and regional levels, and implemented TB-HIV control interventions in penal institutions. In **Nicaragua**, PAHO/WHO monitored and supported TB-HIV collaborative activities aimed at preventing co-infections with TB/HIV.

202. In **Suriname**, the Organization provided support to the newly established National Laboratory with equipment and training and facilitated exchanges with other countries in the Region and CARICOM. CAREC continued to support TB surveillance efforts in Suriname and other member countries and facilitated standardized collection of data by the countries for submission to WHO's Stop TB initiative.

203. On the **U.S.-Mexico** border, the Organization developed a community guide to treatment and prevention of TB and HIV in the border area and produced a technical report on TB and social determinants of health in the border states of Tamaulipas, Texas, Coahuila, Chihuahua, New Mexico, Sonora, Arizona, California and Baja California. The study examined rates of TB and MDR-TB in the 44 U.S. counties and 80 Mexican municipalities and included a comparative analysis of TB in 16 "sister cities." The report was launched on World TB Day 2011.

Neglected Diseases

204. In addition to its support for efforts to fight HIV, TB, and malaria, the Organization helped advance MDG-6 through technical cooperation on neglected diseases, which continue to affect vulnerable communities throughout the Americas. The framework for this work includes the WHO Global Plan to Combat Neglected Tropical Diseases 2008-2015 and PAHO's Elimination of Neglected Diseases and Other Poverty-Related Infections (CD49/9). During 2010-2011, PAHO/WHO's activities in this area ranged from advocacy and consensus-building to support for surveillance and prevalence studies.

205. In 2010, the new regional Strategy and Plan of Action for Chagas Disease Prevention, Control, and Care was finalized and subsequently approved by PAHO's 50th Directing Council (CD50.R17). The strategy urges an integrated approach to the prevention and control of Chagas and improved medical care for those suffering from the disease. It also calls for redoubling efforts to eliminate vector-borne transmission of the Chagas parasite, *T. cruzi*, by 2015 through interprogrammatic collaboration and intersectoral action that addresses the social determinants of the diseases.

206. Jointly with the Sabin Vaccine Institute, the IDB, and the Global Network for Neglected Tropical Diseases, PAHO/WHO in 2011 published the advocacy report *A Call to Action: Addressing Soil-transmitted Helminths in Latin America and the Caribbean*, signed by the heads of all four organizations. It details the health and economic toll of parasitic intestinal worms (geohelminths) on at-risk populations, particularly children, and presents recommendations for action and policies to advance the elimination of these diseases as a public health problem by 2015. Its recommendations include creating a coalition against intestinal parasites in the Americas, involving first ladies as advocates of deworming, and supporting a new trust fund for neglected tropical diseases. With the same partners and with support from the Bill & Melinda Gates Foundation, PAHO/WHO continued work on the creation of the trust fund, which would mobilize resources for projects to control intestinal parasites and other neglected diseases.

207. At the country level, the Organization helped develop integrated plans for the control of neglected diseases in **Colombia**, the **Dominican Republic**, **El Salvador**, **Guyana**, **Haiti**, and **Honduras**. Other technical cooperation included support for **Colombia** to eliminate trachoma and onchocerciasis and to control geohelminths; for **Haiti** to eliminate lymphatic filariasis and control geohelminths during the post-earthquake reconstruction phase; and for **Guyana** to implement a mass-medication strategy to eliminate lymphatic filariasis. In the **Dominican Republic**, the Organization supported a study of transmission of lymphatic filariasis and evaluated current efforts to eliminate that disease.

208. Technical cooperation was provided in **Colombia, El Salvador, and Honduras** to develop protocols for surveys of prevalence and intensity of geohelminth infections and in **Suriname** for a prevalence study of both geohelminths and schistosomiasis in school-age children. **Bolivia** developed a deworming program for preschool and school-age children to be incorporated into existing immunization and IMCI programs.

209. In the **Dominican Republic**, the Organization worked with six other UN agencies on a three-year program to benefit banana plantation workers and their families. In collaboration with the Ministry of Health, the Organization was responsible for health interventions aimed at preventing HIV/AIDS, malaria, cholera, leptospirosis, and other infectious diseases. The interventions included improvements in environmental conditions at hospitals in three provinces as well as community capacity-building for disease prevention. The program is being financed by Spain's MDG Achievement Fund.

210. Jointly with the IDB, the Sabin Vaccine Institute, and the Global Network for Neglected Tropical Diseases. PAHO/WHO supported the development and implementation of two pilot projects for control of neglected diseases in Chiapas, **Mexico**, and Recife, **Brazil**.

211. A number of publications on neglected diseases were produced in 2010-2011, including an article in the Public Library of Science (PLOS) journal *Neglected Tropical Diseases* arguing that several neglected diseases could be eliminated or reduced as public health problems through stepped-up implementation of existing plans and guidelines. The paper focuses on schistosomiasis, lymphatic filariasis, onchocerciasis, geohelminths, and rabies, and uses the results of a mapping and modeling exercise to highlight "major hotspots" where two or more of these diseases overlap.

212. A number of workshops and meetings were organized to advance efforts to eliminate neglected diseases. They included a workshop organized jointly with McGill University on integrating deworming into existing health programs for school-age children; the First Regional Meeting on the Elimination of Trachoma, in Bogota, **Colombia**; the 10th regional meeting of heads of programs to eliminate lymphatic filariasis, held in Georgetown, **Guyana**; and, in **El Salvador**, a regional training workshop on developing integrated plans for the prevention, control, and elimination of neglected diseases. Another workshop in **El Salvador** focused on using the Kato-Katz technique to determine prevalence of helminth infections.

Global Fund to Fight AIDS, Tuberculosis and Malaria

PAHO/WHO helped develop proposals for submission to the Global Fund to Fight AIDS, Tuberculosis and Malaria and supported the implementation of projects approved by the fund.

In **Argentina**, for example, the Organization joined with UNAIDS in supporting a US\$ 12 million proposal on behalf of NGOs that work with men who have sex with men, trans-gender people, sex workers, and drug users. The proposal was approved in the Global Fund's Round 10.

In **Colombia**, PAHO/WHO helped develop a proposal for a TB project, recommended adjustments in an HIV-related proposal, and supported the implementation of a malaria project already approved by the fund. The Organization also supported malaria and TB proposals in **Nicaragua** and a US\$27 million proposal to scale up efforts to fight TB in **Haiti**.

The Ministry of Public Health of **Uruguay** received support to implement the country's first Global Fund-financed project, which promotes social inclusion and universal access to prevention and comprehensive HIV care for vulnerable populations. PAHO/WHO's technical cooperation supported the installation of a Project Management Unit within the Ministry of Public Health.

The Organization also helped implement Global Fund projects for malaria control in **Ecuador** and care of orphaned children and others vulnerable to HIV in **Honduras**, and in **Guatemala** helped health authorities advocate with the legislative and executive branches to ensure the necessary legal steps for acceptance of Global Fund financing.

MDG-7: Ensure Environmental Sustainability

213. As discussed in Chapter 1, the countries of the Americas have significantly expanded access to drinking water and sanitation and have reduced gaps in access between urban and rural residents. Nonetheless, some 40 million people in the Region still lack access to improved sources of drinking water. Technical cooperation was provided to ensure progress not only toward the MDG-7 targets but also toward universal access to water and sanitation for the Region's inhabitants.

214. Much of the work in this area focused on water safety plans, which promote comprehensive risk assessment and risk management in all steps of water supply, from catchment to consumers. The Organization supported the development of evidence-based standards for regulatory purposes, the design of plans and programs for surveillance and monitoring of water quality, and capacity-building in ministries of health in these areas as well as in epidemiological surveillance of water-borne diseases.

215. In **Jamaica**, technical cooperation was provided to improve drinking water and waste disposal as part of larger efforts to promote healthy housing and communities. This work included stakeholder consultations to promote compliance with water quality

guidelines and water safety plans. The Organization also advocated with the Ministry of Local Government and the Ministry of Water and Housing for the extension of water and sanitation coverage to areas previously supplied with rain water catchments, showing the importance that water has on economic development and health. **Jamaica** implemented a database on water quality findings, updated its Cholera Outbreak Prevention and Control Operational Plan, and carried out a promotional campaign for the prevention of cholera.

216. In **Bolivia** the Organization supported efforts by Environmental Sanitation Units to monitor water sources for 13,000 homes in the departments of Cochabamba and Chuquisaca, as part of a larger program on food and nutritional security (see under MDG- 1). As part of this project, portable water-quality testing instruments were provided to three health networks and “Aguamiga” water-quality kits to eight schools.

217. **Brazil’s** Ministry of Health updated national quality standards on water for human consumption and consolidated a system for water surveillance. This was done through a participatory process that allowed both water providers and consumers to make proposals and engage in debate over the new standards.

218. **Ecuador** prepared a national plan for surveillance of water quality and increased knowledge and capacity in water quality surveillance in 20 cantons in four provinces, which are home to some 2 million people. These efforts were part of a larger program on water and sanitation governance financed by Spain’s MDG Achievement Fund and carried out with support from PAHO/WHO, UNDP, the United Nations Human Settlements Program (UN-Habitat), and ILO.

219. **Nicaragua** prepared and presented legislative proposals including a National Water Law and a Law on Potable Water Committees, as well as a National Wastes Law, which is currently in process. The country also mobilized municipalities and environmental youth groups to implement policies and initiatives in the area of environmental health.

220. Continuous support was provided to safe water and sanitation efforts in post-earthquake **Chile** and **Haiti** and in Central America and the **Dominican Republic** for the development of a strategy for risk management in water and sanitation in case of disasters.

221. The Organization also worked with other UN agencies within the “Sanitation and Water for All” Global Framework for Action and supported the Global Annual Assessment of Sanitation and Drinking-Water (GLAAS), a WHO-led initiative to provide policymakers with evidence and analyses to make informed decisions in sanitation and drinking-water.

222. In addition, MDG-7 was advanced by promoting primary environmental care and healthy settings, including healthy housing, schools, and workplaces.

Healthy Housing in Chiapas, Mexico

An initiative in southern **Mexico** is contributing to progress toward MDG-7 by improving living conditions for people in marginal communities.

After conducting studies of sociocultural and sanitary conditions in the state of Chiapas, PAHO/WHO in late 2010 developed a prototype for a “healthy housing” project in the town of San Cristobal de las Casas. The project uses low-cost materials, appropriate technologies, and flexible components that can be adapted to the needs of different communities throughout the area. It also promotes community participation and a primary health care approach. The project’s first stage is expected to benefit more than 2,000 families in three towns.

In response to the initiative, the state government of Chiapas has asked the Organization to help other communities throughout the state replicate the “healthy housing” prototype as a way of overcoming poverty, integrating dispersed communities, protecting people living in high-risk zones, and promoting human development.

The project will be carried out through a partnership with the state government and health department of Chiapas and Mexico’s Institute of Rural Populations and Cities. Funding is being provided by the Spanish Fund for MDG Achievement.

Environmental Health in Argentina

Following a 2008 decision in which Argentina’s Supreme Court asked the State to improve the environmental health of the Matanza-Riachuelo River, Argentina’s government launched a comprehensive environmental clean-up program to improve the quality of life of residents of the river basin. PAHO/WHO provided technical cooperation to the Ministry of Health and the Ministry of Environment and Sustainable Development to help implement the program.

The Organization’s contributions included a study of 1,358 children under 6 that established a baseline diagnostic profile of nutritional status, psycho-motor development, and levels of contaminants in biological fluids. PAHO/WHO also helped strengthen the existing information and surveillance system, implement 20 new surveillance nodes, and orient health teams on health problems associated with living and environmental conditions. Other support included training in prevention, diagnosis, and treatment of environmental intoxication; training in laboratory and data entry methods; production of surveillance protocols; and implementation of the National Registry of Congenital Malformations in six maternity hospitals, coupled with training for health staff in epidemiology, prevention, treatment, and social work. PAHO/WHO also supported the creation of new Rapid Response Health Teams to respond to environmental emergencies.

223. The Organization's support for efforts to advance MDG-7 also included technical cooperation in the area of climate change. In **Jamaica**, this included the preparation of a national document on climate change and health, the establishment of a technical group on the subject, and joint sponsorship of several events with the Jamaican Meteorological Office and related professional organizations.

224. In addition, inter-agency efforts were advanced to prepare for the 20th United Nations Conference on Sustainable Development (Rio+20), to be held in **Brazil** in June 2012. A key topic at the conference will be the green economy in the context of eradicating poverty and promoting sustainable development.

MDG-8: Develop a Global Partnership for Development

225. PAHO/WHO has historically been a catalyst for international partnerships to advance health and development in the Americas and has continued this leadership with respect to the MDGs. As noted in Chapter 1, the Organization is a participant in or a founding member of a number of important regional partnerships dedicated to accelerating progress on the MDGs. These include the Newborn Health Alliance for Latin America and the Caribbean, GTR, the Safe Motherhood Initiative, and PAND (these initiatives are described in more detail under MDG-4 and MDG-5 above).

226. Another key regional alliance for advancing the MDGs is the UN Regional Directors Team (UNDG-LAC). Founded in 2003, UNDG-LAC brings together the regional heads of 20 UN agencies active in Latin America and the Caribbean. The group works to enhance the effectiveness of UN technical cooperation and aid at the country level by improving inter-agency collaboration, promoting country priorities, and creating synergies. PAHO's Director worked closely with other regional directors in the group on issues including nutrition, maternal mortality, indigenous rights, and youth involvement in advancing the MDGs.

227. At the country level, the Organization also worked with other UN agencies under the Common Country Assessment/United Nations Development Assistance Framework (CCA/UNDAF), as a participant in the UN Country Teams and as an implementing agency for projects financed by multilateral trust funds including the MDG Achievement Fund (Spain), the UN Trust Fund for Human Security (Japan), the UN Trust Fund to Eliminate Violence against Women (multidonor), and the Rural Development Joint Program in **Guatemala** (Sweden).

Spain's MDG Achievement Fund

The MDG Achievement Fund was established by the Government of **Spain** in 2006 in coordination with UNDP to accelerate efforts to achieve the MDGs and to support UN reform efforts at the country level. Spain's €528 million commitment to the fund has financed projects in 50 countries of Africa, Asia, the Middle East, and Eastern Europe as well as in Latin America and the Caribbean, where the fund has its largest portfolio.

PAHO/WHO participated in MDG Fund-financed programs in 16 countries of the Americas—**Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, and Peru**—in areas including children, food security and nutrition; gender equality and empowerment of women; environment and climate change; democratic and economic governance; conflict prevention and peace-building; development and the private sector; and culture and development.

The Organization also has collaborated with the UNDP-Spain MDG Achievement Fund Secretariat in New York to promote health priorities in the fund's programs and to facilitate administrative processes for expeditious transfers to UN Country Teams.

228. PAHO/WHO also partnered with bilateral development agencies including AECID, CIDA, the Japan International Cooperation Agency (JICA), the Norwegian Agency for Development Cooperation (NORAD), PEPFAR, the Swedish International Development Cooperation Agency (SIDA), USAID, and CDC, which provided both funding and technical cooperation for projects and programs. In addition, joint projects, programs, and activities were carried out with a number of international NGOs, including the GAVI Alliance, Save the Children, Enfants du Monde, the Church of Jesus Christ of Latter-day Saints, the General Conference of Seventh-day Adventists, Partners in Health, and the Canadian Red Cross.

229. The Organization also worked with a wide range of domestic partners in its member countries, including professional, academic, community-based, charitable, faith-based, and other civil society organizations. All these partnerships were in addition to collaborations with national, departmental, and local government authorities from sectors including health, education, agriculture, development, environment, and women's and indigenous affairs, in activities and projects that are described in more detail above.

Access to Medicines

230. Technical cooperation in the area of essential medicines has helped Member States expand access to quality drugs and biological products while reducing out-of-pocket expenditures by individuals and families, especially the poor. This work ranged from support for the development, implementation, and monitoring of pharmaceutical policies to negotiation of lower drug prices and procurement of drugs and supplies on behalf of countries through the PAHO Strategic Fund.

231. The framework for actions in this area includes the third WHO Medicines Strategy (2008-2013), Essential Public Health Functions (CD42.R14, 2000), Access to Medicines (CD45.R7, 2004), the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (WHA61.21, 2008), and its regional counterpart, Public Health, Innovation, and Intellectual Property: A Regional Perspective (CD48.R15, 2008).

232. An important addition to this framework was the new strategy Strengthening National Regulatory Authorities for Medicines and Biologicals (CD50.R9), which was finalized during 2010 and approved by PAHO's 50th Directing Council. It seeks to improve the abilities of national regulatory authorities to guarantee the quality, safety, and efficacy of pharmaceutical products through such functions as authorizing clinical trials and approving products for market, inspection and licensing of manufacturers and distributors, and oversight of advertising and the rational use of medicines. To support these efforts, the national regulatory authorities of **Argentina, Brazil, Colombia, and Cuba** were identified as regional references.

233. The Organization also developed a new strategy on the use of generic medicines to improve access to and the rational use of medicines. A draft was web-published for review by stakeholders in late 2010, and the resulting feedback was incorporated into the final version, which was launched at the 6th Pan American Conference on Drug Regulatory Harmonization (CPANDRH) in Brasilia (see also below).

234. Another important area of work was the promotion of health research and development that better address public health needs in the countries, including R&D on neglected diseases and diseases of poverty. In 2010, *Innovation for Public Health in the Americas: Promotion of Research and Development of Health Products* was published based on the conclusions of a 2009 conference organized jointly by PAHO/WHO and the Special Program for Research and Training in Tropical Diseases (TDR). The report includes recommendations on how to create systems for innovation at the national, subregional, and regional levels to promote affordable and appropriate health products that address the health priorities of PAHO/WHO member countries.

235. The Organization also continued developing a new Regional Platform for Access and Innovation for Health Technologies, a series of internet-based tools that allow stakeholders from different sectors to interact in ways that promote access, rational use, and good governance in the area of essential medicines and other health technologies. PAHO/WHO presented a proposal and received feedback on the platform from health and regulatory authorities, academicians and researchers, science and technology authorities, and representatives of the manufacturing sector. Partners in the project include INFOMED **Cuba** and BIREME; support is being provided by the **United States** Food and Drug Administration (FDA), the European Union (through TDR), **Brazil**, and **Spain**.

236. The Pan American Network for Drug Regulatory Harmonization (PANDRH) organized the 6th Pan American Conference on Drug Regulatory Harmonization (CPANDRH) in Brasilia in July 2011. The conference drew more than 300 participants from 26 countries, including health authorities, experts on regulatory and related issues, and representatives of the pharmaceutical industry. PANDRH working groups on good laboratory practices, biotechnology products, drug registration, and counterfeit drugs presented the results of their recent collaborative work.

PAHO Strategic Fund

One of the Organization's most important contributions to expanding access to quality essential medicines is the PAHO Regional Revolving Fund for Strategic Public Health Supplies, also known as the PAHO Strategic Fund. Founded in 2000 at the request of member countries, the fund procures medicines and supplies at reduced prices by pooling demand and achieving economies of scale, while providing technical cooperation to countries on planning, programming, and forecasting of medicines and supplies. The fund also provides lists of reference prices and prequalified suppliers, whose products and manufacturing practices adhere to PAHO/WHO standards.

In 2010 and the first half of 2011, the PAHO Strategic Fund purchased medicines and supplies worth a total of more than US\$50.5 million on behalf of 16 countries: **Argentina, Belize, Bolivia, Brazil, Colombia, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Panama, Paraguay, Peru, Suriname, and Venezuela.**

As described under MDG-4 above, the PAHO Revolving Fund for Vaccine Procurement provided similar support for the purchase of vaccines, syringes, and cold chain supplies, procuring nearly US\$723 million in purchases on behalf of 40 countries and territories during 2010-2011.

237. On World Health Day 2011, which was devoted to the issue of antimicrobial resistance, PAHO/WHO hosted a special panel discussion moderated by CNN in Spanish's weekend news anchor, Claudia Palacios, and featuring experts including

Dr. Anthony Fauci, Director of the U.S. National Institute of Allergy and Infectious Diseases; Dr. Marcelo Galas, of the Ministry of Health of Argentina; Dr. Susan Foster, of the Alliance for the Prudent Use of Antibiotics; and PAHO Deputy Director Jon Andrus. The event called attention to problems such as multidrug-resistant hospital- and community-acquired infections; growing resistance to drugs for TB, malaria, and HIV; the use of antibiotics in livestock production; and patient and health-provider practices that contribute to antimicrobial resistance.

Faces, Voices, and Places of the MDGs

238. While nearly all PAHO/WHO technical cooperation contributes to progress toward the MDGs, the Faces, Voices, and Places (FVP) initiative has become the Organization's flagship effort to advance the MDG agenda in communities that need it most. Launched in 2006, the multisector initiative works in vulnerable communities through partnerships with local leaders, as well as nongovernmental and grassroots organizations, with the aim of raising awareness about the MDGs and promoting community participation and empowerment.

239. FVP departs from the premise that national-level indicators can hide extreme poverty and social exclusion that continue to affect many communities, particularly in middle-income countries, where 90% of the poor live. FVP addresses this problem by working in vulnerable communities throughout Latin America and the Caribbean, using the social determinants of health as a point of departure. As of 2010-2011, more than 40 communities in 23 countries were participating in FVP.

Faces, Voices, and Places of the MDGs in the Americas

Anguilla Vulnerable population groups	Guatemala Los Encuentros, San Juan Ermita, Chiquimula
Argentina Laguna Blanca, Formosa	Guyana Essequibo Coast and Georgetown
Belize Vulnerable population groups	Grenada Young men in the Tivoli Medical Center
Brazil Guarulhos, Sao Paulo Olina, Pernambuco Duque de Caxias, Rio de Janeiro Fortaleza, Ceará Campinas, São Paulo	Honduras La Mosquitia region
Bolivia Cuarirenda, Charagua, Chaco region Huacullani, Tiwanaku, near Lake Titicaca	Mexico Through the Municipalities for Health Network
Colombia One-hundred municipalities through the	Montserrat Areas affected by Hurricane Hugo and

National poverty reduction program; six municipalities through the national healthy environments strategy	Soufriere Hills volcanic eruption
Costa Rica Corredores, Puntarenas Brunca region	Nicaragua San Carlos, Rio San Juan Miskito region
Cuba El Cotorro, La Habana Santa Isabel de las Lajas, Cienfuego	Panama Santa Fe de Veraguas Five municipalities in Santa Fé
Dominican Republic Comendador and Pinzón, Elías Piña Batey Madre, Batey Walterio, and Batey Santa Cruz, Montecristo	Paraguay Machareti, Mariscal Estigarribia, Chaco Reducto and Laurety, San Lorenzo
Dominica Carib territories	Peru Belén, Loreto, Iquitos Coporaque, Cuzco
Ecuador Colta, Alausí, Guamote and Nabón, Azuay	Uruguay Canelones
El Salvador Rosario de Mora, Santiago Texacuangos, San Salvador, and Villa Centenario, Sonsonate	

240. The initiative uses participatory strategies and integrated interventions to empower communities to overcome the social determinants that have kept them in poverty and that prevent them from achieving the MDGs. It promotes horizontal communication and information exchange between technical cooperation providers and beneficiaries to ensure that interventions address problems and priorities identified by the communities themselves and also that those solutions are sustainable over time.

241. In **Bolivia**, FVP is being implemented in Cuarirenda, Santa Cruz, which is a Guarani community of fewer than 500 residents. Through a participatory diagnostic exercise, community members identified their priorities as producing sufficient food to meet each family's nutritional needs; empowering women; expanding the local health post to have a delivery room and offer HPV screening; training community members on how to prevent common illnesses such as Chagas disease; and improving water and sanitation services by constructing a new well, improving latrines, and recycling trash.

242. In the Cuban communities of Cotorro, La Habana, and Santa Isabel de las Lajas, Cienfuegos, FVP is benefiting primarily children at risk of neuro-developmental disorders, pregnant teens, and older adults, using an approach that mobilizes and empowers the community to address these groups' special needs.

243. In the **Dominican Republic**, the initiative is working in communities with high levels of malnutrition, poor environmental sanitation, and a significant presence of Haitian refugees. In coordination with the Ministry of Health, FVP has provided training for community members in nutrition, malaria, dengue, cholera, and leptospirosis, as well as latrine construction.

244. Starting in 2010, FVP began expanding autonomously into communities and municipalities near those already participating in the initiative. Participating mayors in **Panama** invited leaders from 11 new municipalities to join the initiative during 2010, and in 2011 extended a similar invitation to leaders of indigenous communities. In **Costa Rica**, FVP has spread throughout Brunca, the country's poorest region. In South America's Chaco region, mayors from communities in **Argentina, Bolivia and Paraguay** pledged to promote the initiative in other communities through a TCC project.

245. In rural Olinda and Guarulhos, **Brazil**, participating mayors have created their own mayors' network and invited other mayors from surrounding communities to their annual meetings. In 2011, Brazil's Ministry of Health formally recognized FVP as a health program and provided it with official health sector financing. Brazil's National Council of Municipal Health Departments (CONASEMS) also pledged its support.

246. FVP was launched for the first time in the English-speaking Caribbean during 2010-2011, thanks to the work of members of the Young Professionals for the MDGs program (a joint initiative of PAHO/WHO and several U.S. and Canadian universities). Participants include members of the Carib tribe in **Dominica** and vulnerable communities in **Anguilla, Grenada, and Montserrat**.

247. Based on its experiences in 23 countries, FVP has developed a Virtual Basket of Best Practices at the community level for advancing each of the MDGs.

248. Four key elements have proven essential for successful and sustainable implementation of the initiative: the committed participation of mayors and other local authorities, the creation of a core group of community leaders who can provide direction and momentum, the involvement of an academic institution as an implementing partner, and community empowerment through capacity-building. PAHO/WHO is promoting the latter through an educational program in "Health and Local Development", which has graduated 162 community actors from 23 countries since 2009.

Chapter III. Lessons and Challenges

249. The Millennium Declaration and the Millennium Development Goals demonstrated the power of global political will at the highest level with a common purpose: eradicating poverty. The MDGs made it possible to go beyond declarative language and make specific commitments at the national, regional, and global levels for the short, medium, and long terms, with monitoring of progress and follow-up by governments, civil society, the United Nations system, and development partners. This focus on accountability has been an integral part of the MDG agenda and has undoubtedly contributed to the progress made.

250. The MDGs also made it possible to set guidelines for integrated and synergistic work among sectors and agencies, recognizing that the living conditions of the most vulnerable can only be improved through coordinated efforts based on development strategies that address the issues of nutrition, work and employment, education, and health and sanitation and that involve commitments shared by developed and developing nations. In this sense, the MDGs reinforce PAHO/WHO's focus on the social determinants of health and the necessity of addressing them with multisectoral interventions. At the same time, by putting health at the center of the development agenda, the MDG framework has raised the visibility and the recognition of health in public policies.

251. Over the past decade, the Organization has integrated the MDGs into its technical cooperation programs, which already addressed issues such as hunger and malnutrition, gender-based inequality, maternal and child health, infectious and neglected diseases, environmental health, and partnerships for development. The MDGs have advanced and strengthened the efforts of PAHO/WHO and its Member States in these key areas.

252. At the same time, recognizing the serious income inequality in the Region, PAHO/WHO has emphasized the need to go beyond the MDGs and their official targets to address major disparities that are concealed by national averages. In launching its Faces, Voices, and Places initiative, PAHO/WHO stressed the importance of reaching the most vulnerable and neglected municipalities and territories, reviving the principles of primary health care, and empowering people in their communities. It is not enough for heads of state and government to know and make a commitment to the MDGs. Mayors, local authorities, and residents of the communities themselves must understand that the MDGs are the basic elements of a development agenda based on human rights. By emphasizing this, PAHO/WHO has made a unique contribution through an ethical framework for advancing the MDGs.

253. The experiences of the Organization in providing technical cooperation to advance the MDGs in Member States have produced lessons that can help accelerate

progress toward those goals during the four years that remain before 2015 and shed light on the way forward after 2015.

254. One clear lesson is the need to give greater attention to the problems of maternal and neonatal mortality, which are two of the MDGs on which the Region has advanced the least, especially in rural areas and areas of vulnerability and poverty. The recent concentration of populations in peri-urban areas poses special challenges in terms of access to health services to reduce maternal and child mortality. The target is also distant regarding chronic malnutrition. As for access to safe water and basic sanitation, in numerical terms this has become an urban challenge due to demographic trends, but there are still broad segments of the population in poorer rural areas that also lack these development benefits. All these pending issues need to be addressed in a more targeted manner while the comprehensiveness and intersectoral nature of policies, programs, and projects must be reinforced.

255. At the same time, while there is evidence that poverty has declined, progress has been uneven, and there are still segments of the population that remain vulnerable, particularly as a result of geographic location, cultural identity, and gender. It is therefore essential to continue working to advance the MDGs at the local and municipal levels and among marginalized and disadvantaged groups, even though these disadvantages may be difficult to see with the available evidence. Similarly, although progress has been made in reducing inequality in the Region, promoting equality of opportunities and results remains critical to reduce gaps within countries.

256. Another important lesson that has been confirmed in recent decades is that there is a virtuous circle in which economic growth and health, together with social development, are mutually reinforcing. It is therefore essential to closely monitor business cycles, because the vulnerability of the poor increases during recessive phases of these cycles, largely because social spending and investment tend to be reduced as part of corrections that are required to overcome crises. The lessons learned from middle-income countries need to be systematized not only to curb economic crises but also to reduce the equity gap and promote sustainable development.

257. For example, the impact of the 2008-2009 recession has been less profound than in earlier recessions, such as during the 1980s, because the Region's economies were better prepared and because of social programs that were specifically designed to protect the most vulnerable. This shows the importance of protecting and increasing social spending, especially for social protection programs.

258. These and other lessons learned from the experiences of PAHO/WHO and its Member States in pursuing the MDGs point to a number of conclusions and recommendations for future efforts, as noted below.

- (a) It is essential to constantly generate the evidence necessary for developing policies, plans, programs, and projects. This requires strengthening national health information systems. Evidence is the fundamental basis for decision-making and implementation of effective policies. Only with good-quality data and information can goals be transformed into results. The observatory for the health-related MDGs should be promoted to monitor progress and setbacks at the national and subnational levels and to facilitate appropriate and timely action.
- (b) Constant monitoring of public health spending is also necessary, including spending to improve health system performance and to make social protection programs universally available, with emphasis on the most vulnerable sectors and municipalities. This could be achieved through the creation, with the ministries of health, of a program to monitor social spending, with annual reports.
- (c) As long as high levels of poverty and inequality persist in the Region, public spending will need to be increased for the health sector and for social protection programs that imply structural changes. These programs should not only use resources from different sectors but also lead to synergies in processes and results; facilitate empowerment processes and not be limited to assistance to individuals; focus not only on access but on quality; and be monitored for results not only in terms of alleviating extreme poverty but also overcoming it, so that gains are harder to reverse. This requires the countries of the Region to make progress in fiscal reforms that can support increases in and sustainability of social spending.
- (d) Technical cooperation focused on geographical areas—including poverty zones in urban municipalities, hard-to-reach communities, and transnational territories—will continue to be critical to accelerating progress toward the MDGs. The Faces, Voices, and Places initiative has helped call attention to the unfinished agenda and inequity within countries. This agenda must maintain a high profile, and its political, technical, and financing dimensions must be addressed so that policies and resource allocation do not end up once again neglecting these areas.
- (e) To ensure a multisectoral and multidimensional approach, inventories of national policies are needed to facilitate evaluation and to concretely promote “health in all policies.” This is the only way to make achievements sustainable and to guarantee effective action on the social and environmental determinants of health.
- (f) It is also important to complement harmonization of international cooperation with efforts to enhance governance and the coordinating capacity of national authorities. This means mobilizing, harmonizing, and aligning international cooperation for achieving the MDGs and addressing national health and development priorities.
- (g) Large-scale projects that require significant resources, such as infrastructure for drinking water supply and basic sanitation, require support from multilateral financial institutions. To guarantee quality services and to ensure their

- sustainability, the efforts of international financial entities and other agencies devoted to achieving these goals must be coordinated, and relationships with development banks and United Nations agencies must be strengthened to address national priorities. As noted above, a series of partnerships have been launched during the past 11 years that exemplify integrated work toward a common goal.
- (h) Finally, the fact that the Latin American and Caribbean countries have been able to meet many of the MDG targets implies a responsibility to share their cumulative experience with other developing regions. With this in mind, PAHO will continue to share its experience, promote South-South cooperation, and organize efforts for cooperation and knowledge transfer between countries with support from donors and member governments, as well as WHO and other specialized United Nations entities.

The Millennium Development Goals after 2015

259. The goal of reducing poverty and improving quality of life will not be fully achieved in 2015—either in the Region of the Americas or in the rest of the world—despite the substantial progress made. It will be necessary to continue pursuing the ethical imperative established in the MDGs using an approach informed by an analysis of experiences to date. Among the considerations that should be incorporated into this approach are the following:

- (a) The commitment should be global, but goals, targets, and indicators should be adapted to the regional level to take into account relevant differences. For our Region, this implies higher targets that are focused on excluded populations, indigenous peoples, and African descendants, as well as women, children, and the elderly. Only with differentiated targets can the core of inequality be breached.
- (b) The MDG agenda must go beyond the national level and exert a decentralizing influence to encourage subnational analyses and actions within communities. Given the unequal distribution of capacities, efforts to create human capital at the local level must be emphasized.
- (c) Lessons learned during the past 15 years can be used to develop regional, national, and subnational baselines and to systematize evidence, making it possible to adjust action and clear the way for progress. This will give rise to processes to accelerate progress toward achieving the MDGs, supported by national policies, local action, and public awareness efforts.
- (d) The development agenda set by the MDGs in 2000 must be enriched with sustainable development models that address the challenges of climate change as well as the positions taken at the Rio+20 Summit. Poverty and inequality must be at the heart of the discussions at the Earth Summit. The most vulnerable are the ones who are suffering the most from the effects of climate change, so this is

where efforts to prepare for disasters and mitigate the consequences of climate change should begin.

- (e) At the same time, the Region's demographic transition, together with its inhabitants' consumption habits, has created a new and greater challenge that was not part of the MDG agenda. Although considerable progress has been made in controlling infectious diseases in the Americas, the epidemic of chronic diseases is growing. It affects rich and poor countries and individuals alike, to such an extent that health and development targets for Latin America and the Caribbean after 2015 should assign the same or higher priority to noncommunicable diseases, which have harmful consequences for vulnerable populations and whose treatment is more complex and expensive. Health promotion must play a key role in creating good habits and turning urban settings into healthy settings, while raising awareness about new, healthier ways of living.
- (f) The issues of productivity and employment will become more important in the second-generation MDGs, with emphasis on young people and work skills development. Efforts to reduce poverty will not be sustainable unless economic growth and productivity are prioritized and forms of dignified and healthy employment are created in both the formal and informal sectors. Occupational health and safety, linked to social protection, health insurance, and pensions programs, make it possible to maintain quality of life, not only during the economically active years but also during retirement. Creative alternatives are also needed to ensure that workers in the informal sector have retirement funds that are sufficient for a decent life.
- (g) The priorities of the second-generation MDGs should be centered on multidimensional development with a human face and within an ethical framework based on human rights and peace. In addition to economic and social development, other challenges must be tackled because they have a major impact on daily life, especially—in the Region of the Americas—violence and insecurity. This will require targets and indicators on public safety to respond to organized crime and policy reforms in the justice sector to end impunity. A new era of human security in which the health sector plays a key role is yet to come.
- (h) Finally, to continue along this path, strengthening partnerships among different development actors will remain critical. International solidarity must continue but must also make adjustments to become more effective. The complex situation of middle-income countries must be recognized, and international support must become more harmonized and less fragmented, must be based on a systemic vision, and must be directed more toward strengthening country capabilities and autonomy, while recognizing and strengthening national leadership. These characteristics would make it possible to consolidate achievements, address shortcomings, and continue to face the development challenges of the decades to come.

ACRONYMS AND ABBREVIATIONS	
ACEMI	Colombian Association of Comprehensive Medical Companies
ACP	African, Caribbean and Pacific Group of States
AECID	Spanish Agency for International Development Cooperation
AIDS	Acquired immune deficiency syndrome
ALAPE	Latin American Pediatrics Association
ALARM	Advanced labor and risk management
AMI	Amazon Malaria Initiative
ART	Antiretroviral treatment
CALMA	Center for Breastfeeding Support (El Salvador)
CAREC	Caribbean Epidemiology Center
CCA	Common Country Assessment
CCHS	Canadian Community Health Survey
CDC	U.S. Centers for Disease Control and Prevention
CEES	Concerted Action in Education, El Salvador
CELADE	Latin American & Caribbean Demographic Center (ECLAC)
CENTA	National Center for Agricultural and Forestry Technology (El Salvador)
CIDA	Canadian International Development Agency
CLAP/SMR	Latin American Center for Perinatology/Women's and Reproductive Health
COMISCA	Council of Ministers of Health of Central America
COMMCA	Council of Ministers for Women in Central America
CONASAN	National Council on Food and Nutritional Security (El Salvador)
CONE	Essential Obstetric and Neonatal Care
CPANDRH	Pan American Conference on Drug Regulatory Harmonization
CRS	Congenital rubella syndrome
DASALUD-Chocó	Administrative Department of Health and Social Security of Chocó (Colombia)
DOTS	Directly observed treatment - short course
ECC	Eastern Caribbean Countries Office (PAHO/WHO office in Barbados)
ECLAC	Economic Commission for Latin America and the Caribbean
ECO	Community-based Family Health Team
ENIPLA	National Intersectoral Strategy for Family Planning (Ecuador)
ESAVI	Events supposedly attributable to vaccination and immunization
FAO	Food and Agriculture Organization
FDA	United States Food and Drug Administration
FEPPEN	Pan American Federation of Nursing Professionals
FIGO	International Federation of Gynecology and Obstetrics
FOROSAN	Regional Forum on Food and Nutritional Security
FLASOG	Latin American Federation of Obstetrics and Gynecology Societies
FVP	Faces, Voices, Places of the MDGs
GLAAS	Global Annual Assessment of Sanitation and Drinking-Water
HAART	Highly active antiretroviral therapy
GAVI	Global Alliance for Vaccines and Immunization
GTR	Regional Inter-Agency Task Force for Maternal Mortality Reduction
Hib	<i>Haemophilus influenzae</i> type b
HIV	Human immunodeficiency virus

ACRONYMS AND ABBREVIATIONS (cont.)	
HPV	Human papilloma virus
ICM	International Confederation of Midwives
IDB	Inter-American Development Bank
IHSDN	Integrated health service delivery networks
ILO	International Labor Organization
IMAI	Integrated Management of Adolescent and Adult Illnesses
IMCI	Integrated Management of Childhood Illness
INCAP	Nutrition Institute of Central America and Panama
IPPF	International Planned Parenthood Federation
JICA	Japan International Cooperation Agency
MDG	Millennium Development Goals
MDR-TB	Multidrug resistant tuberculosis
MIFC	Program to Empower Women, Families and Communities (El Salvador)
MND	Belize Ministry of National Development
NGO	Non-governmental organization
NORAD	Norwegian Agency for Development Cooperation
OAS	Organization of American States
OCHA	Office for the Coordination of Humanitarian Affairs
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership Against HIV and AIDS
PAND	Pan American Alliance for Nutrition and Development
PANDRH	Pan American Network for Drug Regulatory Harmonization
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHAC	Public Health Agency of Canada
PLoS	Public Library of Science
PRISM	Performance of Routine Information System Management
RAVREDA	Amazon Network for the Surveillance of Anti-malarial Drug Resistance
SICA	Central American Integration System
SIDA	Swedish International Development Cooperation Agency
SIG	Free Child Care (Haiti)
SIP	Perinatal Information System
SOG	Free Obstetric Care (Haiti)
STI	Sexually transmitted infection
TAG	Technical advisory group
TB	Tuberculosis
TCC	Technical Cooperation among Countries
TDR	Special Program for Research and Training in Tropical Diseases
UF	Undifferentiated fever
UN	United Nations
UNAIDS	United Nations Joint Program on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDOC	United Nations Office on Drugs and Crime
UNDP	United Nations Development Program
UNEP	United Nations Environment Program
UNFPA	United Nations Population Fund
UNDG-LAC	United Nations Development Group Regional Team for Latin America and the Caribbean

ACRONYMS AND ABBREVIATIONS <i>(cont.)</i>	
UNESCO	United Nations Educational, Scientific and Cultural Organization
UN-HABITAT	United Nations Human Settlements Program
UNHCHR	United Nations High Commissioner on Human Rights
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNIVO	Eastern University of El Salvador
UNOPS	United Nations Office for Project Services
USAID	United States Agency for International Development
USDA	United States Department of Agriculture
WFP	World Food Program
WHO	World Health Organization

- - -