

# CLOSING THE GAPS IN HEALTH IN THE LEAST PROTECTED POPULATIONS



ANNUAL REPORT OF THE DIRECTOR 2006



**Pan American  
Health  
Organization**



*Regional Office of the  
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# CHAPTER 1

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## REDUCING HEALTH INEQUITIES

The search for equity in health is one of the main objectives that guide PAHO's actions in the Americas, a region that continues show inequities. These inequities can be measured in terms of resource allocation, the design and implementation of health policies, and the outcomes from the implementation of such policies. In the field of health, inequities are manifested in unequal access to services, the adaptation of infrastructure to address priority problems, disparities that are particularly apparent between rural and urban areas, in areas where poverty is highly concentrated, and the situations of disadvantaged groups such as women, children, indigenous populations, young people, and the elderly, or in populations exposed to greater risks, with a greater incidence of disease or higher levels of social exclusion.

### **Measuring Health Inequalities**

Identifying and measuring disparities and having an understanding of the specific health status of the population and its trends—while also identifying the most critical groups and areas—are essential for gathering adequate and relevant information that can be used in decision-making, developing health policies, and evaluating the results of initiatives. Measuring inequalities among countries and within a given country is a first step in the effort to reveal differences and foster decision-making that leads to actions and strategies designed to reduce, and ultimately eliminate, these inequalities.

In early 2005 in Argentina, a working group on inequalities in health was constituted in conjunction with the Ministry of Health. It sponsored a workshop on methodologies for determining health inequalities. A computer software known as “Brechas” (“Gaps”) also was developed to promote and facilitate the analysis of health inequalities in Argentina and other countries in the Region.

Progress also has been made in disaggregating health data at the subnational level. In the series *Health Situation in the Americas: Basic Indicators*, the booklets present up-to-date information by province or state, and even by municipio or district; similar gains have been made in the *Immunization Newsletter*. The biennial regional statistical booklet, *Gender, Health, and Development in the Americas*, also deserves mention. This joint PAHO, United Nations Development Fund for Women (UNIFEM), and United Nations Populations Fund (UNFPA) receives funding from the Ford Foundation and the governments of Norway and Sweden. The publication disaggregates core data by gender. Similarly, data

on antiretroviral coverage, sexually transmitted diseases, and HIV/tuberculosis co-infection have been added to the information published on Human Immunodeficiency Virus (HIV).

The Ministerial Summit on Health Research, held in Mexico in November 2004, and its declaration on health research and knowledge have led to the creation of a research registry that supports the regional launching of the *International Clinical Trials Registry Platform* (ICTRP). Progress also was made in the effort to align PAHO's regional research agenda with that of the World Health Organization (WHO). The Organization supported countries through innovative cooperation strategies designed to achieve better use of scientific evidence to inform decisions on health, and contributed toward the development and strengthening of a network of experts and related institutions.

PAHO helped participated in the drafting of the joint report of the UN regional agencies, *Millennium Development Goals: A View from Latin America and the Caribbean*, published by the Economic Commission for Latin America and the Caribbean (ECLAC). PAHO was charged with writing the chapter on health and the Millennium Development Goals (MDG), which included contributions from UNFPA.

The Central American Survey on Diabetes, Hypertension and Risk Factors for Chronic Diseases, which is part of the Central American Initiative on Diabetes, represents a one-of-a-kind approach that relies on a single methodology to monitor chronic diseases and risk factors in an entire subregion. The survey studied the prevalence of diabetes, hypertension, obesity, and overweight, among other risk factors, in 8,383 individuals in the seven Central American countries; nearly 75% of them were administered blood tests to detect diabetes and high cholesterol. The Institute of Nutrition of Central America and Panama (INCAP) helped train and standardize the interviewers and optometrists; this important aspect of this endeavor helped increase the countries' technical capacity for surveillance of chronic diseases and risk factors.

The Survey of Risk Factors for Chronic Noncommunicable Diseases, which was conducted in Argentina in 2005, is designed to analyze inequalities by population groups. Results will make it possible to quantify health differences in vulnerable groups, target activities in the health sector, and facilitate promotion in other sectors.

The Caribbean Commission on Health and Development, which is a response to a regional and global initiative, presented a report on the health situation in the Caribbean and possible solutions to be pursued. The report concludes that the issues whose improvement would have the greatest effect on health are obesity and chronic noncommunicable diseases, HIV/AIDS, and violence. The report also urges that resources be mobilized to strengthen national and regional capabilities in health measurement and health statistics.

Ten years from the deadline set for meeting the Millennium Development Goals, various plans for social protection in health in the Region have been analyzed. Among the topics studied are the ability to improve equity in access to and use of health services, the capability to counteract social determinants harmful to health, and the ability to expand coverage and access to technically appropriate health programs.

The Global Youth Tobacco Survey—which collects information on prevalence, attitudes, and beliefs with regard to tobacco consumption—continued to be carried out in 2005. Meetings were held with government officials to analyze survey data as a way to formulate public policy for smoking control. To date, the survey has been used in almost every country in the Region.

In regards to epidemiological surveillance, PAHO continues to monitor the countries' progress in eradicating polio and eliminating measles and rubella on a weekly basis. In 2005, the weekly surveillance of congenital rubella syndrome was added to this effort. The countries, in turn, monitor progress at the municipal level. Most Regional surveillance indicators surpass the goal of 80%.

The SABE survey (Health, Well-being and Aging) was designed and conducted using a representative sample of 10,000 adults older than 60 years of age in seven capitals in the Region: Brasilia, Brazil; Bridgetown, Barbados; Buenos Aires, Argentina; Havana, Cuba; México City, Mexico; Montevideo, Uruguay; and Santiago, Chile. Bridgetown, Barbados; Brasilia, Brazil; Havana, Cuba; Santiago, Chile; Mexico City, Mexico; and Montevideo, Uruguay. Results revealed the health status of this population group and implications for the Region's health systems. Based on the information gathered by the survey, strategic guidelines have been developed to improve access to better services, train human resources in health to cope with the needs of this age group, achieve better health care and monitoring of older adults, implement regulatory frameworks to protect senior citizens living in long-term care institutions, and conduct public health research to identify major threats. A framework has also been

proposed to help define public health system functions that promote health and well-being in old age, as well as standards to evaluate these functions and to establish performance and result indicators.

## **Policy-making in Health**

Knowledge about existing disparities in health status makes it possible to analyze the main determinants of inequalities and, thus, to help establish policies that ensure equity in health.

In Chile, coordination between the Ministry of Health, other ministries, the Solidarity and Social Investment Fund (FOSIS), the Latin American Faculty of Social Sciences (FLACSO), and PAHO has made it possible to focus the social agenda on health determinants. Clearly, partnerships between the government and civil society, as well as among various sectors, help make inequalities in health more visible and help place them on the social agenda; they also help redirect resources toward critical areas, where they are most needed.

Efforts continued to be made to place public health prominently in the regional political agenda. In the main, this was pursued by providing support for subregional health ministry meetings, such as the Health Sector Meeting for Central America and the Dominican Republic (RESSCAD), the Southern Cone Common Market (MERCOSUR), the Caribbean Community (CARICOM), the Organization of Eastern Caribbean States (OECS), the Amazon Cooperation Treaty Organization (ACTO), the Andean Health Agency-Hipólito Unanue Agreement (ORAS-CONHU), the Andean Community of Nations and the Council of Central American Ministers of Health (COMISCA).

At the IV Summit of the Americas held in November 2005 in Mar del Plata, Argentina, priority topics discussed included preparedness for the avian flu and the influenza pandemic, as well as the fight against HIV and efforts to achieve universal coverage with antiretroviral treatment.

Work continued on the WHO Framework Convention on Tobacco Control, which to date has been signed by 18 countries in the Region. Among the Convention's mandates, special emphasis was given to promoting smoke-free environments. Uruguay's successful experience in this regard is worthy of mention. Uruguay has become the first country in the Region to officially declare indoor public spaces to be 100% smoke-free.

The adoption of the International Health Regulation in 2005 was an important milestone. This powerful global instrument makes it possible to coordinate activities among Member States and provides a framework through which to recognize and report on international public health emergencies and to respond to them. Adopting the Regulation will pose challenges and present opportunities for PAHO and its Member States in the coming years. The state of alert regarding the avian flu and the influenza pandemic continues to be addressed, strengthening the countries' capacities and adapting their systems according to regulation standards.

Networks of laboratories, epidemiological surveillance, and response to outbreaks—such as the Central American Network for Prevention and Control of Emerging and Reemerging Diseases (RECACER), the AMAZON NETWORK, CONOSUR network, and Carisurvnet (Caribbean Surveillance Network)—have joined the Regulation's work. The Caribbean port sanitation project—an appropriate response to a specific health-and-tourism problem—is yet another example of the progress that can be attained through horizontal cooperation among countries.

Chile's Ministry of Health has worked to regulate complementary and alternative medicine practices by issuing a decree that creates a legal framework for legalizing such practices. A working group was constituted to formally recognize alternative medical practices as auxiliary health professions; the group's work led to the issuance of a decree to this end. This progress is important because complementary practices (acupuncture, homeopathy, naturopathy, chiropractic and flower essence therapy) constitute an important part of health services, and one relied upon by marginalized populations with problems of access to traditional services.

Regarding the prevention of and caring for the victims of gender-based violence, PAHO's model was used as a base for developing laws and policies on the issue: Brazil established a new law, Honduras amended an existing one, the Dominican Republic developed a proposal for municipal policies, and Costa Rica designed a system for monitoring the implementation of public policies on the issue. Also, according to recommendations from the Subcommittee on Women, Health, and Development, and with participation of 10 countries, the Regional Observatory on Health and Gender-Based Violence was launched.

## ***Strengthening Operating Capacity***

Adequate and reliable data on health problems, as well as evidence-based policies and plans, are critical elements for developing a sustainable capability for effectively solving public health problems.

The English-speaking Caribbean countries have relied upon a strategic approach for strengthening the evaluation, implementation, and improvement of national health information systems. Brazil has enhanced the National Surveillance System of Food and Nutrition by generating indicators and training state- and municipal-level technical personnel in how to use the system.

In Brazil, PAHO, the Ministry of Health, and the Council of State Secretaries of Health adapted the methodology and instruments of the essential public health functions to Brazil's Unified Health System. Performance self-evaluations are being carried out in five states; where completed, results are being incorporated into health plans and initiatives. In Argentina, evaluations of essential public health functions also have been conducted in three provinces with high levels of poverty and health care models that in recent decades have excessively concentrated resources in urban hospitals. Applying these evaluations at the subnational level also makes it possible to identify critical areas, reallocate resources, design and carry out initiatives and plans, and help reduce regional gaps within a country.

In a joint effort with the World Bank, the Internet distance-learning course "Strengthening Essential Public Health Functions" was carried out from October 2005 through January 2006; 840 public health workers from around the world submitted requests for enrollment. The course's first round had 84 participants, half of whom came from the Americas. Of those registered, 51 (61%) successfully completed the course.

In Ecuador, the Ministry of Public Health's budget has been steadily increasing in terms of its percentage of the overall government budget—in 2000 it was 2.4%, and in 2006 it reached 6.2%. This growth reflects the political will to increase social investment and the joint efforts of PAHO, the Ministry of Public Health, the Ministry of Economy and Finance, and the National Congress.

The public health campaign to prevent obesity in Latin America: ¡A comer sano y a moverse América! ("America: Eat Healthy and Move!") was launched in partnership with UNIVISION, the Spanish language network, as part of the Global Strategy on Diet, Physical Activity, and Health in Latin America and the Caribbean.

Bioethics committees and research committees continue to be formed and strengthened in the Region. In some countries these committees have been created only recently, but in others they have penetrated all levels of the health systems, resulting in greater protection of the population and increased confidence in the quality of benefits it receives.

The Virtual Health Library (VHL) is also part of the effort to promote and disseminate PAHO's knowledge; VHL has been adopted by all Member Countries and evaluations have demonstrated its impact at the national and international levels. The Dominican Republic is undergoing a consolidation process, having reiterated its commitment to VHL in 2005. VHL has made it possible for health information generated in the country to be made available to all interested parties, without geographic or time limitations. Furthermore, it has facilitated linkages with other projects such as HINARI (the Health InterNetwork Access to Research Initiative), a WHO initiative that has entered into agreements with the world's major publishing houses whereby they offer free electronic access to many biomedical journals. The Dominican Telecommunications Institute is negotiating with HINARI to establish a shared subscription covering 15 provincial and municipal hospitals and one general hospital.

In Puerto Rico, specific projects have focused on supporting health system reform through three activities: analysis of the country's health sector; analysis of and plan to strengthen the National Health Authority's steering function; and profile of Puerto Rico's health system. The project to implement geographic information systems has helped support the country's Ministry of Health's capabilities in epidemiological analysis and surveillance. Negotiations are under way to cooperate with the Department of Health in e-Health/Telemedicine, with support from the University of Puerto Rico and the Industry University Research Consortium.

In order to reach urban and rural areas that have no medical services, various strategies being implemented in the Region to train physicians and other professionals in primary care and public health and encourage them to work in these areas. In Cuba, the Family Doctor Program has been consolidated, which has complete coverage in the country, and the capability for solving health problems has

increased by expanding and strengthening polyclinics. In Brazil, the Family Health Program is fully developed; it emphasizes multidisciplinary training within the primary care strategy. In Peru, professional health education stresses an intercultural approach and community practice with social participation. In Argentina, the Community Medical Program that was implemented in 2004 is based on an agreement established between the Ministry of Health and 16 universities from different regions of the country. It offers basic training coupled with specialized personnel in pedagogy, planning and locally managed services, environmental health, and epidemiology. In Venezuela, the most recent example of this kind is a mass effort in medical education, with the creation of a new profile of health professionals aimed at serving marginal and remote communities, as well as a proliferation of polyclinics with complete diagnostic and treatment equipment (Barrio Adentro II, “Inside the Neighborhood II” in English).

Other innovative experiences have emerged in the Region in response to the problem of unequal access to skilled health workers. Some institutions train health professionals from marginalized or disadvantaged communities, as does the Rural Medicine Program of the University of Illinois in the United States and the close cooperation that the Latin American School of Medicine in Cuba provides to other countries, which trains more than 8,000 students from 20 countries in the Region.

PAHO, Health Canada, and the Province of Ontario’s Ministry of Health joined forces to hold the Seventh Regional Meeting of the Observatory of Human Resources in Health in Toronto, Canada, in October 2005. Working-group conclusions converged into the “Call for Action for a Decade of Strengthening Human Resources in Health in the Americas” (2006–2015), which promotes the development and retraining of health workers as a way to meet the MDGs and provide access to quality medical services for the entire population of the Americas by the year 2015, according to national health priorities. Participants at the meeting recommended that the Toronto Call for Action become a document that promotes the collective, long-term, intentional, and coordinated efforts of all levels (international, regional, subregional, and national) in the health sector, in other relevant sectors, and in civil society, to promote, develop, and consolidate the health workforce in every country of the Region.

Serious imbalances persist in the distribution of health workers in the Region, both within countries and from country to country. The number of physicians and nurses per 10,000 inhabitants (density) in 11 countries is greater than 50, which translates into 39.7% of population in the hemisphere having 73.2% of total physicians and nurses. In the 15 countries with a density below 25, the figures translate into

19.5% of the regional population having 6% of the human resources in health. With few exceptions, differences in concentration of physicians and nurses continue to be extreme between urban and rural areas.

This year, the annual commemoration of World Health Day honored health workers as the most valuable public health resource. On that occasion, the Director of PAHO called on everyone to celebrate the dedication, commitment, vocation, and great contribution of all health workers in the Americas. She emphasized the need for continuing to build mechanisms to strengthen the health sector, which for many years has had neither the criteria nor the resources for best performing its functions that are so necessary to society. She also stressed that the day was dedicated to all those who directly or indirectly help improve the well-being of the population by preventing and treating disease—physicians and nurses, other health workers, public policymakers, scientists and professors, as well as all the women and men who devote their time and efforts to promote health as an essential part of their daily work, whether they get paid or volunteer their work.

Advocating for access to essential quality drugs and their rational use is an essential activity in the struggle against inequalities. In Brazil, the National Agency of Health Surveillance, the Department of Pharmaceutical Assistance, and PAHO are working together to improve the use of drugs. In 2005, the results of an evaluation on the availability of pharmaceutical assistance as a baseline for pharmaceutical services in the country were published and the First National Congress on Rational Drug Use was held.

In August 2005, representatives from the ministries of health from Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Mexico, Paraguay, Peru, Uruguay and Venezuela met in Buenos Aires, Argentina, for the Second Round of Price Negotiations for Antiretrovirals and Reagents for Diagnosis and Monitoring of HIV. The main goal was to extend coverage with antiretrovirals by making prices more accessible for people with HIV in the Region, as well as to establish marker prices. Twenty-six pharmaceutical companies responded; the process brought together governments, civil society, and international agencies, with strong support from PAHO. Reductions in prices between 15% and 55% were obtained for the most-used treatments, especially for first-and second-line drugs. As a result of these negotiations, countries can bring on line many more people into their respective treatment regimens. The participants asked PAHO to establish a monitoring and evaluation system for implementing the negotiation results, to overcome obstacles so that the prices could be effectively applied and used in purchases in the Region. It is worth mentioning that the negotiated prices are being

used by various purchase mechanisms as marker prices, not only in the countries that participated in the negotiation, but also in Central America and the Caribbean, as well as in purchases that PAHO makes through the Strategic Fund.

As is customary, international evaluations of national immunization programs were conducted. These evaluations aim to improve the performance of national immunization programs and to develop strategic five-year immunization plans based on the evaluation results. The components evaluated included programming, organization and coordination, human and financial resources, training and supervision, information systems, epidemiological surveillance, operational evaluation and research, safe vaccination, cold chain, supplies, public communication and community participation, and observation of health workers. In 2005, Saint Lucia and the five islands of the Netherlands Antilles and Aruba were evaluated. In 2006 (as of 31 July), the Bahamas, the Dominican Republic, and the French department of Martinique were evaluated.



# CHAPTER 2

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## REACHING DISADVANTAGED GROUPS

The experiences presented represent only a few examples to show the diversity of the areas and groups served, best practices and replicable initiatives, and the Region's vast diversity and geographical scope. This analysis makes it possible to draw lessons that can be used to make adjustments that will effectively benefit excluded and vulnerable populations. It will also have a significant impact on the population's social protection in health, both in terms of the strategies and approaches of PAHO's technical and financial cooperation and those of other partners, and in the design and formulation of public health policies by the countries' decision-makers.

### **Extending Social Protection to the Maternal-Neonatal Population**

In Panama, the Strategic Plan for Reducing Maternal and Perinatal Morbidity and Mortality, 2006–2009 was elaborated, followed by a decree in March 2006 that guarantees free services in preventive care and medical and social care for every woman during pregnancy, childbirth, and the postpartum in all Ministry of Health facilities. In addition, the Presidency's social protection program, which provides support for 25,000 families living in extreme poverty, has included in its Comprehensive Care Package of Health Services free and regular maternal and perinatal home care coverage for communities living in remote areas and excluded communities.

In Argentina, progress was made in priority subnational units, such as the periurban and rural areas of Jujuy Province, as part of the effort to strengthen the provincial health system. The goal was to improve the skills of primary care human resources and the access to and quality of health services for women of childbearing age, girls, boys, and families at high risk of social exclusion. There were 798 first-level-of-care maternal and child health care providers trained, and opportunities were created for conducting critical reviews of care practices so as to improve them and make them more comprehensive.

In Honduras, the program ACCESO continued to apply specific strategies for mothers and children in three northern municipios in Choluteca, in order to improve access to health services for pregnant women, women with newborns, and mothers of children under 5; this effort is based on the right of mothers and children to receive these services. The initiative involves training community leaders so they can become health monitors. In addition, a community-administered collective fund was

established to give delivery care to women who do not have the resources to travel to the maternal-and-child-health clinic.

In Belize, through a horizontal technical cooperation initiative with Jamaica, the Safe Motherhood Program is under way to train health workers in surveillance of maternal mortality, verbal autopsy, and the development of surveillance standards for maternal morbidity and mortality. Safe Motherhood Committees were established at the national, regional, and district levels and criteria-based clinical auditing was introduced. Nontraditional health workers—community nurse’s aides, traditional midwives, public health inspectors, and vector-control personnel—participated in surveillance of maternal morbidity and mortality. Physicians’ offices for managing high-risk patients were established in regional hospitals, most of them operated under a multidisciplinary approach. The experience has helped improve the surveillance system of maternal morbidity and mortality at very low cost or at no extra cost.

In Guatemala, in Microregion IV municipios, the Center for Comprehensive Maternal and Child Care (CAIMI) was turned into an intermediate referral center. Activities included training health care workers, improving CAIMI infrastructure, implementing the active system for health surveillance at the grassroots level, strengthening the referral system, implementing the perinatal information system and establishing the “Maternal House” for housing pregnant women.

In Haiti, free health care services for pregnant women and women giving birth were promoted, which resulted in a presidential decree in August 2005. Financial resources are being mobilized to help implement free maternal health care services in one of the 10 departments in the country by 2006.

In Bolivia, the Health Star Service initiative is helping women in outlying urban areas and urban-rural areas. During the first stage, barriers that blocked access to the services of the Maternal and Child Universal Insurance were identified. This service offers a package of free services to women during pregnancy and childbirth and to children under 5. The initiative has two components: the first aims at strengthening health services management through a gender approach; the second aims at empowering women in the community. At the end of 2005, the strategy was put in practice in a municipio of La Paz, where a baseline study was conducted and participants were trained according to the aforementioned parameters.

In the Dominican Republic, the Family Health Action Project carried out with the Catholic Medical Mission and with support from the Bristol-Myers Squibb Foundation, aims at strengthening the Catholic Church's health network in communities through local leaders, health workers and families and by reaching pregnant adolescent and adults through parish counselors and helping them during pregnancy, childbirth and infant care until the child turns the 5. The plan for monitoring basic indicators of morbidity, mortality, nutritional surveillance, and micronutrient intake, among others, continues to be pursued.

### **Strengthening Primary Care and Broadening Access To Health and Nutrition**

PAHO focused efforts on optimizing the Primary Health Care (PHC) approach/strategy throughout its technical cooperation activities. Several areas/units have adopted or are incorporating this approach/strategy into their planning process and daily operations. For example, PHC is the foundation of the regional strategy for preventing and controlling chronic diseases, and it is acknowledged to be essential for reaching universal access to HIV prevention, care and treatment. Moreover, the optimization that PHC fosters has furthered strengthened the interprogrammatic work within PAHO, which translates into an integrated approach in the cooperation with the countries.

In the Dominican Republic, the Project to Strengthen and Implement the National Program for Food Fortification (GAIN Initiative) targets children under 5 and women of childbearing age through the fortification of sugar and wheat flour. This effort hopes to reduce anemia due to iron deficiency from 27% to 20% and Vitamin A deficiency from 23% to 10% in children younger than 5 years, as well as to reduce the incidence of neural tube defects by 20%.

In Honduras, the Ministry of Health's Program of Nutrition and Food Security determined that nutrition programs were ineffective due to the following causes: a lack of distribution of specific foods to diminish chronic malnutrition and anemia in children aged between 6 and 24 months, weak educational components, a lack of coordination between programs and actions, and duplication. Several NGOs were trained in how to use the EPI-INFO program for managing information, promoting the use of new growth standards, and reviewing their interventions so as to target them to children under 2 years old in geographical areas with a higher incidence of individuals growth retardation.

In Nicaragua's Cusmapa Municipio, the Municipal Council, the local health system (SILAIS), and the community developed an action plan to enhance available health services, strengthen the capability of the municipal government to deal with health determinants and the demand for health services, promote community participation in health activities, and improve environmental conditions in the community. As a result, activities in the municipio were incorporated into health actions, a closer relationship was forged between the government and the community, and health service coverage increased (for example, maternal-and-child health service coverage reached 50%). This plan is a model that can be used by other municipios in the country.

Immunization has come to be a family and community health initiative. Vaccination Week in the Americas (VWA) is expanding, aiming to reach adult men and women, young people, and older adults, as well as children. Furthermore, this initiative focuses on high-risk municipios, border areas, and indigenous communities, among other groups and areas. In the last two years, more than US\$ 1.2 million have been mobilized for VWA. In 2005, 36 countries participated in the initiative, 12 of which focused efforts on public media campaigns. More than 38 million people were vaccinated (17.6 million children, 13 million adults older than 60 years of age, 3 million adults, 2.2 million women of childbearing age, and more than 25,000 indigenous people; 2 million people received the yellow fever vaccine). In 2006, 39 countries and territories of the Region participated in VWA, aiming to immunize about 40 million people. In addition to vaccination activities, VWA is an opportunity to offer other comprehensive health services such as the administration of vitamin A, parasiticides, and folic acid.

### **Implementing Health Programs in Schools**

In Guyana, within the framework of Health Promoting Schools, the Caribbean "National Vision 20:20 Plan" was conducted in 13 schools in low-income communities without social protection. Teachers, health professionals, and volunteer parents participated in testing the vision of 2,710 students. Detected eye-problem cases were referred for additional testing and evaluation at the Poor Vision Clinic at Georgetown's public hospital. The Ministry of Education and Social Services purchases eyeglasses for families that cannot afford them.

In Peru, the Basic Intervention in Oral Health project was implemented schools in excluded and remote communities. Activities promote oral health and repair dental caries using the Atraumatic Restorative Treatment (PRAT) technique. Twenty-four dentists who travel to the country's most vulnerable and

isolated areas to provide itinerant care were trained in the technique. PRAT was disseminated, its inclusion in the comprehensive health insurance scheme was promoted, and support was given for purchasing specific supplies. Technical assistance also has been given to integrate this activity into a broader preventive dentistry strategy that incorporates fluoridating salt for human consumption, oral hygiene, and expanded coverage of oral health services.

In Trinidad and Tobago, work at the elementary school level was conducted to strengthen the comprehensive approach to school health programs. Training programs were prepared on health promotion and disease prevention directed at primary health care workers and personnel at health facilities and schools in three pilot areas.

### **Child and Adolescent Health Protection**

In Honduras, an interinstitutional committee for the protection and care of orphaned children due to HIV/AIDS and children at risk for the infection was constituted to strengthen the organizations that serve this population and help promote and administer resources. The Global Fund to Fight AIDS, Tuberculosis, and Malaria (which did not include this item in the country's proposal) contributed financial resources and the project's activities began to be formulated.

In El Salvador, "Programa Ternura" (the Tenderness Program) aims at coordinating efforts to improve living conditions of families, especially children and adolescents, within the framework of protecting their human rights. The program aims at promoting healthy lifestyles and environments, and at diminishing violent conditions, addictions, maternal and infant mortality, HIV and AIDS, and problems associated with sexual and reproductive health.

Guatemala introduced the pentavalent vaccine (DPT-hepatitis B, plus *Haemophilus influenzae* type B) into the regular vaccination series for children under 1 during Vaccination Week in the Americas (VWA) 2005 (April 24–30), with children born from 1 January 2005 to the time of VWA being gradually vaccinated with the new vaccine component. To that end, an Interagency Coordinating Committee was formed, in which the office of the First Lady, several embassies, United Nations agencies, bilateral cooperation agencies, nongovernmental organizations and government social security organizations, and finance and social investment organizations participated. The initiative has received support from Finland and Sweden.

## **Preventing Violence among Youth**

In February 2005, PAHO held an international conference, “Voices from the Field: Local Initiatives and Research on Juvenile Gang Violence in Central America.” The conference was intended to establish an international and multisectorial dialogue about violence in Central American countries. The activity was jointly conducted with member institutions of the Inter-American Coalition for the Prevention of Violence, the Washington Office on Latin America, and the Foundation for Due Legal Process. More than 250 participants from El Salvador, Guatemala, Honduras, and Nicaragua, as well as from the United States (the Centers for Disease Control and Prevention, the University of California at L.A., and organizations from the Washington, DC, area) discussed youth gangs known as “maras.” Participants expressed opinions about the urgent need for establishing public policies to address the causes—not simply the consequences—of the phenomenon. A call was made for placing more emphasis on preventing the problem rather than on repressing young people. As a result of the conference, the Central American Coalition for the Prevention of Juvenile Violence was established. The Coalition, which is made up of various governmental and nongovernmental organizations in the Central American countries, has been able to get the attention of various sectors of society and the media in just a few months. It intends to bring about changes in public policies in order to define preventive proposals.

Argentina, Colombia, El Salvador, Honduras, Nicaragua, and Peru have implemented the project “Promotion of Juvenile Development and Prevention of Violence” with financing from the German Agency for Technical Cooperation (GTZ) and Germany’s Federal Ministry for Cooperation and Development of Germany (BMZ). Working teams have been organized in each country, and governmental and nongovernmental institutions, along with groups of young people, participate in them. These teams promote and coordinate activities, and seek to increase and improve initiatives. This process has led to the preparation and publication of documents on violence among adolescents and young adults.

## Strengthening Gender Equality

The gender equality policy was launched in September 2005 as a result of a resolution adopted by PAHO's Directing Council. The resolution represents a milestone in PAHO's struggle to ensure equality of opportunities between women and men in terms of access to resources and health benefits, as well as in citizens' right to participate in determining the course and priorities of this development. The policy establishes that the objectives of gender equality and empowerment of women will permeate all PAHO's work, including technical cooperation areas, national policy development, and human resource management resources in the institution itself and in the health sector as a whole.

The strengthening of national capabilities for producing and analyzing data on gender equality crystallized in the formation of intersectorial mechanisms and in the publication of statistical booklets and analytical profiles of the health situation of women and men in Costa Rica, Guatemala, Honduras, Panama, and Peru.

In El Salvador, the Interagency Program for Empowerment of Adolescent Women came to a close. The program was developed by the United Nations Interagency Gender Group under PAHO leadership. The program's achievements include increased care coverage for adolescents, health worker training in caring for adolescents from a perspective of protecting and promoting their human rights and empowering them, the integration of adolescents into community organizations, the lowering of institutional barriers to access to services, and the provision of supplementary equipment for comprehensive health care for this age group.

In Chile, the annual report on the Observatory of Gender Equity in Health was published. The Observatory coordinates academic organizations and civil society. Subjects in the publication include gender violence, citizen participation in health, unpaid health care, work and health, and sexual and reproductive health. The report is the result of efforts to monitor gender indicators from 2005 and the impact of health policies on eradication or reinforcement of gender inequities in health. An Observatory regional station encompassing a comprehensive gender and ethnicity approach was established in the IX Region of Araucanía, home to the country's majority mapuche communities. Mapuche community organizations participated, as did women's organizations that work in gender and health and with people with HIV/AIDS, and academic institutions such as the Temuco Border University. Currently, a database is being generated and monitoring indicators have been selected to measure gender and ethnic inequities

in health in the Araucanía region, as a way to formulate proposals for public policies that can help improve women's health, especially that of Araucan women.

In Puerto Rico, technical cooperation focused on providing support for at-risk communities in prevention of violence, specifically violence against women and domestic violence. Based on research conducted by PAHO in regarding men's knowledge, attitudes, and practices about sexual and reproductive health, in six Central American countries models of sexual and reproductive health initiatives were reviewed and new models of care and information were developed, targeted to men in the workplace and in recreation in the respective countries.

### **Reducing the Stigma and Discrimination Against People Affected by HIV and AIDS**

A study on HIV and gender was designed and conducted. Led by PAHO, the activity also had the participation of ministries of health and civil society agencies, including groups of persons living with HIV. Results will become the basis for reviewing standards and protocols in treatment of HIV in Belize, Honduras, and Nicaragua.

The “3x5” goal in the Region of the Americas was to have 600,000 persons in treatment by the end of 2005. By the end of that year, 680,000 persons were receiving antiretroviral treatment, more than 300,000 in Latin America and the Caribbean. In addition, the number of treatments increased, as did access to counseling, testing, and prevention of mother-to-child transmission interventions. The cost of drugs dropped, and cooperation with 37 countries of the Region was strengthened in line with the five strategic courses of action aimed at strengthening the health system infrastructure. Proposals for additional funding also were submitted to donors, in particular to the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Finally, PAHO's Regional HIV Plan for the Health Sector 2006–2015 was launched, which offers the Region's countries a set of goals and milestones designed to put in place a comprehensive method of expanding the response to HIV.

In the Bahamas and Suriname, an innovative communication campaign was developed to increase access to testing and to promote treatment in the services. The campaign, which relied on television and radio announcements, was carried out under the slogans “Take the Test” in Suriname and “Know Your Status” in the Bahamas. It has been responsible for an increase in the numbers of reported cases and in the number of people receiving treatment. Experts from 10 countries participated in a workshop in Suriname on applying this type of campaign elsewhere in the Caribbean.

In Mexico, a national media campaign was conducted against homophobia. The Ministry of Health’s National Center for AIDS Prevention and Control, working with the National Board to Prevent Discrimination, launched the campaign. The campaign’s slogan, "Homosexuality is not a problem, homophobia is," was disseminated through radio announcements in seven major cities.

Six journalists received awards for their coverage of the HIV/AIDS epidemic. REDSALUD (“Network Health”), the Communication Initiative, and the Ibero-American Foundation of New Journalism sponsored the awards in Latin America; CARICOM sponsored them in the Caribbean.

In Costa Rica and Peru, kits were distributed to health workers and sexual-assault victims for post-exposure HIV treatment. New access venues for HIV care were set up in Belize, Colombia, and Nicaragua; Belize also established access points for reproductive health services, Colombia and Nicaragua did so for victims of domestic violence. Along the Mexican-U.S. border, a project to improve monitoring and estimate the prevalence of HIV infection in vulnerable groups was implemented.

In Barbados and in the countries of the Eastern Caribbean, improvements were made to the care of those infected with HIV, as well as in adopting and adapting treatment standards for those infected. Health care providers and community organizations received training in the management of OPV services, and health care workers working in maternity wards were trained in preventing mother-to-child transmission. To further strengthen prevention, assistance was provided in couples referral, locating contacts, health education, and risk reduction.

In Bolivia, the access to comprehensive preventive services by unregistered sex workers is being evaluated to better guide this population and upgrade the comprehensive preventive services (couples counseling, condoms, diagnosis and treatment of STIs, and voluntary HIV testing with counseling) provided to them.

In Cuba, a national multi-sector support group for the control and prevention of HIV/AIDS program was established and the National Strategic Plan for HIV/AIDS 2006–2010, “Patients Living with HIV,” is under way. The Plan’s goals are to halt and reverse the spread of HIV and sexually transmitted infections; to continue providing universal access to prevention, care, and treatment services; to strengthen the capacity of primary health care services and the operation of the laboratories of the country’s HIV diagnostic network; and to promote communication among health workers.

In Belize, an action plan to prevent and control communicable diseases in the Central Prison was designed. The plan envisions providing training programs on HIV prevention to convicts and prison personnel, as well as ambulatory health care services for prisoners and antiretrovirals for those that require treatment. A support group for convicts with HIV has been constituted. A seroprevalence study revealed that HIV infection levels among prisoners were about the same as those in the overall population. This program is considered to be a “best practice model;” as such, it can be replicated in other prison programs elsewhere in the Region.

In Guyana, work in prisons relied on the “Excite, Include, and Commit”(EIC) methodology to empower and train convicts and officials in HIV infection, awareness of sexually transmitted infections, prevention, behavioral changes, and improvement in communication. Twenty-nine convicts and three prison guards received training; an additional 141 persons in various prisons were contacted during the consciousness-raising sessions.

In the English-speaking Caribbean countries, a manual was prepared on the nutritional management of HIV infection, and health workers from the 18 member countries of the Center for Food and Nutrition of the Caribbean (CFNI) received training in its use and evaluation. The manual was translated into Dutch and adapted for use in Suriname. A training manual on the comprehensive management of adults living with HIV, which is to be used in primary and community health care throughout Latin America and the Caribbean, was launched with the support of the Spanish Agency of International Cooperation.

During the Second Special Session of the United Nations General Assembly on HIV/AIDS (UNGASS), held in June 2006, Member States adopted a new political declaration on HIV. During the session, the Organization’s delegation stated that the existing political will and joint work of all the countries have had a clear and notable effect in the Region. However, efforts and commitments to fight the epidemic

should redouble, clearly stressing an equity, gender, and equality approach as a way to reduce the troubling stigma and discrimination that remain, as well as to identify major inequities to access.

### **Health Care for Indigenous Peoples**

The First National Health Forum for Indigenous Peoples was held in Costa Rica. Approximately 250 delegates from indigenous communities participated, as did representatives from the health sector, civil society, and other related public entities; experiences from Brazil, Chile, Colombia, Ecuador, Guatemala, Mexico, Nicaragua and Panama were presented. Partnerships and joint proposals were established with other sectors for improving living conditions of indigenous groups, increasing the timely access to quality care, and reducing disadvantages with non-indigenous populations.

In Honduras, cooperation focused on harmful conditions faced by Miskito from the Atlantic Coast, who develop a number of disabilities as a result of the acute decompression syndrome they suffer because of the precarious conditions in which they work. In an effort to solve this problem, PAHO and Inter-American Commission on Human Rights of the OAS summoned the health, education, labor, and justice sectors, as well as organized civil-society groups to discuss the issue. As a part of the agreements, PAHO evaluated the health services installed capacity and refurbished two hyperbaric chambers.

In Costa Rica, a project with the Cabécar people includes environmental education and sanitary infrastructure components. The effort receives support from the South Central Regional Directorate and the Department of Basic Sanitation of the Costa Rican Social Security Fund; the Development Association, the community's board of education and school trustee boards, schoolteachers, and primary health care technicians who facilitate the project locally also participate.

In Colombia, health care models have been designed for communities of indigenous people, African descendents, raizales (an ethnic group living in the San Andrés, Providencia, and Santa Catalina archipelago), and gypsies, which will be incorporated into national social protection policies. One of these models, a partnership venture with the Canadian International Development Agency, has helped expand directly observed treatment, short-term (DOTS) to combat tuberculosis in indigenous populations living in departments with a high prevalence of the disease.. An of 80% compliance among the targeted indigenous population was reported, which shows the good effect that the community's participation in the design, implementation, and dissemination of the products can have; closer relations

between the authorities and ethnic groups has also been achieved. The indigenous groups participated in national consensus-building boards, providing technical elements to guide national policies on intercultural aspects.

In Paraguay, dispensaries and health posts continued to be built in the Department of Boquerón as part of the Paraguayan Chaco Sustainable Development Project, which helped reverse the exclusion from the health care system of these indigenous populations. With financial support from the Canadian International Development Agency, the project “Primary health care and interculturalism among indigenous peoples of central Chaco” was implemented to improve sanitary conditions and reduce the communities’ social exclusion. Human resources in health from the community were trained, and methodologies and guidelines for the care and monitoring of priority health problems were prepared, using an integrated approach and intercultural criteria.

The regional project for improving environmental conditions (water and sanitation in indigenous communities that had been carried out with the German Agency for Technical Cooperation came to a close. The project was designed to improve precarious environmental conditions in those communities, particularly in regard to drinking water quality, adequate excreta elimination, and improved hygiene practices. Argentina, Brazil, Bolivia, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Peru, and Venezuela have successfully constructed an organizational network that reaches approximately 45,000 people directly. As a result, indigenous communities have access to water supply, home sanitary units, improvements in housing, communal latrines, and appropriate-technology manual sanitary micro-landfills technology; they also are able to tap additional financial resources. A critical aspect of this effort has been the special attention given to the creation and strengthening of capabilities at the organizational and individual levels, and to the production and dissemination of information.

In El Salvador, with the participation of the Salvadorian Indigenous Coordinating Council, a national working group systematized results and lessons learned from a project designed to strengthen administrative water and sanitation boards in five indigenous communities in 2004–2005;” the administrative water and sanitation boards and members of community support networks also shared their experiences.

In Panama, a project was implemented with the Kuna, Emberá-Wounan, Ngobe-Buglé, and Teribes indigenous groups, who have the worst socioeconomic and health development indicators in the country. The project's goal was to reduce the burden of disease and death due to diseases linked to water pollution and poor sanitation conditions, while adapting technology to these peoples' sociocultural patterns and taking advantage of traditional forms of organizing. Surveillance was conducted on water quality for human consumption and water disinfection using culturally appropriate technologies; hygiene education also was provided, and the community actively participated through environmental committees or administrative water boards. More than 50 Ministry of Health officials who work in aspects of interculturalism with indigenous groups received training.

As of 2006, the regional community project, Integrated Management of Childhood Diseases (IMCI), had been implemented in 32 low-income communities in 10 countries, many of them indigenous, as is the case with in Pailaviri in Bolivia and Huancané in Peru. In Ecuador, a workshop to validate a manual for intercultural work with indigenous communities was conducted as a way to strengthen the intercultural approach to health within the community component of the IMCI strategy.

In Bolivia, a childbirth model using an intercultural approach was pursued in the departments of Potosí and La Paz; it will be implemented throughout the country in accordance with a recently signed ministerial resolution. With support from the Italian Cooperation and Save the Children, guidelines for intercultural maternal care were produced, and the document "Protocol for culturally adapted maternal and neonatal treatment" was published. Two manuals also were produced for traditional midwives: a "Manual for the Traditional Midwife in the Highlands" and a "Manual for the Traditional Midwife in the Lowlands."

In Mexico, the program for preventing and eliminating trachoma in the highlands of Chiapas is being carried out. This disease affects indigenous populations (predominantly Tzeltales), especially women and school-aged children. The program envisions a comprehensive and participatory approach to the problem in the community using the SAFE strategy: surgery to treat end-stage disease, antibiotics to reduce the reservoir of infection, facial cleanliness, and environmental improvements to reduce transmission of *C trachomatis*. Between 2002 and 2005, the program's coverage of ocular exploration to detect trachoma increased from 21% to 97% (as of April 2006) in the at-risk communities, and met all the criteria for eliminating trachoma as a cause of blindness (including providing antibiotic treatment for all detected cases). This experience can serve as a model in other countries.

In Guatemala, trachoma has been detected by screening populations in endemic areas, especially the most affected groups and their contacts. During 2005, 7,800 people were examined in 92 communities (with a total population between 75,000 to 100,00 persons, most of them indigenous) in the departments of Sololá and Suchitepéquez. There were 633 active-disease cases detected, which were treated with tetracycline ointment, at low-cost or no cost, through a program run by Guatemala's Pro Blind and Deaf Committee. An educational and promotion program has been developed, which coordinates its work with activities to improve sanitation and access to clean water.

### **The Challenges of Health Care for Older Adults**

The increase in longevity and the consequent aging of the population poses one of the major public health challenges in Latin America and the Caribbean. In the last 25 years, life expectancy at birth for in Latin American and Caribbean inhabitants has increased by 17 years; 78.9% of persons born in the Region will live to be older than 60 years, and almost 40% will live beyond 80 years old.

In Belize, the Cabinet adopted a policy for elderly persons and established the National Council on Aging to monitor its implementation. A National Plan of Action for the Elderly and a strategic plan were drafted to guide Council programs. A comprehensive health care system will provide drugs for elderly people is currently under study. The system will also enhance the elderly persons' abilities to promote their basic human rights and freedoms.

In Cuba a commission was set up to analyze the factors and conditions that lead to quality life expectancy for those 60 years old and older, and to generate proposals to upper levels of the National Health System and the Government. Among the commission's functions are the identification of adequate indicators for local settings, the management of the national program; development of research, and design of integrated and participatory actions. The Commission is made up of groups of specialists from the health and other sectors; representatives from the municipios; the National Program to Care for Older Adults; the Observatory on Burden of Mortality and Life Expectancy; and the Ministry of Health's Research Center on Longevity, Aging, and Health also participate.

In Chile, a monograph systematizing the experiences of Latin American health institutions with respect to older adults was prepared. It includes material designed to incorporate the concept of self-care into national health policies; it also presents experiences that led to structural or organizational changes that foster self-care, and those used in professional practice at the institutional level. The monograph was prepared with the Pontifical Catholic University, health sector professionals, human resource training institutions in health (academia), health services networks, older adults and their organizations, advisors from Brazil, Chile, and Mexico, as well as North American partners such as the University of Cleveland (USA) and the University of Ottawa (Canada). With support from the National Commission on Scientific and Technological Research, a telephone assistance project for older adults—the “Telephone Model of Care”—was implemented as a component in the cardiovascular program.

### **Protecting the Disabled**

Training workshops on human rights of the disabled were held in Antigua and Barbuda, Argentina, Barbados, Brazil, Chile, Costa Rica, Ecuador, El Salvador, Grenada, Guatemala, Honduras, Nicaragua, Panama, Paraguay, Peru, and the Dominican Republic. These workshops represent a form of technical collaboration to countries designed to help them formulate or reform policies, plans, legislation, and services linked to rehabilitation, as well as to coordinate national networks for promoting and protecting the rights of the people with disabilities, be they physical, mental, sensory, or of any other nature. In some countries, technical committees have been established that are working on disability policies and legislation (especially mental disability), in accordance with human rights and disability international guidelines and standards. Some countries have begun to put in place mechanisms to deal with complaints and to monitor the rights of people with disabilities by conducting on-site visits.

Panama established a National Plan on Disability, 2005–2009. It includes actions to improve access to rehabilitation services and appropriate technical aids. The Cabinet for Social Issues and the National Advisory Board for the Social Integration of People with Disabilities has been charged with developing and monitoring the plan; the National Secretariat for the Social Integration of People with Disabilities is responsible for its implementation and for the coordination and alignment of work with the ministries. Activities such as providing prenatal examinations to detect disabilities early and the fortifying of food with folic acid and vitamin A for preventing disabilities from nutritional causes have been included in a comprehensive health care package that is free to the most vulnerable and remote populations. The

program “Inclusion” also was created, establishing intersectoral activities such as the development of architectural standards or the provision of incentives for “inclusive” schools.

In El Salvador, Honduras, and Nicaragua, a comprehensive care plan for people with disabilities has been developed, incorporating a strategy of community-based rehabilitation. This strategy focuses on the community’s active participation, the use of simple technology, and a reliance on public health service systems. The health, education, and labor sectors, as well as city halls and nongovernmental organizations, are involved in the process, and local rehabilitation commissions have been formed. As a result of putting the plan in action, more disabled persons have been incorporated into the productive arena, children have been mainstreamed into regular schools, and the infrastructure and equipment at rehabilitation services has been renovated.

In Paraguay, after a petition calling for measures to protect persons admitted to the country’s Neuropsychiatric Hospital was reviewed, the management and operation of the mental health services network was strengthened, the hospital’s infrastructure was improved, and mobile mental health teams were created. Work with civil society and other cooperating partners, such as the psychiatry chair at the National University of Asunción, led to a more vigorous development of national processes. Support was provided for training national staff outside of the country, and workshops on “Mental Health Policies and Health Services” and on “Human Rights and Mental Health” were held domestically. A one-day retreat also was carried out with staff from the mental health program and the psychiatric hospital to enhance humanitarian and quality care.

## **Communities Living in High-Risk Areas**

### *Those Affected by Natural Disasters*

In Guatemala, Hurricane Stan caused damage in 251 of the country’s 331 municipios, affecting 130,179 persons; many were left dead or missing. In response, the Government and the United Nations system coordinated humanitarian aid plans to provide water, sanitation, and hygiene; nutrition and food nutritional safety; and health care. The plans were financed with US\$ 3,135,844 contributed by countries that responded rapidly to the urgent interinstitutional plea (Flash Appeal): Canada, the Netherlands, Monaco, Norway, Sweden and the Office of U.S. Foreign Disaster Aid. The flexibility of the administrative systems for facilitating procurement of necessary products at the national level and the

rapid availability of medical services and supplies to prevent the spread of communicable diseases common to disasters deserve mention. In El Salvador, responses also included the establishment of refugee centers, mobilization of health workers, improvement of basic health services, installation of latrines, and provision of water-purifying equipment.

In Guyana, after 2005 flooding, PAHO provided for a water, environment, and sanitation plan to mitigate the disaster's impact in 33 schools in the most affected areas in Georgetown and along the East Coast. Sanitation efforts such as the installation of toilets were undertaken. In addition, water storage capacity was increased by installing additional tanks, and water pumps were installed where there had been none and damaged ones the flood were replaced. Solid waste collection also was improved through provision of storage dumpsters.

In Grenada, a project developed to complete reconstruction of the Richmond Hill Home for Older Adults, whose structure was seriously damaged by the impact of hurricanes Ivan and Emily.

In Haiti, medical equipment and drugs were distributed to hospitals in Jacmel and Les Cayes, and physicians were trained in emergency management of natural and man-made disasters and of industrial accidents.

PAHO also collaborated with the International Rehabilitation Center to develop contingency plans to evacuate disabled patients during emergencies and disasters.

### *Persons Living in Poverty*

Venezuela has 17 social missions that function as state programs for the rapid and massive inclusion of the population and the adaptation to its needs. The mission Barrio Adentro ("In the Neighborhood"), which began in 2003 in a Caracas municipio, lies at the heart of Venezuela's health system transformation. This effort has been made possible thanks to the support of the Cuban government, which by the end of that year had sent nearly 12,000 Cuban physicians to provide coverage nationwide. At this juncture, there are nearly 8,500 new consultation sites in the poorer areas of the country, thousands of which operate out of homes in slums that temporarily house the Cuban physicians and their offices until 5,500 new physicians' offices are built. There also are 4,000 dentists and hundreds of ophthalmologists deployed. In March 2006, a workshop intended to systematize the Barrio Adentro

experience began to be held; it is made up of members of the Cuban Medical Mission, international consultants, and officials from the United Nations Education, Science and Culture Organization (UNESCO) and from PAHO. Barrio Adentro II (involving the construction of 600 centers for comprehensive diagnosis and 600 rooms for comprehensive rehabilitation) and Barrio Adentro III (designed to strengthen and equip the traditional hospital network) will follow.

In Peru, a Comprehensive Health Insurance (SIS) scheme was created in 2002 to administer funds destined to finance individual health care for poor and extremely poor pregnant women and infants, adolescents, and Amazon inhabitants who have no health insurance. SIS has a partial contribution component for population groups with limited purchasing power; its main impact, however, has been to more than double insurance coverage of the poor, which rose from 30.1% in July 2001 to 70.5% in December 2005. The SIS experiences and outcomes have stimulated and fostered a national consensus on the need to move toward a national health insurance plan for the entire population that covers all vital basic needs; all political forces and the recently elected government have committed themselves to this scheme.

In 10 Caribbean countries, the Small Grants Program—funded by the U.S. Department of Agriculture and with the Inter-American Institute for Cooperation on Agriculture functioning as an operating partner—provides opportunities for community groups (23 to date) to design and execute small innovative projects aimed at improving nutrition and food safety and at reducing poverty. An evaluation showed that every group has laid a solid foundation for sustaining production activities, and that it has gained income, generated employment, and provided food for personal consumption through the project. A multiplier effect is expected, as more funds will increase the scale of existing activities and will enable new projects to be carried out.

In Nicaragua, local development efforts have continued to be carried out in poor municipios that are highly vulnerable because they lack food and nutritional safety. Efforts focused on coordinating initiatives aimed at promoting an integrated approach to healthy and productive municipios, technology transfer and training, horizontal technical cooperation, mobilization of resources, and consensus-building. In addition, in order to channel cooperation toward the 11 departments identified as priorities, PAHO's Country Office has been functionally structured so as to be able to effectively provide decentralized technical cooperation. These changes have entailed close work with local authorities (autonomous governments, municipal governments, and entities decentralized from the national

government), as well as the provision of support for the development of local capabilities and the coordination of efforts with other partners. This initiative is being systematically analyzed in order to identify lessons that can be used in other Country Offices in the future.

The strategy of Healthy Municipios and Communities (MCS in Spanish) represents a local manifestation of one of the most effective health promotion initiatives. It focuses its work more on health determinants than on results of disease. Argentina, Costa Rica, Cuba, Mexico, Paraguay, and Peru have national MCS networks; while Brazil, Canada, and the United States have established active networks at the subregional level.

Costa Rica put forth a National Strategic Plan for Ecological and Healthy Cantons, 2005–2015, with 55 cantons participating. The strategy for ecological and healthy cantons is a valuable tool for improving social and health indicators at the local and regional levels, thus reducing gaps and inequities.

In Paraguay there was a participatory evaluation of an ongoing project that began in 2002 in the municipio of Emboscada, where more than 20% of the population lives in extreme poverty. The project is designed to strengthen local management through the development, execution, and monitoring of multisector projects that involve broad social participation and that target improvements in the standard of living and welfare of the population in terms of health, the environment, and education. In three years, several projects were developed: vermiculture ventures for domestic and commercial use, healthy quarries, disposal of contaminated solid waste from a health center, strengthening school and family vegetable gardens, preparation of soy-based food, establishment of dining halls for children (where which mothers are also taught to cook with local products), and improvements in child health care, among others. The IMCI program was implemented, and it has led to an increase in child health monitoring consultations and in training of mothers to better care for their children.

In Uruguay, through a “healthy community” approach, projects were undertaken in needy areas, mainly targeted at promoting community participation in the search for solutions in at-risk rural and outlying urban populations. Areas and regions have been pre-selected, with the active involvement of municipal governments, as well as the participation of the Ministry of Livestock, Agriculture and Fisheries, PAHO, other ministries, national development programs (such as Uruguayan Rural/IFAD), NGOs, and the target communities. In the First National Meeting of Productive and Healthy Communities, held in Montevideo in 2006, progress was reviewed and future strategies and plans were designed.

In Colombia a cooperation program has been carried out since 1998 that is designed to improve access to health goods and health services by displaced populations. It is supported by donor agencies from Canada, the United States, and the European Union. Educational materials have been designed and disseminated with the participation of the beneficiaries and authorities. In addition, software has also been designed and developed for organizing the database of displaced populations, and the use of the health information system and epidemiological surveillance of these populations has been fostered and supported. In coordination with health officials, eight field offices were established in the cities and departments with the most displaced people; in addition to working with the displaced person programs, these offices have supported officials in mitigating the effects of natural disasters that have affected the country this year, particularly floods and landslides caused by seasonal rains, and emergencies resulting from volcanic eruptions.

In Haiti, PAHO helped design, finance, monitor, and evaluate a sanitation project to help improve the appearance of some areas in Cité Soleil, the largest neighborhood in Port-au-Prince. The project's broad general goals are to create a health bridge for peace; generate temporary jobs for young people; and help improve unhealthy environmental conditions through a campaign for public sanitation coupled with health education and social mobilization activities.

In Mexico, the Popular Health Insurance, which officially started in January 2004, aims at progressively providing the uninsured population with an option for voluntary public insurance. The regimen covers member families with a specified package of essential options plus some selected medical treatments considered "catastrophic" because of their high cost. For each member family, the federal and state governments contribute resources, which are supplemented by small family quotas contributed by the beneficiaries and determined according to the family's income level. By October 2005, the number of families protected by the popular insurance scheme had reached approximately 3 million; by the end of 2006, coverage is expected to reach 5 million families, or approximately 20 million Mexicans.

The governments of Ecuador and Colombia have agreed to structure a Binational Border Integration Development Plan, which includes projects to monitor and prevent public health events, as well as strengthen water quality assessment in the systems in the border corridor. At the Meeting of the Binational Technical Health Commission (March 2006), binational cooperation was evaluated and activities and projects on behalf of the border population were identified.

At the U.S.-Mexico border, work is under way to advance the program “Healthy Border 2010”, which aims at improving immunization coverage in children under 4. The program is carried out in partnership with the U.S.-Mexico Border Health Commission, the United States Centers for Disease Control and Prevention, and Mexico’s Ministry of Health, as well as with many collaborators in the border states. As part of the ongoing strategy to monitor vaccination programs, since 2004 three bi-national vaccination weeks are held each year along the border. In El Paso, Texas, Mexican immigrants are vaccinated through the Mexican Consulate’s “Window to Health”.

In 2005, within the framework of the Cross-border Municipios Strategy,” various municipal and cross-border initiatives were proposed and developed, many of them conceived through the horizontal cooperation between countries approach. El Trifinio region (El Salvador, Honduras, and Guatemala border); the Gulf of Fonseca Corridor (El Salvador, Honduras, Nicaragua border); the Nicaragua-Costa Rica border, and the Costa Rica-Panama border are examples of this approach. The Nutrition and Food Safety Initiatives have fostered the development of rural food-production microenterprises managed by women, and the transfer of new technologies to existing enterprises in order to produce safe food.

Along the border of Brazil and Uruguay (in the departments of Artigas and Rivera, which have extremely high levels of poverty), a multi-sector and community-leadership initiative is under way. the activity has been conceived within the framework of the strategy of productive and healthy communities. The initiative in Uruguay promotes specific health promotion and prevention components and treatment of sexually transmitted infections and HIV, coordinated in collaboration with initiatives on the Brazilian side of the border. The initiative targets the most vulnerable population groups, such as street children, adolescents, sex workers, prisoners, and drug users.

The Regional Malaria Program developed a strategic malaria control plan for 2006–2010. The program addresses current challenges posed by malaria in the Region and discusses PAHO's priority areas for technical cooperation. The "Roll Back Malaria" initiative is framed within the Millennium Development Goal for reducing and eliminating the incidence of malaria (and other important diseases) before 2015.

Mexico and the Central American countries are carrying out a project to promote community participation in malaria control. With financing from the U.S. Agency for International Development (USAID), the countries that share the Amazon jungle in South America have formed a network that, among other activities, has facilitated research designed to define malaria treatment policies. Under PAHO's leadership, Bolivia, Ecuador, Guyana, Peru, Suriname, and Venezuela are currently using artemisinin combination therapies to treat malaria. In the last five years, case reductions in Argentina, El Salvador, Mexico, and Paraguay have been constant and substantial enough to conclude that transmission may have been eliminated in those countries. No case of malaria reintroduction has occurred in these countries.

In Central America, PAHO participates in the technical coordination and transfer of the strategy known as "focalized treatment," which has financial support from the Global Environment Fund and technical collaboration from Mexico's Ministry of Health. The strategy, which has been successfully implemented in Mexico, includes comprehensive epidemiological stratification, monthly single-dose treatments, elimination of parasites in populations where cases persist, and ecological anti-larval control involving the community's participation and improvements in housing and family hygiene.

In Suriname, following a Ministry of Health initiative, PAHO has adopted an integrated and coordinated approach to support the control and prevention of malaria among affected groups. PAHO coordinates research activities in the Surveillance Network of Resistance to Anti-malarial Drugs in the Amazon region, in cooperation with the Amazon Anti-Malaria Initiative and USAID, and uses the results to implement the Global Fund To Fight AIDS, Tuberculosis, and Malaria (GFATM).

In 2005, the “Regional Strategic Plan for Tuberculosis Control 2006–2015” was prepared in close collaboration with the countries. It includes a commitment to implement or strengthen TB/HIV collaboration activities and specific strategies for vulnerable populations, with the goal of achieving a tuberculosis-free Region. PAHO also encourages the national TB control programs to respond with innovative initiatives aimed at greater access to health services, adequate identification of cases and positive treatment results. Such initiatives require a combination of intersectoral commitment, social mobilization, and application of internationally recognized strategies.

In Brazil, progress in implementing the action plan for the control of tuberculosis 2004–2007 and the DOTS strategy, with special emphasis on the 315 priority municipios, has produced significant advances in DOTS coverage, which rose from 34% in 2003 to 52% in 2004. With PAHO support, the country is preparing its Strategic Plan 2006–2015, aimed at meeting the millennium goals and reducing the prevalence and mortality of tuberculosis by 50%.

In the Dominican Republic, PAHO has continued to provide technical cooperation to the National Program for Tuberculosis Control, by improving the managerial and operational capacity at the provincial levels and at health centers. As a part of the DOTS strategy and the Zero Tolerance Mobilization, PAHO supports improved capabilities for laboratory diagnosis, information systems, data interpretation and use, and social participation and mobilization. Tuberculosis control and prevention initiatives have helped to cure more than 85% of treated patients, and a attained a detection rate greater than 70%.

PAHO has played a key role in the prevention, control, and surveillance of Chagas’ disease via the technical secretariat of the subregional initiatives (the Southern Cone Initiative, the Central America Initiative, the Andean Countries Initiative, the Amazon Initiative for Surveillance and Control, and the Mexico Initiative), as well as in providing support for specific country activities. As a result of effective control measures, health services in most of the countries where Chagas’ disease is endemic, report fewer incidences of acute cases and a reduced prevalence of chronic cardiovascular or digestive pathologies because primary infection and reinfection in the exposed population are lower. In 2006, within the framework of the Southern Cone Initiative, vector-borne transmission of *Trypanosoma cruzi* by *Triatoma infestans* was interrupted throughout Brazil (in 13 endemic states); soon, Paraguay will certify interruption of transmission throughout its Eastern Region. In Central America, the subregional initiative has significantly advanced in eliminating the leading household vector in all countries; effective

household elimination has been achieved in areas of Guatemala and Honduras. The countries of the Andean Countries Initiative are also working to implement national programs. The Amazon Initiative of Chagas' Disease has begun to implement surveillance, in tandem with malaria surveillance. In Mexico, progress has been made in defining prevention and control priorities by formulating new health standards and pilot initiatives in one state.

In the Dominican Republic, innovative strategies to prevent and control dengue are being developed. These include include community participation and emphasize communication to change behavior. The memorandum on diagnosis and management of dengue/dengue hemorrhagic fever was updated and published, and contributions were made to the preparation and publication of guidelines for management of infectious diseases in the country; both aimed at improving quality care.

In 2005, the socialization and implementation of the Global Strategy to Continue Leprosy Reduction and Sustainable Control Measures (2006–2010) began in the English-speaking Caribbean and MERCOSUR countries. The strategy aims at achieving sustainability by incorporating diagnostic, treatment, and prevention-of-disability activities at primary care services, as well as maintaining an adequate surveillance system of cases, recurrences, and disabilities to continue advancing toward the long-term objective of interrupting transmission of leprosy. A meeting of managers of leprosy control programs was held in Guyana in May 2005, and a meeting also was held for managers from MERCOSUR countries. Paraguay prepared a project to strengthen response capacity in leprosy control, which was submitted to Spain for cooperation, and another for leprosy and tuberculosis control, submitted to Germany for cooperation. The coordinators of leprosy control programs in the Dominican Republic and Paraguay also received support for preparing situation rooms for dealing with the disease.

Vaccination strategies for elimination of rubella and congenital rubella syndrome in the Americas have progressed rapidly. By June 2006, 84% of the countries and territories of the Americas had implemented vaccination plans, and large cohorts of adults had been protected. The English-speaking Caribbean countries, Bolivia, Colombia, Costa Rica, Ecuador, El Salvador, Honduras, Nicaragua, and Paraguay have completed massive vaccination campaigns for adult men and women, while Chile and Brazil vaccinated only women of childbearing age, reaching more than 95% coverage during the campaigns. The remaining countries will carry out campaigns during the second semester of 2006 and the first semester of 2007.

A series of practical guides were been published: on rubella, measles, poliomyelitis, neonatal tetanus, yellow fever, on the control of diphtheria, whooping cough, accidental tetanus, the invasive diseases caused by *Haemophilus influenzae* type b and hepatitis B. The first issue of “Immunization in the Americas,” a pocket reference to monitor annual progress of countries in the Region on subjects of immunization, was published.

Hospital surveillance of rotavirus has been put in place in 10 countries, and an internal alliance has been created within PAHO to accelerate and facilitate the introduction of vaccines against human papillomavirus, which has been linked to cervical cancer.

In 2005, PAHO expressed the need to prepare the Southern Cone countries for the possible emergence of West Nile virus, due to outbreaks in the United States and isolated cases detected in Central America and Venezuela, as well as to the routes of migratory birds that transmit the virus. To this end, in 2005 and 2006, two international workshops were held at the National Institute of Human Viral Diseases in Argentina. At these workshops, epidemiologists and virologists were trained in theoretical and practical aspects of West Nile virus diagnosis and surveillance. On 19 April 2006, West Nile virus was detected in brain samples of three indigenous horses in Argentina; the Ministry of Health alerted provincial epidemiology centers, which disseminated and strengthened preventive measures and recommendations to diminish the risk of contracting the disease. To date, no more cases have been reported in horses or in humans.

## ADVANCES IN PAHO'S INSTITUTIONAL DEVELOPMENT

### **Commitment to the Strategic Plan 2003–2007**

Since 2003, various efforts have converged to promote and facilitate important progress in PAHO's institutional development. Thus, effective advances have been made on the five objectives of the Pan American Sanitary Bureau's Strategic Plan 2003–2007: to respond better to countries' needs; to promote new modalities of technical cooperation; to become a regional forum; to become a knowledge-based learning organization; and to improve management practices.

The institutional building process has been informed by the recommendations of several teams that have analyzed the Organization from different perspectives—the Working Group on PAHO in the 21st Century, which looked at the Organization in light of strategic public health challenges in the Americas; the United Nations Joint Inspection Unit of the United Nations, which examined the application of results-based management; and the internal and external auditors. The shared goal has focused on strengthening PAHO's work as an instrument for national health development, improving country support, strengthening health practices, and effectively contributing to the operation of health systems. Over time, several results have been achieved and many activities have enhanced and strengthened initiatives already under way. All in all, this learning and growth experience has involved the entire organization.

In 2005, the Executive Committee formed a Working Group on the Rationalization of Governance Mechanisms, in order to review some of PAHO's governing bodies and issue recommendations regarding the operations and goals of the Subcommittee on Planning and Programming; the Subcommittee on Women, Health, and Development; and the Standing Committee of Nongovernmental Organizations. It also reviewed the selection process for the Director of the Pan American Sanitary Bureau and improvements of internal rules and procedures of the governing bodies.



# CHAPTER 3

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## **A More Strategic Work Program and Secretariat**

In terms of harmonizing work with WHO's General Work Program, focal points have been redefined in terms of work areas in all of WHO's regions. These focal points have been working within an active network, a modality that has facilitated the definition and distribution of responsibilities among WHO components and levels to achieve previously determined goals. This, in turn, has improved the flow of resources to achieve expected results agreed upon by member countries. Since 2005, WHO has allocated US\$ 30 million in global resources to the Americas (from both regular and voluntary contributions). In addition, Canada has become the first country to contribute specific voluntary resources for PAHO's institutional building, and it closely monitors the fair allocation of global resources for work in the Region and for priority countries of the Americas.

## **More Financial Resources for Technical Cooperation**

In terms of finances, in 2004 the Governing Bodies approved the Strategy to Increase the Collection Rate of Quota Contributions, which includes: making the current state of quotas due accessible through PAHO's Intranet and Internet; accepting payments in local currency; promoting the payment of quotas throughout the fiscal year; and assigning this task to PAHO Representatives and upper-level managers as one of their key responsibilities. In 2005, PAHO experienced an institutional historical marker: every Member State, Participating Member, and Associate Member made some payment toward their assessed contributions, something that had not happened since 1990.

In 2005, income from extra-budgetary or voluntary funds amounted to US\$ 64.3 million, an increase of approximately 25% over the same period in the previous biennium. The amount received for assistance to mitigate natural disasters increased exponentially, from US\$ 800,000 in 2004 to US\$ 9.5 million in 2005. It should be pointed out that several of the leading voluntary donor governments are following a modality of integrated and multi-annual programming support, which shows their greater confidence in the Secretariat's capability. Voluntary contributions for specific regional projects have also increased, gathering more importance in terms of volume and time, which makes it possible to reach more ambitious results and to reduce transaction costs.

## **Stronger and More Modern Planning and Programming Instruments**

Ongoing dialogue and participation have been sustained in order to define country programs in line with national goals, WHO's General Work Program, and global goals. This has been clearly reflected in the evaluation processes of the Biennial Program Budget (BPB) 2004–2005 and 2006–2007. Subregional BPBs have also been prepared, and a new version of the AMPES/OMIS system for project management was installed; this version incorporates the recently approved regional policy program and budget, with its new subregional level. The harmonization process has been bolstered by follow-up visits from Country Support Unit analysts designed to sharpen coordination processes among national and global programs and objectives. Results and lessons learned from the evaluation have been incorporated into each Unit's the planning, programming, and budget.

As part of the definition of new technical cooperation modalities, a conceptual framework was prepared for the Regional Public Health Plans. It is designed to achieve greater coherence with regional mandates and priorities and to standardize PAHO planning and programming terminology. These plans constitute a strategic and convergent instrument that seeks to coordinate all levels and partners in development (agencies, nongovernmental organizations, financial institutions, and civil society), so as to successfully meet common goals and objectives. This process will move forward with the review and adjustment of the current Regional and Subregional Plans; it will serve as a basis for the formulation of new plans; and it will be incorporated into the process of refinement of instruments of the American Region Planning and Evaluation System (AMPES). It should be remembered that AMPES has been widely praised by auditors and members of PAHO for more than 20 years, and that it is one of the fundamental elements for advancing results-based management.

The work of the Pan-American centers is better coordinated with that of the Country Offices, and their resources and activities are being progressively incorporated into the biennial program budget, agreed on by every Country Office and respective ministry of health. In pursuit of the strategy approved by the Governing Bodies, and in close collaboration with the Government of Argentina, the Pan American Institute for Food Protection and Zoonoses (INPPAZ) closed, and technical cooperation on food protection was reorganized. Regional technical cooperation in water and basic sanitation has been assigned to the Pan American Center for Sanitary Engineering and Environmental Sciences (CEPIS), which now functions as a unit within the Area of Sustainable Development and Environmental Health. Technical cooperation on women's and maternal health has been assigned to the Latin American Center

for Perinatology and Human Development (CLAP), which now functions as a unit within the Area of Family and Community Health. The assignment of responsibilities and technical cooperation resources for nutrition also was reviewed in order to adapt it to the Strategy and Regional Action Plan that the Governing Bodies are currently discussing. Some positions that were located at Headquarters were decentralized to some countries, although they retained their regional responsibilities. For example, the newly created regional, subregional, and inter-country positions, whose headquarters were headquartered country offices or Pan American centers.

### **Applying the Country Cooperation Strategy (CCS)**

Extraordinary advances have been made in placing countries at the center of PAHO's technical cooperation, steering programs toward attaining results, and involving all levels and components of the Organization.

The Country Cooperation Strategy (CCS) constitutes a key element of technical cooperation from which transformations in countries are implemented. In the last four years, CCS has been established in Bolivia, Costa Rica, Guyana, Honduras, Mexico, Nicaragua, and Venezuela. It is in the final approval phase in Colombia, El Salvador, Guatemala, Jamaica, Suriname, and Trinidad and Tobago. It is currently under way in Cuba, Panama, Peru, the Dominican Republic, and Uruguay; and it is slated to begin in October 2006 in the Bahamas. Argentina, Belize, Brazil, Chile, Ecuador, and Haiti have decided to initiate CCS in 2007.

The Region of the Americas is the first to implement a multi-country cooperation strategy, which includes Barbados and the eastern Caribbean countries (Antigua and Barbuda, Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia, and Saint Vincent and the Grenadines), in an experience shared with the Islands States of the Western Pacific. Subregional CCS experiences have begun to be implemented through dialogue with institutions of integration. Rapid evaluations were conducted of the 10 CCS in the Region, which made it possible to analyze both the contents of the documents produced and the processes involved in their preparation.

## **Reorganization of the Pan American Sanitary Bureau**

As a way to face current circumstances and to respond to PAHO's mandates and relations arising from the new challenges of international public health, a decision was made to launch a process of strategic assessment and resource alignment (SARA), through an ongoing cooperative dialogue with the PAHO Staff Association. Current and future international cooperation scenarios involve technological advances and also call for periodic adjustments in the responsibilities and mission of each section of the Secretariat, taking into account that the individual and collective capacities of Member States continue to evolve and be modified. The SARA process seeks to align programs with necessary resources so that these programs can be adequately and strategically carried out, to determine the necessary infrastructure and skills, and to facilitate the development and training of existing staff, as well as to adequately guide the recruitment of new personnel to help fulfill the established programming mandates.

An analysis of functions and responsibilities has led to planning the structure of units and areas, mainly at Headquarters, and to the creation of the Unit of Institutional Development, which builds upon the prior experience of the Management Team for Organizational Change. One of the responsibilities of this new unit is to monitor PAHO's progress in results-based management, which is a system aimed at providing all managers with the means to perform their work in the most effective and efficient way, while at the same time guaranteeing accountability. Another task involves coordinating the progress of the 11 initiatives of the "Road Map for Institutional Transformation," most of which have already completed their terms of reference and presented several intermediate and final results.

The Code of Ethical Principles and Conduct for staff performance was adopted, which includes statements of conflict of interests where applicable, as well as confirmation of staff's understanding and commitment to its fulfillment. A mediator was selected and the Ethics Officer post was established and filled; this person will be a key figure in implementing the system required by the new Code.

## **New Health Alliances and Associations**

Many activities were carried out to coordinate and forge associations and strategic partnerships and, above all, to strengthen coordination of PAHO activities with those of other agencies in the United Nations system and the Inter-American system. Among the many interinstitutional activities, worthy examples include, given their importance and timeliness, the Review and Implementation Group of the Summit of the Americas and the coordinated activities related to avian flu.

In order to strengthen the harmonization and alignment of international cooperation for the greater effectiveness of development assistance, PAHO's participation in and coordination of the Round Table of Donors in Health and Reform in Honduras deserves mention. The Round Table is formed by several bilateral and multilateral cooperation organizations, such as the Japanese International Cooperation Agency (JICA), Canadian International Development Agency (CIDA), the Inter-American Development Bank (IDB), the World Bank (World Bank), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), World Food Program (WFP), and the U.S. Agency for International Development (USAID).

Another example of intersectoral activities was establishment of a strategic partnership between health (health and safety of workers in the health sector and expertise of human resources), education (health promoting schools and prevention of HIV), work (health and safety of workers and prevention of HIV), and the environment (water, chemicals and healthy environments for children and workers). In this partnership, social protection and healthy environments are come together, as do the mandates of the Summit of the Americas and strengthening of efforts to reach the millennium goals. Inter-ministerial meetings were held between the health sector and the agriculture sector, and between the health sector and the environment sector, as well as tripartite meetings that included the health, environment, and labor sectors.

In order to promote and strengthen new modalities of work, interdisciplinary working groups were created to strengthen the quality of technical responses in the Secretariat and in the countries. Examples include alert and response groups exist to address epidemics; the regional strategy and action plan on nutrition and development; the regional strategy on an integrated method for chronic disease prevention and control, and the Regional Plan on HIV/AIDS 2006–2015.

Technical tools also have been developed to facilitate the establishment of virtual sites for collaboration with international partners. To this end, SharePoint sites are maintained for the Health Analysis and Information Systems, the Millennium Development Goals, the Study Group on Pandemic Influenza, the Technical Advisory Committee on HIV and STIs, the Ibero-American Networks on Standards of Clinical Practices, and the members of the Americas who are part of the Executive Board of WHO, to name a few. To date, more than 40 participation and collaboration sites have been created, each with three to 50 secondary sites. On average, more than 300 employees and members interact through these sites, and more than 2,000 consultations are made weekly.

The establishment of partnerships and associations with other international community agencies encourages joint efforts to address the unfinished agenda, protect achievements, and face new health challenges in the Region. For example, PAHO collaborates closely with the Organization of American States (OAS) to link health priorities in the Region with the political agenda of the continent. To this end, PAHO participates as a member of the Summits Working Group and of the Summit Implementation Review Group (SIRG). As such, the Organization supports the implementation of the Declaration and Action Plan of the Summits of the Americas and takes part in organizing the coming Summits.

In coordination with the OAS Secretary General, PAHO has been participating in the meetings and Inter-American conferences of ministers of sectors other than the health sector. For example, it has participated in the Conference of Labor Ministers held in Mexico on health and occupational safety; the Inter-American Meeting of Education Ministers in Trinidad and Tobago, where PAHO was in charge of coordinating intersectoral efforts in the struggle against HIV/AIDS; the Meeting of the Ministers of Health and the Environment, held in Mar del Plata; and the meeting of Ministers and other top officials in social development held in Venezuela, where a preliminary version of the Social Charter of the Americas was discussed.

Joint efforts with agencies of the Inter-American system include work with the Inter-American Commission on Human Rights (IACHR), the Inter-American Commission of Women (CIM), the Inter-American Commission of Control of Drug Abuse (CICAD), the Inter-American Commission of Control of Terrorism and Crime (CICTE), the Inter-American Institute for Cooperation on Agriculture (IICA) and the Inter-American Development Bank (IDB).

To this end, and in order to meet the goal of health for all, PAHO has been working to strengthen its existing networks. Worth mentioning are the Healthy Municipalities and Communities Network, which makes it possible to coalesce efforts to promote healthy populations; the Avian Surveillance Network, whose role is essential in preparing for and responding to a possible pandemic; the Network for Harmonization and Pharmaceutical Regulation, which is one of the most important initiatives in the Region in that it permits the availability of safe, effective, high-quality pharmaceutical products, thus contributing to the protection of public health; and the Health Promoting Schools Network, which helps promote and care for the health of future generations and their families and communities, as well as to establish and maintain healthy study and work environments. The Observatory of Human Resources in Health is yet another example of this cooperative work, since through a network of national groups, the issue of human resources has been able to be introduced into health policies and national planning processes.

In this context, and by devising other cooperation strategies, it is important to point out that at the XV Ibero-American Summit, held in Salamanca, Spain, in 2005, four Ibero-American health networks were established, which will submit progress reports at the next Summit scheduled for November 2006 in Uruguay. These Ibero-American networks are: the Donation and Transplant Network, coordinated by Spain; Drug Policies Network, coordinated by Argentina; Public Health Teaching and Research Network, coordinated by Costa Rica; and the fight against Tobacco Consumption Network, coordinated by Brazil.

As a founding member of the regional directors' group of cosponsor agencies of the United Nations Joint Program on HIV/AIDS (UNAIDS), PAHO has continued to organize and attend the permanent meetings to strengthen the UN's response to HIV/AIDS in Latin America and the Caribbean. PAHO also is part of the UN team of regional directors in Latin America and the Caribbean; this team—normally reserved for the Regional Directors of the member agencies of the Executive Committee of the United Nations Group (United Nations Development Program, UNICEF, UNFPA and WFP)—meets quarterly to coordinate the joint actions of these agencies in the Region. Among the main themes addressed is the UN reform process, joint missions in priority countries and the coordinated support for country development (particularly in Haiti), interagency coordination under PAHO's leadership on avian flu and a possible influenza pandemic, the impetus to advance the Millennium Development Goals, and administrative issues linked to UN reforms, such as the Program of Common Services throughout the Region, in which PAHO participates actively and whose principal advantages have been saving

resources by incorporating economies of scale, simplifying administrative management, and process transparency. Several of these subjects will be addressed at the meeting of the regional directors' team of the United Nations in Latin America and the Caribbean, to be held at PAHO Headquarters from 31 August to 1 September 2006. As host, PAHO will present the latest advances achieved in the field of immunization, and will launch the website "Faces and Places" on the MDGs in the Region.

### **Technical Cooperation Among Countries (TCC)**

In 2005, a progress report on the application of TCC was submitted, including final reports on PAHO-supported projects. All the material was made available to the public on the Country Support Unit's Web page. TCC is a concrete example of the advantages of forging and consolidating health alliances among countries and their institutions on behalf of the most vulnerable populations in the Americas. TCC is one of the modalities of technical cooperation that figure prominently in PAHO's new work management strategy, along with the promotion and strengthening of the National Excellence Institutions, the use of Collaborating Centers, and Decentralized Technical Cooperation. This cooperation strategy has been supported since it began in 1998. Each country of the Region has participated with some project, in subjects such as sustainable development, health information and technology, universal access and health services, disease control and risk management, and family and community health. During 2005, all the priority countries as established by the Organization—Bolivia, Guyana, Haiti, Honduras and Nicaragua—actively participated in TCC projects, reflecting the regional generosity and solidarity in sharing resources and overcoming disparities in health.