CHAPTER 3: HEALTH ACHIEVEMENTS AND SOCIAL PROTECTION IN HEALTH

Extension of Social Protection in Health

233. In the early years of the 21st century, the inclusion of poverty, social exclusion, and inequity on the political agendas of countries and international organizations led to increased discussion about social protection. The institutional space in which public policies must be formulated and implemented has gained greater importance in the regional context. It is characterized by four elements: (a) questioning the sectoral reforms of the 1980s and 1990s; (b) lack of a cohesive social protection network capable of serving as a foundation for social development in the new context; (c) commitment to achievement of the MDGs by 2015; and (d) concern about persistent inequity, social exclusion, and poverty in the countries of the Region.

234. Within the framework of PAHO technical cooperation, social protection in the field of health considers four conditions that are directly related to the determinants of health exclusion. These conditions are access to services; economic security of households and families; collective financing; and health care with quality, dignity, and sensitivity to cultural diversity.

235. During the past five years, an attempt has been made to replace or supplement the traditional organization of health systems in the Americas with new models. Some of these models entail significant changes in government organization as regards formulation and implementation of social policies. Some examples are the Unified Health System in Brazil; the Ministry of Social Protection in Colombia; the Social Security System in Health in the Dominican Republic; National Health Insurance in Aruba, Bahamas and Trinidad and Tobago; and the Explicit Health Guarantees system in Chile.

236. Other countries have opted for creation of limited plans for financing and provision of health goods and services. These plans focus on improving access to health care and health outcomes observed in specific population groups. Such plans include Chile Solidario; Maternal and Child Universal Insurance (SUMI) in Bolivia; Comprehensive Health Insurance (SIS) in Peru; Social Protection Health System (SPS) in Mexico; the Free Maternity and Infant Care Act in Ecuador; Maternal and Child Provincial Health Insurance in Argentina; Mission into the Neighborhood (MBA) in Venezuela; Extension of Coverage to Rural Populations in Guatemala, El Salvador, and Honduras; and the family protection policy in Nicaragua. In 2006, there were 16 countries in the Region that had or were preparing strategies or interventions to extend social protection in public health to mothers and children, particularly in poor strata and the informal labor sector.

237. In November 2006, the “Social Protection in Health for Women, Newborn, and Children in Latin America and the Caribbean: Lessons Learned To Prompt the Way Forward” Regional Forum was held in Tegucigalpa, Honduras. The project, which was organized by PAHO, and also sponsored by the United States Agency for International Development (USAID), the Spanish Agency for International Cooperation (AECI), and the Swedish International Development Agency (SIDA), examined the general situation of social protection in health in the Region and issued recommendations for extending protection to the maternal, neonatal, and child population in all countries. The information served as a basis for the “Social Protection in Health Schemes for Mother and Child Populations: Lessons Learned from the Latin American Region” document prepared by PAHO.

The 13th Ibero-American Social Security Congress was held in Salvador de Bahia, Brazil

Since the First Ibero-American Social Security Congress was held in Barcelona in 1950, several countries in the Region have adopted social protection programs, or have expanded or changed the programs they already had in order to improve the protection offered, management models, and financing methods. These changes have been discussed in the different Ibero-American congresses held since then, including the congress that took place from 23 to 26 March 2004 in Salvador de Bahia, Brazil.

At this congress, agreement was reached on measures to be taken to expand social security system coverage, particularly as regards social and health services, seeking to achieve optimum transparency, effectiveness and efficiency, and establish mechanisms to prevent improper use of special privileges and benefits. The countries also agreed to safeguard equality of opportunities and combat all types of discrimination, as well as establish mechanisms that are flexible enough so that part-time workers and workers hired for short time periods will have the same access to social protection systems as other workers.

National Social Security in Bahamas

From 2002 to 2007, Bahamas created a Social Security system following the recommendations of an accreditation committee designated by the prime minister.

The initiative involved consultation with interested parties, providing technical training on the principles of national social security, and formulating proposals in order to strengthen the health system and insurance. One of the main objectives was to improve equitable access to health care by seeking to eliminate the obstacles that prevent it, particularly those faced by persons without private insurance that are unable to pay for services not provided by the public health system.

PAHO provided technical assistance to the accreditation committee during review of the different financing options, and helped prepare the proposal.

Bahamas decided that the Canadian Integrated Public Health Information System (i-PHIS) was the one that was most suitable for its needs. A provisional draft was prepared in order to test the system during a pilot phase, which was conducted in 2003 and 2004, and evaluated at the end of 2004.

The i-PHIS is an automated and integrated program for reporting and control of medical records, which can be accessed at the site where services are provided by all health care providers. The program improves the continuity of health care. Moreover, it includes the information required to evaluate the health status of the entire population as well as specific subgroups. Consequently, it facilitates the study of most vulnerable groups as well as gaps in the health status of the population.

238. The Commission on Social Determinants of Health was established by WHO in 2004 for the purpose of making recommendations based on the available scientific evidence regarding interventions and policies for modifying the social determinants of health and reducing health inequities. In the Region of the Americas, the Commission was launched in Chile in 2005, and subsequently other countries established their own national commissions on the social determinants of health.

239. With support from the OAS and the governments of Brazil and Chile, in April 2007 a consultation process with civil society took place in Brasilia in which the governments of the Region and international organizations were urged to commit themselves to supporting the process initiated by creating the Commission. After these events, PAHO conducted a series of consultations and carried out a global continuing education effort for the benefit of its staff, government officials, and members of academia.

The legacy of the sectoral reforms of the 1980s and 1990s

240. In the framework of the macroeconomic reforms of the 1980s and 1990s, several countries in the Region reformed their health systems in order to increase cost-efficiency, economic sustainability, and decentralization, and provide a more prominent role for the private sector.

241. In general, health sector reforms were carried out without taking into account the characteristics of each country, nor the degree of development of their health institutions. Rather, the multilateral economic aid agencies promoted certain standardized models that focused on certain financial and administrative changes, deregulation of the labor market, and decentralization. The reforms gave little attention to the effect these changes could have on certain groups, particularly on health care workers. There was no connection between different functions of the systems, and the national health objectives were not defined. Although the reform processes were oriented towards development of a regional work plan that promoted pluralism, efficiency, and quality in provision of health services, in practice it led to a reduction in the government's steering capacity. There was a general weakening of health system operation and matters related to public health were relegated to a secondary role.

242. As part of the efforts to remedy the situation, the International Course on Development of Health Systems was held in Nicaragua from 17 April to 6 May 2005. This course was designed for health care professionals, and high and intermediate level managers. It was organized and planned on a joint basis by PAHO, the Swedish International Development Agency (SIDA), and different educational institutions in the Region.

Progress toward the Renewal of Primary Health Care in the Region of the Americas

243. Following approval of the Regional Declaration on the New Orientations for Primary Health Care (Declaration of Montevideo) by the 46th Directing Council in September 2005, several countries in the Region have renewed their efforts to include the values, principles, and essential elements of primary health care (PHC) as a strategy for development of their national health systems. Furthermore, the priority currently granted to primary health care by WHO has been another powerful factor to promote the commitment by PAHO, which was reaffirmed in 2003, to restore the spirit of Alma-Ata and adapt it to the new social context.

244. PAHO promotes an initiative to determine the status of good PHC practices in each country in the Region. It collaborates in a project promoted by the GAVI Alliance to strengthen health services in Bolivia, Cuba, Haiti, Honduras, and Nicaragua. PAHO also participates in a project based on an agreement with the government of Antioquia, Colombia, in order to integrate the Food and Nutrition Improvement in Antioquia (MANA) program, Integrated Management of Childhood Illness (IMCI), and primary health care projects in the country. The organization is creating an international network of centers of excellence in the field of primary health care with the participation of academia and the health services, in order to promote generation and circulation of scientific evidence in this area. In its recent position paper regarding renewal of primary

health care, PAHO has expressed its viewpoint on reorientation of the health sector and strengthening health systems in the Region. Furthermore, in April 2007 the *Pan American Journal of Public Health* dedicated a special issue to PHC.

245. At the primary care level, other initiatives are also being implemented in order to improve the quality of PHC services. One of these is an accreditation project for primary health care networks based on a system validated by pilot tests in Brazil, Costa Rica, and Nicaragua. Another project is an evaluation instrument for clinical management, while a third project, in the preparatory phase, seeks to improve home and community care for older adults, particularly those with functional limitations, in several capitals in the Region.

A comprehensive health care model in Nicaragua

In 2007 Nicaragua designed and implemented the comprehensive health care model (MAIS). This model is characterized by a biopsychosocial approach; comprehensive, accessible, longitudinal, and continuous care; and an emphasis on promoting health and preventing disease. The model, which is based on the primary health care strategy, focuses on the family, community, environment, and the individual. It seeks to guarantee a series of public health services throughout the life cycle. In addition to the health care component, the model has components for provision, management, and financing.

Provision of services to the population is based on two basic foundations: (a) delimitation of space in sectors with up to 3,000 inhabitants in the rural area and 5,000 inhabitants in the urban area, and (b) assignment of a basic health care team (EBA) made up of a physician and two nursing staff members in each sector. The MAIS includes popular education on health as an essential element for achievement of healthy lifestyles. It organizes public health facilities so that they are oriented towards: (a) improving the health conditions of the Nicaraguan population, (b) satisfying the need for health services, (c) protection from epidemics, (d) improving the quality of services, and (e) strengthening inter-institutional and intersectoral relations. The MAIS includes activities for promotion, protection, health recovery, and rehabilitation.

246. At PAHO Headquarters, the different technical areas are including the PHC strategy in their technical cooperation projects. The Human Resources Unit (HSS/HR) is preparing an educational strategy to develop the competencies of the multidisciplinary PHC teams in accordance with the renewal approach. Different policies and instruments for integrating health services in PHC-based health systems are also being formulated, in conjunction with the Health Policies Unit (HSS/HP). A virtual course for managers and leaders of the PHC area will be launched soon.

Essential Public Health Functions

247. In 2000, PAHO launched the Public Health in the Americas initiative, whose purpose was (a) to generate a regional consensus on the concept of public health and its essential functions, (b) to create methods for evaluation of performance of these functions in the Region, and (c) to develop strategies in order to strengthen them based on research findings. A method for self-evaluation of essential public health functions in the national area was created and application of this method was promoted. As a result, 41 countries and territories in Latin America and the Caribbean performed their evaluations in 2001. Throughout the quinquennium, PAHO has helped 12 countries to conduct new national measurements and adapt the instrument for evaluation of public health performance in their states, departments, provinces, and *municipios*. In Peru, for example, the initiative has facilitated public health planning in all departments. Essential public health functions are also being measured in each province in Argentina. In the *municipios* and departments of Colombia, the initiative has made it possible to include public health components in national development plans and local government work plans.

Essential public health functions in Brazil

With the participation of the Ministry of Health and the National Council of State Ministers of Health (CONASS), several meetings were held in Brazil in 2003 in order to discuss the Public Health in the Americas initiative and strengthen the essential public health functions. CONASS and PAHO signed a technical cooperation agreement to adapt and apply these methods for management of the Brazilian Unified Health System (SUS). In the Brazilian states that voluntarily requested cooperation, the process was conducted by a joint PAHO and CONASS team using methods and an instrument adapted to the national reality through a technical and political consultation process. All financing was provided by the states, the Ministry of Health, CONASS, and PAHO.

248. Although the plans formulated by the aforementioned countries have been oriented toward strengthening public health and its essential functions, other countries and territories such as Puerto Rico have concentrated on institutional organization of public health. The School of Public Health of the University of Veracruz in Mexico has used these concepts to analyze training of public health experts. Honduras has used them to formulate policies and the Ministry of Health of Costa Rica has used them to conduct research in the field of public health.

249. In general, the Public Health in the Americas initiative has made it possible to better define the responsibilities of health authorities in the national and territorial area, identify functions with low performance, identify deficiencies in the areas of infrastructure and capacity, and formulate plans to improve public health.

Steering role of the health authority

Several countries in the Region have shown great interest in applying the performance measurement instrument to the steering role of the National Health Authority (NHA) and the NHA mapping instrument. In the Dominican Republic, use of these instruments at the subnational level has led to generation of data used to prepare action plans that seek to strengthen the steering role of local health authorities. In March 2007, PAHO sponsored a workshop on the subject, which was attended by several high-level staff members throughout the Region.

250. In its interest for safeguarding the quality of health care and strengthening the steering role of the national health authority, PAHO supports actions that strive to improve national capacity to respond to new challenges resulting from globalization and free trade.

251. Globalization, proliferation of free trade agreements, increased mobilization, and introduction of new products pose new challenges for government regulation and control of imported raw materials used to manufacture drugs and medical supplies, as well as introduction and marketing of new technologies and equipment.

252. With the support of PAHO, Panama has introduced a process to strengthen its drug and technology regulatory systems. For this purpose, it has formed interdisciplinary working groups with professionals from the Ministry of Health (MINSA), PAHO, the Social Security Fund (CSS), the University of Panama, the Specialized Institute of Analyses, and the National Association of Pharmacists. The country has developed draft legislation that includes changes in current standards and creation of a National Drug and Technology Authority as an autonomous entity under the Ministry of Health.

253. PAHO contributed the instrument for characterization and diagnosis of regulatory processes and the role of the regulatory entity. In addition, it ensured that the regulations and processes adopted by the country were harmonized with the international standards of the Pan American Network on Drug Regulatory Harmonization (PANDRH).

Public Health Spending to Assure Universal Access to Health Services

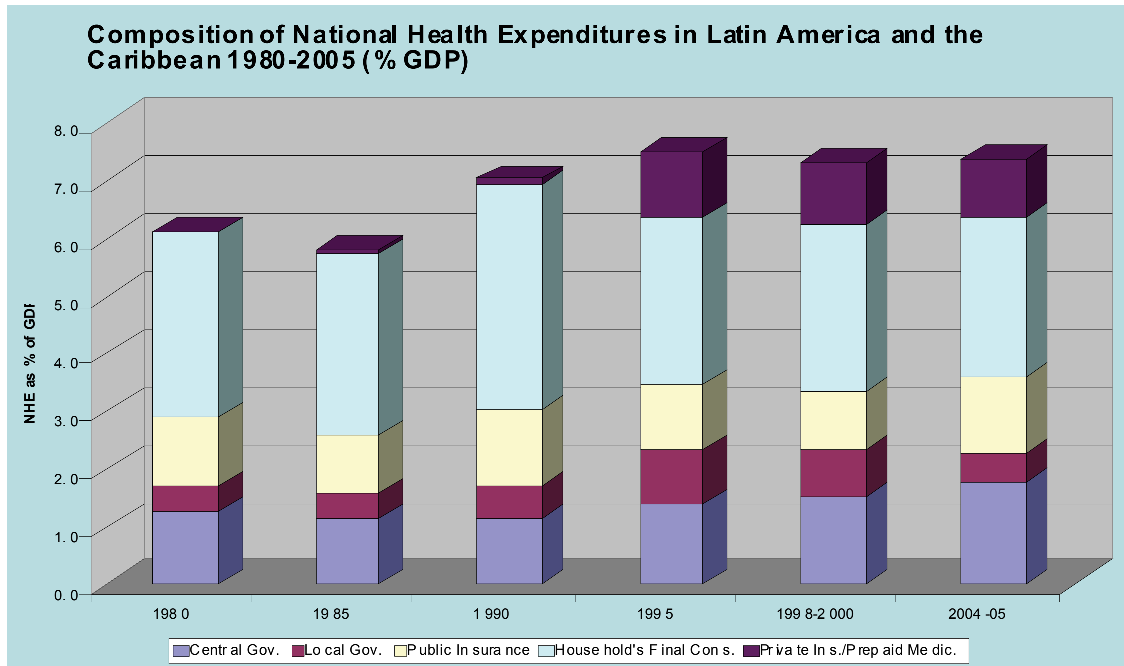
254. Public health spending is one of the main public policy tools for assuring universal access to health services. In Latin America and the Caribbean, total health spending as a proportion of gross domestic product (GDP) has been increasing since 1990, with its having risen to just over 7%, public health spending the central and local governments and public health insurance systems was just over 3.6% for 2004-2005. This proportion has remained largely unchanged since the mid-nineties. The reform processes

of the nineties were based on the premise that public expenditure was sufficient and that the problem lay in inefficient spending. As a result, increases in public health spending were halted for nearly a decade, undermining many countries' ability to provide universal access to health services. What is even more troubling is the change that invariably took place in the ratio of public to private spending for over three decades, during which private spending has comprised a share of over 50% for nearly 30 years. Furthermore, the out-of-pocket expenses borne by families have not only been uncommonly high, but have fluctuated widely over that period. The opposite is true for developed countries of the Organization for Economic Co-Operation and Development (OECD), which have shown absolute increases in public health spending and where the proportion of the GDP comprised by the latter has not been under 6% for the past 10 years. This shows that if universal access to health services is to be provided, it becomes necessary to attain at least a similar proportion, independently of the model and health care system adopted by each country.

255. Insufficient public health spending comes in addition to a lack of mechanisms for assuring that public financing will benefit society's most disadvantaged groups. While several countries in the Region have implemented policies and mechanisms that have had a distributive impact on public health spending in lower-income groups, there are still some countries in the Region that are far from attaining these objectives.

256. In short, a lack of sufficient public health spending and of mechanisms for assuring its distributive impact are the main factors in the way of any strategy that aims to reduce poverty, provide universal access, and attain greater equity in health.

Latin America and the Caribbean Public Expenditure for Health



Source: Pan American Health Organization, 2006

257. Throughout the quinquennium, PAHO has worked with the Ministries of Health, the central banks, the Institutes of Statistics and Ministries of Finance in the annual production of economic and financial health indicators within the framework of the System of National Accounts (SNA-1993) and functional classification of expenditures according to the Public Finances Statistics Manual. As a result, during this period it has facilitated use of economic and financial indicators for decision-making and generating public health policies. In addition, the health economics and accounts institutes, centers, and departments in the Ministries of Health have been strengthened. Availability of regional estimates of health expenditures has improved with application of the Satellite Health Account Manual launched by PAHO in July 2005.

258. PAHO's work in Costa Rica over the biennium 2005-2007 stands out as a successful experience at the country level. With the support of an international expert, the method used to create the satellite health account was designed and implemented. This account currently includes information for 2004 and 2005. Starting in 2008, information will be included for 2006 and 2007, as well as each of the previous years.

259. As a result of this work, the Ministry of Health now has a permanent work team made up by specialists in health economics. The functions of this team are to guarantee

that each institution responsible provides the input required to generate the satellite health account each year and to create, analyze, and circulate information about the satellite account, so that the competent authorities can make decisions that contribute to the achievement of equitable, sufficient, and sustainable financing for the health sector.

Human Resources and their Fundamental Role in Health

260. The workforce plays a critical role in fulfillment of the MDGs and other health-related national objectives. In 2005, 28 countries of the Americas and several different international agencies agreed on certain lines of action in order to overcome human resources difficulties. The Toronto Call to Action pointed out the need: (a) to define policies and plans to satisfy the fluctuating needs of health systems, and generate the work capacity to implement these systems and review them periodically; (b) placement of different types of personnel as required; (c) control of migration and displacement of health care workers so that the entire population has continuous access to health care; (d) create healthy occupational environments; and (e) promote cooperation between teaching institutions and health services in order to ensure that the curriculum for health care workers is adapted to the needs of the population.

261. At PAHO, strengthening policies and information related to human resources has occurred in connection with the Observatories of Human Resources for Health initiative, which is a network for research, analysis, information exchange, and advocacy designed to guide human resource policies.

262. The observatory initiative was created in order to collect information and scientific evidence that could serve as a basis for formulating policies, renewing and improving the work force, and strengthening the relationship between unions, the academic world, and health authorities in order to correct deficiencies and imbalances in the distribution of health care workers.

263. By 2006, 26 countries took part of the network, which began only with nine countries. It also had more than 40 nodes and workstations in a widely known network that has produced national studies and analyses, and generated a movement that is currently a regular component of planning activities and policy design in the countries of the Americas. At present, many of these countries, such as Brazil, Colombia, Cuba, Nicaragua, and Peru, have introduced an observatory unit in the institutional framework of their ministries of health.

Planning health human resources for 2006-2015

264. In 2006, this was reinforced by interest aroused by World Health Day and the WHO World Health Report 2006, *Working Together for Health,* as well as PAHO's

celebration of Pan American Health Week 2006. These focused the world's attention on the current human resources crisis and provided an opportunity for advocacy and generating additional technical instruments. The initiative, which at one time was promoted exclusively by PAHO, has now become a partnership between different interested parties, not only from the Americas, but also from other regions that respond to the same principles.

265. Taking advantage of the commitments by the countries and worldwide support, PAHO Human Resources Management (HRM) Unit and the Regional Network of Observatories joined with Brazil and Canada, in addition to Costa Rica, Jamaica, Peru and other countries, in order to create the Pan American Steering Committee and a human resources planning consortium that guarantees a coordinated response to the Toronto Call to Action. Two subregions (Central America and the Andean countries) began an intense process of strengthening capacities in the political and administrative areas by offering on-line courses, training at different sites, and teaching activities from country to country.

2006-2015 Ten-Year Human Resources Plan

Costa Rica participated in preparation of a position paper on challenges in the human resources area, and in the 2006-2015 Toronto Call to Action for a Decade of Human Resources in Health for the Americas meeting. It has also created an intersectoral technical committee for development of human resources that began its functions in 2005. Moreover, it supports formulation and adoption of national policy for management of health human resources. Costa Rica has a 2006-2015 Ten-Year Human Resources Plan that includes activities such as establishment of a human resources information system, professional recertification, research in the field of human resources, and work with institutions from several different sectors, including the health sector.

266. This integrated multinational approach confirms that a subject that has been overlooked in health work plans can become the central element of international action within a relatively short period of time. It also shows the value of leadership when promoting international commitment and horizontal cooperation to introduce national and regional movements of change.

267. A central component of this human resources planning strategy consists of finding ways to stop or reduce to a minimum the harmful effects of migration of health workers with essential functions from developing countries to developed countries. Although this phenomenon is observed worldwide, the entire Region of the Americas has joined forces in order to take measures in this regard. Argentina, Brazil, Canada, Chile, Colombia, Ecuador, United States, Peru, Uruguay, and Venezuela are participating in multinational studies on migration of nurses and physicians in the Americas. These studies served as basis for a political dialogue between ministers of health from Latin America and several

European countries, which led to identifying ways to counteract its effects on populations with inadequate services. CARICOM countries are establishing guidelines for travel and interchanges of health human resources between member countries so that health care workers can migrate within the subregion without worsening the scarcity of personnel in their native countries, while also seeking to favor workers and benefit the economies of destination countries. The guidelines for migration of health workers will include training and certification standards, and interchange of resources from destination countries to countries of origin.

Epidemiological Surveillance Systems

268. In June 2007, 19 out of 21 countries had implemented the subregional communicable disease surveillance system; 17 had formulated national manuals on the subject; 4 had prepared national manuals; and 9 had held national training workshops on surveillance.

269. Epidemiological surveillance is one of the basic functions of the Caribbean Epidemiology Center (CAREC), which works with Member States in formulation of national and regional policies and guidelines. During the Cricket World Cup held in nine countries in the Caribbean, on-line reporting systems were introduced in order to facilitate transmission of data and information. It is hoped that this initiative will be expanded as the systems continue to be strengthened.

270. In recent years, surveillance activities have been expanded to comprise creation of surveillance systems for noncommunicable diseases and their risk factors. Four countries have conducted population surveys on these factors and six more countries are planning to do so. PAHO and CAREC also collaborate with countries in implementation of the regional plan for noncommunicable diseases in the Caribbean.

International Health Regulations

Since May 2003 the national health authorities of Panama have participated in review of the International Health Regulations (IHR) and approval of the version revised in 2005. These authorities established a model of protective measures for countries in the event that a public health problem of international scope is declared, ensuring a timely response.

Furthermore, information and know-how about the new IHR are also circulated in the country. This includes early alert and timely response measures for present and future challenges posed by infectious diseases and other health problems of importance for the country and the international community. In this context, Panama has taken measures to strengthen epidemiological surveillance and detection, and prevent and contain communicable diseases. It considers that, regardless of its origin, an epidemic in the country could spread rapidly and produce economic losses that worsen the situation of poor populations.

Current population and environmental determinants, continuous international travel of persons and goods, and the threat of a flu pandemic highlight the need to strengthen epidemiological surveillance and analytical capacity in order to implement timely interventions based on clinical, epidemiological, and laboratory data. These interventions should increase the effectiveness of national health services and provide an efficient system of warning and response to epidemic emergencies.

The health authorities are developing their National Focal Point related to functions, basic structure, and capacity to receive, analyze, and transmit information that may be politically or economically sensitive in some cases. Although the epidemiological surveillance unit of the Ministry of Health has the technical responsibility for this focal point, efforts are made with regard to detection, analysis, reporting, and actual response time, in the terms established by the IHR (2005).

In order to resolve limitations related to implementation of the IHR (2005), Panama is leading the proposal for technical cooperation (CTEP) between Central America, the Dominican Republic, and Cuba. The purpose is to develop and/or strengthen capacities and networking in order to prevent, protect, and control international spread of diseases through appropriate public health responses to risks, preventing unnecessary interference in international trade and commerce in accordance with the provisions of the IHR (2005).

271. The Latin American Center for Perinatology and Human Development (CLAP) is preparing new versions of the perinatal information system and the adolescent computer system, a task that includes updating the content of perinatal medical records and adolescent medical records in accordance with optimum current scientific tests. The purpose is to generate more efficient information systems that facilitate data recording and automatic analysis, as well as development of operational investigation, and monitoring quality of care and decision-making. CLAP is finalizing evidence-based situation analyses that seek to support local processes in development of standards of care and training of resources in reproductive, maternal, and perinatal health with a primary health care focus, in accordance with the concept of continuum of care. These guides are accompanied by several different technologies, including standards and guidelines that are easy to use and interpret, which support the recommended care processes.

Epidemiological surveillance in the Caribbean

The epidemiological surveillance systems in the Region have gained critical importance in recent years. As a result of the events of 11 September 2001 in the United States and the emergence since 2003 of West Nile virus, severe acute respiratory syndrome (SARS), Creutzfeldt-Jakob spongiform encephalitis ("mad cow disease"), avian flu, and other emerging and reemerging fatal diseases that spread rapidly, some countries in the Caribbean have requested the assistance of PAHO to strengthen their port health systems in order to control penetration of these diseases in their territory.

Tourism and international movement of animals and products lead to problems related to food safety, water, vector-transmitted infections, exposure to certain transmissible diseases imported from abroad, and occupational safety. By May 2004, Bahamas, Barbados, Dominica, Saint Kitts and Nevis, Santa Lucia, and Trinidad and Tobago had opted for mutual collaboration in order to improve competence in the field of port health.

Before the International Health Regulations took effect on 15 June 2007, the Caribbean Program Coordination (CPC) had already prepared a list of points in order to facilitate the capacity of national resources and structures to meet minimum requirements for implementation of the regulations. In collaboration with the PAHO/WHO representative in Suriname and the national authorities in this country, the list has been used to evaluate Suriname's capacity to implement the requirements of the regulations. Saint Lucia has also used it to conduct its own evaluation, and other countries are preparing to use it.

Achievements in the fight against vaccine-preventable diseases

272. As a result of the Expanded Program on Immunization (EPI), significant progress has been made in the Region in the past 10 years as regards protection of inhabitants from vaccine-preventable disease, as shown by eradication of polio, elimination of measles and neonatal tetanus, control of yellow fever, and introduction of the rubella and pentavalent vaccines. In fact, mortality caused by most diseases for which there are vaccines has been reduced by over 90%. These achievements have been due to the sustained commitment by governments, health care professionals, and the general population.

273. Hepatitis B and *Haemophilus influenzae* type b (Hib) vaccines have been introduced in all the countries in the Region but one, and the combination diphtheria-hepatitis B-Hib pentavalent vaccine is used in 34 countries. Since Hib vaccines were introduced in public sector vaccination regimens, the number of cases reported has decreased significantly. Several new vaccines have been introduced in the vaccination regimen..

274. Before the rotavirus vaccine is introduced, PAHO is supporting countries in establishing a rotavirus surveillance system. The purpose of surveillance is to determine the burden of disease in the countries and the viral subtypes circulating in these countries.

275. In 13 countries, including the Netherlands Antilles and Aruba, a general evaluation of the immunization program was conducted and identified areas to be strengthened. All countries have taken measures to correct most of the deficiencies detected. Evaluation has been used as a strategy to share experiences and teach skills to health care professionals in the evaluating country, as well as team members from other countries.

276. Haiti is the only country in the Region that has not yet introduced the rubella, hepatitis B, and *H. influenzae* type b vaccines. With the technical support of PAHO and the other members of the Interagency Coordinating Committee (ICC), these vaccines will be introduced in the next two years. This year, the rubella vaccine will be introduced through a national campaign and will continue to be included in the basic vaccination regimen. Furthermore, the country will be supported technically in presentation of a proposal to the GAVI Alliance (previously known as the Global Alliance for Vaccines and Immunization) on introduction of DPT-Hib-HB pentavalent vaccine in 2008. PAHO Immunization Unit will continue to help the national immunization program in Haiti to raise funds and implement sustainable financing strategies such as creation of laws that establish a specific budget for vaccination.

277. In the 2003-2007, Cuba has introduced three vaccines in its vaccination regimen: the synthetic Hib vaccine produced exclusively at the national level, the tetravalent vaccine (DPT-HB), and the pentavalent vaccine (DPT-Hib-HB) of national production. In addition, the country prepared a vaccination series to protect over 40,000 Latin American students against measles, rubella, hepatitis B, meningococcal meningitis, and tetanus. In general, the country improved the surveillance system by guaranteeing systematic data analysis and provision of reliable and timely information.

278. During the quinquennium, typhoid fever and Hib infection are no longer public health problems in Cuba, and morbidity and mortality related to mumps, meningococcal meningitis, and hepatitis B have decreased significantly. There is over 95% vaccination coverage with all vaccines in the regimen, which combat 12 diseases. In 2004, PAHO conducted the international evaluation of this program. It has also supported several research projects and negotiation of a GAVI Project to strengthen the health services.

279. Guatemala maintains optimum standards for epidemiological surveillance of vaccine-preventable diseases. It has introduced sentinel surveillance of diarrhea caused by rotavirus, seasonal flu, meningitis, and bacterial pneumonia. National coverage with all vaccines has been over 90% since 2002. This country, which does not have measles or poliomyelitis, has included the pentavalent and seasonal flu vaccines, and is preparing to introduce other new vaccines.

Ecuador without poliomyelitis, measles, tetanus, rubella, or rabies

In Ecuador, poliomyelitis has not been a public health problem for 17 years. Measles has not been a problem for 10 years and rubella, congenital rubella syndrome, and neonatal tetanus have not been a problem for 3 years. At present, only sporadic cases of these diseases occur. This is due to the priority the government has granted to financing the vaccination program, as shown by the 600% increase in the vaccine budget in the quinquennium 2003-2007. New vaccines have been introduced, including pentavalent and hepatitis B vaccines for groups at risk, and flu vaccine.

For rabies, mass vaccination campaigns, increased epidemiological surveillance, adequate treatment of exposed individuals, and active community participation have led to a significant reduction in cases of human and canine rabies. In 2006, no cases of these diseases were reported.

The progressive increase in vaccination coverage has been brought about by strengthening the managerial level of the Expanded Program on Immunization (EPI) in the health areas and provinces, reinforcement of the cold chain, and adaptation of processes at all levels, including epidemiological surveillance of vaccine-preventable diseases.

280. After detection of the last case of poliomyelitis due to wild poliovirus in the Region, which took place in Peru in 1991, this virus is no longer circulating in the countries of the Americas. Cases of acute flaccid paralysis (AFP) are still being monitored, as there is over 1 case per 100,000 children under 15 years of age. The countries in the Region are completing an inventory of laboratories with poliovirus or material possibly infected with poliovirus as part of a plan to contain the virus in the laboratories. While poliovirus continues to circulate elsewhere in the world, the countries on the continent will be at risk of importing it. When polio vaccine coverage is low in countries, municipals, and towns, there is danger of an outbreak of infection with the vaccine strain, as occurred in the Dominican Republic and Haiti in 2000-2001.

281. Cases of tetanus have been reduced as a result of widespread use of tetanus toxoid in children and women of reproductive age in order to prevent neonatal tetanus (NNT). Elimination of NNT as a public health problem (defined as less than 1 case per 1,000 live births in each district) has already been achieved throughout the world, except in Haiti. In Latin America, cases of whooping cough have decreased progressively in recent years, from 9,421 cases in 1999 to 4,921 cases in 2003. Nevertheless, 4,928 cases were reported in 2004 and 6,807 cases were reported in 2005. There continue to be outbreaks. Over 70% of all cases of whooping cough reported in the Americas during these years occurred in the United States, where incidence of disease has increased gradually since the early 1980s. For diphtheria, nearly 100 cases were reported each year throughout the Region between 1999 and 2003. However, 181 cases were reported in 2004, and 272 cases were reported in 2005 after an outbreak in Haiti and the Dominican Republic. An

abrupt decline in Hib infection has occurred in some countries with good detection systems. Finally, the results of hepatitis B vaccination will not be evident for a few years. But they are expected to be good, since there has been over 90% regional coverage with the third dose since 2004.

Annual Vaccination Week in the Americas

In April 2007, the Region celebrated the fifth Annual Immunization Week. Forty-five countries and territories participated, and more than 47 million people were vaccinated. In the Andean subregion 11,284,046 were vaccinated: in Central America and the Spanish-peaking Caribbean, 10,810,337; in the Southern Cone and Brazil, 18,347,938, and in the English- and French-speaking Caribbean, 162,220. Canada, some Caribbean countries, and the United States focused on social communication.

282. Although overall vaccination coverage is good in the countries, there is great disparity between different *municipios* in each country. In order to extend global protection with the vaccine to all children and vulnerable persons in the Region, countries are determining which *municipios* are at risk in order to be able to concentrate interventions in these areas. Furthermore, the Vaccination Week in the Americas (VWA) held in April is a regional initiative that enables countries to target the groups at greatest risk and neglected areas in their interventions. As a result, they can generate the political support required for prevention and control of vaccine-preventable diseases.

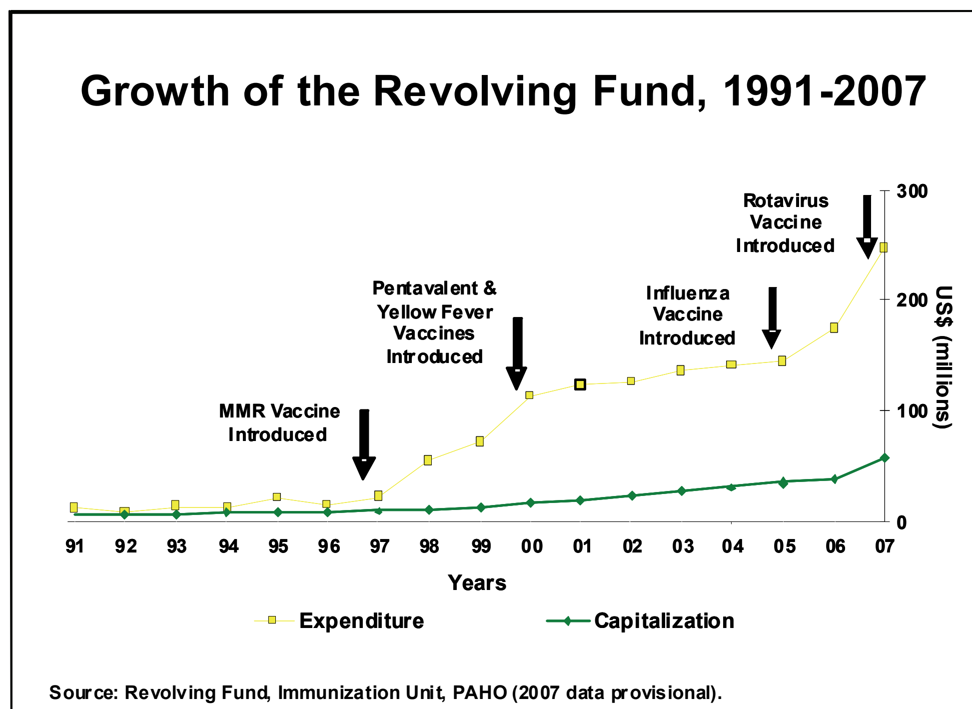
283. Several new vaccines are being prepared or have already been prepared. The decision to introduce these vaccines must be based on scientific data. These new vaccines are much more expensive than the traditional vaccines, and they pose new challenges in terms of planning. Six countries have included the rotavirus vaccine in their ordinary vaccination regimens. Three more countries will do so before the end of 2007. The conjugate pneumococcal vaccine has been partially introduced in three countries as part of public vaccination programs. The human papillomavirus (HPV) vaccine offers an opportunity to reduce the burden of infection of HPV and cervical cancer. However, its cost (more than $100 per dose in the three-dose regimen) and the need to strengthen cancer prevention and control programs as well as vaccination services could hinder introduction of the vaccine in the short term.

284. PAHO helps countries improve their immunization and surveillance programs, diagnostic capacity, and regional laboratory networks. It helps strengthen political priorities and vaccination program sustainability by adopting laws and guaranteeing a timely supply of quality vaccines through the PAHO Revolving Fund for Vaccine Procurement. In the current quinquennium, use of the Revolving Fund by countries has been the highest recorded to date.

Revolving Fund for Vaccine Procurement

285. The Revolving Fund is PAHO's mechanism for bulk purchasing of vaccines and immunization supplies. It has helped Member States manage their vaccine and immunization supply needs since 1979. Each year, PAHO consolidates vaccine orders from participating countries and carries out an international bidding process with the participation of all vaccine manufacturers. PAHO procures vaccines with funds drawn from the fund, and countries reimburse the fund for purchases made on their behalf.

286. As of 2006, 37 countries are making regular use of the Revolving Fund for the procurement of up to 45 different vaccine products. The fund is streamlining its integrated services to countries and further reducing the costs of procurement, holding, distribution and use of vaccines throughout the supply chain. At the close of 2005, the fund was capitalized at just over $34 million, and total expenditures exceeded $154 million that year. The Revolving Fund, as a highly efficient procurement agency, is positioned to continue its strategic role in strengthening the sustainability of national immunization programs throughout the Region.



287. The Pro-Vac initiative for the promotion of political decisions based on scientific data regarding introduction of new vaccines in Latin America and the Caribbean, and the regional vaccination vision and strategy will enable PAHO to continue to lend technical support in order to help countries face the challenges approaching in the upcoming years.

288. Achievements with regard to vaccination have strengthened the general public health infrastructure and regional laboratory networks in particular. They have promoted good intersectoral coordination, improved equity, and increased awareness of the importance of prevention in the population.

Elimination of rubella and congenital rubella syndrome in the Americas

In 2003, the PAHO Directing Council adopted Resolution CD44.R1, which advocated elimination of rubella and congenital rubella syndrome (CRS) in the Americas by 2010. The measure responded to the need for availability of a safe, reasonably priced, and effective vaccine. It was based on experience acquired in administration of measles and rubella vaccines to large heterogeneous population groups, and the data available as regards the relationship between cost and efficacy/effectiveness. The countries were urged to prepare action plans in order to reach the goal. The PAHO Director was asked to prepare a regional action plan to mobilize the resources required. In 2006, Resolution CD47.R10 reaffirmed the need for elimination of rubella and CRS.

By June 2007, 41 countries (93%) and territories (91% of the population in the Region) already had vaccination strategies for adolescents and adults (men and women) with at least 95% coverage. From 1998 to the first semester of 2007, Argentina, Bolivia, Brazil (only women), Chile (only women), Colombia, Costa Rica, Ecuador, El Salvador, the English-speaking Caribbean, Guatemala, Honduras, Mexico (subnational), Nicaragua, Paraguay, Peru, the Dominican Republic, and Venezuela (only cohorts of young people) conducted extensive vaccination campaigns for adolescents and adults (men and women) in order to rapidly interrupt rubella transmission and prevent CRS. By mid-2007, more than 125 million men and women (children and adolescents) had been vaccinated against measles and rubella in the context of elimination of these diseases. When the campaigns planned for 2008 are completed, an additional 108 million people will have received the measles and rubella vaccines.

As a result of the satisfactory coverage obtained with the different vaccination strategies, incidence of rubella has been significantly reduced on the American continent. Between 1998 and 2006 the number of confirmed cases of rubella decreased by nearly 98% (from 135,947 to 2,912). In 2006 only 14 confirmed cases of CRS were reported. Reduced incidence of rubella has been more pronounced in countries where both men and women were vaccinated.

PAHO has integrated rubella elimination activities with the basic principles of primary health care. This has led to improved health care services. Furthermore, elimination strategies have strengthened the health infrastructure. They have led to increased coordination, improvement of blood banks and services for newborns and infants, and generated greater awareness of safe vaccination practices. By improving maternal and child health, and enabling women to reaffirm their right to satisfactory health care, elimination of rubella is contributing to fulfillment of the MDGs and reduction of health inequities.

Bolivia launches a campaign to eliminate rubella and congenital rubella syndrome

With the slogan "Once and for All," Bolivia introduced the rubella and congenital rubella syndrome elimination campaign in May and June 2006. In this context, the bivalent measles-rubella virus vaccine was administered to men and women from 15 to 39 years of age in the 327 *municipios* of the country. The Ministry of Health, prefectures, *municipios*, and the population were mobilized by union organizations, and the goals established were achieved.

After 6 weeks of vaccination, national administrative coverage was 106.8%. The percent surplus has been attributed in part to vaccination of persons over 39 years and under 15 years of age in some areas due to demand. All departments in the country attained administrative coverage of over 95%. Surprisingly, vaccination was very well-accepted by the adult male population, which was uncertain at the beginning of the campaign.

No confirmed cases of rubella have been reported in Bolivia since week 6 of 2006. The campaign has also strengthened measles elimination in the country, since the last case of measles detected occurred in 2000. For the first time, "safe vaccination" has been a component of a vaccination campaign in the Region.

Eye Health in Latin America and the Caribbean

289. The regional eye health initiative seeks to increase access to eye health services for the economically and socially marginalized population. This is conducted with a view to preventing nearly 80% of the cases of blindness and visual impairment that currently occur in the Region. In Latin America and the Caribbean, nearly five out of 1,000 persons are blind, and 20 out of every 1,000 persons have a visual impairment. The leading causes of avoidable blindness in the Region are cataracts that have not been operated on. These lead to over half of the cases of blindness, refractive error, child blindness, diabetic retinopathy, and glaucoma.

290. Reducing blindness and poor vision helps relieve poverty and underdevelopment. It improves educational and work opportunities for persons. In the last five years, access to eye health services has increased in marginalized urban and rural areas in many countries of the Region as a result of the support of PAHO, 20-20 Vision, and international NGOs, as well as bilateral cooperation by countries such as Cuba and Venezuela. During the past five years, the number of countries with national eye health plans has increased significantly. Access to services, as seen by the annual number of cataract removal operations performed per million inhabitants, has improved considerably in the Region. More than 1,500 such surgeries per million inhabitants were performed in 26% of the countries in 2002, and in 50% in 2006.

291. The role of the Regional Eye Health Program, headquartered in Colombia, has consisted of demonstrating the magnitude and causes of the problem through epidemiological studies. This has presently been completed in nine countries in the Region. The studies have measured prevalence of blindness and visual impairment, the percentage of cases of blindness caused by cataracts, coverage and quality of services, and barriers to access. The results have shown that there is higher prevalence of blindness and visual impairment in marginalized and poor populations than in other groups. This data has been an instrument for planning and advocacy.

Oral health in the Americas

292. There have been important strides in the area of oral health in the Americas. The consolidation of fluoridation programs has reduced the burden of dental caries in the entire Region by 35% to 85%. The technical cooperation provided by PAHO's Oral Health Program has tried to motivate countries with high mortality and a lack of preventive policies to begin implementing effective policies and generating better indicators of the status of oral health. A successful fluoridation program was presented as a case study in the publication titled *Millions Saved: Proven Successes in Global Health.* So far, more than 25 countries and over 350 million people have had accesses to fluoridation programs in the Americas.

293. With support from the IDB, the Oral Health Program has developed a basic best-practices model that is intended to improve access to treatment for dental caries through simple techniques. In three Latin American countries, clinical trials have shown that the atraumatic restoration technique (PRAT systems) is more cost-effective than traditional treatment and prevention measures. Several countries have incorporated the PRAT system in their health agendas, and an increasing number of countries are requesting help in establishing this system.

Health Promotion

294. In addition to the communicable and nutritional diseases characteristic of underdevelopment, the countries in the Region have high morbidity due to injuries and noncommunicable diseases with risk factors associated with the typical lifestyles of industrialized societies. In these societies, factors such as inequitable distribution of income, urban development, technological advances, growing influence of the media, violence, and social inequality contribute to a sedentary lifestyle, nutritional imbalances, alcohol consumption, smoking, and other practices that are detrimental to health. The consequences include obesity, cardiovascular disease, lung cancer, colon cancer, and diabetes mellitus.

295. Throughout the quinquennium, PAHO Member States have been extremely active in adopting health promotion measures that combat the social, behavioral, and biological determinants associated with risk of contracting noncommunicable diseases or experiencing injuries caused by acts of violence, occupational accidents, or travel accidents. These measures have focused on the recommendations of the Ottawa Charter.

296. In 2005, the Bangkok Charter for Health Promotion led to reorientation of work toward establishing partnerships with government agencies and civil society. The same year, the health promotion capacities of 28 Member States were mapped in order to strengthen national and local capacities. Since 2006, PAHO has included health promotion activities horizontally in all technical areas. The "healthy spaces" approach (e.g., healthy communities, cities and *municipios*; healthy schools; healthy workplaces) has been applied with very good results in many countries in order to empower the community and attempt to reduce risk factors and social determinants that are detrimental to health. In 2007, 19 of the 35 countries and 3 territories in the Region participate actively in the Healthy Communities, Cities and Municipalities Initiative. In addition to the Network of Healthy communities, Cities and Municipalities in the Americas, 10 countries have established national or regional networks and have contributed to promote initiatives in favor of healthy spaces in the working plans of countries.

297. In May 2005, PAHO and the Basque government signed a collaboration agreement in which the government agreed to support strengthening of health-promoting schools in Latin America. As a result, several products are being prepared, including the First Ibero-American Competition on Good Health Promotion Practices in the School, an on-line training course, a "tool box," and a series of educational materials on health promotion.

The National Network of Healthy Communities and Municipios of Peru

In Peru there are 750 *municipios* that are members of the Healthy Communities and Municipios (MCS) initiative. There are 15 regional MCS networks which also have local development plans that seek to have a positive effect on health determinants and respond to local priorities. In July 2007 the national network of healthy communities and *municipios* was formed, with 15 regional networks.

In order to stimulate the processes, a series of health promotion pamphlets were prepared, which has been circulated throughout the Region. Several of the 23 issues in the series deal with the subject of healthy *municipios*, primarily as regards road safety policies, solid waste, smoking, violence, childhood, adolescence, gender, older adults, human rights, social determinants of health, the MDGs, and education.

In terms of efficacy and effectiveness, the MCS initiative has strengthened the competencies of the institutions participating through continuous training processes with methods based on scientific evidence, such as Youth Participation, WHO TEACH-VIP, and Strong Families, in addition to local projects. As a result of the initiative, there is an active strategic partnership between the national government, the *municipios*, civil society, and cooperation agencies. Furthermore, strengthening competencies has led institutions to work directly with adolescents and families in their areas of intervention, using the methodologies taught.

The Healthy and Productive Communities Strategy in Uruguay

The Uruguayan Initiative for Health-Agriculture Joint Activities, signed by the ministries of both sectors under the sponsorship of PAHO, promotes the productive and healthy communities strategy as part of a government plan to achieve a productive, healthy, and caring country. The strategy promotes creation of local opportunities so that communities can work together for the common objective of improving their quality of life and health status, and changing the social determinants of health.

The Ministry of Livestock, Agriculture and Fisheries and the Ministry of Public Health introduced the strategy at the national level in conjunction with municipal governments, PAHO, and some national organizations. With the active participation of organized civil society, local production projects based on promotion of comprehensive health care and social inclusion are conducted. The objective of these projects is to improve living conditions for small farmers and their families, particularly small farmers with or without land, women and schoolchildren in rural areas, artisanal cheese makers, unemployed youth, small subsistence producers, and seasonal workers. A wide range of activities and resources are used to attempt to improve the physical and sociocultural environment in extremely poor areas where social policies seldom reach.

The results of the strategy include establishment of local intersectoral teams; introduction of training processes in areas such as horticulture, animal husbandry, food preparation, hydroponics, and product packaging; as well as promoting health through healthy nutrition; encouraging physical activity and preventing smoking; fostering collective work and "empowerment" for negotiation in local management; greater participation by the educational sector in development of the strategy; and coordination of the strategy with the oral health initiative promoted by PAHO as well as several programs and projects established by the national government.

The strategy has been extended progressively to nearly all administrative political units in the country. Binational strategic partnerships have begun to be established between Uruguay and Brazil, including the Rivera-Livramento binational committees and the alliance between Aceguá (Brazil) and Aceguá (Uruguay).

298. Based on the Intersectoral Strategic Partnership between Health, Education, Work, and Environment presented at the 47th PAHO Directing Council, regional consensus-building has been promoted with education, health, and development agencies in order to grant priority to promoting health in early education. PAHO supported the Health-Promoting Schools Technical Meeting organized by WHO and the Canadian Consortium for Education and Health, which was held from 5-8 June 2007. At this meeting, the countries in the Region stated that they were in favor of strengthening the alliance between the ministries of education and the ministries of health. They decided that a meeting would be held in Fortaleza, Brazil in October 2007 to strengthen the alliance between the two sectors in the national as well as the regional area, in order to reorient health promotion in view of the social determinants of health and the MDGs.

299. PAHO has prepared a series of planning and evaluation guides for strengthening national capabilities and generating scientific evidence of the effectiveness of health promotion initiatives. During the period from 2004 to 2006, participatory evaluations were conducted in several countries in the Region.

300. On 15 September 2007, the CARICOM Summit for Non-Communicable Diseases was held under the theme "Stemming the tide of non-communicable diseases in the Caribbean." The Summit was attended by policy-makers and representatives of CARICOM and other regional and international health agencies wanting to develop and undertake actions to combat diseases that are related to lifestyle. The objectives of the Summit were to develop a common regional approach for the prevention and control of non-communicable diseases, to assess the burden of such diseases in the Region, and to propose imminent control measures.

301. The Summit was called in response to the results obtained in 2005 by the Caribbean Health and Development Commission, which was launched in 2003 with PAHO's assistance in order to act on the Nassau Declaration that "the wealth of the Region is the health of the Region." The report of the Commission, which was initially headed by Sir George Alleyne, former Director of the Pan American Sanitary Bureau, showed that non-communicable diseases, HIV/AIDS, and injuries are very important health problems in the Region

The fight against tobacco

302. Tobacco is one of the leading causes of morbidity and mortality in the Region. It has been widely demonstrated that in order to reduce smoking, clear and forceful laws must be adopted. Moreover, actions must be introduced to promote health and prevent diseases caused by smoking.

303. Uruguay was the first tobacco smoke-free country in America. In June 2003, Uruguay signed the Framework Convention on Tobacco Control. Decree 268/05 on 100% smoke-free environments took effect in the country on 1 March 2006. These achievements were mainly due to the activities of the National Alliance for Tobacco Control. PAHO promoted formation and consolidation of this alliance.

304. Several activities have been conducted in the context of tobacco control, including the "A Million Thanks" campaign (2006), which expresses appreciation for the commitment by persons opposed to smoke in indoor places. Over 1,200,000 Uruguayans participated in this campaign. A toll-free telephone line (0-800-HUMO) was also established, which allowed people to consult and participate in the global campaign. Public awareness-raising campaigns have also been conducted.

305. In order to evaluate public opinion on Decree 268/05, a knowledge and attitude study was conducted in 2006. The study demonstrated that most of the Uruguayan society has come to understand that breathing other's tobacco smoke is dangerous and it is a violation of a legitimate individual right. In 2007, another study was conducted in order to evaluate the impact of Decree 268/05 on commercial activity. According to the results, the economic impact is insignificant.

306. In 2006 the president of Uruguay received the WHO Director-General's Award, which was awarded by the WHO Director during the celebration of the 8th Ibero-American Conference of Ministers of Health in Colonia.

WHO Framework Convention on Tobacco Control

The Framework Convention on Tobacco Control is the first international public health treaty that has been negotiated with the mediation of WHO. It was negotiated in a four-year period, opened for signatories in June 2003, and took effect on 27 February 2005. In the Americas 32 countries have already signed it and 21 have ratified the Convention.

Countries that have ratified the Framework Convention		
Antigua and Barbuda	Dominica	Panama
Barbados	Ecuador	Paraguay
Belize	Guatemala	Peru
Bolivia	Guyana	Saint Lucia
Brazil	Honduras	Trinidad and Tobago
Canada	Jamaica	Uruguay
Chile	Mexico	Venezuela

From 2003 to 2007, training workshops on tobacco smoke elimination policies were held in 11 countries: Argentina, Costa Rica, El Salvador, Guatemala, Honduras, Jamaica, Panama, Peru, Saint Lucia, Suriname, and Uruguay. As a result, many advances have been made in the Region as regards enactment of legislation.

Tobacco smoke-free environments in the Americas (new laws enacted between 2003-2007)*		
100% tobacco smoke-free environments (bars, restaurants, discotheques, clubs)	**100% tobacco smoke-free environments at the subnational level**	**2 out of 3 tobacco smoke-free: health, education, and government facilities**
Uruguay (2006)	Argentina, with 3 provinces (where 20% of the total population lives): Córdoba (2003), Santa Fe (2005), Tucumán (2005)	Ecuador (2006): health, education, and government facilities
		Peru (2006): health, education, and government facilities
		Panama (2005): health and government facilities

In Canada and United States, tobacco laws are enacted by each state. Consequently, approximately 80% of Canadian residents and 50% of United States residents live in a jurisdiction where there is no tobacco smoke in public spaces, including bars, restaurants, and workplaces.

307. In Argentina, the provinces of Córdoba (2003), Santa Fe (2005), and Tucumán (2005), which represent 20% of the population of the country, have been the first to adopt standards to eliminate tobacco smoke in indoor public places. The significance of the event is even greater since Argentina has not yet ratified the WHO Framework Convention on Tobacco Control.

308. The province of Córdoba has implemented the Permanent Provincial Program for Smoking Prevention and Control, which was created by a provincial act that was enacted in 2003 and took effect in 2004. Since then, there has been another provincial law that

prohibits smoking in public institutions dependent on the national government, and a national law that limits tobacco advertising. The Santa Fe Act has a wider scope, as it also prohibits direct and indirect advertising of tobacco products, sales to children, having automatic vending machines, and distribution of free samples. The province has other laws that establish definitions, prohibitions, limitations, and penalties, as well as clear mechanisms of control and penalization.

309. In Tucumán, a law prohibited smoking in convention halls, museums, libraries, banks, offices, bars, movie theatres, restaurants, and other indoor public places, even if they are private. Furthermore, it established that the owners or persons responsible for these places could request the aid of the police, and the appropriate penalties for failure to abide by the law. It has been supported by the media and by nonsmokers.

310. PAHO has supported health promotion programs in Brazil, Chile, Guyana, Jamaica, Mexico, Panama, Peru, Trinidad and Tobago, as well as other countries. The Actions for Multifactorial Reduction of Non-communicable Diseases (CARMEN) and the Integrated Initiative for Prevention of Non-communicable Diseases are regional initiatives that aim at increasing the physical activity by the population. Television host Mario Kreutzberger (*Don Francisco*), whom PAHO named a “champion of health” in 2002 because of his role in promoting health in the Americas, attended the opening ceremony of the 46th Meeting of the Directing Council of the PAHO in Washington, D.C. Don Francisco took the opportunity to launch the campaign “Let's eat healthy, live well and get moving Americas,” which is part of WHO’s Global Strategy on Diet, Physical Activity and Health.

Chile's fight against obesity

In Chile, being overweight is common in all age groups, even childhood, and it is increasing. Obesity affects 7.4% of children under 6 years, 17% of schoolchildren in their first year of school, and nearly 25% of adults and the elderly. It is estimated that the country currently has 3.4 million obese persons. If the current trend continues, by 2010 there will be over 4 million persons.

Like other countries in the Region, Chile is experiencing a cultural, social, and economic process that favors unhealthy lifestyles. Comparison of the last two national surveys on family budgets and expenditures shows that a significant portion of the increase in the income of the poorer strata has been used to purchase food with high levels of fat and refined sugar, processed food, televisions, electrical appliances, telephones, and vehicles. These are products that contribute to an unbalanced diet and a sedentary lifestyle.

In 2006, Chile adopted the Global Strategy against Obesity (EGO-Chile), which is based on the recommendations of the Global Strategy on Diet, Physical Activity, and Health. It supplements and expands the nutritional intervention strategy throughout the entire life cycle. This strategy has an important communication component that seeks to foster better eating habits and regular physical activity.

PAHO and the Ministry of Health have established a joint national effort that focuses on physical activity. The goal is to increase individual and population levels through the *Ciclo Recreo Vía* program in Santiago, which offers children and adults a safe environment for recreation and physical activity. In Chile, PAHO seeks to guarantee the sustainability of the program.

Prevention of Accidents and Injuries caused by Acts of Violence

311. Since 2002, PAHO and the Centers for Disease Control and Prevention (CDC) have participated in a joint project in hospitals in Colombia, El Salvador, and Nicaragua with a view to establishing surveillance systems that facilitate collection of up-to-date and timely information on the magnitude and characteristics of injuries by patients that visit the health care services for this reason. The ministries of health and some hospitals have used these analyses to make internal decisions and propose interventions that prevent injuries. The initiative is currently being extended to other countries.

312. With funds from the German agency GTZ, PAHO has been promoting the Youth Development and Prevention of Violence project in Argentina, Colombia, El Salvador, Honduras, Nicaragua, and Peru since 2004. The project seeks to strengthen government institutions and NGO networks, and publish national materials on public policies and participatory experiences related to prevention of violence in these countries. Work with other agencies has also been promoted during the quinquennium. PAHO has sponsored the Inter-American Coalition for Prevention of Violence (CIPV) since 2003. This coalition is made up of several multilateral and bilateral agencies that formulate strategies and possible solutions to reduce violence and crime in countries of the Americas.

313. In March 2007 the directors of these agencies held a meeting at PAHO Headquarters, and a five-year report was submitted. Since it was established five years ago, the coalition has introduced specific activities with measurable results. In addition, it has acted as a catalyst for inter-agency collaboration and implementation of effective strategies throughout Latin America.

314. In collaboration with the PAHO/WHO Collaborating Center for Prevention of Injuries and Violence, the Center for Health Research and Violence (CISALVA) of the Universidad del Valle in Cali, Colombia, USAID, PAHO and CIPV have applied an intersectoral model in some *municipios* of El Salvador, Nicaragua, and Panama in order to improve the poor quality of registries of deaths caused by deliberate and involuntary injuries. In Colombia, the model has produced good results in at least 30 *municipios*.

315. Since World Health Day was held in 2004, PAHO has reaffirmed its commitment to promoting the safety of the road network. Cooperation with national authorities has led to approval and publication of National Road Safety Plans in several countries, including Costa Rica, Ecuador, El Salvador, and Peru. PAHO ensured that activities were conducted in nearly all countries in the Region in April 2007 on the occasion of Road Safety Week and the Youth Assembly for Road Safety. A document with recommendations on obtaining, analyzing, and circulating information about traffic accident-related injuries has been prepared and made available.

Disaster Preparedness and Other Unforeseen Situations Important for Health

316. At the request of the Ministers of Health in the Region, PAHO has established a regional response team for emergencies and disasters. A total of 111 national experts have been trained in 15 countries. This multidisciplinary team, which includes specialists in disaster management, epidemiology, water and sanitation, communications, mental health, health services, civil engineering, administration, and logistics, has been mobilized with very good results in the emergencies that have required international solidarity and PAHO technical cooperation.

317. Since 1976, when the PAHO Disaster Program was created, there has been continuous progress in activities by the health sector to reduce, prepare for, and respond to disasters in the Region. However, this progress has never been systematically measured. Therefore, PAHO designed and applied a regional evaluation survey. This survey has produced results that have been used to establish the level of institutional development and evaluate the status of planning, training, and availability of resources in order to respond to disasters and reduce their health consequences.

318. During the past five years, PAHO has consolidated the experience gained in the countries in the Region by producing guides and technical materials for comprehensive

management of emergencies and disasters in the field of health. These materials have been produced with the participation of entities such as WHO and other agencies of the United Nations, Red Cross, and the World Bank. With the support of the Regional Disaster Information Center (CRID), several countries have developed health information systems. The CRID is an initiative sponsored by six organizations, including PAHO, which have joined to compile and circulate information about disasters in Latin America and the Caribbean.

319. Although the impact of disasters has varied during the quinquennium, PAHO has always managed to assist the countries by mobilizing funds and response teams, and especially by providing technical cooperation in situations of internal conflict such as those that occurring in Haiti and Colombia. By opening decentralized offices, they have been able to concentrate cooperation in the communities that are directly affected.

320. Honduras, a country that is susceptible to hurricanes, offers an example of the progress achieved. Honduras currently has departmental emergency plans in 19 of its 20 regions. The Ministry of Health disaster unit has placed a great deal of importance on training resources in the departments. Training has been implemented for local teams so that they can predict and respond better to disasters.

321. Disaster management training has also been included in master's level courses on public health and risk management given by the National Autonomous University of Honduras. In addition, the country has the Emergency Operations Center manual for the health sector, an instrument that defines organization of the sector in order to respond in the event of an emergency or disaster.

Guatemala recovers from damages caused by the tropical storm Stan

In 2005, the tropical storm Stan shook Guatemala, where it caused loss of life and significant damage to the public and social infrastructure of 15 departments in the country. As a result of the storm, 670 deaths, 844 missing persons, 495,927 direct victims due without housing, and 2.7 million affected inhabitants were reported. Many of them had to be lodged in 762 provisional shelters. Furthermore, there were damages to 38,058 dwellings in 1,372 communities located in 251 of the 331 *municipios* in the country. Eighty-seven health stations, 31 health centers, and more than 15 thousand water wells were affected. The areas affected most were important centers of Mayan population (*Mam, Kaqchiquel* and *K´iché*), where many poor and vulnerable households headed by women are located.

Under the management of the Ministry of Public Health and Social Welfare (MSPAS), with the participation of PAHO, UNFPA, UNICEF, UNDP, CDC and USAID, comprehensive interventions were conducted in several areas. PAHO mobilized more than $3 million from the governments of Canada, United States, Netherlands, Norway, Monaco, and Sweden. The initiative reduced death and disease in the populations affected, and made it possible to maintain dynamism and solidarity for reconstruction of the social fabric, social services, governance, and the local economy. It also strengthened the local capacity to cope with future natural disasters.

Mental health care for the populations affected became a fundamental element of comprehensive care. Teams of psychiatrists, psychologists, and social workers evaluated the situation and provided care for the persons affected. Intersectoral brigades were formed, comprised of these experts as well as physicians, nurses, nursing assistants, nutritionists, epidemiologists, sanitation engineers, vector specialists, pharmacists, health promoters, and volunteers.

Integrated and coordinated food assistance was provided by the agricultural and health sectors, the food and nutrition safety program of the Ministry of Health (PROSAN), the Ministry of Food Safety and Nutrition (SESAN), and other institutions. A nutritional surveillance system was created in seven *municipios*. This system facilitated detection of deficiencies, as well as provision of food and micronutrients for children and pregnant women at risk of malnutrition.

322. In January 2005, torrential rains caused serious floods along the coast of Guyana, which is the most populated area in the country. Approximately 290,000 people were affected (39% of the total population). Within a few hours, thousands of victims had to leave their homes in the capital and coastal towns, and nearly 5,000 had to go to improvised shelters.

323. With the support of PAHO, the Ministry of Health organized and dispatched 30 to 40 mobile medical teams every day to provide medical care, and administer medication and oral rehydration. Environmental health experts also advised inhabitants on the best water treatment practices at home, and distributed bleach and cleaning products.

324. A public campaign for the prophylactic treatment of leptospirosis was conducted, and suspected cases were sent to Georgetown Public Hospital. Extensive public information campaigns were also conducted on water, sanitation, personal hygiene, diarrhea prevention, oral rehydration salts, and cleaning measures after floods.

325. PAHO provided assistance for epidemiological surveillance, health systems management, water and sanitation, hygiene measures, and food supply. It collaborated in supervision of 43 registered shelters and prepared a manual on health protection in the shelters. It also helped the health authorities on the island to improvise health care centers.

The Cricket World Cup held in the Caribbean poses health challenges

Between 11 March and 28 April 2007, several countries in the Caribbean served as hosts for the Cricket World Cup (CMC), an event of international importance sponsored by the International Cricket Council. Host countries were Antigua and Barbuda, Barbados, Grenada, Guyana, Jamaica, Saint Kitts and Nevis, Saint Lucia, Trinidad and Tobago, and Saint Vincent and the Grenadines. During the Cup, the countries were considered to be a single domestic area for safety and immigration purposes. The arrival of over 100,000 visitors was expected, including spectators, participants, and the press. Due to its magnitude, the event required implementation of public health measures and reinforcement of epidemiological surveillance. The emergency and port health services applied international standards in order to guarantee a safe and healthy environment for competition, and protect the health of the local population as well as visitors.

Starting two years before the Cup, PAHO supported training activities in all countries that participated in the competition. A total of 1,302 people were trained, and a database was provided with experts from several disciplines trained in disaster management. Simulation activities were conducted in several host countries. PAHO also provided the countries with direct technical assistance on environmental health, waste disposal, and food hygiene. The collaboration between agencies enabled the countries to gain experience in procurement of ambulances, critical care equipment and instruments, personnel training, and use of operating systems. As a result of this collaboration, there were no disease outbreaks with epidemiological importance.

326. In 2004, the 45th PAHO Directing Council approved Resolution CD45.R8 urging Member States to adopt the "Hospitals Safe from Disaster" slogan as national policy in order to reduce hospital risks. The resolution established a regional goal that all new hospitals must be built with protective measures that guarantee they continue to function during disaster situations. It also calls on governments to ensure that reinforcement and refurbishing of existing health facilities, particularly those providing primary and emergency care, includes introduction of appropriate disaster reduction measures.

National Border Health

327. As a result of the current processes of commercial integration in the Region, national border health has become increasingly important. In order to control sexually transmitted diseases, the United States and Mexico requested that PAHO create a field office on the Mexican-American border. This office, which was established in 1942, has conducted activities that have been implemented in other border areas in Central America and South America.

Health at the Brazilian, Colombian, Ecuadorian, Peruvian, and Venezuelan borders

Within the framework of different subregional agreements, the border areas between Andean countries conduct activities that integrate several sectors of development. One of the most dynamic sectors is the health sector, which emphasizes epidemiological surveillance committee (COVES) activities, disease prevention and control activities, and agreements on common use of services. In recent years, the spheres of action have been extended to also include pesticide poisoning and water quality surveillance (Colombia-Ecuador border); development and application of methods to analyze the comprehensive health situation (ASIS) (all borders) as a basis for development of the Andean Border Health Plan; local reinforcement for functions considered in the International Health Regulations (Colombia borders with Brazil and Peru); studies on prevalence, behavior, and availability of services for persons with HIV (Ecuadorian border); and development of care models for the indigenous population (Venezuelan border); training in epidemiology, situation rooms, and the geographic information system.

The progress of activities is evaluated continuously, and reviewed and adjusted by neighborhood committees, binational technical health committees, and the presidential committee on border integration (COPIAF). PAHO has provided technical support for preparation of disease control modules based on epidemiological principles (MOPECE), the geographic information system (SIGEPI), the ASIS method, and the water quality monitoring and situation room, as well as other activities. In addition, it has provided economic cooperation through three technical cooperation projects with these countries (Colombia-Ecuador, Colombia-Venezuela, and Brazil-Colombia-Peru). The instruments described above are distributed and used in all projects.

In addition, binational health actions support the integration efforts agreed on by the respective ministries of foreign affairs and subregional agencies (Meeting of Ministers of Health of the Andean Area and Andean Health Agency).

328. On the border between Belize, Guatemala, and Mexico, projects focusing on surveillance, prevention and control of communicable diseases such as human rabies, Chagas' disease, and malaria have been conducted. These have been promoted by the Tuxtla Agreements, the Puebla-Panama Plan, and other formal collaboration treaties supported by PAHO as well as other international cooperation agencies.

329. Uruguay has worked in conjunction with Brazil, particularly Rio Grande do Sul, with extensive participation by the municipal governments of Uruguay and the prefectures of Brazil, on border matters of mutual interest related to promotion of productive and healthy communities; development of zoonosis control strategies; integration of actions in health and agriculture; performance of coordinated municipal activities on food safety; and integration of joint binational bodies with local integration.

330. On the binational border between Brazil and Uruguay, PAHO has formed binational health committees; productive and healthy communities in neglected areas of Artigas, Rivera, and Cerro Largo; and coordination meetings between several different national agencies. All of this work has been demonstrated by national and subregional projects, such as the PAHO subregional projects, the Southern Cone Project for Hydatidosis Surveillance and Control, and Chagas' disease control.