Strategic and Programmatic Orientations, 1999–2002
We are committed to health for all, to the primary care strategy, to health promotion, and to the reduction of inequities and social exclusion.

Mirta Roses Periago
Inauguration Speech as Director of PAHO
Health Systems and Services Development

“Public Health in the Americas” Initiative

In 2002, the main lines of work in the area of health policies and systems were the extension of social protection in health; the reorientation of sector reforms; the strengthening of national health authorities’ capabilities to provide leadership and guidance; and health economics, financing, and regulation. Technical cooperation aims at ensuring that these processes are firmly grounded in the development, execution, and evaluation of national health policies and objectives.

Extension of Social Protection in Health

The strategy for extending social protection in health strengthens Member States’ capabilities to expand access to health care through activities designed to generate information on the extent of exclusion to health care in the countries, increase social dialogue as a way to reach consensus on the most appropriate strategies for reducing exclusion, and support the countries in their efforts to improve collective insurance systems.

These activities were carried out within the framework of cooperation between PASB and the Government of Sweden through the Swedish Agency for International Development (SIDA) and between PASB and the International Labor Organization (ILO). The former effort supported Latin American countries in their efforts to address social exclusion in health and to promote social protection strategies. Projects were carried out in Ecuador, the Dominican Republic, Guatemala, Honduras, Mexico, Paraguay, and Peru.

In order to support a diagnosis of the exclusion situation, a research protocol was developed to define social exclusion in health and identify its leading causes and characteristics. The Dominican Republic, Ecuador, Guatemala, and Paraguay have already completed their diagnoses by applying the protocol, and Honduras, Mexico (D. F.), and Peru have begun the process.

Ecuador and Guatemala launched a social dialogue to create awareness of the problem of exclusion in health, its extent, and the need to reduce or eliminate it. This will help promote consensus among social actors on the most appropriate methods and mechanisms for formulating policy and increasing social protection in health. The most important result of the social dialogue will be the development of a concerted action plan. A protocol to implement social dialogue is being designed in support of
countries that have agreed to participate in this activity.

Health sector reforms designed to improve collective insurance systems were supported in Ecuador and Peru. The objective is to strengthen the health system’s capacity to provide social protection to its citizens, regardless of their ability to pay, through mechanisms aimed at the creation and extension of protection systems and the promotion of a more integrated and appropriate regulatory system that will be of use to the entire health sector, and not just the public sector.

In addition, through their joint work to extend social protection in health, PASB and ILO have been working since 1999 to launch a regional initiative promoting the systematic diagnosis of exclusion in health, identifying solutions, and taking the necessary steps to support Member States in their efforts to minimize social exclusion and strengthen institutional capacity to extend health protection. The proposal includes the development of training methodologies and tools, research, and the exchange of successful experiences and recommendations.

One of the most important support measures for these activities is the mandate that Member States gave PASB and the ILO Directors in 2002, requesting that they disseminate the conceptual basis of exclusion in health and the means for combating it throughout the countries of the Region. Both institutions also were asked to work with Member States to promote social dialogue in this regard and to specify the cooperation mechanisms necessary to support the process.

Strengthening the National Health Authority’s Leadership and Guidance Role

One of the most important challenges in carrying out health sector reforms is the need to strengthen the health authority’s leadership and guidance role. The health authority’s main responsibilities include the performance of essential public health functions, such as State’s responsibility over health at the central, intermediate, and local levels. This requires the development of tools for assessing the performance of those functions. These tools identify strengths and weaknesses in the practice and infrastructure that support the essential functions, thereby reinforcing the institutional capacity to improve public health operations.

The health sector’s transformation requires a clear determination of its scope and function, as well as the need to implement the concepts on which it is based. To accomplish this, the Bureau cooperated with 41 countries and territories to assess the performance of 11 essential public health functions. This exercise provided the basis for evaluating the national authorities’ performance in exercising public health functions and in developing an agenda for improving them through national and international cooperation.

The assessment carried out within the framework of the “Public Health in the Americas” initiative yielded the following immediate results:
• Public health and its essential functions in the Americas were defined.
• A framework for evaluating the performance of essential public health functions applicable to all countries of the Americas was established; it respected the organizational structure of each country’s own health system.
• Public health practice was assessed in each country, gauging the extent to which essential public health functions are performed.

The assessment also yielded other results, which, in addition to strengthening technical cooperation in the preparation of comprehensive development programs, encouraged cooperative activities among countries and among areas in different countries. Moreover, the assessment led to an ongoing improvement of the tool, its implementation at subnational and local levels, the development of an analytical framework of the funding for essential functions, improved training of the health workforce, and improved professional practices. The book Public Health in the Americas was published; it lays out an innovative theoretical and conceptual reassessment, the methodology, and the Regional results of the assessment.

Health Sector Reform Initiative in Latin America

The health sector reform initiative in Latin America is designed to support the countries’ efforts to reform their health sectors so as to promote a more equitable access to effective and efficient health services. The interest in assessing the health systems’ performance increased the pressure on them to strengthen their capacity. To this end, the initiative’s second phase, which began in 2002, focused on the development, redefinition, and implementation of new tools and on the formulation of methodologies for supporting the countries in strengthening their national capacities.

To monitor the progress of reforms, 33 countries participating in the initiative have completed the first draft of their health systems and services profiles; with the exception of Canada, Haiti, Suriname, and the United States, they also have completed a second version. A comparative regional analysis of health sector reform progress was concluded. The ongoing monitoring and evaluation process makes it possible to develop national, subregional, and regional progress reports on problems identified in the health sector reform processes, and fosters comparative analyses and the exchange of experiences among countries. Based on the information obtained with the profile methodology, PASB recently undertook a second evaluation of the reforms.

The initiative also produced a sectoral analysis methodology that can be used as a guide for the comprehensive and systematic analysis of health sector performance and, in turn, promote a solid foundation on which to formulate health sector reform policies and strategies. The methodology was successfully pilot tested in Costa Rica, Cuba, Guyana, Nicaragua and Paraguay. As a result of these trials and the contributions of experts, the
methodology is being revised and expanded. A chapter on HIV/AIDS was incorporated, underlining the urgency of strengthening the health systems and services to address this pandemic.

An investment master plan published in 2002 is intended to help the countries achieve consistency between investment plans and sectoral reform activities. The master plan encourages the mobilization of national and international resources for activities that pave the way for achievement of the national goals. Bolivia, El Salvador, Guatemala, Honduras, Nicaragua, and Paraguay formulated master plans and tested their effectiveness in mobilizing resources for sectorial reform.

The initiative is being disseminated through the health sector reform information and analysis system, as a component of its Web page. This system played an important role, integrating the first and second phases of the initiative and offering a dynamic mechanism for compiling, organizing, and disseminating information on experiences in the Region. It includes an inventory of initiative products and is being updated to include on-line access to tools and methodologies produced by specialized institutions that participate in health sector reform processes. It also includes a thesaurus on reform that has been adapted to the changing needs of the process, and to which a database developed in the Region has been added. Finally, an on-line database was created with information on experts and institutions experienced in health sector reform.

Health Economics, Funding, and Expenditures

Technical cooperation in health economics and funding was aimed at developing the Health Accounts/National Health Accounts (HAs/NHAs); promoting analysis of the relationships among health, human capital, and economic development; and developing tools to measure inequalities and inequities in the health systems. The Health Accounts/National Health Accounts are tools for estimating and using economic and financial indicators to achieve greater efficiency and equity in national health system funding and expenditures.

Actions were undertaken to strengthen national capabilities for estimating and using economic-financial indicators, developing and applying methodological guidelines for the formulation of internationally-comparable economic and financial indicators, and developing and maintaining PASB’s database on health expenditures and funding (NHExp Database).

To strengthen national capabilities, direct technical cooperation was provided to Aruba, Curaçao, Bolivia, Costa Rica, Ecuador, El Salvador, Honduras, Panama, and Venezuela. Support was provided for the design and implementation of training workshops for HA/NHA development in Costa Rica, Ecuador, and Venezuela. Through the institutions that participate in the Shared Health Agenda, country resources were mobilized to con-
duct studies on health sector expenditures and funding in Bolivia, Chile, Colombia, Haiti, El Salvador, Guyana, Nicaragua, Paraguay, Peru, and Suriname.1

Updated estimates of internationally-comparable indicators of national health expenditures (NHE)—per capita NHE, NHE as a percentage of gross domestic product (GDP), and public-private composition—for 48 countries and territories of the Region can be found in *Health in the Americas, 2002 edition,* and in the Basic Indicators, 2002 brochure. Estimates have been developed on expenditures for and coverage of the social protection programs up to 2000 and on public investment in health for 1970–2000 for Central American countries and Panama.

PASB’s database on health sector expenditures and financing (NHExp Database) continued to be developed and maintained as a way to generate comparable economic and financial indicators on national health expenditures and on the leading macroeconomic variables used in deriving such indicators. The NHExp database covers the 1980–2001 period and contains detailed information, by country, in accordance with the items in the United Nations System of National Accounts. It includes estimates of health expenditures by the economy’s various institutional sectors: government, including social security institutions (public sector); households (private expenditure); and by other institutional sectors of the economy, such as health expenditures by finance companies and non-financial companies (businesses) and by non-profit institutions that serve households.2

In order to formulate comparable methodologies for estimating health expenditures that will enable the countries to obtain precise estimates based on the National Health Accounts System, the Spanish version of the proposal, “A System of Health Accounts,” prepared by the Organization for Economic Cooperation and Development (OECD), was revised in collaboration with that organization and Eurostat.3

In regards to health, economic growth, and human capital, actions were taken to ensure that health figures prominently on the development agenda. To learn more about the impact of health on the quality and improvement of the necessary human capital to foster economic growth and social development by reducing poverty and inequities, a seminar on health, human capital, and economic growth was held in 2002 in Washington, D.C. This seminar, which focused on theory, evidence, and policies, was aimed at decision makers and high-level researchers; it included presentations and discussions on factors related to macroeconomic growth, which were designed to identify the importance of this global focus for the Region in terms of future lines of work on tuberculosis, malaria, and AIDS.4

As a way to measure inequalities and inequities in the health system, comparative studies of health system inequalities and inequities and poverty were conducted in Brazil, Ecuador, Guate-

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1 The reports will be available on the Pan American Health Organization’s Health Accounts/National Health Accounts web page.
2 The information is available on the Pan American Health Organization’s web page and on the specialized web page on Health Accounts/National Health Accounts of the Shared Health Agenda http://www.paho.org/. Go to Health Expenditures; http://www.lachealthaccounts.org
3 The Spanish version of this document was published by the Inter-American Development Bank (IDB) as part of the collaborative program within the framework of the Group of Health Accounts/National Health Accounts of the Shared Agenda.
4 http://www.paho.org/english/DEC/shareagenda.htm
The results of this research were published in 2001 in Investment in Health: Social and Economic Returns, Scientific and Technical Publication No. 582.

The studies were carried out within the framework of research projects designed to measure health inequalities that have been funded by the World Bank, the United Nations Development Program, and the Pan American Sanitary Bureau (EquiLAC Project).

Health Legislation and Regulation

Many countries of the Region continued to promote regulatory processes for health sector reforms in order to help extend social protection in health and improve the exercise of the essential public health functions. As part of its technical cooperation for regulation and legislation, PASB supported Bolivia, Ecuador, El Salvador, Nicaragua, and Panama in their efforts to revise their national health system regulations and general laws on health in order to replace outdated health codes. Regulations were approved in Ecuador and Nicaragua and are under discussion or being addressed in the legislatures of the remaining countries. English-speaking Caribbean countries also are actively debating the update of basic health sector legislation.

As part of the process of strengthening regulatory and control capabilities in the ministries of health, legal advisors of ministries and departments of health were trained in order to bolster their relationship with the legislatures. The role of right-to-health advocacy and defense institutions was evaluated. The IX Course-Workshop on Health Legislation, held in Mexico by the PASB, the Inter-American Center for Social Security Studies (known by its Spanish acronym, CIESAS), and other academic institutions of the Region, which emphasized regulatory aspects of health access, deserves special mention.

Production of the Virtual Library on Legislation also was encouraged as support for the regulatory process. This is a component of the Virtual Health Library (VHL) coordinated by BIREME. Argentina and Mexico incorporated information into the Regional VHL in a decentralized manner, while the information for the rest of the countries is prepared centrally with the cooperation of the Global Legal Information Network, coordinated by the United States Library of Congress.

Assessment of Primary Health Care since Alma-Ata and Its Implications

The development and strengthening of primary health care (PHC) has been a key concern of the Pan American Health Organization and the World Health Organization in the 20th century’s last three decades. The reliance on PHC as a development strategy was aimed at im-

5 The results of this research were published in 2001 in Investment in Health: Social and Economic Returns, Scientific and Technical Publication No. 362.
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improving living conditions in the communities, reducing the burden of disease, and encouraging access to health care for the population.

Conceptually, PHC has been variously defined, which, in turn, reflects different perspectives. Despite unquestionable progress in terms of defining PHC, viewpoints remain confused. In this respect, the historic importance of the International Conference on PHC held in Alma-Ata in 1978 should be highlighted. This importance stems from the Conference’s contribution to at least two complementary dimensions: progress in the conceptualization of PHC, and the political legitimacy of promoting its development, which derives from the recommendations of said International Conference subsequent to the 30th World Health Assembly (1977). At this Assembly, WHO Member States unanimously decided that their main social goal was to attain, by the year 2000, a level of health for all citizens that would ensure them a socially and economically productive life. The States’ commitment is captured in the slogan “Health for All (HFA) by the Year 2000.”

The PHC definition set forth in the Alma-Ata Declaration became a mandatory reference in analyses of the issue. Starting with the Alma-Ata Conference, PHC was defined as “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.”

The Alma-Ata Conference also proclaimed that PHC “forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.”

By 2002, 25 years after Alma-Ata’s historic milestone, the population of the Americas had made health gains attributable to priority PHC activities in health education and health promotion, food and nutrition, water supply and sewerage, maternal and child care and family planning, immunization, prevention and control of endemic diseases, treatment of prevalent diseases and trauma, and access to essential drugs.

The collective experience gained with primary care has enriched the theory and practice of public health, while creating new challenges and priorities in both public health policy and population health interventions designed to achieve equity in health, and so revitalize the redistributive component of HFA.

These advances notwithstanding, the Region of the Americas continues to face serious difficulties in ensuring an equitable access to health services for all population groups. Curative, medical-
specialty, and hospital-based models of care still predominate in the Region. Poor quality care also is a problem, manifesting itself in deficiencies of the effectiveness, efficiency, acceptability, legitimacy, and safety of health services. Finally, community participation is limited to sporadic consultations in many instances, and the political and institutional frameworks to ensure adequate social participation are lacking.

In terms of the services themselves, much has changed worldwide and in each of the countries of the Americas since 1978. The economic, political, and social contexts have changed, not just as a consequence of the national historical processes, but increasingly as a result of an ever more interdependent world subject to extraordinarily rapid changes in all human life dimensions. The populations’ epidemiological patterns and demographic profiles have changed within the context of a greater exposure to risks and the transformations of the social and economic environment. Important changes also have occurred in the health systems in terms of the State’s functions and the higher level of responsibility citizens take for their own health care.

Given the above, and in view of the new challenges of the 21st century, the Bureau felt the need to initiate a PHC renewal process. To this end, PASB in 2002 moved forward in diagnosing the current status of PHC in the Americas, establishing the bases for initiating a process of conceptual and operational renewal, identifying potential future areas for technical cooperation, providing technical assistance on PHC issues to Member States, promoting the development of certain approaches to the practice of medicine and models of care under PHC, and developing a proposal to commemorate Alma-Ata’s 25th anniversary in 2003–2004.

The current situation’s diagnosis, the conceptual and operational revitalization, and the identification of potential future areas of technical cooperation are being carried out within a general framework set forth in PAHO/WHO’s position paper on the health services for 2004–2009 (“Documento de Posición de la OPS/OMS sobre Servicios de Salud para el período 2004–2009”). The most significant activity in this regard is the global project, launched by WHO in mid-2001, to review primary care. The project has three basic components—specific regional reports on PHC, regional advisory workshops on PHC, and a consolidated, global report with policy guidance for member countries.

Preparation of the report for the Region of the Americas was assigned to the University of Chile’s School of Public Health. The study is designed to review implementation of policies in Latin America and the Caribbean. Overall, the study encompassed two major themes. The first is a systematic review of the information on the Region of the Americas and the Caribbean available from different sources; the second involves the development and implementation of a tool to gather information from significant players with decision-making authority from the countries included in the terms of reference. To this end, 209 participants from the following 16 countries were interviewed—Argentina, the Bahamas, Bolivia, Brazil, Chile, Colombia, Costa Rica.
Cuba, the Dominican Republic, Honduras, Jamaica, Mexico, Nicaragua, Peru, Saint Lucia, and Trinidad and Tobago.

The other component of the global study—a Regional advisory workshop—was held in Brasilia, Brazil, in November 2001, and brought together 43 representatives from 16 countries of the Americas. The workshop helped identify challenges to PHC in the Americas and potential areas and strategies for PASB technical cooperation in this area.

Also noteworthy was the publication, in October 2002, of *Primary Health Care in the Americas: Conceptual Framework, Experiences, Challenges and Perspectives*, a study prepared by the University of Illinois School of Nursing in Chicago, Illinois, United States.

With respect to promoting the development of certain approaches to medical and health care practice models within the framework of PHC, support was provided for the I Ibero-American Summit of Family Medicine, held in Seville, Spain, in May 2002. The Summit issued the Seville Declaration and produced four technical documents on health systems and the demands and needs of the population, quality of care, undergraduate training, and postgraduate training in family medicine.

Regarding technical consultations with Member States for PHC, PASB supported two international seminars at which global and Regional trends in PHC were explored and challenges to PHC in the 21st century were discussed. The first, the II International Seminar on Experiences in Basic Care/Family Health, was held in Brasilia, Brazil, in November 2001. PASB identified the international participants and financed their participation; the experiences of Brazil, Costa Rica, Cuba, England, Mexico, New Zealand, Portugal, South Africa, and Spain were reviewed.

The second event, the VIII International Seminar on PHC and III Congress of the International Confederation of Family Medicine in the Region: Central America and the Caribbean, was held in Havana, Cuba, in June 2002. At this seminar, the Bureau identified and provided funding for participants in two special sessions—one on the results and future impact of the I Ibero-American Summit of Family Medicine, and the second on innovative PHC experiences in Latin America, which examined the experiences of Brazil, Mexico, and the Autonomous Community of Andalusia, Spain.

In a similar activity, PASB supported a round table to discuss practical experiences with PHC at the Fourth Congress of Municipal Secretaries of Health of the Americas, held in Rosario, Argentina, in November 2002. PASB contributed to identify and provide funding for participants from Brazil, Cuba, and Mexico.

In terms of technical consultations, in December 2002, a delegation from the Bureau participated in a workshop on implementing PHC strategies organized in Montevideo by Uruguay’s Ministry of Public Health.

Finally, PASB developed a proposal for commemorating Alma-Ata’s 25th anniversary in 2003 and 2004. The proposal includes the conceptual revitaliz-
tion of PHC through a joint participatory process with the member countries, the adoption of a Resolution on PHC by PAHO’s Directing Council meeting in September 2003, commemorative meetings in the member countries, and the formulation of a Regional Declaration on PHC in September 2004.

Community-based Rehabilitation and Rights of the Disabled

El Salvador, Honduras, and Nicaragua developed community-based rehabilitation (CBR) strategies involving the education, health, and labor sectors and their respective institutions. More than 15 Central American municipalities are covered, and more than 300 persons from these countries’ most affected areas attended 20 workshops. Workshops dealt with such issues as awareness of disabilities, CBR planning, and clinical skills for underserved communities. Three regional workshops also were carried out, addressing such topics as patient care for persons with physical, sensory, and mental disabilities. When the project’s first year came to a close in 2000, a more sustainable model—“training of trainers”—was developed, and it has been used since. This approach allowed project resources to be better utilized to develop skills and knowledge among nationals, who then could teach others about community-based rehabilitation.

CENTRAL AMERICA Cares for Land Mine Survivors

PASB has been working with the Canadian International Development Agency’s (CIDA) Mine Action Unit and the Government of Mexico since 1999 to assist disabled persons, including land mine victims, in El Salvador, Honduras, and Nicaragua. CIDA provided substantial funds for the project, which will end in 2003.

The initiative relied on a four-pronged effort to address the physical, social, and economic problems of land mine victims and persons otherwise disabled—integrating community-based rehabilitation into primary health care programs; developing a disability information system; promoting the reintegration of the disabled into their communities’ economic life; and improving access to training for personnel who provide prosthetic and orthotic devices.

In order to tailor the response to each country’s needs, project activities were set during an annual planning meeting held in each country. Ministries of health, of education, of labor, and of social security, as well as NGO representatives and disabled persons participated in these meetings. Each country identified demonstration sites where most land mine accidents had occurred and where the needs of land mine victims and other persons with disabilities could be met. Regional activities also were carried out so that resources could best benefit land mine survivors in Central America. Demonstration sites included Santa Ana and Chalatenango in El Salvador; Tojes, Aluca, and Danlí in the Region of El Paraíso, as well as work in the regions of San Marcos de Colón, Choluteca, and Valle in Honduras; and Nueva Segovia, Estelí, Madriz, Jinotega, Matagalpa, and León in Nicaragua.
A seminar about the initiative was held to consolidate and systematize the experiences gained through CBR training, and use them as part of an ongoing overall effort to promote community development.

Rehabilitation Information System

A disability information system (SIEDIS, from its acronym in Spanish) was developed to design and tailor programs and services so as to effectively address the needs of disabled persons; it will be eventually included in regular health information systems. This tool is used to profile the changing demographic patterns of disability causes, identify the distribution and nature of facilities needed, and define appropriate intervention programs and plans. Several training workshops were provided to health officials and technicians regarding data analysis, system design, and how to tailor the software to local needs. To date, El Salvador is using the information system in all the centers of the Salvadorian Institute for Integral Rehabilitation and at the Ministry of Health’s statistical unit; Honduras is using the system at the rehabilitation services in San Felipe Hospital and in the Ministry of Social Security; and Nicaragua has finished installing the system in eight health centers across the country (Nueva Segovia, Estelí, Madriz, Jinotega, Matagalpa, Granada, Chinandega and Leon).

Socioeconomic Reintegration

Noteworthy activities carried out as part of this component included workshops designed to create awareness among managers and employers’ organizations of the problems posed by disabilities. Workshops emphasized community-based efforts aimed at finding employment for persons with disabilities, as well as the disabled’s overall socioeconomic reintegration in society. In all three countries, the ministry of labor has been enlisted to coordinate and actively participate in these efforts. In addition, the United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities has been adopted as law in some of the countries. By providing training and financing microenterprises, the project also helped to promote vocational opportunities so that disabled individuals and their families could compete in the open labor market, facilitating their socioeconomic reintegration into the community.

Activities conducted under the project’s socioeconomic reintegration component were varied. Situational and diagnostic needs assessments for persons with disabilities were conducted in several departments and municipalities in each of the three countries; a workshop designed to provide training and increase awareness about accessibility, employment skills, and adaptations for disabled persons was offered to employers and persons with disabilities; six workshops for microenterprises carried out in El Salvador were designed to assist persons wishing to expand existing
initiatives and to develop skills in business plan development and marketing strategies; and a municipal strategic plan was developed in Honduras in collaboration with community leaders to develop short and long-term plans to look at appropriate solutions for the socio-economic reintegration of persons with disabilities, especially those affected by land mines.

The following are highlights of accomplishments of the project to assist landmine victims. Strategies were developed for the inclusion of all persons with disabilities. Activities to this end included workshops on community infrastructure designed to lead to barrier-free environments, which were held in collaboration with community and municipal leaders, engineers, architects, NGOs, and university representatives. Coordination was established at the international and national levels to promote cooperation and mobilize resources, as well as to avoid duplication of efforts. National coordinating committees were formed to ensure that all government sectors—legislatures and ministries of health, of labor, of education, and of social affairs—as well as NGOs and representatives of associations of and advocating for persons with disabilities. Victims assistance activities were incorporated into existing national rehabilitation plans, so that programs would include elements needed for the prevention and treatment of disabilities. A joint project with the Polus Center for Social and Economic Development, Inc. proposed a project to make the city of Leon, Nicaragua, more accessible to people with physical disabilities.

Virtual Campus of Public Health and the Development of the Public Health Workforce

The Virtual Campus of Public Health project is especially important because of its potential for developing human resources for the services and strengthening the public health institutions. Advances in 2002 made it possible to launch the virtual campus in the first quarter of 2003. The virtual campus’s basic objective is to develop human resources in public health, and its aim is to “bring knowledge to practice.” The campus will provide access to information on critical issues related to reform, management, and essential public health functions, and will offer Internet courses developed or selected because they can respond to public health training needs in the countries of the Region.

Directed by PASB, the campus was conceived as a collaborative project organized as a consortium of 14 prestigious public health and virtual education institutions in Latin America, Spain, and the United States. An advisory board composed by representatives of health sector employers, promotes an active exchange of service proposals offered by the campus and identifies training needs.
The campus’s teaching model is geared toward adult education, whereby the participant plays a leading role and the teacher assumes the role of facilitator. The model entails development of an atmosphere conducive to active learning, with the availability of a set of teaching resources, reference material, tutorials, and exchanges.

As a consequence of health sector reform processes, the scope of work in the health field and the development of human resources have considerably increased. Although consensus on the importance of human capital for the operation of health systems has grown, there are still challenges in terms of formulating consistent human resources policies and satisfactory management models. Moreover, strengthening the public health capability of the national health authorities requires the urgent development of human resources in this field. During 2002, PASB targeted human resources policy, regulation and management of human resources, and development of the public health workforce.

Many of the Region’s countries began to formulate policies and plans for correcting human resource imbalances affecting the health services. Seventeen countries have already joined the Observatory of Human Resources Network and a cooperation initiative with Canada has been designed to extend these processes to the English-speaking Caribbean countries. Through a work agreement with ILO’s Labor Information and Analysis System, the countries will be able to use statistical census data to obtain detailed information on the health sector’s labor situation.

An international seminar brought together representatives from several countries to discuss the institutional strengthening of human resources policy units. In support of this process, 36 experts from 13 countries participated in a cooperative study to discover the leading future trends and problems that will face human resources development in the Region.

The findings of the national working groups of the Observatory of Human Resources Network led to support for the review and discussion of statutes governing careers in the sector, both those exclusively related to the medical profession and those related to workers in general. Discussion of health professionals’ sphere of activity introduces a new vision of the regulation of professional practice and of the role of the State and professional associations.

The decentralization of human resources management has made it increasingly necessary for decision makers at peripheral levels of the system to have adequate tools. Methodologies for determining workloads in the services and improving the ability to forecast and make decisions about needs and staffing in hospitals and care systems are under development. In addition, an Internet distance learning program on human resources management for decentralized units has been finalized. It is available in Spanish, English, and Portuguese through the Virtual Campus of Public Health.
The evaluation of the performance of essential public health functions, carried out within the framework of the “Public Health in the Americas” initiative, highlighted the limited development of public health human resources in the Region’s countries. This is a matter of some urgency, in light of the importance of human resources in the public health systems and in the performance of essential functions.

While it is recognized that the countries of the Region invest considerable resources in educational interventions to improve the performance of health services and programs, little is known about the efficiency and effect of those interventions because there is no evaluation framework. Based on the results of a study of 15 projects involving the training of health services personnel in 8 countries of the Region, the Bureau encouraged the incorporation of evaluation modules into the training processes.

PASB cooperated fully with the Latin American and Caribbean Association of Public Health Education to design a joint initiative for developing the workforce and improving the quality of public health education. In response to the desire to strengthen the performance of essential public health functions set forth at the Special Meeting of the Health Sector of Central America and the Dominican Republic (known by its Spanish acronym, RESSCAD), held in the Dominican Republic in 2002, the Central American and Caribbean Network of Academic Institutions for the Development of Essential Public Health Functions was established with the support of the Andalusia School of Public Health (Spain).

A primary concern regarding the strengthening of the health authorities’ capacity is their interface with family and community care services. Given the interest in health care models based on primary care, community orientation of undergraduate training programs in clinical sciences and the development of concentrations in family and community health were encouraged.

The globalization and Regional integration processes highlight the international dimensions of the determining factors for health and the exercise of essential public health functions by the national health authorities. PASB studied in depth the competence required for an appropriate interpretation of the complex relationships among local, national, and global levels in health and for generating the ability to provide leadership in international cooperation.

Drug Observatory of the Americas

The Drug Observatory is a component of the Shared Health Agenda’s action plan for drugs, which the Organization signed with the World Bank and the Inter-American Development Bank. In addition, the Catalán Institute of Pharmacology, a WHO collaborating center for research and training in pharmacoepidemiology; the United States Agency for International Development
BRAZIL’s National Drug Policy Takes A Leap Forward

Brazil’s drug policy, approved in 1998, encompasses eight basic principles: adoption of a national list of essential drugs; sanitary regulation of drugs; rearrangement of pharmaceutical care; promotion of the rational use of drugs; scientific and technological development; promotion of drug production; guarantee of the safety, efficacy, and quality of drugs; and development and training of human resources. Two 1999 legislative decisions were crucial to the subsequent achievements: the creation of the Brazilian Sanitary Surveillance Agency (ANVISA) and the passage of the Generic Drug Law.

Significant progress was made in 2002 in the implementation of the policy. Advances had the full support of PAHO and the Pharmaceutical Care Center of the Oswaldo Cruz Foundation’s National School of Public Health. The last one is a PAHO/WHO collaborating center on pharmaceutical policy. The following achievements are noteworthy:

- Brazil took the lead in the international struggle to ensure that the United Nations would consider access to drugs a basic human right and that a 2001 meeting of the World Trade Organization would issue a declaration on intellectual property rights and public health. These efforts have resulted in a larger supply of generic products and a price reduction which, in turn, has increased the population’s access to drugs.

- Generic products were conceived as a strategy to enhance access to and the rational use of drugs; these products were quickly accepted by the people, thanks to an intensive information campaign. According to a study conducted in November 2001, 95% of the population was aware of generic drugs and 80% believed they had the same effect as brand name products.

In February 2000, ANVISA approved the registration for the marketing of the first generic drug; by February 2003, 37 pharmaceutical companies were producing generic drugs and 751 drugs with 226 active ingredients in 52 therapeutic classes had been registered. The introduction of generic products helped control the market and lower the prices of similar and innovative drugs. In fact, in Brazil, generic products are 45% cheaper than the innovative products, which in turn results in a significant decrease in the cost of treating diseases, especially chronic diseases.

Moreover, this process, which receives support from the national and multinational industry, has strengthened Brazil’s technological capability to carry out the clinical bioequivalence studies necessary for approval of these products. At this time there are 27 centers authorized by ANVISA to conduct these tests.
Pan American Conference on Drug Regulatory Harmonization

The Pan American Conferences on Drug Regulatory Harmonization are continental forums held every two years to support the drug regulatory harmonization processes within economic integration groups in the Americas. These conferences ensure that constructive dialogue takes place between drug regulatory authorities and groups concerned with drug regulation, and that harmonized guidelines and proposals regarding specific aspects of regulation are adopted and technical cooperation among countries is promoted.

The III Conference was held in April 2002, with the participation of drug regulatory authorities from the member countries, representatives of economic integration organizations such as CARICOM, MERCOSUR, NAFTA, ALADI, and the Andean Community of Nations.
HEALTH CANADA Helps to Fight Antimicrobial Resistance in Latin America and the Caribbean

Since 1996, Health Canada’s National Laboratory for Enteric Pathogens (NLEP) has been working with the Pan American Health Organization (PAHO) and 20 Latin American and Caribbean countries on a laboratory-based surveillance project to study antimicrobial resistance associated with enteric pathogens in the Region. The project has looked at the occurrence and significance of antimicrobial resistance, and worked to develop an effective prevention and control program against three major groups of enteric pathogens that cause diarrheal disease: salmonella, shigella and vibrio cholera.

The project includes a laboratory component with workshops to introduce participating countries to the standard methodology used for identifying, serotyping and conducting antimicrobial susceptibility testing; a proficiency and quality control program for the exchange of strains of enteric pathogens between NLEP and participating countries; a mechanism for sharing methods for data collection, verification and dissemination; site visits by NLEPB/PAHO teams to help enhance laboratory capacity and surveillance capabilities for enteric diseases; and annual meetings to exchange information.

In 2002, NLEP’s major activities included:

• an annual meeting held in Santa Cruz, Bolivia, to exchange information among participating countries;
• support for the participation of 20 countries (21 laboratories) in the Proficiency and Quality Assurance Program;
• a site visit to Paraguay that included an evaluation of capabilities of the reference laboratory, various regional laboratories, and various hospitals within the country’s health net; and
• quality control testing of various antisera from production centers in South America and Mexico.

as well as representatives of the pharmaceutical industry, consumer groups, academia, and regional professional associations.

During the conference, rules and regulations governing operations of the Pan American Network for Drug Regulatory Harmonization were updated and an executive committee was designated. The committee is composed by five drug regulatory authorities, one from each country representing the different integration groups in the Americas: Mexico (NAFTA), Guatemala (Central America), Colombia (Andean Area), Brazil (MER-COSUR), and Jamaica (Caribbean). It also includes a representative from the Latin American Association of Pharmaceutical Industries and a representative from the Pharmaceutical Industry Federation. Drug regulatory authorities from Argentina, Bolivia, Costa Rica, Trinidad and Tobago, and the United States function as alternate members of the network’s executive committee. The confer-
ence approved criteria for prioritizing bioequivalence studies, which include a preliminary list of drugs required in those studies. In the area of clinical research, guidelines for the establishment and operation of an ethics committee and guidelines for preparing requirements for informed consent were approved. The conference also reported on the status of the project for pre-qualification of products that WHO is jointly promoting with UNICEF, USAID, and the World Bank. This project, which in its first phase is focusing on antiretroviral products, will later be extended to cover tuberculosis and malaria drugs.

Also addressed at the conference was the struggle against counterfeit drugs. To this end, results obtained by the Government of Colombia were presented, as were those from the external quality control program being conducted in collaboration with the United States Pharmacopeia, and in which the official drug quality control laboratories of PAHO/WHO member countries participate.

The implementation of good manufacturing practices that ensure the quality of drugs is a priority in support of the agreements among countries in terms of their harmonization and free trade processes. This priority was assumed by the Pan American Network for Drug Regulatory Harmonization and, between April 2001 and September 2002, a broad plan of educational activities was implemented. It included two regional seminars supported by the United States Food and Drug Administration (FDA) and the University of Puerto Rico, a subregional seminar for Caribbean countries, and national courses in 18 Latin American countries. All these activities enjoyed the collaboration of college professors from Colombia, Costa Rica, Mexico, and Venezuela. Some 571 professionals from government sectors (inspectors of good manufacturing practices), the education sector, and the private sector (pharmaceutical industry) received refresher training.

Blood Safety

Safe blood remains as a critical issue in the Americas. Although blood collection and screening has improved, better quality control is still needed to achieve universal access to safe blood.

The emergence of AIDS in the 1980s and the fact that HIV can be transmitted through blood transfusions helped raise concern for risks associated with unsafe blood transfusions. Today, it also is clear that other infectious diseases such as hepatitis B and C and Chagas’ disease can be transmitted through blood. In addition to conventional screening, work is under way to make testing more specific.

All the Region’s countries, except Cuba, are experiencing blood shortages for transfusions. According to WHO and the International Federation of Red Cross and Red Crescent Societies, a country or a community must have enough blood so that 5% of its population has an adequate blood supply. Only Cuba meets this requirement; other countries only have enough blood to cover 1%.
Through its support of national blood programs in Latin America and national blood banks in the Caribbean, PASB has helped to improve blood safety in the Region. PASB technical cooperation was based on agreements reached by consensus with coordinators of the national programs or directors of the blood banks, during subregional meetings; agreements were followed up with discussions with PASB’s technical partners. Activities aimed at improving the safety of blood for transfusions; they were funded with contributions from the Government of Spain, the Pan American Health and Education Foundation (PAHEF), and the Bill and Melinda Gates Foundation, were carried out with the collaboration of institutions and experts from Latin America, the Caribbean, Europe, and the United States. The most recent Three-year Regional Action Plan was presented to the Bill and Melinda Gates Foundation and received funding for the 2000–2003 period.

With the support of a US$ 4.9 million donation from the Bill and Melinda Gates Foundation, PASB launched a “Regional Blood Safety Initiative,” aimed at improving the quality of blood for transfusion in the Americas. It emphasizes the promotion of voluntary blood donation and the complete screening of donated blood. This is especially important in the Americas, where only a small number of the Region’s countries and territories obtain blood for transfusion from voluntary, unpaid donors. The initiative envisions that all units of blood in every country in the Americas will be screened for HIV, hepatitis B and C, syphilis, and Chagas’ disease by the end of 2003. One of the main requirements for a safe blood supply is that donations be from volunteers—the patient’s family and friends—rather than remunerated or replacement donors. Volunteer donations are linked directly with another major problem facing the Region: the blood shortage. PASB’s technical cooperation has been emphatic about processing blood to guarantee it is screened properly.

PASB, in collaboration with a group of anthropologists, has developed methodological guidelines to explore the knowledge, attitudes, and practices of the general public regarding blood banks and those who work in them. This research aims to gain an understanding of the factors that encourage and discourage voluntary blood donation.

PASB’s work intends to improve the safety of blood bank services throughout the Hemisphere and meet the targets set by the Region’s ministers of health—screening of all blood and ensuring that all blood banks participate in quality control programs. Activities carried out as part of the blood safety initiative have improved the coverage and quality of screening by blood banks.

With the participation of national blood program coordinators and national blood bank directors, the factors that determine the need for blood for transfusions were analyzed at the Pan American Conference on Safe Blood. National blood requirements are determined by morbidity and mortality patterns, the coverage of the health systems, and the level of technological development of medicine. In addition, conference participants analyzed the leading blood safety considera-
tions, such as the epidemiology of the infections transmitted by transfusion, and discussed the quality of serologic analyses and of blood typing and grouping was discussed. These discussions served as a basis for analyzing the functional aspects of the blood banks in the Region: the legal basis, national coordination, financial matters, and PASB’s response. Also, the Canadian and Spanish experiences were presented as examples of new approaches to improving the efficiency of blood services. The potential contribution of the Red Cross, Rotary Clubs, and certain religious groups also was analyzed. Finally, the technical areas, strategies, and regional activities for 2004–2006 were discussed.

Disaster Preparedness and Disaster Management

Incorporating Disaster Management into PASB’s Technical Cooperation

PASB has made considerable progress in mainstreaming disaster management over the past few years. To that end, the Bureau has worked closely with international counterparts in disaster preparedness and mitigation. WHO, the United Nations World Food Program, the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), the Office of the United Nations High Commissioner for Human Rights, and the United Nations Children’s Fund all have adopted the system based on the Humanitarian Supply Management System (SUMA). The importance of this system also has been increasingly recognized by several countries outside the Region.

PASB is the Inter-American system representative at the global task force for the International Strategy for Disaster Reduction. The Bureau also participates in the elaboration of the Inter-American Strategy Plan for risk management and disaster response, which will be endorsed by the OAS member states. PASB prepared most of the text for the chapters on health and potable water in ECLAC’s manual for socioeconomic impact assessment, which was finished in 2002. The long-standing relationship with the International Federation of Red Cross and Red Crescent Societies was formalized in 2002, through a memorandum of understanding that includes disaster preparedness as one of the four main topics. This agreement has strengthened cooperation among ministries of health, national Red Cross Societies, and PAHO/WHO Country Offices in the implementation of their joint action plan.

Institutional Development in the Countries

Working to establish a disaster program within the ministries of health has been a PASB programmatic strategy for some time. The strength of these programs and the political influence they
wield has changed due to external factors beyond the control of PASB. An important task of PASB’s subregional disaster advisors has been to monitor the functioning of these programs and target support to where it is most needed. Recently, there has been a resurgence of interest in strengthening national disaster programs within ministries of health. This is particularly true in Bolivia, Colombia, Ecuador, and Peru, where these programs are exercising leadership and acting as advisers to the highest-level health authorities. In some cases, they handle substantial resources, and their reach extends beyond the central level to the municipalities, which gives them added capacity to respond to real post-disaster needs. In Ecuador, the National Disaster Health Council (known as CONASE, from its Spanish acronym) was reactivated and given responsibility for emergency planning for the El Niño; in Bolivia, the Ministry’s disaster office managed recent emergencies. PASB’s focus on developing institutional capacity can be credited for the positive results of these disaster programs.

PASB’s disaster-preparedness work has reached beyond the health sector to include other government sectors, national and subregional disaster systems, civil defense organizations, the Red Cross, NGOs, and academia. Major actors in the Region have acknowledged the Bureau’s leadership in strengthening disaster preparedness and response.

Through its active participation in a range of regional forums, PASB has helped to increase knowledge about and improve programming and policy development in disaster management. PASB has strongly supported subregional organizations such as the Caribbean Disaster Emergency Response Agency (CDEMA) and the Coordination Center for the Prevention of Natural Disasters in Central America (CEPREDENAC); it also has played an important role in creating networks and bringing stakeholders together.

A Central American contingency plan was developed with CEPREDEMAC to provide guidance for ministries of foreign affairs and missions abroad in case of disasters. The plan was tested during an exercise conducted by Humanitarian Allied Forces, FAHUM 2002, and coordination problems at the national level and among countries were identified. CEPREDEMAC agreed to take the lead in incorporating the necessary changes into the plan.

A memorandum of understanding also exists between PASB and the United Nations World Food Program (WFP), allowing WFP to use the Bureau’s institutional capacities in areas where the former has no assets. The agreement was tested for the first time during simulation exercises—interagency cooperation was found to be excellent, with WFP effectively using PASB facilities in the Caribbean to deliver assistance to five affected countries.

In Guatemala, PASB has helped to enhance the Ministry of Health’s capabilities in disaster management, by providing technical support in such areas as health-sector preparedness, emergency planning, mitigation, and supply man-
agement. As a result, the Ministry established a new risk management unit staffed with seven full-time officers, incorporated other divisions into disaster prevention, used SUMA in its central warehouse, and set up an early warning system in health centers. The Ministry also prepared a national health disaster plan, and developed 11 hospital emergency plans in collaboration with local staff. The emergency plans were successfully implemented during a recent dengue epidemic. The health disaster network has been so effective that the Ministry of Health uses it to deliver other programs as well.

In Nicaragua, through a project funded by the Latin American Department of the United Kingdom’s Department of International Development, the municipality of Moyogalpa formed a municipal disaster committee, which prepared a health emergency plan and developed a methodological guide for local health-sector preparedness. Municipal health officials were trained in how to use SUMA in their warehouse, and local health centers were equipped to serve as emergency shelters. Project participants developed teacher training materials, then incorporated disaster preparedness into the curriculum for Moyogalpa’s 3,000 students. Increased public awareness about health-sector preparedness motivated the municipal government to integrate disaster management into their municipal by-laws, development plans, and annual budgets. Through training workshops and exchanges, project participants are now sharing their experience with other municipalities in Nicaragua and with neighboring countries.

In Saint Lucia, PASB has had a significant impact in promoting mitigation within the health sector through training courses, subregional meetings, and technical materials. The country’s Ministry of Health is now strongly committed to mitigation, and has convinced the Ministry of Finance and donors such as the European Union of the need for incorporating mitigation in new structures and retrofitting existing ones. The Ministry of Health has conducted a vulnerability assessment of Saint Lucia’s 4 hospitals and 35 health centers, and has allocated 30% of its maintenance budget to retrofit at least two facilities per year. To date, 80% of health facilities have an emergency water supply, compared to only 25% five years ago. A PASB expert will help incorporate mitigation in the design and construction of a new hospital and mental health facility. The Bureau also has provided technical support and booklets for a European Union project to repair and retrofit nearly 200 vulnerable homes of elderly people.

**Bioterrorism Preparedness**

The risk that a Latin American or Caribbean country could be the target of an international terrorist act, though slight, is possible. Consequently, countries in the Americas have identified the need to improve the capacity of their health services to prepare for and re-
spond to potential emergencies resulting from biological, chemical, or radiological (BCR) terrorism. Because the impact of biological terrorism can rapidly cross borders, timely detection and response in any country is of paramount importance for the Region as a whole.

It is important to place the threat of bioterrorism in the context of the Americas, however. Each year, respiratory infections, diarrheal diseases, and a host of other preventable illnesses claim a far greater toll than is likely to occur from a biological, chemical, or radiological terrorist act. Therefore, developing the capacity of the health sector to address any sudden epidemic outbreak or the release of hazardous substances, regardless of the cause, is the most effective public health investment to prepare for acts of terrorism. Countries should take steps to enhance their ability to detect, identify, investigate and respond rapidly to reports of emerging infectious diseases as part of their usual programs. This may include establishment of rapid response teams, strengthening of laboratory networks, expeditious epidemiological surveillance, inter-sectoral coordination and public health awareness for priority purposes that will be useful also for bioterrorism.

PASB began a broad consultation with Member Countries in order to respond to requests for assistance in helping prepare for and responding to BCR. At the end of 2001, PASB convened an advisory meeting on bioterrorism, at which experts from several countries outlined potential scenarios and issued recommendations to strengthen the countries’ capacity to cope with bioterrorism. Meeting results were disseminated throughout 2002. In addition, the principles for managing the health consequences of BCR terrorism were presented and discussed in the annual meeting of the PAHO/WHO Country Representatives and Center Directors. A newly created bioterrorism working group is chaired by PAHO’s Director.

The curriculum of several training events was modified to reflect the concern over BCR terrorism, and the health consequences of acts of biological, chemical, and radiological terrorism were introduced into the training of disaster focal points in PAHO/WHO Country Offices in Latin America. Similar training was provided to national disaster management officers within ministries of the health in the Region. Bibliographic material regarding deliberate use of biological, chemical, or radiological agents are now available in CD-Rom, and WHO prepared guidelines on the public health response to biological and chemical weapons.
Disease
Prevention
and Control

Communicable Diseases

Development of Surveillance Networks for Emerging and Reemerging Diseases

Acute communicable diseases have a high potential for spreading among the countries due to major population shifts, especially along border areas; commercial food trade; deficient health services; a persistently high level of poverty in some countries; and frequent natural disasters. Given these factors, the public health services’ capability to quickly recognize and respond to these outbreaks or epidemics caused by multiple agents is a growing challenge.

For many years, the countries have acknowledged the need to set up warning and rapid-response systems for communicable diseases with high epidemic potential, and important efforts have been made to strengthen national capabilities in this regard. Currently, three subregional networks for the control of emerging and reemerging infectious diseases are in operation—in the Amazon Region, in the Southern Cone, and in Central America.

Networks aim at sharing information on a timely basis, strengthening ties between laboratories and epidemiological services, and applying common protocols for specific diseases and syndromes using standard laboratory procedures. With the support of the United States Centers for Disease Control and Prevention (CDC), the Malbrán Institute in Argentina, and the Evandro Chagas Institute in Brazil, work has gone forward in training, consulting, technology transfer, supply of reagents, and development of treatment guides. A meeting with representatives from the three networks, held in Atlanta, Georgia (U.S.A.), in 2002, provided a key forum for exchanging experiences on progress achieved and obstacles encountered, and for identifying future cooperation needs.

A subregional meeting held in San Salvador, El Salvador, in 2001, examined each country’s and the subregion’s current capabilities to respond to emergencies caused by epidemics of emerging and reemerging diseases and to draw up action plans to strengthen those capabilities. The Central American Network for the Prevention and Control of Emerging and Reemerging Diseases (known by its Spanish acronym, RECACER) was created, and the duties of its general coordinating committee were established. RECACER operates under the guidelines and mandates of the health policy and technical coordination forums and mechanisms of the Meeting of the Health Sector of Central America and the Dominican Republic (RESSSCAD).
and the Council of Central American Health Ministers (COMISCA).

The coordinating committee held two meetings in 2002: the first, in February, in San José, Costa Rica, and the second in November in San Salvador, El Salvador. In July 2002, a listserv was established for RECACER members. It was subsequently incorporated into the electronic platform of INFOCOM, the system of Information and Communication in Health for Central America, a fast and secure communication mechanism that enables the countries to exchange data, information, documents, and technical standards. Joint actions were taken to control dengue in border areas, and the guide for drawing up a subregional plan on dengue prevention and control was completed and submitted to the ministers of health at the most recent meeting of COMISCA, held in Panama in March 2003.

Actions were taken to integrate the laboratory component into the surveillance system. Efforts consisted of defining the essential functions of public health laboratories and establishing a quality control system in the national networks. After technical and management training was provided to laboratory directors, the methodology used in Central America was harmonized through the procedural manuals, developed by consensus, for acute diarrheal diseases, acute respiratory infections, bacterial meningitis, dengue, leptospirosis, measles, hantavirus, anthrax, and tuberculosis. The external performance evaluation process was expanded and a tool was developed to evaluate the laboratory’s response capability for surveillance of emerging and reemerging diseases.

Biosafety standards were disseminated; guidelines were established for the operation of containment laboratories to ensure the risk-free processing of samples related to agents that pose a high risk to human, animal, and environmental health; and, after training technical personnel, a manual was developed for the use, disinfection, and maintenance of biosafety enclosures. Within the framework of implementing a unified information system on the net for public health laboratories in Central America that would be compatible with the national systems, in collaboration with the Walter Reed Research Institute of the United States Army, modules were designed for the epidemiological surveillance of dengue, tuberculosis, measles, Chagas’ disease, and HIV, and a significant grant of computer equipment was finalized.

Technical groups have been organized in all the countries (some are multi-institutional) to coordinate activities for the prevention and control of epidemics, update the technical and operational standards, strengthen the diagnostic capacity of the laboratory network, and develop contingency plans for specific diseases. In Guatemala, progress was made in the development of a medium-term action plan to strengthen the capacity of the country’s public health services to detect, investigate, and control emergencies caused by epidemics. This plan is based on a profile of the current status of services that identified the country’s strengths and weaknesses in terms of its infrastructure and per-
formance, with special emphasis on human resources training.

With PASB support, RECACER sponsored two subregional scientific conferences on emerging and reemerging diseases, one in Guatemala in 2001 and one in El Salvador in November 2002. These conferences updated professionals in the country and subregion scientifically and technically regarding patterns of disease in the area, new threats such as West Nile Virus, advances in diagnosis, evaluation of reagent kits, applied research in priority areas, and laboratory quality control.

Transfer of Chagas’ Disease Research from WHO to PAHO

The Pan American Sanitary Bureau and WHO’s Special Program for Research and Training in Tropical Diseases (TDR) have helped expand knowledge of various factors related to the control of Chagas’ disease (Trypanosomiasis americana) and of actions taken to interrupt its vector transmission in various countries.

Based on achievements in the reduction of Chagas’ disease in the Southern Cone countries and improvements in control activities in some Andean and Central American countries, TDR reached an agreement with the PASB to transfer to the Bureau two Chagas’ disease research products: “Validación de herramientas epidemiológicas” (Validation of epidemiological tools) and “Nuevas estrategias y políticas para el control de la transmisión de la enfermedad de Chagas” (New strategies and policies for the control of Chagas disease transmission). These products and their funds were transferred from TDR/WHO to PASB, which became responsible for all activities in January 2002.

Research Agenda

Research priorities were established on the basis of proposals formulated at the meeting of a committee of experts held in Brasilia in November 2000. The committee examined all achievements of the Southern Cone efforts and the epidemiological situation in the other endemic countries of the Region; it also issued recommendations and assigned research priorities. An executive committee also was set up, in accordance with TDR criteria for implementing the new strategy. In 2002, PASB called for the submission of new research proposals and research progress reports.

Elimination, Control, and Surveillance of Chagas’ Disease

The control and elimination of this vector-borne systemic parasitosis, spread through uncontrolled transfusions from infected donors and through transplacental transmission, has been addressed through subregional projects that link the programs of endemic countries with PASB. There have been coordinated activities in the Southern Cone among Argentina, Bolivia, Brazil, Chile, Paraguay,
and Uruguay, with Peru as a guest, and in Central America among Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama. Work is currently under way to revitalize efforts in the Andean countries and to address the control of Chagas’ disease in Mexico. These country initiatives have generated the necessary technical cooperation for control and surveillance to progress, be evaluated, and achieve the proposed objectives.

In the Southern Cone, work with the Intergovernmental Commission of the Southern Cone for the Elimination of Triatoma infestans and the Interruption of Transmission of American Trypanosomiasis through Transfusions, achieved an intermediate goal of interrupting the vector transmission of Trypanosoma cruzi by Triatoma infestans in all of Uruguay (1997) and Chile (1999); in most of the endemic area of Brazil (2000); in the provinces of Jujuy, Río Negro, Neuquén, and La Pampa in Argentina (2001) and in the Department of Amambay in Paraguay (2002). In Bolivia and the remaining endemic areas of the subregion, household vector infestation by T. infestans has decreased, which assumes a reduced transmission and decreased risk of infection. Different countries have shown varying degrees of progress in controlling the transfusion route of transmission in terms of legislation, coverage, and quality of the serologic screening in blood banks.

In Central America, coverage of antivector spraying increased, as has the sustainability of activities in vast endemic areas of various countries. Technical meetings such as a workshop for establishing technical guidelines for the control of Triatoma dimidiata (San Salvador, March 2003), a technical workshop to study Rhodnius pallescens, its surveillance, and control (Panama City, September 2002), and a workshop to establish indicators for eliminating Rhodnius prolirus (Guatemala City, March 2003), have improved activities by applying a knowledge-based strategy to combat the vectors. Progress has been made toward the elimination of R. prolirus, a principal objective of this project, with noteworthy cooperation among countries, as has been seen in the project involving El Salvador, Guatemala, and Honduras. PASB also is coordinating activities with the Japan International Cooperation Agency (JICA) to create synergistic working conditions in the control of Chagas’ disease in Guatemala; these actions will be extended to El Salvador, Honduras, and Nicaragua.

At the workshop on surveillance and control of Chagas’ disease in Mexico, held in that country in July 2002 and organized by the National Institute of Public Health, the Ministry of Health participated in subregional activities with Central America countries, marking the beginning of future control actions.
Advances in Regional Goals for the Control of Onchocerciasis, Lymphatic Filariasis, Geohelminths, and Leprosy

Elimination of Onchocerciasis

Current assessments place the population at risk for onchocerciasis at an estimated 544,009 (Table 1). That population lives in 2,773 villages, of which 211 are considered to be hyperendemic and exposed to a high risk of developing ocular disease.

The target of massive drug administration is the total eligible population at risk, and is referred to as the ultimate treatment goal, or UTG. Programs are monitored through the percentage of the UTG attained every year by each of the endemic countries. UTG-2 refers to the coverage attained after two treatment rounds of all the eligible populations at risk; it is the core activity of the Regional initiative.

The Region has made significant progress in attaining high treatment coverage (Figure 1). Not reflected in the figure is the fact that Brazil and Ecuador have since attained treatment coverage exceeding 80%. Success has relied on the decade-long partnership among the country programs, PASB, the Onchocerciasis Elimination Program in the Americas, and the Carter Center (USA).

Onchocerciasis is considered a problem that now has a relatively easy and economical solution. Since the advent of Ivermectin in 1987 and the Mectizan donation program, the world now can suppress and control the disease by chemotherapy. The Americas is beginning to experience the benefit that the Regional initiative has had upon morbidity and transmission rates. It is hoped that the Americas will be the first region where morbidity will cease to be a public health problem and where transmission will be interrupted. Mexico and Colombia are nearing this stage, followed by Ecuador and Guatemala. Currently, Venezuela and Brazil seem to pose the greatest challenge to the elimination of onchocerciasis in the Region.

Elimination of Lymphatic Filariasis

Lymphatic filariasis typically affects the poorest people in the poorest countries of the world. Most cases are concentrated in and around urban and periurban slums. In the Americas, 3,196,464 persons are estimated to be infected with *Wuchereria bancrofti*, the only known causative agent of lymphatic filariasis in the Region (Table 2).

Lymphatic filariasis can be eliminated as a public health problem globally, and has been identified as a disease that
Throughout 2002, PASB played a leading role in providing technical cooperation to support the implementation of eradication programs, prepare national plans and annual reports, prepare proposals for the mobilization of resources; it also coordinated the annual manager’s meeting that took place in Haiti.

Immunocromatographic-based tests conducted in 2002 suggest that Costa Rica, Suriname, and Trinidad and Tobago may have eliminated lymphatic filariasis. Should this be confirmed, the number of endemic countries in the Region will have been reduced to four. Guyana has opted for a treatment scheme based on the use of diethylcarbamazine fortified salt, and the country is expected to eliminate the disease within two years after implementing the selected strategy. Two out of the three existing foci in Brazil are on the verge of being eliminated, leaving only Recife and some of its surrounding areas.

### TABLE 1. Status of onchocerciasis in the Americas, by country, endemic foci, populations and communities at risk, and high-risk communities.

<table>
<thead>
<tr>
<th>Country</th>
<th>Endemic foci</th>
<th>Population at risk</th>
<th>Communities at risk</th>
<th>High-risk communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brazil</td>
<td>1. Amazônas</td>
<td>9,067</td>
<td>19</td>
<td>5</td>
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<tr>
<td></td>
<td>2. Roraima</td>
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</tr>
<tr>
<td>Colombia</td>
<td>1. López de Micay</td>
<td>1,270</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Ecuador</td>
<td>1. Esmeraldas</td>
<td>24,151</td>
<td>119</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>2. Satelite foci</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Guatemala</td>
<td>1. Huehuetenango</td>
<td>200,000</td>
<td>517</td>
<td>45</td>
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<tr>
<td></td>
<td>2. Sololá/</td>
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<td></td>
<td>Suchitpéquez/Chimaltenango</td>
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<tr>
<td></td>
<td>3. Escuintla</td>
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<td></td>
<td>4. Santa Rosa</td>
<td></td>
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</tr>
<tr>
<td>Mexico</td>
<td>1. Oaxaca</td>
<td>210,155</td>
<td>953</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>2. Chiapas</td>
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<tr>
<td>Venezuela</td>
<td>1. North Central:</td>
<td>99,366</td>
<td>1,164</td>
<td>80</td>
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<tr>
<td></td>
<td>Aragua, Carabobo, Cojedes, Guárico, Miranda and Yaracuy</td>
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<td></td>
<td>2. Northeast:</td>
<td></td>
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<tr>
<td></td>
<td>Anzoátegui, Monagas, and Sucre</td>
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<tr>
<td></td>
<td>3. South: Amazonas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>544,009</td>
<td>2,773</td>
<td>211</td>
</tr>
</tbody>
</table>

*aHyperendemic communities*
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**Control of Geohelminths**

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In 2002, PASB conducted an extensive review of the current situation of geo-helminths and schistosomiasis in the Caribbean and compiled a report that will be published in 2003. Although the overall tendency seems to be a reduction in the prevalence and intensity rates, geohelminth infections continue to pose a public health problem in some countries and in some areas of the Americas.

Geohelminths cause infections in neglected populations. The Regional Plan will take this into consideration, focusing on poverty stricken countries, areas, and population groups where transmission is favored by environmental and other risk factors. With PASB technical support, Brazil, the Dominican Republic, Guyana, Haiti, and Suriname have prepared annual plans that begin modestly with national activities, and then ratchet up to a subregional effort. External funds were mobilized to support pilot interventions in Suriname and Brazil. Efforts also were undertaken to articulate geohelminth control with other ongoing public health initiatives, such as efforts to control lymphatic filariasis in Guyana, Brazil and the Dominican Republic and Haiti.

**Elimination of Leprosy as a Public Health Problem**

In 2002, PASB’s leprosy elimination project made several significant advances: Paraguay attained leprosy prevalence rates that were on a par with levels at which the disease is considered to be eliminated a public health problem; Argentina, Cuba, the Dominican Republic, Ecuador, Paraguay, and Peru established national leprosy elimination plans; Ecuador implemented leprosy elimination monitoring; Uruguay set up a post-elimination project for low prevalence situations (clearinghouses and local sentinel surveillance systems); and Brazil and Venezuela reduced their prevalence rates at the national level and at the subnational level in several states, and certain departments in Colombia and provinces in Argentina also reduced their rates.

**HIV/AIDS**

As the HIV/AIDS pandemic continues unabated, the burden of disease, disability, mortality, expenditures, and decrease in productivity continues to climb. Health systems everywhere in the Region are facing the HIV/AIDS challenge while they also try to cope with a lack of resources that prevents them from meeting the needs associated with the increase in demand for and use of services. Given the already limited capability to ensure universal access and quality care according to established standards, a series of actions have been undertaken to analyze the barriers and difficulties that the health sector faces, propose avenues of action, and provide specific technical cooperation activities. Several actions have been carried out to strengthen the central role of the health sector in providing prevention, care and treatment, mobilization of resources, and coordination of actions with other sectors.

As part of the effort to analyze the situation of health systems and services vis-à-vis HIV/AIDS and to find the necessary responses to cope with this challenge, the Bureau held a consultation meeting with
representatives from Member Countries and international cooperation agencies. Delegates from 21 countries and several international organizations participated in a hemispheric forum to analyze and discuss how the HIV/AIDS pandemic jeopardizes health sector reform process and efforts to strengthen health systems in the Americas. The meeting, called “Challenge of HIV/AIDS for the Reform and Strengthening of Health Systems and Services in the Americas,” took place in Ocho Rios, Jamaica, in February 2002.

Participants at the meeting helped to develop strategies and mechanisms for strengthening the health sector’s capability to combat HIV/AIDS, improving health systems response to HIV/AIDS, and planning specific strategies for health systems development and reform to face the HIV/AIDS challenge in Latin America and the Caribbean. The meeting also sought to enhance the collaboration with partners and other organizations within the Latin America and Caribbean Regional Health Sector Reform Initiative (LACHSR) in setting up systems for technical assistance and for monitoring and evaluating country efforts to focus health sector reforms on the HIV/AIDS pandemic.

PASB and WHO provided guidance and support for developing applications to be submitted to the Global Fund to Fight AIDS, Malaria, and Tuberculosis (GFATM) in 2002. GFATM is a new global financial mechanism designed to attract, manage, and strategically disburse additional resources in countries with the greatest need. The Fund aims to help in-country public/private partnerships to scale up prevention, treatment, care and support efforts.

All GFTAM potential financial partners have highlighted the need to emphasize primary prevention and rekindle HIV/AIDS awareness among all sectors.

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CANADA Works with PERU and COLOMBIA to Fight HIV/AIDS and Tuberculosis

Health Canada assisted a Canadian expert on HIV/AIDS to undertake work in Peru and Colombia to:

- provide assistance to physicians and nurses giving health care to patients living with HIV/AIDS and/or tuberculosis in “Hogar San Pedro” in Lima, Peru;
- help conduct and participate in conferences regarding the pathogenesis of HIV-1 infection and HIV prevention;
- help conduct and participate in conferences about the pathogenesis of *Mycobacterium tuberculosis* infection, malaria, and leishmaniasis;
- deliver courses on cardiopulmonary resuscitation;
- undertake child education in Lima, Peru; and
- instruct on HIV/AIDS prevention education in Colombia.
of society. To that end, PASB, UNICEF and Mexico’s HIV/AIDS Program organized a meeting in Cuernavaca, Mexico, in March to review the current experiences in the prevention of mother-to-child transmission (PMTCT) of HIV and make recommendations for Latin American and Caribbean countries. Participants recommended that PMTCT’s three-pronged strategy be more comprehensively pursued. Currently most initiatives in Latin American and Caribbean countries focus on preventing vertical transmission, at the expense of primary prevention among HIV-negative women and prevention of unwanted pregnancies, especially among HIV-infected women who have decided not to get pregnant. According to the participants, PMTCT communication would be more accepted, less threatening, and less stigmatizing if it is integrated into existing communication efforts to promote prenatal care, mother and child health, family planning and comprehensive management of child illnesses.

In 2002, Latin America and the Caribbean made significant progress in their efforts to expand access to antiretroviral drugs. Two successful subregional initiatives—one in the Caribbean and one in Central America—deserve special mention. These two negotiations brought down the price of brand-name antiretroviral drugs to levels similar to those available in sub-Saharan Africa.

In the Caribbean, negotiations led the price of combinations of antiretroviral drugs to drop to as much as US$ 1,100 per patient per year, which is similar to prices offered to countries in sub-Saharan Africa for brand name antiretroviral drugs. Preparations for the Caribbean negotiation started in February, and the agreement with the companies was signed in July by the Pan Caribbean Partnership against HIV/AIDS (PANCAP) and the companies. Negotiations were conducted by the Caribbean Community (CARICOM) Secretariat, PASB/WHO, and UNAIDS.

The negotiations between the five Central American governments and five pharmaceutical companies also led to historic reductions in the prices of antiretrovirals. The most common treatment in the subregion (AZT+3TC+EFV) will cost between US$ 1,035 and US$ 1,600 per patient per year. This represents an average reduction of 55% over the then current prices of brand-name drugs in Central America. The Central American negotiation began in September 2002 and was coordinated by the Secretary of Social Integration of Central America, with technical support from PASB/WHO. Price reductions came about as a result of the countries’ concerted effort to negotiate with pharmaceutical companies at the national and subregional levels (see Figure 2).

The Accelerating Access Initiative supported the negotiations in Central America and the Caribbean. This initiative brings together five United Nations agencies and six pharmaceutical companies to accelerate access to care for people with HIV/AIDS by developing public/private partnerships. A PASB/WHO survey indicates that negotiation agreements between ministries of health and the pharmaceutical companies were
responsible for a drop of 54% in antiretroviral-drug prices in Latin American and Caribbean countries.

Subregional negotiations have brought about several benefits: lower and uniform prices throughout the Region; support to countries with smaller negotiation capabilities; strengthening of intercountry cooperation; and rationalization of technical cooperation by PASB/WHO, so as to help more countries negotiate in a shorter period of time. The subregional negotiations helped to advance a process that was already taking place at the national level, with countries looking at different strategies to ensure price reductions.

Another factor contributing to the increased access to antiretroviral drugs was the rationalization and standardization of treatment protocols. One of the current barriers to using these drugs is the perception that developing countries must follow therapy protocols established in wealthiest countries, practices that are beyond the means of many Latin American and Caribbean countries. To offset this, PASB prepared a guide with recommendations for treating adults with antiretroviral drugs. Designed by a group of experts from 15 countries, the “Guidelines for Antiretroviral Treatment in Adults for Latin American and Caribbean Countries” recommend the use of seven such drugs, which are expected to cover 90% of the cases requiring treatment at an accessible cost. The guidelines were a response to health authorities’ many requests for how to improve antiretroviral treatment for people living with HIV/AIDS in the Region.
Dengue

In September 2001, PAHO’s 43rd Directing Council discussed the status of dengue in the Region and adopted a resolution urging the Member States to promote intersectoral and environmental measures to prevent and control the disease. In response to the resolution, A Dengue Decalogue was drawn up in 2002, which establishes the critical points of a national dengue prevention and control program. Other noteworthy actions undertaken during the year are the distribution of “PASB Frame of Reference,” a document that analyzes the Regional situation and the decalogue to disseminate PASB strategy for dengue prevention and control; the signing of an agreement with IDB to strengthen social communication activities related to dengue control in Central America; the preparation of a social communication guide for program managers to promote behavioral modification in families to further dengue prevention; the presentation to the Canadian International Development Agency (CIDA) of a plan to train a working group of dengue specialists that would seek to establish a new way for PASB to deliver technical cooperation to the countries; the launching of Dengue Net, a global system of dengue notification by the countries; the evaluation of national programs; and an annual quality-control check of diagnostic lab-

COSTA RICA Puts in Place a Grassroots Community Strategy for the Comprehensive Management of Dengue

In Costa Rica, the grassroots community strategy for combating dengue, which is part of the “Post-Mitch” project, strengthened social participation with the establishment of three community networks in three districts of the Gran Puntarenas area: Chacarita, Barranca, and Puntarenas. These districts were selected to be included in the project because they had the highest number of dengue cases. The networks have permanent operating plans that include surveillance, education, and communication activities. The experiences of these community networks have been replicated in other districts of the Region.

As a way to support these networks, educational material was developed tailored to the local experience. This material includes the cartoon story, “Let’s Control Dengue,” the family plan to fight dengue, and the community plan to combat the disease. In addition, social actors in the Gran Puntarenas area were identified; technical cooperation was provided for the development of social participation and communication strategies based on the experiences, actual situations, and needs of each district; and a document systematizing local institutional and community experiences since the beginning of the dengue epidemic was prepared.

Moreover, cooperation was provided for equipping and putting in operation a situation room designed to strengthen regional capacity for analysis and surveillance. The situation room is an open space where health officials at the sectoral and community levels can conduct analyses and hold technical discussions to address various problems and situations related to dengue prevention and control.
ratories in collaboration with the Pedro Kouri Institute of Havana.

Finally, several documents were prepared and distributed in 2002 to facilitate technical cooperation with the countries; these were uploaded to the PAHO web page for easy access (http://www.paho.org/dengue).

In cooperation with the collaborating centers and CEPIs, the virtual course on healthy households, which focused on dengue control, was delivered, and dengue control activities were supported with the Ecoclubs of 11 countries.

Noncommunicable Diseases

Cervical Cancer

Latin America and the Caribbean have some of the world’s highest incidence and mortality rates for cervical cancer, despite the fact that most of the Region’s countries have been screening women with the Papanicolaou (Pap) test for more than 30 years. PASB has evaluated alternative approaches to screening and treatment in Peru and in El Salvador; tested methods for improving the quality of care in El Salvador; and supported Antigua and Barbuda, Bolivia, Guatemala, Honduras, Jamaica, Panama, Suriname, and Venezuela, as well as efforts of the the Caribbean Cervical Cancer Prevention Program and the RedPAC Program to strengthen existing cytology-based cervical cancer prevention programs.

In the Department of San Martín, Peru, a demonstration project is under way to evaluate the effectiveness of two screening methods—visual inspection with acetic acid (VIA) and magnified visual inspection (VIAM)—and an ambulatory treatment method for precancerous cervical lesions—cryotherapy. These alternative screening and treatment methods have been integrated into the routine primary care health services for women since November 2001. Data is now being analyzed to compare the sensitivity and specificity of VIA, VIAM, Pap, HPV-DNA testing, liquid-based cytology and the effectiveness of cryotherapy. This could result in the implementation of innovative cervical cancer prevention programs in low-resource settings.

In El Salvador, two service delivery approaches are being evaluated in the health regions of Nueva Concepcion and Chalatenango. An analysis of the effectiveness of the two will be used to organize cervical cancer screening services in the country as a whole, as well as in other Central American countries. In the Department of Cabañas continuous quality improvement model (CQI) is being tested; this effective, low-cost intervention for routine health service delivery is intended to reduce barriers for women’s participation in screening services. In this demonstration area in El Salvador, health personnel and national health authorities have developed CQI plans to be executed within their available material and human resources.

After six months of implementing the CQI plans, the following improvements have been observed: all health clinics, with the support of hospitals, have
trained personnel in how to better administer and fix Pap smear samples, which has improved the quality of the tests; turnaround time for Pap test results has been reduced; flow of supplies has been streamlined; infection prevention measures have been improved; client privacy in pelvic exams has been ensured in clinics that previously had none; efforts have been increasingly targeted to at-risk and rural women by community health workers; health workers are coordinating community resources to organize transportation and child and elder day care for women attending the clinics; and educational materials on cervical cancer and its prevention and care were developed and tested for use in all health services. Based on the success in this demonstration area, this model will be promoted for use in other regions of El Salvador and in other countries of the Region.

In terms of support for enhancing the effectiveness of cytology-based cervical cancer prevention programs, PASB provided the following technical cooperation in the countries:

- **In Antigua and Barbuda**, a needs assessment revealed deficiencies such as a lack public services for cytology and diagnosis. As a result, the Ministry of Health is improving the situation so that women can have access to public health services for screening and treatment.

- **In Bolivia**, PASB and its partner, EngenderHealth, worked with the Ministry of Health to conduct a comprehensive needs assessment to identify gaps, weaknesses, and strengths in Bolivia’s cervical cancer prevention program. As a result of the assessment and through PASB’s financial assistance, the Ministry of Health is strengthening secondary health services and improving the capacity for screening and treatment at the primary care level.

- **In Guatemala**, following the recommendations of a PASB-sponsored needs assessment to strengthen the organization of services, the Ministry of Health and an interinstitutional committee have launched a demonstration project in Guatemala City that organized a screening program using Pap smears and possibly VIA.

- **In Honduras**, PASB has assisted the Ministry of Health to strengthen its national cervical cancer prevention program, targeting health education and health promotion, retraining health personnel in administering the Pap smear test, and strengthening the performance of its cytology laboratories.

- **In Jamaica**, based on an assessment of the cytology laboratory and associated information system conducted by PASB, the Ministry of Health is working to strengthen the cytology laboratory’s performance and management structures, in order to meet the demand to process Pap smears generated by the screening program.

- **In Panama**, PASB supported the Ministry of Health’s collaboration with the country’s Cancer Institute in launching a national cervical cancer prevention program that will involve health education and recruitment campaigns; the dissemination of national screening and treatment guidelines; training of health personnel in screening, diagnosis, and
treatment; and strengthening the national cancer registry.

• In Suriname, the Lobi Foundation, Leiden University of the Netherlands, and PASB have begun a cervical cancer screening and treatment project in the country’s Hinterlands. The project aims to provide cervical cancer screening with immediate treatment for indigenous women from Suriname’s interior, and will assess the performance of VIA and Pap smear test as the screening methods. Recruitment of women will begin in 2003; 4,000 women 25–50 years old will be screened over a nine month period.

• In Venezuela, PASB supported an evaluation of the structure, process, and effects of the cervical cancer program in the State of Aragua, which has been functioning since 1996. The program has achieved a Pap screening coverage of about 32% among women 25–64 years old, has shown good follow-up of women who screen positive, and has begun to show a slowly decreasing trend in mortality rate from cervical cancer. The Ministry of Health is strengthening its cytology laboratories and secondary health services, improving the organization and management of its program, and improving the national cancer registry.

• The Caribbean Cervical Cancer Prevention Program, with a secretariat at CAREC, has developed Caribbean-specific screening and treatment guidelines, is undertaking advocacy activities.

• The RedPAC Program, as a way to enhance the performance of cytology laboratories in the Region, has been conducting proficiency testing of 45 laboratories in Bolivia, Chile, Costa Rica, Ecuador, Mexico, Peru, and Venezuela. Test results and feedback from experts to the laboratories have led to improvements in reporting accuracy, especially in Costa Rica.

Violence and Injury Prevention Project


The World Report on Violence and Health recommends that strategic plans for the prevention of violence be developed in each country. To date, Bolivia, Costa Rica, Honduras, and Jamaica have such a plan under development. The Special Meeting of the Health Sectors of Central America and the Dominican Republic (RESSCAD) requested PASB’s support for developing a strategic plan for violence prevention, and the unit has assisted in the development of these multisectoral plans.
BOLIVIA Moves from Words to Local Action

In the Cosmos 79 area of the PAHO Centenario District, Municipio de El Alto, La Paz, an initiative for citizen participation and the prevention of violence was put in place. The model used involved the community’s participation along three levels—individual, group, and organized, which channels activities toward the prevention of the most commonly seen forms of violence and abuse.

The Community Orientation Unit, which is part of the Residents’ Association, serves as a liaison between the community and those institutions that are charged with dealing with the problem. The Unit’s main roles involve orientation, information, referral, and, when appropriate, the settlement of cases. The unit provides support to community surveillance through the production of “risk maps,” suggestion and complaint boxes, recording of data, and the holding of monthly “action” meetings, which are designed to foster coordination with the institutions in charge of responding to the problem of violence.

The initiative’s major accomplishments are:

• More than 60% of cases of abuse are handled within the community, without the need for bringing in outside institutional attention.
• In a simple way (“neighbor to neighbor”), the people in the community learn about their rights and where to go if problems occur.
• Through the Community Orientation Unit, the community lets the institutions in charge of maintaining public order know where the danger areas are and what the most common types of violence are. Together they take action, thereby optimizing resources.
• The members of the Unit enhance their self-esteem and develop sensitive, solidary behaviors.

To date, the departments of Santa Cruz, Tarija, Cochabamba, and La Paz are working to replicate the model in different areas along the urban periphery, benefiting from the experience acquired in community projects such as this one.

PASB and the United States Centers for Disease Control and Prevention have co-funded the development of hospital-based injury surveillance systems in San Pedro Sula and Tegucigalpa, Honduras; San Salvador, El Salvador; León, Nicaragua; and Cali, Colombia. An international workshop was held in January in order to present the work of the different researchers. At this gathering, a commitment was made to continue pursuing efforts focused on hospital-based surveillance systems and to develop a universal patient history form to be used throughout Central America.

The World Report on Violence and Health was launched in October 2002 in Brussels, and subsequent presentations in Brazil, Colombia, Costa Rica, and El Salvador served to promote the book and the violence prevention strategies in
The initiative is known for the Spanish acronym for Conjointo de Acciones para la Reducción Multifactorial de las Enfermedades No-Transmisibles, meaning “A Set of Actions for the Multifactorial Reduction of Non-Communicable Diseases.”

Traffic-related injuries and deaths plague the countries of the Region. A workshop was held in Mexico in December to address traffic accidents, and Costa Rica has been working on prevention and surveillance of traffic-related injuries.

PASB is a member of the Inter-American Coalition for the Prevention of Violence (IACPV), along with the Inter-American Development Bank, the World Bank, the (U.S.) Centers for Disease Control and Prevention, the Organization of American States, the United States Agency for International Development, and UNESCO. This coalition acts as a catalyst for preventing violence, and works at the national and local level.

The Bureau has entered into several partnerships with collaborating centers such as the institute devoted to conducting research and to develop violence prevention and promote harmonious social coexistence (CISALVA) at the the Universidad de Valle in Colombia; the Centers for Disease Control and Prevention’s National Center for Injury Prevention and Control and National Center for Health Statistics; the University of California, Los Angeles; Emory University in Atlanta, Georgia (U.S.A.); and the University of Quebec, as well as with other agencies and organizations such as the Federation of Central American Municipalities (FEMICA) (Guatemala); the mayor’s offices of Bogota (Colombia), San Pedro Sula (Honduras), Quito (Ecuador), and La Paz and Santa Cruz de la Sierra (Bolivia); and the Center for Latin American Studies at Georgetown University. These partnerships facilitate the incorporation of intentional and unintentional injury as an item in the agendas of policy makers in the countries, giving the problem greater visibility and raising the potential for better addressing it.

The CARMEN Initiative

In September 2002, in response to the impact of the noncommunicable disease epidemic in the Region’s countries, the 26th Pan American Sanitary Conference endorsed an approach for combating the epidemic. The Conference also approved a resolution endorsing the CARMEN\textsuperscript{6} initiative as one of the main strategies for preventing chronic diseases, and requested that PASB provide technical cooperation to Member States in developing an integrated approach to noncommunicable diseases based on the initiative.

CARMEN aims to improve the health status of the populations in the Americas by reducing risk factors associated with noncommunicable diseases. The initiative has two components: risk reduction and capacity building. With its risk-reduction component, the initiative promotes and supports the reduction of noncommunicable disease risk factors and conditions through community-based interventions. To carry this out, the following three strategies are applied:
CARMEN in Chile
Chile was the first Latin American country to join the CARMEN network. Chile has chosen its national program—CARMEN-Chile—as the strategy for attaining greater health equity and the country’s health objectives for 2010. Achieving the national health objectives still poses a challenge for CARMEN-Chile, as it requires interprogramatic and intersectoral actions that will lead to a jump in quality in the health care system so as to be able to control noncommunicable diseases and their synergistic risk factors. CARMEN-Chile has, however, succeeded in implementing CARMEN demonstration areas in various locations. Currently, there are demonstration sites in five regions or areas, covering a total population of approximately 5.3 million persons. These demonstration areas are working at two intervention levels and in three learning projects.

- **Low-intensity, Broad-coverage Intervention.** The CARMEN MIRAME targets Chile’s primary-school student population and aims at improving the quality of life starting from childhood. This subprogram is part of CARMEN “Niños” MIRAME project being carried out by the Pontificia Universidad Católica de Chile.
- **High-intensity, Narrow-coverage Intervention.** This project aims to foster cardiovascular disease prevention through the control of risk factors in patients participating in the Cardiovascular Health Project. It is being implemented in thirteen physicians’ offices in two regions.
- **Continuous Skills-Training Programs in Primary Care.** The continuous skills-training programs in primary care is intended to encourage professionals in all areas of the health services sector to work toward the early detection and intervention of cardiovascular disease risk factors; to issue clinical guidelines for health care professionals; and to prepare educational materials for patients. A technical team formed by experts from the Pontificia Universidad Católica de Chile, the Ministry of Health, the National Institute of Food Technology (INTA), USACH, and PASB/WHO systematized an integrated therapeutic plan in a series of clinical guides delivered to professionals through a training cycle.
- **Skills-Training Project in Nutrition for Public Health Care Professionals.** This CARMEN project was carried out by INTA and the Ministry of Health, under the auspices of PAHO/WHO Country Office and WHO Headquarters. An evaluation process is currently in place to see if there was a difference in the utilization of the nutrition tool kit aimed at primary health care professionals that was used in demonstration areas compared to the rest of the country.
- **Distance Learning Project for the Prevention and Control of Noncommunicable Diseases.** A curriculum with specific courses and models is being prepared. The University of Santiago, the Ministry of Health, the PAHO/WHO Country Office, and the Archives and Abstracts Corporation are collaborating on the project. The program will be used internationally for distance education.
• **Integrated prevention** entails simultaneously preventing and reducing a set of risk conditions common to major noncommunicable diseases.

• **Demonstrative effect** involves conducting interventions in a demonstration area, so that their acceptability, safety, and ultimate effectiveness can be evaluated within a given context.

• **Promotion of health equity** pursues strategies aimed at reducing overall population risk, while simultaneously reducing gaps among different population groups.

The initiative also pursues the following lines of actions: policy building, community-based actions, and responsive health care services. The objective is to increase the technical capabilities of Latin American and Caribbean countries for preventing risk factors of noncommunicable diseases.

The CARMEN initiative promotes and supports networking efforts among Member Countries so they can learn from each other in regard to the prevention of noncommunicable diseases. The Region’s CARMEN network is linked to similar networks in the other five WHO Regions, as well as to the Global Forum on Noncommunicable Disease Prevention and Control. The 3rd Meeting of the Global Forum will be held in November 2003 in Brazil and PASB is already providing the necessary technical support.

CARMEN has received much support in the Americas. Argentina, Canada, Chile, Colombia, Costa Rica, and Cuba are the network’s most senior members. Through the collaboration of PASB/WHO and the Caribbean Community Secretariat, a strategic plan for the prevention and control of noncommunicable diseases for the Caribbean was created in September 2002. Through the Caribbean Lifestyle Intervention program, the Caribbean has joined the CARMEN Network.

### Integrated Management of Childhood Illness (IMCI)

The Integrated Management of Childhood Illness (IMCI) strategy aims to improve the health of children under 5 years old by focusing on the well-being of the whole child and stressing the care of children at the community and family levels. IMCI is an integrated approach that considers the various factors that put children’s health at serious risk. As such, it is considered a key strategy for the continued reduction of childhood mortality, especially from infectious and respiratory diseases, and for increasing the life expectancy in the Region of the Americas.

PASB has been strengthening the implementation and expansion of IMCI in health facilities and at the community level within the context of the “Healthy Children: Goal 2002” initiative. Mortality in children under 5 years old dropped for the second year in the initiative’s two years, and the number of
deaths prevented increased to more than 43,000, as compared with 1988 figures, which is the baseline for the goal of reducing 100,000 such deaths in the 1999–2002 period.

Most deaths averted (83.9%) were from causes targeted by the IMCI strategy, mainly pneumonia and diarrheal diseases. The number of deaths from diseases targeted by IMCI dropped 14.4% during the first year of the initiative and 7.9% during the second year. These rates of reduction were higher than those observed for mortality from all causes which was reduced by 5.6% for the first year and 2.8% for the second year of the initiative (see Figure 3).

Two important surveys have been conducted to gather information on the teaching of pediatrics. The first, which targeted faculties of medicine, was conducted and published with the Latin American Association of Pediatrics (ALAPE); its results are now being disseminated throughout the Region. The other, targeting nursing schools, was coordinated with the Latin American Association of Nursing Schools (ALADEFE); its results are being processed and will be published in 2003. PASB also provided technical assistance to develop perinatal and neonatal activities and formulate district-level plans in this regard.

PASB distributed IMCI Operational Research Guide, which gives health workers in the countries the basic methodological tools to carry out low-cost, short-term research studies to answer specific questions related to health worker skills, health systems, and the family and community. The Bureau pro-
vided technical assistance so countries could carry out studies in priority areas.

Member Countries have requested that PASB strengthen and expand IMCI implementation. The 26th Pan American Sanitary Conference approved a resolution urging Member Countries to reinforce their commitments to achieve universal access to IMCI and stressing the need to work in the most vulnerable population groups. The resolution urges PASB and countries to introduce IMCI teaching as part of the pre-service and post-graduate courses of medicine, nursing, and other health disciplines, thus providing students with the necessary knowledge and practices to give children the best quality of care.

Community Component

In the past few years, the international community has increasingly expressed an interest in providing technical cooperation to support IMCI’s community component. In a joint effort, PASB and the American Red Cross have begun to develop the “Regional Community IMCI Project,” a five-year, ten-country effort that relies on the WHO/UNICEF “Key Family Practices” for preventing common childhood illness and changing behaviors at the household and community level.

The project is rapidly spreading throughout the Region, thanks to local level efforts of ministries of health, local Red Cross offices, nongovernmental organizations, and other partners who are working with the most vulnerable population groups. The United Nations Foundation provided additional funds to support IMCI community activities in Bolivia, Ecuador, and Peru.

From the onset, the project sought to provide the necessary leadership and support to render IMCI’s community component a national programming strategy, not have it function as merely a pilot activity. As such, the project planned for the component’s expansion from the onset, and coordinated with other agencies and organizations to create sustainable partnerships.

Expansion efforts are now under way in ten countries, with international and national organizations and NGOs involved in the effort. To date, more than 115 community-based organizations and institutions, international agencies, and NGOs are engaged in the implementation of community projects in nine countries. In 2002, training activities continued, as did activities aimed at strengthening local capacity to formulate community projects in the ten countries. More than 1,600 health workers and local actors took part in training courses and more than 2.1 million people have direct access to project interventions. As a result of these advances, many major international NGOs—for example, CARE, Save the Children, and Project Hope—as well as other agencies such as the Junior Chamber International and the International Federation of Red Cross and Red Crescent Societies, are working with PASB to expand the community component.
Preventing Diarrheal Diseases through Behavior Change

This joint project between PASB and USAID’s Environmental Health Project aims at establishing hygienic activities in selected areas of Nicaragua and Peru. During two years, this project will put in place a behavioral change methodology, actively involving the target community. Subsequently, educational and social communication interventions tailored to the community’s needs will be developed. Specific actions to be promoted are the adoption and consistent practice of proper handwashing, sanitary excreta disposal, and use of safe water.

Social communication in IMCI

Within the IMCI strategy, social communication serves two major purposes. First, improving the quality of communication among health professionals, health service providers and users, and the community at large. Second, stimulating the adoption of key messages and practices by individuals and the community that will lead to embracing healthy behaviors. PASB prepared an orientation manual for journalists (Ayu-dando a crecer: información de referencia sobre el desarrollo integral de niñas y niños menores de seis años) that provided reference information on the integral development of boys and girls under 6 years old. This manual seeks to increase the amount and quality the press devotes to health issues that affect children from 0 to 6 years old and ensure that they receive a higher priority on the public agenda.

Work also was carried out with the Latin American Federation of Faculties of Social Communication (known by its Spanish acronym, FELAFACS) and the United States Agency for International Development (USAID) on incorporating health issues into the training of social communicators in the Region and generating more interest in public health issues among communication schools.

Veterinary Public Health

PASB cooperates with Member States in formulating policies and executing plans and activities to prevent and control zoonoses and foodborne diseases and to eradicate foot-and-mouth disease.

In recent years, PASB has sought closer integration with the agricultural sector. An agreement signed in 2002 with the Inter-American Institute for Cooperation on Agriculture (IICA), which entails the development of a joint action plan to support the countries of the Americas in achieving health and prosperity in the rural communities, is noteworthy. The plan defines its sphere of cooperation in terms of strengthening the organizational management capacity of directors and supervisors in national agricultural health and veterinary public health programs; promoting the use of information from existing systems; and increasing the exchange of information and experiences.
PASB also strengthened its relationship with other organizations, such as the International Epizootic Organization (IEO) through a cooperation agreement promoting joint action in the control of foot-and-mouth disease, the implementation of the International Animal Health Code, and in animal welfare. Joint actions for surveillance of zoonoses such as equine encephalitis were carried out with the Regional International Organization for and Animal Health (known by its Spanish acronym, OIRSA). The Inter-American Network of Food Analysis Laboratories (INFAL) was set up with the Food and Agriculture Organization of the United Nations (FAO), and epidemiological surveillance of swine fever was established.

Prevention and Control of Rabies and other Zoonoses

The elimination of human rabies transmitted by dogs is one of the mandates of the Organization’s Governing Bodies and one of the priorities of the Bureau’s technical cooperation. PASB’s current goal, endorsed by the countries of the Region, is to eliminate human rabies transmitted by dogs by the year 2005. In the early 1980s, the countries committed themselves to eliminate urban rabies from the Region’s major cities. In 2002, 19 of the 21 Latin American capital cities reported no cases of human
rabies transmitted by dogs, and just 12% of the major cities (state or provincial capitals) reported cases.

Cases of human rabies have decreased significantly in the Region of the Americas in the last 10 years, dropping from 227 in 1992 to 56 in 2001, with a 75% reduction in deaths from that disease. In 2002, partial notification reports showed an even greater reduction, with 25 human cases. Trend analysis shows that between 1992 and 2001, the average reduction was 20 human cases per year (Figure 4).

The trend in canine rabies was similar. In the last 10 years, canine rabies declined 76%, with 1,652 cases reported in 2001. In 2002, partial data show that 432 cases were reported. This success was possible thanks to efforts by the governments of the Region’s countries—with PASB support—mainly in mass canine vaccination campaigns.

In October 2002, Santa Cruz de la Sierra, Bolivia, hosted the IX Meeting of Directors of Rabies Control Programs (known by its Spanish acronym, REDIPRA) to bolster the strategic plan for the elimination of human rabies transmitted by dogs in Latin America, study the current situation of the different components of the regional action plan, and define technical cooperation strategies and activities for formulating the 2003–2004 operating plan.

In 2002, external evaluations of Bolivia’s and Brazil’s national rabies programs were carried out. The objective was to verify the effectiveness of the elimination measures that the countries have implemented and to make recommendations for the respective pro-
gram adjustments. The Meeting of Directors of Rabies Control Programs of Central America was held in Guatemala that same year, as was the International Seminar on Human Rabies Treatment after Exposure. Support for Haiti’s canine vaccination campaign also was noteworthy.

Bovine brucellosis and tuberculosis continue to be an important problem for Latin America’s public health and economy. Canada is free of the two diseases, as is much of the United States (41 of the country’s 50 states). In most of the countries and territories of the English-speaking Caribbean, the presence of brucellosis has not been confirmed. These diseases remain endemic in almost all the countries of Central America and South America.

There is still only partial information on the presence of brucellosis and tuberculosis in reservoirs and in people, given that the Integrated Continental Brucellosis and Tuberculosis Information System is in its final phase of preparation at the Pan American Foot-and-Mouth Disease Center (PANAFTOSA). During 2002, however, information about seven countries was obtained by validating data capture forms.

Brucellosis control programs were strengthened in Mexico, Peru, and the Southern Cone countries. Brucellosis caused by *Brucella melitensis*, which is mainly transmitted by caprines, continues to be a serious public health problem in Mexico and Peru, as well as on the border between Argentina, Bolivia, and Paraguay. Control programs based on mass vaccination of sheep and goats were implemented to combat it.

In 2002, the Southern Cone countries held working sessions and embarked on the selection of common strategies for combating brucellosis and the harmonization of procedures to establish a subregional program. According to a PANAFTOSA survey, 22 countries were actively working to control brucellosis in 2002, compared to 16 in 1998. Bolivia, Brazil, Colombia, Ecuador, and Venezuela drew up or revised their projects with assistance from PANAFTOSA, thus increasing to 10 the number of countries implementing brucellosis-free land certification projects.

In terms of bovine tuberculosis, national coordinators of Southern Cone country programs held working sessions in 2002 to improve surveillance, health intervention, and coordination among countries, and developed a proposal to create a Regional strategy for transforming the affected zones into zones that can be officially recognized as free of the disease. The proposal is based on these countries’ experiences in the struggle against foot-and-mouth disease and with the use of surveillance in order to take the most appropriate measures.

In 2002, PANAFTOSA began to produce a bovine purified protein derivative (PPD) standard to enable the official national control laboratories to carry out potency tests on their respective tuberculin production. The bovine PPD standard will be available in April 2003.
Eradication of Foot-and-mouth Disease

The eradication of foot-and-mouth disease is critical for the health of the economies of South American countries, especially those that export meat and meat products. In 1987, the countries of the Americas adopted the Hemispheric Plan for the Eradication of Foot-and-Mouth Disease, and in the 1990s they made important headway in the control and eradication of the disease. The Central American, North American, and Caribbean countries remained free of the disease.

With the adoption of the Hemispheric Plan, South American countries began to undertake changes that a decade later translated into the strengthening of veterinary systems and the fostering of a joint public/private management model for planning, executing, and evaluating eradication strategies and activities. These changes have enhanced the effectiveness of animal health policies and improved the infrastructure of programs and services in almost every country.

In South America, 41% of cattle herds and 60% of the geographic area had no clinical manifestation of foot-and-mouth disease in 1999. Up to mid-2000, an area covered by Argentina, Chile, Paraguay, Uruguay, and all states comprising Brazil’s southern, west-central (except El Dorado de Mato Grosso do Sul), and eastern livestock circuits remained free of the disease.

This positive epidemiological situation was largely due to systematic foot-and-mouth disease vaccination campaigns in the region, with an annual average of 250 million doses distributed. In 1995, vaccination coverage of the bovine population reached 94%. But the situation changed in the second half of 2000, with outbreaks in Argentina, Brazil, and Uruguay—which were promptly eradicated. In early 2001, the region suffered a major setback when Argentina and Uruguay (recognized as being free of foot-and-mouth disease without vaccination) and the state of Rio Grande do Sul in Brazil (recognized as free of foot-and-mouth disease with vaccination) experienced a reintroduction of the disease and lost their favorable epidemiological status. With the cooperation of PANAFTOSA, and based on the experience gathered over the years, affected countries reacted quickly and the situation was controlled. In December 2002, a focus of foot-and-mouth disease detected in Paraguay resulted in that country’s losing its status as an area free of this zoonosis.

Important determinants of the reintroduction of foot-and-mouth disease in the Southern Cone are the institutional and financial erosion of the official health programs, the weakening of the binational or multinational border health programs, and the trends in international trade in animals and animal products, which increased the risk of the introduction and spread of the disease.

The Amazon Basin Project in Brazil made significant progress, and 16 of Brazil’s and 27 of Guyana’s federative units were recognized as free of foot-and-mouth disease.
In the Andean countries, Colombia was internationally recognized as free of foot-and-mouth disease with vaccination, in an area that encompasses the Atlantic Coast Project, with an estimated population of 7 million head of cattle. PASB is working with the Community of Andean Nations to promote programs in that area, and thus reach the goals of the hemispheric program—eradication of the disease in the South American countries by 2009.

The intensification of the disease in the Southern Cone during 2001 prompted the ministers of agriculture of that subregion to seek ways to strengthen veterinary services and promote the transparency of information on structures and services in their countries. In that respect, it was decided that PANAFTOSA would lead a group of professionals from national programs in Argentina, Bolivia, Brazil, Chile, Paraguay, and Uruguay in carrying out annual inspections, making it possible to periodically evaluate the national programs at all levels. By the end of the second inspection, various problems had been resolved and the system of veterinary care responsible for combating foot-and-mouth disease had been strengthened.

**Control of Foodborne Diseases**

Working through the Pan American Institute for Food Protection and Zoonoses (INPPAZ), in 2002 PASB supported public health surveillance in the countries and the organization and implementation of local surveillance efforts for foodborne diseases. In specific geographic/population spaces, PASB sought to coordinate with the national surveillance system and the prevention and control response infrastructure, adapting its work to local conditions; an action plan encompassing objectives, technical development, monitoring, evaluation, and management mechanisms was drawn up. To support this initiative, workshops were held throughout the Americas, highlighting the local experiences of Maldonado (Uruguay) and Gálvez (Argentina), sites in which an integrated food safety program was established.

As a way to better understand the epidemiology of foodborne diseases, in 2002 PASB prepared and published training material intended for doctors and primary care service personnel, which included 12 modules of technical, self-assessment, and reference material. It also published a book (*Enfermedades transmitidas por alimentos en Uruguay*) on foodborne diseases in Uruguay, with the support of well-known Uruguayan professionals.

With regard to the updating of inspection services, PASB helped officials from Argentina’s National Institute of Food plan strategies for formulating a comprehensive program for the sanitary handling of food in “barter clubs,” a new modality for the exchange of products and services in the community by people with limited resources. A manual of recommendations for handling food in those venues was a noteworthy result of this effort.
Another PASB priority in terms of the modernization of inspection services, involved the development of a project with authorities of the Brazilian National Health Vigilance Agency (known by its Portuguese acronym, ANVISA), through which a training program for food inspection personnel in the states was developed. This program will strengthen the adoption and verification of good manufacturing practices and standard operational hygiene procedures, as well as the system of Hazard Analysis and Critical Control Points (HACCP) in establishments that are part of the food production chain under ANVISA’s responsibility. The objectives of this phase of the project include training the human resources that will be assigned to food inspection duties, thereby developing a critical mass of trainers who will, in turn, ensure that training continues over the long term. Some 214 inspectors were trained during the first phase.

To strengthen cooperation in referral services, INPPAZ created the “laboratories of excellence” system. To date, five laboratories have completed the process and four have been designated as centers of excellence: LATU (Uruguay, covering 159 tests), SFDK (Brazil, 128 tests),

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**BOLIVIA Builds Healthy Marketplaces**

The municipal government of Santa Cruz has established policies for the construction of healthy public spaces—including marketplaces—whose sanitary conditions must ensure the proper supply, preservation, sale, and handling of food and drink.

In 2002, close coordination by the municipal government of Santa Cruz, the departmental health service, the Bolivian Evangelical University, and the Food Research and Technology Center resulted in a proposal for pursuing active interventions along three fronts: health-hygiene and the environment, education-nutrition, and economics-productivity.

The interventions were aimed at increasing the knowledge base and improving the practices and attitudes of small producers, sellers, and consumers. Efforts included training in health, hygiene, food safety, proper food handling, and improvements in the workplace.

Based on the human development policies established in the **municipio**, a work team was set up. Its analysis of the situation revealed existing deficiencies, which were the starting point for strategic planning carried out in conjunction with the people who work in the marketplace.

The study conducted by the interinstitutional work team found a high rate of food contamination. It showed that fully 45% of the food sampled had levels of fecal coliforms that exceeded 100 microorganisms per gram, and it also was contaminated with such pathogens as salmonellae, shigellae, and fungi. Since these levels of contamination entail a high risk of diarrheal diseases, operating strategies were developed for the construction of healthy, community-based marketplaces.
Xenobióticos (Argentina, 10 tests), and the National Institute of Nutrition and Food Hygiene (Cuba, 9 tests).

As part of the effort to guide technical cooperation, a survey of the Inter-American Network of Food Analysis Laboratories concluded in 2002. The network currently has 66 laboratories in 32 countries. The survey was evaluated by a team of outside consultants, and 54 laboratories in 27 countries participated. The survey showed that countries need to strengthen quality assurance, conduct tests of laboratories, and support the development of standards and reference material.

As part of the cooperation for institutional harmonization and development, PASB worked with the countries to compile and organize their food legislation. As of 2002, the computerized system of food legislation (Legalim) had been installed in Argentina, Brazil, Costa Rica, Cuba, Nicaragua, and Venezuela. The database is designed to analyze the countries’ laws in order to harmonize food safety regulations.

With regard to the Codex Alimentarius, PASB drew up a strategic document to support participation by the countries of the Region. It also supported the Codex Alimentarius Coordinating Committee for Latin America and the Caribbean by setting up virtual discussion forums on the INPPAZ web page. There are currently five active discussion forums for biotechnology, additives, labeled food safety, and topics of specific interest to the Coordinating Committee.

In 2002, PASB developed an Internet site for consumers—“Community Channel”—which provided scientific information in accessible language. The site includes various key messages on food safety in English, Portuguese, and Spanish. They have been made available to the leading media outlets in the Americas, and the information has been used in various training programs by public organizations and institutions. This effort is designed to benefit high-risk groups, such as children and indigenous communities.

Diarrhea caused by foodborne diseases remains a challenge to health authorities, particularly in countries and communities that lack basic sanitary services. Outbreaks of foodborne diseases continue to affect tourism, which is the major source of revenue in many of the Region’s countries. In 1999–2002, 22 countries of the Region reported 2,266 outbreaks with 77,605 cases and 70 deaths to the Regional Foodborne Disease Surveillance Network (known by its Spanish acronym, SIRVETA). Bacteria were the most common etiological agents of foodborne disease outbreaks (63%).
Progress in the Control of Diseases Preventable by Immunization

Measles

The Region of the Americas has made impressive progress in reaching the goal of interrupting indigenous transmission of measles. Since September 2001, a new measles genotype, d9, was introduced in the Region, causing outbreaks in Venezuela and subsequently being exported to Colombia. After intense vaccination efforts, the outbreaks were successfully controlled. The last case of d9 genotype measles occurred in Venezuela in November 2002 (Figure 5), and no indigenous measles cases have been reported in the Region since. This extraordinary achievement has come about because of the firm commitment of every government in the Region to fully implement PASB’s recommended vaccination strategy.

The Americas will continue to be under constant threat of importations of measles virus from other areas of the world where the disease remains endemic. The experience in the Americas, however, shows that country programs with high (95%) routine and campaign coverage, supported by systematic and thorough supervision, including active case finding and house-to-house monitoring, can successfully interrupt measles transmission.

**FIGURE 5. Measles in the Americas, by week and year of rash onset, January 2001 to December 2002.**
Haemophilus influenzae

Since the introduction of *H. influenzae* type b (Hib) vaccine to the Americas in 1994, significant advancement in the disease’s control has been achieved. As of 2002, the Region’s countries included Hib vaccine in their immunization programs, with the exception of Haiti, Guatemala, and Suriname (Figure 6). The fact that countries have well structured surveillance systems has been fundamental for the success of the new vaccine introduction. Hib vaccination efforts have led to a substantial decrease in bacterial meningitis cases (Figure 7). PASB will continue to support surveillance to monitor the impact of Hib immunization and to assist in investigating possible vaccine failures and changes in the Region’s epidemiological status.

Rubella

Rubella and congenital rubella syndrome are now recognized as high priority public health problems. In 1999, PASB developed an accelerated rubella control and congenital rubella syndrome prevention strategy for the Americas, which followed the successful adult mass vaccination campaigns in Cuba and the English-speaking Caribbean.

By October 2002, 41 countries and territories in the Americas had introduced rubella-containing vaccine in their national childhood immunization programs. The Dominican Republic, Haiti, and Peru will launch such immunization campaigns in 2003 and 2004. Many countries also have initiated specific strategies for the accelerated control of rubella and
congenital rubella syndrome (Figure 8). As countries launch accelerated rubella control campaigns, documenting the endemic strain in each country will become critical for determining whether the case is imported or not. Even though a country may have eliminated rubella, importations of the virus may occur and can only be avoided when other areas of the world carry out similar efforts.

**Equity in Immunization: Reduction of Disparities**

In deciding to make equity in the provision of health services a key organizational goal, PASB has placed renewed emphasis on accelerating local-level activities to improve coverage. Municipalities with insufficient coverage levels constitute high-risk areas for epidemics. Using information from seven countries in which coverage data by municipality is available, the percentage of municipalities with greater than 95% DTP3 vaccine coverage increased from 44% in 2000 to 50% in 2002 (Figure 9).

PASB, in collaboration with the countries, has pursued specific initiatives to increase equity. In November 2002, with PASB’s support, all ministries of health...
PASB and other partners in specific initiatives to improve equity in various countries. For example, PASB is working with Bolivia’s Ministry of Health and the World Bank in the design and implementation of a strategic plan aimed at reducing the number of municipalities at risk by seeking local level commitment through communication with community leaders and support of the national immunization program.
Greater Attention to Sustainable Financing

The ongoing economic crises in the Region, coupled with the uneven management of the Region’s health reform and decentralization processes, call for renewed policies and strategies by countries and the international community to maintain and expand the accomplishments in the field of vaccination. Fluctuations in the allocation of resources due to economic downturns jeopardize the implementation of the national immunization programs, potentially opening the way for higher morbidity and mortality and, consequently, higher health costs. PASB has facilitated critical dialogue with Member Countries and the international community, including finance ministries, to safeguard the public health achievements and the proven impact of national immunization programs to enable their continued growth.

PASB is advocating the development of legislation that establishes a specific line item in national budgets committing resources for recurrent costs associated with the purchase of vaccines and syringes. The basis for this initiative is that vaccination is a human capital investment. The interruption of vaccination efforts, even for a limited time, harms the continuity of the program, increases morbidity and mortality, and undermines this human capital investment. Six countries have enacted legislation toward this end.

Efforts also have been made towards clarifying the stewardship role of ministries of health in immunization, and strengthening technical and financial
HAITI’s National Program of Immunization Makes Important Gains

In 2002, the work and success of Haiti’s National Program of Immunization tracked along four broad objectives—preserving the gains made in earlier immunization campaigns, strengthening the epidemiological surveillance of diseases covered under the Expanded Program of Immunization, strengthening the regular immunization program, and strengthening the cold chain. The following are some highlights of successful efforts in 2002.

Preserving the gains from earlier vaccination campaigns. In 2002, a national campaign against the epidemics of measles and of poliomyelitis due to mutant vaccinia virus was conducted. The Ministry of Public Health and Population decided to launch this third round in order to consolidate immunity among children under 10 years old and infants 6–23 months old, two groups that had received two vaccination doses against polio and one against measles in 2001. In this campaign—as in those in 2001—95% of the 3.3 million children under 10 years old to be vaccinated received a third dose of oral polio vaccine, and 95% of the 500,000 infants 6–23 months old received an additional dose of measles vaccine.

The success of these campaigns is attested to by the fact that the last confirmed case of polio due to mutant vaccinia virus dates to July 2001, and that the last confirmed case of measles dates to September of that year. Haiti—and the Dominican Republic—are working to stop the polio epidemic that threatens the recertification of the eradication of this disease in these two countries, and in the Region of the Americas as a whole. It should be noted that the epidemics of polio and measles that buffeted the country in 2000 and 2001 resulted from the significant number of susceptibles that have accumulated between 1995 and 2000, and which testify to the inefficacy of the quarterly catch-up campaign conducted in 1998, as well as to some weakness in the regular vaccination program.

The success of the 2002 campaign is in large measure due to the mobilization of some 24,000 schoolteachers, 5,000 volunteers, 1,200 Ministry staff members, and 40 support staff. The campaign also benefited from the technical, financial, and logistical support of PASB, UNICEF, the World Bank, the Centers for Disease Control and Prevention (CDC), and CIDA.

The National Program of Immunization will use the lessons learned from these campaigns to guide the development of a new five-year plan for 2003–2007, which will aim at consolidating gains made in the fight against polio and measles, reinforcing the regular immunization program, ensuring that the country’s Expanded Program of Immunization (EPI) is financially viable, reinforcing epidemiological surveillance, and improving the program’s management.

Reinforcing the epidemiological surveillance of EPI diseases. To this end, the national program actively investigated cases of flaccid paralysis and of measles throughout the country’s hospitals. In 2002, this effort was carried out through the technical support of PASB consultants, who also helped train and retrain national professionals in the investigation of cases.

As part of this objective, wild poliovirus or mutant vaccinia virus were contained in the country’s laboratories, for which PASB consultants provided much assistance. In addition, 100 epidemiological sentinel sites were put in operation. Nurses that PASB had engaged to reinforce the regular program at the health department level, received training in epidemiological surveillance.
responsibilities at the state and local level for decentralized systems.

Health and the Environment

Climate Change

PASB/WHO organized the “Climate Variability and Change and their Health Effects in the Caribbean Conference and Workshop,” held in May in St. Philip, Barbados. This event was conducted under the auspices of the Government of Barbados and the Interagency Network on Climate and Human Health formed by WHO, the World Meteorological Organization, and the United Nations Environment Program.

Most of the participants were from the Caribbean, although representatives from elsewhere in the Region and the world also attended. The conference drew representatives from Anguilla, Antigua and Barbuda, Australia, Bahamas, Barbados, Belize, Bermuda, British Virgin Islands, Canada, Colombia, Cuba, Dominica, Dominican Republic, Grenada, Haiti, Jamaica, Kenya, Mexico, Netherlands Antilles, New Zealand, Panama, Puerto Rico, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Samoa, Suriname, Trinidad and Tobago, United Kingdom of Great Britain and Northern Ireland, and United States of America.

Technical presentations overviewed the basic concepts of climate variability and change; reviewed health status in the Caribbean Region with particular reference to climate variability and change; presented frameworks for evaluating the vulnerability of the health system to climate variability and change; presented frameworks for assessing and responding to climate-related health risks; examined linkages between climate and human health; and examined public health policies and strategies for adaptation to climate variability and change.

Major health issues taken up at the conference were vector-borne diseases (dengue, malaria), waterborne diseases, heat stress, asthma, disaster response to climate and weather phenomena, and toxins in fish. The emphasis was on work conducted in or relevant to the Caribbean basin. Some presentations discussed ecological effects that are unique to the Caribbean, focusing on an episode of massive contamination of the sea linked to river outflows from South America, as well as the annual atmospheric transport of African dust across the Atlantic to the Caribbean. The policies and strategies for adaptation to climate variability and change covered a broad range of topics, from the control of specific diseases to general communication strategies on climate and health.

During the workshop portion of the event, 39 participants from the Region came together, including representatives of the public health, climate/weather,
and environmental sectors, mainly from Caribbean islands and Caribbean Community countries. The countries and territories represented were Anguilla, Antigua and Barbuda, Bahamas, Belize, British Virgin Islands, Cuba, Dominica, Dominican Republic, Grenada, Haiti, Jamaica, Netherlands Antilles, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, and Trinidad and Tobago.

Work groups, facilitators, and resource people discussed issues of awareness, use of data, roles of health and climate professionals, and needed institutional linkages. They reached consensus on 22 recommendations for future work on climate and health in the Region. Recommendations generally fall into the categories of strategies for enhancing awareness about the effects of climate change, more effective use of data, and mechanisms for strengthening related institutions.

As a result of the conference and workshop, health scientists, practitioners, and officials were informed about the impact of climate variability and long-term change in the Caribbean; sectors relevant to health—water resources, agriculture, and fisheries—were brought on board; strategies in coastal zone management related to sewage disposal and other health issues were introduced; joint interdisciplinary research projects were fostered among local participants and partnerships were established between scientists from developed and developing nations; and national climate information was promoted and incorporated into planning for public health services in the countries.

Health and sustainable development

As a way to contribute toward institutional strengthening, the Latin American Toxicology Network; national networks in Argentina, Brazil, Chile, and Mexico; and the Workers’ Health Network, were consolidated. The subthematic network on persistent organic contaminants and the Occupational Health Laboratories Network were established.

The CEPIS/GTZ project designed to harmonize records of poisoning cases and the project on chemical emergencies conducted with São Paolo’s CETESB (Brazil), a PAHO collaborating center on chemical disasters, also got under way in 2002. The Peru/Ecuador and Colombia/El Salvador technical cooperation project on surveillance systems for pesticide poisonings continued to operate.

Finally, the following tools were completed: a virtual library on health and environment-toxicology; a virtual library on health and environment-workers’ health; electronic libraries on pesticides for household use; eight self-instructional courses published on compact disc, which are being accredited by several universities; a glossary of health and environmental terms; a registry of
toxicology professionals who belong to the Toxicology Network of Latin America and the Caribbean (known by its Spanish acronym, RETOXLAC), which will mobilize resources; and a registry of toxicological centers with an expanded directory.

**Inter-American Environmental Sanitation Information System**

In 2002, PASB developed the Inter-American Environmental Sanitation Information System (known by its Spanish acronym, SISAM), a dynamic support information system for the countries that covers basic institutional and quality-of-service aspects and facilitates the coordination of sectorial initiatives. The system, which can be accessed on the CEPIS website (www.cepis.osp-oms.org), will help national institutions and agencies to expand sectorial information based on need.

SISAM directly contributes to the follow up of the United Nations Millennium Development Goals by providing organized and reliable regional information on the coverage and quality of drinking water and sanitation services, as well as other key aspects for the sector. SISAM also will promote the creation of national sectoral information systems in the countries, and will make it possible to cross-check information related to drinking water and sanitation, solid waste management, and pollution prevention and control, using health and social indicators obtained from various sources, including household surveys.

SISAM also will cover three broad fields of action: drinking water and sanitation; solid waste; and the prevention and control of air, water, and soil pollution. To date, the drinking water and sanitation module has been put in place in Cuba, Honduras, and Panama, where the system’s efficiency and effectiveness will be pilot-tested. The SISAM water and sanitation module provides government and business entities, and international organizations, with information on institutions and agencies associated with the sector, as well as with information on the quality of drinking water and sanitation services.

**Environmental Services: Regional Assessment of Solid Waste**

The conceptual design for the 2002 regional assessment of solid waste management services was completed. The model and its implementation strategy were discussed and adjusted during regional seminars at which most of the countries of the Region were represented. The overall objective of this pioneering exercise is to gather information on the current status and future prospects of urban cleanup services in the countries.
countries, thereby facilitating the establishment of policies, plans, and programs for improving those services and reducing the adverse effects on people’s health and the environment.

The assessment is being carried out under the direction of national groups in each of the countries. These groups are composed of public and private institutions, NGOs, and professional associations. PAHO/WHO Country Offices supported the work of each national group, and the groups also received technical cooperation from CEPIS and PASB.

National Laboratories

As a way to promote and coordinate activities for developing the capabilities and enhancing the quality of environmental health laboratories, training and development projects were carried out for staff of environmental and health laboratories in Belize, Bolivia, Colombia, Costa Rica, the Dominican Republic, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, and Uruguay. Fourteen environmental laboratories in the Region received technical assistance.

A regional network of laboratories in Latin America and the Caribbean was consolidated to provide training and compare environmental samples. The network includes a database of the laboratories. This project was partially funded by the United States Centers for Disease Control and Prevention (CDC).

National networks of environmental laboratories were established in Argentina, the Dominican Republic, El Salvador, Guatemala, Honduras, Mexico, and Nicaragua.

A laboratory portal was developed on the CEPIS website. The portal allows network members to interact with one another and disseminates information of interest to the environmental laboratories. In 2002, PASB signed an accreditation agreement with the Canadian Association for Environmental Analytical Laboratories and the Standards Council of Canada, which four laboratories already have endorsed. A patent was obtained for a product that removes arsenic from drinking water in remote communities, and advisory assistance and technical cooperation were provided on this matter to Argentina, Mexico, Nicaragua, and Peru; the CEPIS laboratory is self-sufficient, with improved capability to test human and environmental samples for parasites.

Populations at Risk

Indigenous Communities

The acceptance of the environmental health project in indigenous communities that began in 2002, has far exceeded expectations. The project is now fully operational at the regional level and in 15 participating countries. National working groups executed demonstration projects in Bolivia, Colombia, Ecuador, Guatemala, Peru, and Venezuela; these countries are pooling efforts and, consequently, integrating the financial
ARGENTINA Improves an Indigenous Community’s Quality of Life

Late in 2001, a pilot project was launched to improve the quality of life of indigenous peoples in Argentina’s Chaco region—the Chorote community was selected for the project. The Chorote community of Misión Lapacho Uno has a population of more than 300 and is located three kilometers from Tartagal, in the north of Salta Province. It had a high rate of gastrointestinal and lung ailments, and its inhabitants were exposed to vector-borne diseases such as Chagas’ disease, malaria, dengue, and Hantavirus infections.

The community’s poor health conditions were due, in large part, to inadequate housing, lack of latrines, insufficient water supply, and lack of an adequate place in which to cook and prepare food. The Chorotes cooked their food outdoors, using a handful of logs for fuel. Persons in charge of food preparation—mainly women—often had to shift the location of the cooking area, in search of a little shade.

In order to help correct this situation, which affected all of the Chorote community’s 21 family groups, it was decided to build three water storage tanks with a capacity of 5,000 liters each, three areas to wash clothes, and bathroom facilities. In addition, a model home that the community could use as a sewing and handicraft workshop was constructed, 21 cooking areas were set up for hygienic food preparation, and 21 solar ovens and 21 latrines that convert waste to fertilizer were installed.

In mid-2001 UNICEF’s office in Argentina joined in, providing materials for constructing these installations. Each family group participated in the construction of its own cooking area and latrine. Construction began in 2001, and in December of that year, Dr. Mirta Roses, then Assistant Director of PAHO, visited the Chorote village, learning first-hand of the community’s needs while assessing the progress of the planned activities.

Subsequently, at the community’s request and with the support of the Ministry of Health of Salta Province, the project was expanded and community women were offered courses in sewing and in nutrition and cooking, so they could make their own and their children’s clothing and prepare more nutritious meals. In September 2002, the Pan American Institute for Food Protection and Zoonoses added its support, providing instruction for the safe use of cooking areas and latrines, as well as educational material on hygienic food-handling.

On December 18, 2002, the new facilities were inaugurated with a ceremony in which the entire Chorote community participated, as did leaders of other indigenous ethnic groups, the Governor of Salta Province, officials from Tartagal, and representative of Argentina’s Ministry of Health, the Indigenous Provincial Institute of Salta, the National Institute for Farming and Livestock Technology, PAHO/WHO, UNICEF, Bolivia’s Sumajhuasi Foundation, and the Padre Ernesto Martareana NGO.
contributions from the members of the group.

Eighteen demonstration projects are under way, involving the preparation of training and educational materials and of a database. Argentina, Brazil, Costa Rica, Chile, El Salvador, Honduras, Mexico, Nicaragua, and Panama are participating, but they are not executing demonstration projects. Each country has a national working group comprised of institutions involved in development of the indigenous population; these form a network with 95 professionals from 65 institutions.

Workers’ Health

In Central America, PASB designed a “tool-kit to foster healthy work environments” in the economy’s formal sector, as practical support for the Strategy to Promote Healthy Workplaces in Latin America and the Caribbean. To this end, a team of consultants is working to implement the strategy in Brazil’s informal sector of the economy.

The tool-kit promotes various scattered efforts that have been partially used to implement hygiene and safety activities, occupational medicine efforts, cost-benefit analyses on productivity, general medical care, and other areas. As such, it seeks to generate holistic processes that integrate various approaches with a human development perspective, and to reinforce the leadership role of those involved in the workplaces.

This strategy underwent a validation process in Central America (El Salvador, Guatemala, Honduras, and Nicaragua), beginning in August 2002 with funding from the Swedish International Development Authority (SIDA). To date, national teams are organizing and training local teams at the pilot sites where the validation exercise is being carried out, in accordance with the methodology proposed in the tool-kit.

These activities have been carried out through the consensus and participation of governmental, private, academic, and NGO sectors. They have helped to consolidate existing national health and safety commissions in the countries. In addition, this project helped to raise awareness among businesspeople and managers, and influenced the methodology for evaluating the cost-benefit of investing in workers’ safety and health.

ILO contributed materials to the tool-kit that will enhance that organization’s opportunities to send a message to all the involved countries about the possibility of planning joint actions that increase the efficiency of those already being carried out in the Region, and so further the cause of creating healthy workplaces.

Healthy Environments

Citizen Participation

PASB cooperated in preparing the Inter-American Water Day (IAWD) by developing and distributing information
to the countries to promote national working groups. It also developed the IAWD portal (http://www.cepis.opsms.org/bvsadiaa/e/home.html), with reference documents from previous years, experiences from the countries, and links to the other participants in the IADW initiative.

Through CEPIS, PASB supported health-promoting schools as an environmental health strategy, highlighting the creation of healthy environments. In Peru, the PAHO Country Office is part of the Multisectoral Committee of Health Promoting Schools, and it has encouraged the signing of the Cooperation Agreement by the ministries of health and the ministries of education to strengthen the strategy at the national level.

Disaster Prevention in Water and Sanitation Infrastructures

The Regional Course on Disaster Mitigation in Drinking Water and Sanitation Systems was held in 2002, with the participation of 16 countries of the Region. A CD-ROM with technical and training material was developed for this course. New technical material was also developed and material was updated on seismic design of water systems and design criteria for treatment plants in the face of natural threats. This spurred universities in Guatemala, Honduras, Nicaragua, and Peru to include disaster prevention in their sanitary engineering curricula.

Health Promotion and Disease Prevention

Lifestyle Changes and Obesity

Environmental and lifestyle changes that have occurred in the last 50 years are responsible for the epidemic emergence of obesity throughout the Americas. Increasing obesity rates are now observed in several of the Region’s countries, affecting persons of all social and cultural backgrounds. The alarming rise in obesity is partly due to an increase in more sedentary occupations, particularly among urban dwellers; a greater reliance on motorized transportation; longer television viewing; and ubiquitous labor-saving devices that favor physical inactivity. Some key environmental changes such as the rapid pace of urbanization, economic growth, and more efficient agricultural production also are factors. Together, these factors have made possible what for was unattainable for many centuries—year-round food availability at affordable prices for larger segments of the population.

Treatment approaches for obesity have shown only modest results so far, and are unlikely to halt the epidemic. They
are not only technically unfeasible but also unrealistic, given the extraordinary financial resources that might be required even for developed countries in the Region. Therefore, preventive and health promotion strategies are most likely to succeed at the population level. Public health’s role in the Americas should be to make healthy choices be the easiest choices, and the objective over the next decade is to bring about key behavioral changes at the population level.

To commemorate World Health Day, whose motto in 2002 was “Move for Health,” PASB organized a regional contest to award prizes to small cities in the Americas that are setting an example of active living by improving recreational areas and protecting public spaces. More than 150 municipalities took part, attesting to the great interest that the issue has awakened in the Americas. Loja, Ecuador; Surco, Peru; and Balcarce, Argentina received awards. Bogotá, Colombia, and Curitiba, Brazil, also have significantly transformed their urban landscapes, enhancing pedestrian activities.

Community Mental Health Services

An assessment of the delivery of mental health services in Latin America and the Caribbean that PASB conducted in 2001, showed that in most countries traditional psychiatric hospitals remain as the centerpiece of their mental health systems. Moreover, despite advances made in formulating mental health policies in the 1990s, the implementation of mental health services reform is still very incomplete.

As a way to change this situation, in 2002 PASB embarked on a comprehensive strategy to support the countries develop community-based mental health services. This approach includes building
The CARIBBEAN PROGRAM COORDINATION Fights for Mental Health Care

The Caribbean Program Coordination (CPC) engaged in many and varied activities designed to improve mental health care in the countries served by the office. At the subregional level, the first draft of a Mental Health Strategic Plan was presented to the Caucus of CARICOM Ministers Responsible for Health.

CPC’s technical cooperation with the countries under its jurisdiction included the following activities:

- A technical-cooperation-among-countries project in **Barbados and Saint Lucia** seeks to shift mental health care away from institutional settings and into the community.
- With PASB support, mental health legislation was updated in **Antigua and Barbuda, Barbados, Grenada, Saint Lucia, and Saint Kitts and Nevis**.
- Police and prison officers in **Barbados, Saint Lucia, and Montserrat** received sensitivity training regarding mental health issues.
- **Barbados and Saint Lucia** received support for their participation in the WHO/PASB Mental Health Policy Project.
- The CPC office provided technical cooperation for the development of a mental health plan in **Montserrat**.
- Mental health reforms in **Barbados and Saint Lucia** were reviewed in a subregional mental health meeting, which also discussed whether the methodology used in these two countries was applicable elsewhere in the Caribbean.
- In **Barbados and Saint Lucia**, the CPC office, working with PASB, held a workshop, “The Human Rights and Fundamental Freedom of Persons with Mental Disabilities and their Families,” to sensitize stakeholders about issues related to the human rights and basic freedoms of persons with mental disorders and their families.
- In **Dominica**, the CPC office helped launch a mental health campaign aimed at health workers and provided assistance to train primary health care staff.
- In **Grenada**, a curriculum was developed and disseminated for the in-service education of primary health care staff on how to recognize and begin to manage common mental disorders; a training-of-trainers program on the use of that curriculum also was carried out. It is hoped that the curriculum will be used throughout the subregion.
- **Saint Vincent and the Grenadines** received support for drafting a mental health plan aimed at improving mental health care and facilitating promotion and prevention activities.
organized a course on planning and managing mental health services for officers from Latin American ministries of health. An advisory group was created to provide technical support to countries developing new community services, and training in the use of WHO modules on mental health policy and in plan development was provided.

In 2002 PASB continued to support reforms to mental health services in Barbados, Brazil, Chile, Guatemala, El Salvador, Mexico, Paraguay, Peru, and Saint Lucia. Projects in this regard also were started in Argentina, Bolivia, Ecuador, and Nicaragua. With PASB support, a meeting to discuss mental health reforms in the Caribbean was held in Barbados; in-depth discussions led to potential collaborative projects in this area.

Several countries are implementing innovative community mental health services. Some examples include the development of a program to treat depression at the primary care level in Chile, the deinstitutionalization of psychiatric patients in Brazil and Mexico, the downsizing of the psychiatric hospital and the development of community-based mental health projects in Barbados, and the promotion of community programs in Guatemala and El Salvador.

To ensure that the new community services will be monitored and evaluated, PASB launched two initiatives. The first involves a project to develop indicators and methodologies for evaluating mental health reforms in Barbados, Ecuador, and Saint Lucia; this project was supported by the Montreal Collaborating Center. The second involves the development of a network for research on mental health with the participation of Latin American, Canadian, and United States centers. The network is developing training activities and promoting studies to obtain data that could foster the development of cost-effective mental health services in the Region.

Empowering Population Groups

Adolescents and Youths

Adolescents (10 to 19 years old) and youths (15 to 24 years old) in the Region are a heterogeneous population. To improve the health of these groups, PASB has pioneered the development of health policies and legislation, the design of distance education, the establishment of networks and alliances, and support for health services.

Drafting of youth-related legislation was encouraged in Honduras and Nicaragua, and in El Salvador, citizen consultations were held on youth legislation. These three countries, along with Belize and Guatemala, have explicit national policies on adolescents that include sexual and reproductive health. In addition, the five countries have established intersectoral committees on adolescents with the participation of government organizations, NGOs, international cooperation agencies, and ministries of education. All except Belize have published and disseminated a document analyzing laws and regulations on adolescents and youths. Some 100 professionals have been trained in the
EL SALVADOR Empowers and Trains At-risk Population Groups

Adolescents in El Salvador have many serious unmet needs. As a way to provide training for this population group, the Bureau cooperated in designing the Interagency Program for the Empowerment of Adolescent Girls and in managing its funds, with the support of the United Nations Interagency Gender Working Group (IGWG). The program deals with the needs of the most vulnerable adolescents in terms of factors such as health, entry into the world of work, participation at decision making levels, education, and violence prevention. PASB also cooperated in consolidating organized groups of adolescents and youths. For example, it promoted work for adolescents and youths in the municipio of El Paisnal, thus helping to improve food and nutritional safety and decrease levels of violence.

The Bureau also cooperated in the design and dissemination of the National Plan to Prevent and Respond to Family Violence, which has a strong intersectoral and community participation. Part of this plan involved promoting local groups’ involvement in the care of women, boys, and girls who had been victims of family violence. These initiatives, along with the interventions related to the health sector reform process, have helped improve the detection of and response to family violence in all the sexual and reproductive health services of the country’s 28 basic comprehensive health systems.

All these activities were strengthened by the incorporation of the gender perspective. In addition to the work with the groups, health indicators that demonstrate the gender inequities in health and measure progress in achieving equity, reducing gender disparities in health, and planning timely interventions were validated. This work was accomplished with the participation of 13 national governmental and non-governmental institutions.

drafting of public policy; 350 youth organizations, NGOs, 120 government organizations, 125 legislators, and more than 100 community leaders receive advocacy notifications issued by the intersectorial committees on adolescence.

PASB also has played an important role in developing the countries’ capabilities to train professionals, who currently lack experience, in adolescent health at the undergraduate and graduate levels and in the services. It worked with three universities to design and deliver distance courses. The University of Monterrey, Mexico, the Catholic University of Chile, and the University of Río de Janeiro, Brazil, have trained many health professionals. Johns Hopkins University (U.S.A.), in cooperation with the Bureau, designed a Spanish-language CD-ROM to train first level health care providers in the sexual and reproductive health of adolescents.

The Bureau also designed and expanded the ADOLEC/BIREME project (http://www.adolec.org). This regional Web page offers those interested in adolescent health access to reports, newspaper articles, and the results of research and experiments through its virtual health library. Brazil, Costa Rica, Honduras, Mexico, and Nicaragua have their
own Web pages with interactive forums for youths.

In October 2002, PASB supported the First Virtual Conference on Adolescence, held over the Internet from Guadalajara, Mexico. For the conference’s 14 days, nearly 1,000 specialists in adolescent health saw and heard presentations on the Internet, participated in virtual courses, and shared lessons learned in various forums.

PASB is improving the lives of adolescents through an innovative approach: a project that engages adolescent males in an activity they enjoy, playing soccer. The goal is to promote positive health behaviors and gender equity in preadolescent males (ages 8 to 12 years) by developing, testing, and validating a training curriculum for soccer coaches.

Since 2002, PASB has been supporting the countries in the development of projects and models to prevent HIV/AIDS among adolescents. A network of more than 500 specialists has been established; they periodically receive advocacy notices on AIDS and youths, as well as a quarterly news bulletin on the subject. A model for changing behavior in young people was developed and disseminated; it will contribute to the formulation and evaluation of interventions aimed at adolescents and youths.

The Elderly

The fact that people are now living longer lives poses a challenge in the 21st century. In almost all the countries of the Region, life expectancy at birth increased by 20 years during the last 50 years of the 20th century. PASB actively participated in establishing the Interagency Working Group on Aging, which promotes monitoring of the agreements reached at the World Assembly on Aging, held in 2002 in Madrid. The International Plan of Action approved in the Madrid Summit by the United Nations Member States is complemented in the Region by the Policy Framework on Active Aging and by a protocol for the execution and evaluation of comprehensive programs that support older adults. In collaboration with regional experts, indicators for monitoring and evaluating priorities in the area of health and aging were developed. To initiate implementation of the International Plan of Action, the countries were supported in evaluating and promulgating regulations for laws and national plans to guarantee older adults’ right to health.

As part of the effort to improve older adults’ access to primary care, PASB created a network of experts to develop a clinical guide to primary care for older adults. The guide’s objective is to provide health personnel with essential tools for evaluating older persons’ health problems, identifying risk factors for loss of function and disability, and establishing comprehensive primary care programs that address these persons’ health.

PASB and ALMA spearheaded the effort to train teachers in geriatrics in the Region’s medical schools and promoted ongoing dialogue between geriatric spe-
HEALTH CANADA and MEXICO’S Ministry of Health Work for the Mexican Elderly

The Ministries of Health of Canada and Mexico joined hands to improve the health and well-being of seniors in Mexico.

Both entities developed a joint plan of action, which focused on four main areas:

- developing policy and program recommendations for Mexico, based on analyses of the country’s data for the “Health, Well-being and Aging in Seven Urban Centres of Latin America and the Caribbean” (SABE) survey;
- developing policies that help both countries plan for and assess the continuing care of seniors and an aging population;
- sharing knowledge on healthy-aging issues, particularly nutrition and dementia;
- sharing information on long-term and continuing care models, including training and educational models for professionals and para-professionals, with a view to building capacity to develop innovative programs and services for seniors.

The project responded to a joint memorandum of understanding on health matters signed by the governments of Canada and Mexico in 1999. A coordinating committee consisting of representatives from Health Canada’s Division of Aging and Seniors, Mexico’s Ministry of Health, and the Pan American Health Organization oversaw the project. In October of 2002 this project culminated in a joint workshop in Ottawa, October 10–12, 2002. The result of this conference was a Health Canada/PAHO/Ministry of Health of Mexico co-publication entitled “A Guide for the Development of a Comprehensive System of Support to Promote Active Aging.”

A sedentary lifestyle and malnutrition are the leading risk factors for disease and disability in advanced age. Therefore, PASB, in collaboration with a group of experts from the Region, published the Regional Guide for Promoting Physical Activity, which will help to acknowledge the importance of physical activity for older people and will provide a conceptual framework for physical activity programs for older persons.

The “Health Promotion Forum of the Americas”

The “Health Promotion Forum of the Americas,” held in Santiago, Chile, in
October 2002, was one of the most important gatherings of its kind in Latin America. The meeting brought together more than 600 participants from the Region’s countries to analyze progress made in the health promotion commitments adopted in the Mexico Declaration (2000). Participants included mayors and other local government officials, ministers of health and of other sectors, public health professionals, community leaders, and NGO representatives from Argentina, Aruba, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, Suriname, Trinidad and Tobago, the United States of Amer-

CUBA Addresses the Care of Specific Population Groups and the Creation of Healthy Spaces

The National Program for the Comprehensive Care of Adolescents’ Health has been a valuable tool for integrating PAHO cooperation within the framework of broad intersectorial participation. The program includes care targeted to adolescents in the health services, the training of health personnel to raise the quality of care, and the training of adolescents as health promoters. Community and school projects have been implemented in various areas considered as priorities by adolescents. The projects, which enjoy the strong support of the local governments and social institutions and organizations, have yielded excellent results.

Cuba, with PASB’s cooperation, has been a member of the Latin American Network of Healthy Municipios and Communities since 1997. At this time, 52% of the country’s municipios are part of the National Network and are working in various arenas—communities, schools, universities, hospitals, workplaces, marketplaces, penitentiaries, and agricultural cooperatives—thanks to policies that enhance the community’s and the various sectors’ decision-making and managerial capacities.

The Network of Schools for Health includes 987 schools and 22 universities that implement projects aimed at the comprehensive development of children, adolescents, and youths and the restoration of values, self-esteem, and individual and social responsibility. The Bureau worked with the education sector to finalize the Master Plan for Health Promotion and Education.

Some 42% of older adults participate in the “Grandparents’ Circles,” taking part in physical, recreational, and cultural activities. The number of “grandparents’ houses”—community institutions that provide comprehensive care to older adults while enabling them to retain their family ties—has increased.

Care for adolescents and older adults, who are the target groups chosen by the localities in the Municipal Development Projects, has made it possible to diversify and expand the technical cooperation provided by the Bureau.
Participants identified several challenges and future prospects for health promotion in the Region. First, the health sector must embrace health promotion as a mission and as a priority. Second, while health promotion concepts and strategies are fairly well understood and implemented, discussions at the policy level remain weak and need to be fostered and strengthened through strong leadership and clear vision. In addition, the countries’ capabilities to develop health promotion plans of action that include clear targets should be made a priority; citizen participation must be fostered and intersectoral alliances and partnerships with the private sector and universities must be forged; and all levels of the health systems and services must be strengthened.

Throughout the year, consultants and regional advisors supported intersectoral country teams in the preparation of country reports that summarized and reviewed the progress made toward these commitments. The Bureau supported countries in preparing their reports—27 countries presented their progress reports and outlined their future perspectives. Reports showed significant progress since the Mexico Declaration and since PAHO’s Directing Council adopted the pertinent Resolution (DC 43/14) in 2001.

Promoting Healthy Spaces

PASB’s programs provided input to the preparation of the technical guidelines and summaries in the “Mayors Guide to Health Promotion and Quality of Life.” These guidelines were reviewed with groups of mayors in Brazil, Costa Rica, Cuba, Ecuador, Mexico, and Peru.

In addition, PASB, with support from the Kellogg Foundation, produced an innovative local strategic planning tool—the “Healthy Municipalities and Communities: Mayors’ Kit for Promoting Quality of Life.” The kit gives mayors and city planners the wherewithal to create healthy environments, and has been published in English, Spanish, and Portuguese. Dr. George Alleyne, then-Director of PAHO, and Dr. Francisco Tancredi, Director of the Kellogg Foundation’s Program for Latin America and the Caribbean, officially launched the kit at the Health Promotion Forum’s inaugural ceremony, and a copy of the kit was made available to all participants. One session was devoted to giving mayors an orientation on how to use the kit. At special sessions, mayors presented and reflected on their experiences building healthy municipalities and communities. At other sessions, mayors received guidance on such issues as how to use Geographic Information Systems and strengthen networks of healthy municipalities and communities. To date, 24% of the Region’s countries have national networks of healthy municipalities or communities. During the Forum mayors committed themselves to revive and strengthen the
“Regional Network of Healthy Municipalities and Communities.”

The kit was pilot-tested in Chile with a group of mayors from Brazil, Canada, Costa Rica, Ecuador, El Salvador, and Mexico. Four municipalities have received recognition for their efforts in creating healthy environments—Balcarce, Argentina; Surrey, Canada; Loja, Ecuador; and Surco, Peru. The awards were given after a contest sponsored by PASB and CDC as part of World Health Day. Dr. George Alleyne and Dr. David McQueen, Director of Global Health Promotion at the CDC presented the awards.

Two other important health promotion documents were prepared and reviewed by a group of experts from several organizations and institutions. The “Tool Kit for the Participatory Evaluation of Health Promotion at the Local Level” contains guidelines for evaluating healthy municipalities and communities. “Recommendations for Policymakers” examines how to work with decision makers and policy makers to ensure that evaluation of healthy municipalities and communities and of health promotion in general is a priority and given appropriate support.

The following highlights the year’s important direct technical cooperation and support efforts designed to strengthen country efforts in developing their national health promotion plans of action and to position health promotion in the national policy agenda:

- Support for the development and strengthening of healthy communities and health promoting schools as part of the VIDA Chile national plan of action. In addition, PASB fostered the exchange of experiences with other countries in the Region—with Canada, in the context of the CIDA-funded project to build and strengthen capacity in health promotion among the Region’s countries, with El Salvador and with Argentina in preparing a technical cooperation among countries project.
- Support to Brazil, Honduras, and El Salvador in the development of their health promotion national policy and plans of action.
- Support to Ecuador for the implementation of healthy municipalities in the context of the Loja Healthy Spaces Project and the USAID-funded “Making Cities Work” project, which focused on strengthening the capacities of local government to adequately respond to municipal needs.

Health-Promoting Schools

Educational systems in Member States have undergone structural reforms, resulting in decentralization, greater community involvement, increased school autonomy, and curricula changes that have incorporated such subjects as health education and health promotion. Taking advantage of the opportunity of-
Strategic and Programmatic Orientations, 1999–2002

fered by these changes, PASB launched the “Health Promoting Schools Regional Initiative” in 1995, as a way to create, foster, and maintain healthy and supportive physical and psychosocial school environments. The initiative is designed to strengthen comprehensive school health programs to facilitate human growth and sustainable development, including the adoption and maintenance of healthy lifestyles by students and the school community at large.

Some initiative accomplishments in 2002 deserve mention. First, the Third Meeting of the Latin American Network of Health-promoting Schools in Quito, Ecuador, in September. Every Latin American country except for Mexico and Argentina participated, exchanging information and materials about the design and implementation of comprehensive school health programs and activities. In addition, the analysis of data collected through a Regional health promotion survey is almost complete, and results will soon be published. Results show that most Latin American countries have already established health-promoting schools to one extent or another, and also have established intersectoral and interinstitutional committees for developing integrated school health programs. PASB also collaborated with INCAP to publish “Escuelas Promotoras de la Salud: La Experiencia Centroamericana,” documenting the development of integrated school health programs and activities in seven Central American countries. Finally, the “Regional Health-Promoting Schools Plan of Action, 2003–2012,” was developed, taking into account the status and trends of school health programs and activities in the Region. This document, which has been reviewed and validated by a multidisciplinary and multisectoral panel of school health experts, will help hone PASB’s support to Member States as they further develop and integrate health-promoting schools.

In 2002, PASB entered into important multisectoral and multidisciplinary alliances to further its work in health promoting schools. For example, the Bureau signed a collaborative agreement to strengthen health promoting schools with UNESCO in October. The agreement highlights the importance of research to assess the process and impact of different components of the initiative, especially of life skills training.

During 2002, and with PASB’s support, several countries developed and started implementation of healthy policies in their health-promoting schools, including schools free from smoke, violence, and with adequate space for physical education. Countries developed action plans for health promoting schools at the preschool, primary, and secondary-school levels. Several countries also developed plans of action to strengthen health promotion and health education in their university programs. Universities in the Region are developing and implementing strategies to promote health activities where students and teachers work, as well as in teaching curriculm and materials.

Universities in the Region, such as the Institute of Nutrition and Food Technology (INTA), the Chilean Catholic Univer-
University, Universidad del Valle in Colombia, and University of São Paulo in Brazil, developed on-site and distance courses that helped to significantly strengthen health promotion capabilities in several countries, including Brazil, Colombia, Cuba, Ecuador, and El Salvador.

Control of Tobacco Use

In 2002, PASB achieved five basic objectives in the control of tobacco use. First, it facilitated and energized the discussion and negotiation of the Framework Convention on Tobacco Control (FCTC). During the year, funds and technical cooperation were mobilized to support two regional meetings to discuss the FCTC text and support the participation of the countries of the Americas in two meetings of the Intergovernmental Negotiating Body in Geneva, and in an international meeting on illegal trade in tobacco products co-sponsored by the Government of the United States.

Second, it consolidated the “Smoke Free Americas” initiative launched in 2001. Seven countries have begun to create smoke-free spaces, that include the establishment of a nicotine environmental surveillance system to monitor the effectiveness of those actions. Argentina, Brazil, Chile, Costa Rica, Paraguay, Peru, and Uruguay participate in this system, the first multinational system of its type. Advocacy and training materials have been developed to ensure the effective implementation of this initiative; these materials include examples of innovative experiences in countries such as The United States of America and Canada.

Third, it developed and published a model and guidelines for the writing of tobacco control legislation. The model, translated into several languages, explains why the regulation of tobacco products is important, what types of legislation are and are not effective, and how to draw up and enforce the legislation. This document is intended to help the PAHO Member States adopt effective policies for the fight against tobacco and to provide valuable background information on tobacco legislation.

Fourth, for the first time information was available on most of the countries of the Americas, as a result of the Global Youth Tobacco Survey (GYTS), a worldwide surveillance system of tobacco use, implemented in cooperation with the Office on Smoking and Health of the U. S. Centers for Disease Control and Prevention (CDC). GYTS collects information on the prevalence of tobacco use, exposure to environmental tobacco smoke, exposure to the marketing techniques of tobacco advertising, and educational activities in educational centers for youths aged 13 to 15.

Finally, PASB prepared and published a report revealing that transnational tobacco companies have conducted deliberately misleading campaigns over the past 10 years in Latin America and the Caribbean, designed to delay or evade restrictions on tobacco use and limitations on its marketing. The report, whose objective is to alert the govern-
ments and civil society to the sorts of obstacles they may encounter in effectively combating smoking, was the result of a review of internal tobacco company documents, principally those of Philip Morris and British American Tobacco, which together control the largest market share in tobacco in Latin America and the Caribbean.

Maternal Health

In 2002, PASB placed emphasis on encouraging legislative changes in sexual and reproductive health, particularly individual rights; promoting the use of modern contraceptives; adopting public policies; and embarking programmatic activities to decrease maternal mortality and improve perinatal health.

Some of the Region’s countries have recently introduced important changes in their policies and legislation that deal with sexual and reproductive health (Argentina, Colombia, and Uruguay), and changes are under review in Barbados, Jamaica, and Trinidad and Tobago. These changes notwithstanding, the prevalence of use of modern contraceptives is still below 70% in most Latin American and Caribbean countries (Figure 10).

With regard to high-quality family planning services, two WHO manuals were translated and adapted: “Improving access to high-quality family planning care” and “Selected recommended practices for contraceptive use.” Technical recommendations also were made for modifying the WHO document “Safe abortion, technical and policy guide for health systems.”


![Graph showing the prevalence of contraceptive use in different regions of the Americas.](image-url)
Maternal mortality continues to pose a challenge to public health in the Region. In 2002 the Bureau, at the request of PAHO Member States, developed a new regional strategy to decrease maternal morbidity and mortality. Two resolutions were adopted at the 26th Pan American Sanitary Conference, at which all the Member States committed themselves to reduce maternal mortality by 75% by 2015, as compared to 1990 levels, and to ensure skilled care at delivery.

The reducible gap in maternal mortality for all the countries of the Americas, as compared with Canada’s maternal mortality rate, which is the lowest in the Americas, is approximately 90%, and compared with that of Uruguay, it is around 85% (Figure 11).

Working with the Interagency Working Group for the Reduction of Maternal Mortality, the Bureau prepared a document on the strategic consensus for the reduction of maternal mortality, which the countries have been consulted about and have discussed.

PASB continues to work to ensure that men participate in matters relating to sexual and reproductive health, especially in the seven Central American countries, where research will look at involving men in health care. The pilot test has already been conducted and data collection will begin in 2003.

To foster the national plans and programs, it was established that all research on sexual and reproductive health funded or supported by international organizations would have a dissemination plan targeted at program managers, ministers of health, political leaders, and the general public.
PASB completed case studies in five Latin American and Caribbean countries to strengthen health promotion in the areas of children’s health, adolescent health, reduction of maternal mortality, aging, and healthy spaces.

To strengthen the epidemiological surveillance systems for maternal and perinatal morbidity and mortality, support was provided for the introduction of a perinatal computerized information system in the Caribbean countries, and the perinatal clinical history was updated. While mortality due to perinatal conditions represents more than 60% of infant mortality, it has experienced the greatest relative decline in the last 20 years (34%), compared with the other major groups of causes.

Among technical cooperation activities carried out by the Latin American Center for Perinatology and Human Development, special emphasis was given to supporting 17 countries in improving the quality and use of maternal-perinatal information, training national experts to make test-based medical decisions tests, and strengthening the network of associated centers for the dissemination of the perinatal computerized information system.

The Center’s web page was finalized and the Library on Perinatal Maternal Reproductive Health was launched, which improves the dissemination of information and fosters ongoing contacts with institutions and persons associated with this area of work.

Health in Human Development

Health in Economic and Social Development

In consultation with ALADI, UNCTAD, WTO, IDB, and WHO, criteria were formulated in 2002 for the preparation of a database on international trade in health goods and services in the Region. This tool will be essential for negotiating commercial agreements at the global, Regional, subregional, and bilateral levels, and for formulating national policies in fiscal and regulatory spheres that take health sector priorities into account. Cooperation with Canada helped establish a network of health and trade researchers who will study the implications of the General Agreement on Tariffs and Trade (GATT) for the health sector in the Region. A report also was completed on trade negotiations related to health services, and, in cooperation with WHO, a book on trade in health services, based on an international workshop held in 1999, was published.

Progress was made in discussions among national statistical and census offices and statistical units in the ministries of health with respect to the ethnic and racial breakdown of persons and
and populations in the data and statistics produced by the health sector and by other sectors that are relevant to health. A publication on this issue was prepared, based on the results and conclusions of a workshop held in Quito, Ecuador, with the participation of national statistical and census offices, ministries of health, and representatives of interested NGOs. National initiatives were promoted to reduce health inequities based on ethnicity and race, as a followup of the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance, held in Durban, South Africa in 2001. PASB participated in the followup meeting to the Conference, sponsored by the Government of Mexico and the United Nations High Commissioner for Human Rights. This work is supported by an interagency coordination in which IDB, the World Bank, the Inter-American Dialogue, the Ford Foundation, the Inter-American Foundation, and PAHO participate. It coordinates the activities of participating institutions in support of governmental and civil-society initiatives whose goal is to reduce ethnicity-based inequities in the Region.

In cooperation with IDB, the systematic evaluation of health legislation in 24 of the Region’s countries was completed. The evaluation covered seven areas relevant to health for those populations—drugs, insurance, certification and accreditation, the environment, food protection, occupational health and safety, and blood banks and transfusion services. The evaluation showed the level of development of health legislation in participating countries and areas. The evaluation’s report will be a key tool for strengthening health legislation in the Region’s countries. The legislation database (Leyes), which contained 11,600 records by the end of 2002, was updated. Its dissemination through the virtual health library/legislation accounts for its growing use as a reference source by governments, legislatures, and civil-society organizations interested in health, as well as the health sector’s public and private officers, professionals, researchers, and institutions. As part of this effort, Mexico, in cooperation with the Inter-American Center for Social Security Studies, held the IX Course-Workshop on Health Legislation, which had 40 participants from 18 countries of the Region.

A database on household surveys of interest to health was updated and disseminated on the Internet. By the end of 2002, it contained general characteristics and sources of access to 110 surveys on living conditions, demographics, and health carried out in the Region. Cooperation with WHO to implement the World Health Survey in the Region also intensified. In its first phase, this survey is being carried out in eight countries (Brazil, Chile, the Dominican Republic, Ecuador, Guatemala, Mexico, Paraguay, and Uruguay). Experts from these countries participated in a training and coordination workshop at the Institute of Public Health in Cuernavaca, Mexico. Collaboration continued with MECOVI, an initiative for improving living conditions surveys, promoted by ECLAC, IDB, and the World Bank to improve the design of health-related modules and promote wider use of the results of these surveys by health authorities, professionals, and researchers.

In addition to increasing the countries’ capabilities to identify and monitor...
health inequities, the aforementioned activities are also intended to support the development and assessment of national policies to reduce those inequities. These issues were addressed at the workshop on policies for equity in health and social security, held with CIESS in Mexico in March 2002, and the seminar on policy tools for equity in health, held in Toronto in June 2002 with the Government of Canada, the University of Toronto, and the International Society for Equity in Health. In 2002, PASB’s cooperation with WHO in the field of health and poverty reduction was the subject of a seminar held in Crete, Greece, and an interregional consultation held in Gaborone, Botswana. Health and poverty reduction initiatives also were implemented, especially among the heavily indebted poor countries (HIPC) initiative.

The Virtual Health Library and the Network of National Councils for Science and Technology

Noteworthy among the Bureau’s cooperation activities in 2002, is the implementation of the Virtual Library in Science and Health (VLH/S&H). The virtual library was officially launched during the VI Regional Congress on Health Sciences Information in Puebla, Mexico, in May 2003.

VLH/S&H supports the management of scientific activity in health on the basis of PASB’s technical cooperation strategy for research, known by its Spanish acronym, DECIDES (Democratizing Knowledge and Information for the Right to Health). This strategy was designed to help overcome some of the major problems observed in the organization of scientific activity in health in the Region, such as limited participation in the establishment of research agendas, low utilization of research results in health policies and programs, weak cooperation and weak exchange of researchers among countries of Latin America and Caribbean, and unequal access to health knowledge and information.

VLH/S&H is taking advantage of the opportunities opened up by new communication and information technology to increasingly position itself as an integral part of the management of scientific activity in health based on information and scientific proof, as well as on the active participation of various actors associated with this activity. In short, VLH/S&H promotes the strengthening of scientific activity in health and cementing its relationships with the various sectors of society.

VLH/S&H has a decentralized organization that functions through networks of national and international science and technology organizations, scientific and technical units of the ministries of health, and other institutions in the Region. One of these networks, the International Network of Information and Knowledge Sources for the Management of Science, Technology, and Innovation (ScienTI Network), currently comprises 10 national science and technology organizations in Latin America and Portugal, four international science and technology
ARGENTINA Establishes the Virtual Health Library

Since the issuance of the San José Declaration in 1998, the PAHO/WHO Country Office in Argentina has been providing technical cooperation for the establishment of the Virtual Health Library (VHL)-Argentina Branch, at: http://www.bvs.org.ar.

Some 70 institutions from all parts of the country are participating in this project. Together they form the National Health Sciences Information Network (known by its Spanish acronym, RENICS). Its three principal resources are the National Health Sciences References database (known by its Spanish acronym, BINACIS), with 40,000 bibliographic records of the country’s documents; the Collective Catalogue of Periodic Publications, which includes the collections of cooperating libraries; and the Combined Databases of the RENICS Cooperating Centers (known by its Spanish acronym, UNISALUD), which includes all the libraries’ databases, with a total of 80,000 bibliographic records.

The Documentation Center of the Inter-American Association of Sanitary and Environmental Engineering (AIDIS)-Argentina coordinates the Virtual Library on Health and Environment of Argentina, in which 20 cooperating centers within the country participate. The site is on the CEPIS server: http://www.cepis.org.pe/argentina/E/home.html. This library gathers many sources of information for those interested in the evaluation and control of environmental risk factors that affect the health of the population. It uses CEPIS methodological tools for recording, quality control, and dissemination of these sources. Included are database manuals, guides, and the health and environment thesaurus in five languages. In addition to offering access to 5,000 full-text documents, the site provides information on on-site, distance, and virtual training and education resources. It also provides information about various types of meetings, access to environmental indicators, legislative databases, discussion lists, information locators, educational material, news, journals, and the bibliographic database for the CEPIS journal collection.

The Virtual Library on Toxicology provides access to more than 20 databases on chemical substances. With PAHO’s cooperation, databases containing sectoral information are being created, and the Global Evaluation of Drinking Water and Sanitation, which includes statistical information on every country in the Americas and information by groups of countries, has been initiated. Also, work is in progress on the Inter-American Environmental Sanitation Information System (known by its Spanish acronym, SISAM).

PAHO/WHO’s Country Office in Argentina also is cooperating in the establishment of Argentina’s Virtual Library on Adolescence and Youth (http://maestria.rec.uba.ar/NUEVA/home.htm), a project that began in 2001. Technical coordination is the responsibility of the Documentation Center for the Master’s Degree in Public Health of the University of Buenos Aires. The databases of the participating institutions were converted to standardized Latin American Health Sciences Literature Database (LILACS) formats for incorporation into this library, which also has directories in keeping with the VHL model. At this time, compilation, processing, classification, and standardization in accordance with BIREME methodology is under way. The hope is that this resource will be enriched, in the future, through the addition of other products and services.
organizations, and three groups that develop information science technology.

These institutions collaborate with VLH/S&H by providing indicators and data on projects, researchers, and scientific and technology entities of the Region. A database of resumes in standardized electronic format is the first product of this collaboration. In December 2002, the first coordination meeting of the ScienTI Network was held in Florianopolis, Brazil to assess the progress of implementation and the planning of future actions; it was attended by representatives of all its members.

Reducing Gender Inequities in Health

PASB has earmarked the production of health information that considers gender issues as one of its highest priorities. A resolution adopted by the 26th Pan American Sanitary Conference in 2002, urges Member States to include gender analysis in their policy-making. The Bureau now has an expert who collaborates with countries to develop gender and health indicators and tools for their analysis.

Strengthening National Capacity to Carry Out Gender and Health Analysis

The Bureau has worked with national users and producers of health statistics from the health sector, women’s bureaus, statistical offices, and women’s organizations to strengthen their capacity to conduct and apply the results of gender analysis. PASB has developed a strategy for the application of basic gender and health indicators that: sensitizes decision-makers to the importance of gender analysis, conducts a technical review and adaptation of PASB’s basic health and gender indicators with counterparts, facilitates training for producing and applying gender and health statistics, and leads to the production and publication of national health-and-gender equity situation profiles. Five Central American countries have begun their profiles; in Chile and Peru, the process is tied to monitoring sector reform policies.

One of the main goals of these situation analyses is to provide information and improve policies that have differential effects on the health of men and women, such as many of the countries’ health sector reform policies. There is evidence that some health care and financing models promoted by these processes may further marginalize the poor, the elderly, some ethnic groups, and especially women. In most countries women’s organizations and other stakeholders are often excluded from defining health sector reform policies or monitoring their outcomes.

Strategy for Reducing Gender Equities within Health Sector Reform

PASB and its national counterparts have developed a strategy to identify
and address these inequities. Components of this strategy include the development of information on gender and health inequities and their relation to health policies; the dissemination of this information to health and other sectors and to civil society, and the inclusion of these informed stakeholders in the formulation of better policies and the monitoring of their implementation and effect on the health of women and men. The Bureau has developed several working and conceptual papers on gender, reproductive health, and health sector reforms to help implement the strategy.

The “Gender Equity and Health Sector Reforms” project was launched in Chile in 2001 and in Peru in 2002. It focuses on the participation of civil society in the analysis and monitoring of new health policies. In Chile, PASB’s team working on the project was instrumental in supporting an intersectoral gender advisory committee that the Minister of Health convened to assure that gender is taken into consideration throughout the reform process. The advisory committee also issued a strategy paper that was presented to the National Health Sector Reform Commission and that was debated with civil society.

One of PASB’s key objectives is to provide information, training materials, and communication and learning channels to its network of focal points and counterparts. For example, the Bureau put in place a multifaceted GenSalud information strategy, which includes access to information and publications via PAHO’s website (www.paho.org/genderandhealth), offering advocacy packets and monthly fact sheets on health and gender issues (i.e., “Trafficking of Women for Sexual Exploitation,” “Gender and HIV/AIDS in the Americas,” “Gender Equity in Health”); a listserv (gensalud@paho.org) that disseminates information about websites, publications, conferences, and training to more than 1,000 subscribers; a virtual information center on women, gender, health, and development that includes an information portal and a virtual library; a gender and health training database; and a virtual learning center (http://genero.bvsalud.org).

Addressing Gender-based Violence

The Nordic countries’ original support for the domestic violence project in Central America came to a close in 2002; Bolivia and Ecuador continued to receive support for their projects from the government of the Netherlands. The governments of Sweden and Norway renewed their support for the Central American countries during the year, expanding their support to include other issues. The results of the evaluation of the Central America project were shared with national counterparts, in an effort to replicate successes and identify challenges. To date, PASB’s efforts to mobilize the health sector to address gender-based violence has resulted in achievements at the Regional, national, and community levels.

• At the regional level, PASB held the “Symposium 2001: Gender Violence, Health, and Rights in the Americas,” which brought together more than 100 participants from governmental and NGO sectors.
SAINT LUCIA and Gender Health

In 1998, St. Lucia’s Minister of Health, Human Services, Family Affairs and Gender Relations expressed interest in learning about Canada’s support services for family violence and violence against women. Since then, the two countries have been involved in a series of exchanges involving professionals, which has led to Saint Lucia’s development of domestic violence policies, including the country’s first shelter for abused women. In addition to partnering with Health Canada, Saint Lucia also joined hands with the Manitoba Ministry of Family Service and Housing. The latter is providing expertise on policy development, program assessment, shelter design and operation, and strategic planning to deal with violence against women.

One of the highlights in this initiative in 2002 involved a Saint Lucia delegation that travelled to Winnipeg, Canada, to view existing programs related to men’s health and positive behaviours; and to review policies and identify programs that would be helpful to Saint Lucia’s plan to work towards the elimination of violence against women.

At the national level, the Bureau established multisectoral coalitions in 10 countries to advocate for legislation and policies in this regard—legislation was passed in all 10, monitoring bodies were set up in 6, and gender-based violence was incorporated in health sector reform processes in 5. Tools (norms and protocols in 10 countries, surveillance systems in 5, and training modules in 10) were developed and put in operation; more than 15,000 representatives from health and other sectors were trained each year. Community assessment of women and providers was carried out in more than 20 communities in 10 countries; a prevalence study on gender-based violence and the role of men in promoting violence was conducted in Bolivia; and a knowledge, attitudes, and practice study was conducted in Peru. In addition, gender-based violence prevention campaigns were carried out in 10 countries. Finally, the study of violence was included in primary school curricula in Belize and Peru, and in college curricula in public health and nursing schools and police academies in Central American countries.

At the community level, more than 200 community networks were formed, comprising of health, education, and judicial sectors, police, churches, community leaders and women’s organizations. In addition, community-support groups were trained and are functioning in eight countries—more than 390 of these are in Central America.