



PAN AMERICAN HEALTH ORGANIZATION  
WORLD HEALTH ORGANIZATION



## **49th DIRECTING COUNCIL**

### **61st SESSION OF THE REGIONAL COMMITTEE**

*Washington, D.C., USA, 28 September-2 October 2009*

---

*Provisional Agenda Item 3.2*

CD49/3, Rev. 1 (Eng.)  
18 September 2009  
ORIGINAL: ENGLISH

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

#### **Advancing toward “Health For All”: Progress In Primary Health Care In The Americas**

#### **Message from the Director**

To the Member States:

In accordance with the provisions of the Constitution of the Pan American Health Organization, I have the honor to present the 2008-2009 annual report on the work of the Pan American Sanitary Bureau, Regional Office for the Americas of the World Health Organization. The report highlights the Bureau’s major work in providing technical cooperation during this period within the framework of the 2008-2012 Strategic Plan of the Pan American Sanitary Bureau, defined by the Governing Bodies of the Pan American Health Organization.

Mirta Roses Periago  
Director

*There are countries in our Region and in the world that have managed to build health systems that effectively guarantee universal and equitable access, that are collective and participatory, and that at the same time ensure efficiency, effectiveness, and quality. All of these systems are based on primary health care.*

— *Mirta Roses Periago*  
*Director, Pan American Sanitary Bureau*

## CONTENTS

	<i>Page</i>
Introduction.....	4
Chapter I. A New Vision .....	5
Chapter II. Moving toward Universal Coverage.....	11
Chapter III. Building People-Centered Health Services.....	14
Chapter IV. Promoting Public Policy for Health.....	26
Chapter V. New Leadership for Health.....	29
Chapter VI. Facing Future Challenges .....	37

## **Introduction**

1. The Region of the Americas has made impressive health gains over the past quarter-century, as measured by nearly every key indicator. Since the early 1980s, infant mortality has declined by more than one-half, deaths from communicable diseases are down nearly as much, and average life expectancy has gained six years.

2. Unfortunately, these gains reflect only averages and mask continuing, often gaping, inequities in health across and within countries of the Region. Life expectancy is 20 years longer for people from the richest countries in the Americas than for people from the poorest countries. Within some countries, the wealthiest individuals live 30 years longer than the poorest. Sixty percent of all maternal deaths in the Region occur in just the poorest one-third of countries. The current global economic downturn and newly emerging health threats—especially the rapid rise of chronic noncommunicable diseases—threaten countries' overall health gains while exacerbating inequities, as they impact disproportionately on the poor and the vulnerable.

3. To address these challenges, the Pan American Health Organization's (PAHO) Member States, with support from PAHO's Secretariat, have undertaken major efforts to reform and restructure their health systems with the aim of making them more efficient, more effective, more accessible, and more inclusive. The best of these efforts are being guided by the principles and strategic orientations of a new vision of primary health care, which PAHO and the World Health Organization (WHO) have identified as the most effective approach for promoting equitable and sustainable improvements in health.

4. This report highlights PAHO Member States' advances in implementing reforms and interventions oriented toward the new primary health care vision, as well as PAHO's role in encouraging and supporting those advances. Through this report, PAHO hopes to further promote this new approach to primary health care and thereby strengthen efforts throughout the Region to advance the vision and the reality of "Health for All."

## Chapter I

### A New Vision

5. The countries of the Americas are today grappling with many of the same fundamental health challenges that gave rise 30 years ago to Alma Ata's call for "Health for All by the Year 2000." Despite impressive gains in life expectancy and other aggregate indicators, millions of people still lack access to health care and other conditions essential for good health. Health systems are plagued by high costs and inefficiencies and have had difficulty responding to major changes in epidemiologic and demographic trends. National health budgets are perpetually underfunded despite widespread acceptance of Alma Ata's message that promoting and protecting health is essential to sustained economic and social development and good quality of life.

6. Over the past three decades, many countries have tried to tackle these problems through health system reform, but their efforts have had limited, mixed, and even counterproductive results. Health sector reforms of the 1980s and 1990s sought to improve cost-effectiveness and financial sustainability through decentralization, deregulation, and competition but left health systems segmented and fragmented, providing different kinds of care to different groups with little coordination, continuity, or equity. Even efforts to implement primary health care have often failed to produce the desired results. Many countries have applied the approach only selectively, using a handful of high-impact interventions for specific groups or diseases or offering basic, low-cost care for the poor. Only a handful of countries in the Region (including Canada, Chile, Costa Rica, and Cuba, among others) have traditionally made primary health care a pillar of their health systems. They are among the countries that have achieved the best health results.

7. These experiences and others from around the world clearly show that conventional health systems are ill equipped to meet people's health needs and that the principles and strategies of primary health care offer the greatest potential to improve health outcomes and reduce inequities in health.

8. In recognition of this, PAHO Member States in 2003—the 25th anniversary of Alma Ata—collectively renewed their commitment to primary health care in a resolution (CD44.R6) that called on PAHO's Secretariat to take the principles of primary health care into account in all its technical cooperation activities. The countries urged the Bureau to promote the approach through training of health workers, support for locally defined models, and evaluation of different systems based on primary health care. They also called on PAHO to promote celebrations and discussions of the Americas' 25 years of experience with the approach, with an eye to identifying best practices for implementing primary health care-based reforms throughout the Region.

9. As part of this process, PAHO and its Member States organized a series of national and international consultations on primary health care that reached out to civil society, governments, nongovernmental organizations, universities, professional associations, other U.N. agencies, and the international community. Based on a draft by the special Working Group on Primary Health Care and input from the 46th Directing Council in September 2005, PAHO produced *Renewing Primary Health Care in the Americas*, a position paper that redefines the approach and lays out strategic and programmatic orientations for building health systems based on the renewed vision. Over 40,000 copies of the paper, in all four PAHO official languages, were distributed in the Americas and worldwide. In September 2005, PAHO's 46th Directing Council expressed its support for the new approach in the Regional Declaration on the New Orientations for Primary Health Care (Declaration of Montevideo). It was further endorsed in the final declaration of the international conference Buenos Aires 30/15: from Alma-Ata to the Millennium Declaration (Buenos Aires Declaration) in 2007, in the Iquique Consensus of the 9th Ibero-American Conference of Ministers of Health, in the Health Agenda for the Americas 2008–2017, and at the Fifth Summit of the Americas (Declaration of Commitment of Port of Spain) in April 2009.

10. The PAHO/WHO position paper presents accumulated evidence that shows that health systems based on primary health care are more efficient, have lower costs, and achieve higher user satisfaction than systems that are not. Based on experiences with primary health care in the Americas and other regions, and the inability of existing systems to meet current health needs, the report presents a new vision for primary health care–based reform and offers key strategic directions and lines of action for carrying it out.

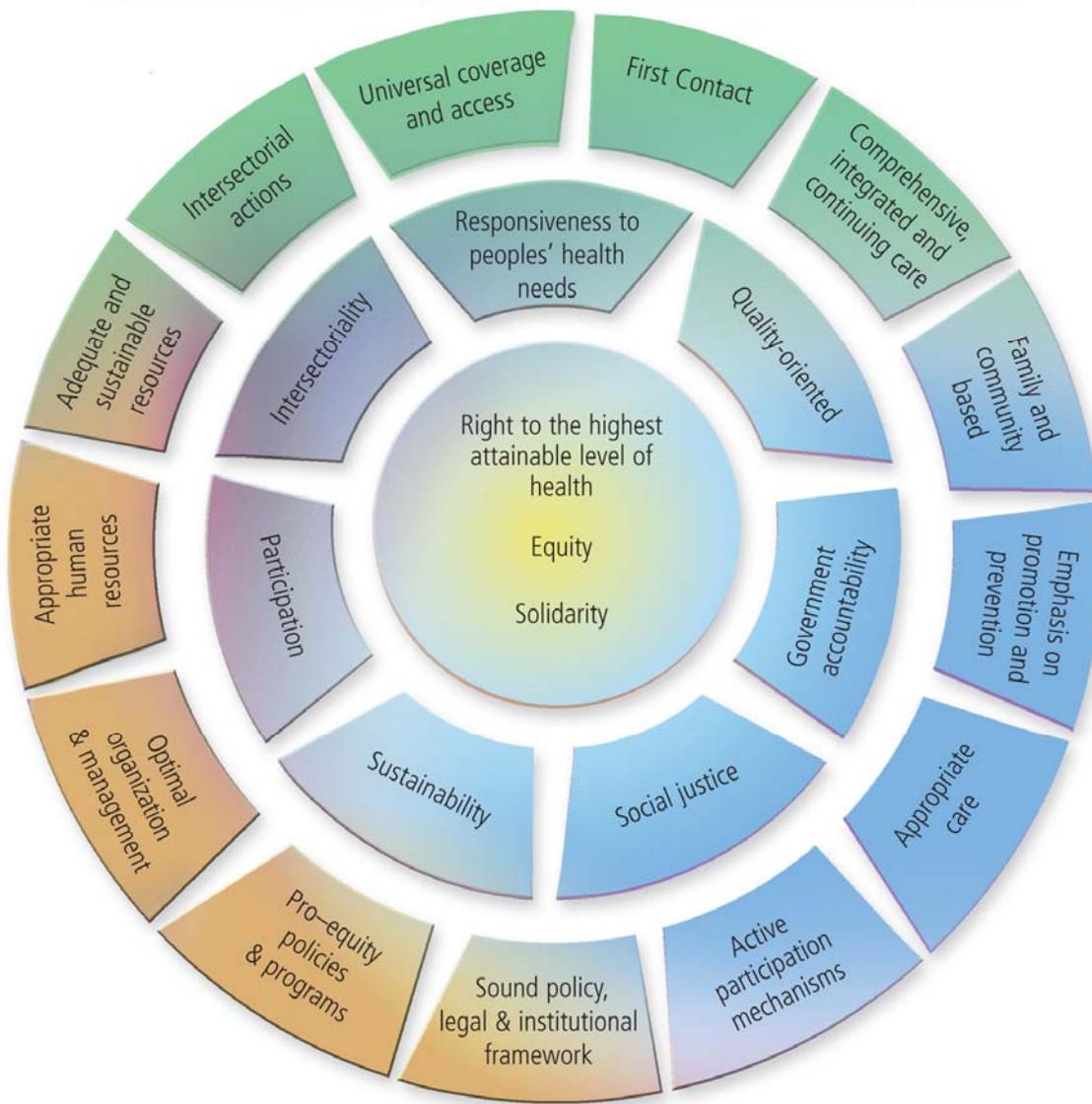
11. The new PAHO/WHO vision remains faithful to the spirit of Alma Ata but differs in important ways from many of the approaches to primary health care that have emerged since 1978. It discards the idea of a defined set of health interventions aimed at specific population groups, calling instead for the transformation of the health system as a whole. It embraces equity, solidarity, and people's right to the highest attainable level of health as guiding principles. But it also emphasizes quality of services and sustainability. It acknowledges the roles of the public, private, and nonprofit sectors in health care as well as the importance of health system functions other than the provision of medical care. It also recognizes that different countries have different needs, levels of resources, administrative capacities, and cultural preferences, so that a one-size-fits-all approach to primary health care is neither possible nor desirable. Instead, it provides guiding principles and essential areas of action for carrying out comprehensive health reform.

12. The PAHO/WHO position paper presents three core values, seven principles, and 13 essential elements that are the building blocks of primary health care–based health systems (see Figure 1). Together they create health systems that guarantee universal

coverage and access to services that are acceptable to the population and that provide comprehensive, integrated, and appropriate care over time, with an emphasis on prevention and health promotion. They make families and communities the basis for planning and action, and maximize both individual and collective participation in policymaking, prioritizing, and decisions regarding their own health. They promote solidarity, social justice, and equity in access not just to services but to other conditions that are essential for good health.

13. The PAHO/WHO vision also calls for a sound legal, institutional, and organizational foundation, and for adequate and sustainable human, financial, and technological resources. It requires optimal management practices to ensure quality, efficiency, and effectiveness, and transparent monitoring and evaluation to ensure accountability. It calls for intersectoral action and the promotion of policies and programs that address the social determinants of health.

Figure 1: Core Values, Principles and Elements in a PHC-Based Health System



14. In 2007, two years after the Declaration of Montevideo, the renewal of primary health care was raised on the global health agenda when the new director-general of WHO, Dr. Margaret Chan, endorsed the approach as “the only way to ensure fair, affordable, and sustainable access to essential care across a population.” A year later, the report of the Commission on Social Determinants of Health provided additional support by documenting the growing gaps in health outcomes within and between countries, analyzing the underlying social, economic, and political causes of these gaps, and citing as one of the best solutions a renewed focus on primary health care.

15. Under Dr. Chan's leadership, WHO carried out its own review of primary health care, drawing on experiences from the Americas and around the globe. This work culminated in the publication of the 2008 World Health Report, *Primary Health Care: Now More Than Ever*, which presents additional evidence validating primary health care as the best way to ensure equity in health and to equip health systems to meet new challenges. A year later, the 62nd World Health Assembly endorsed the approach and urged its widespread adoption (WHA 62.12 and WHA 62.14).

16. The 2008 World Health Report analyzes major shortcomings that have left conventional health care systems unable to meet the needs of large numbers of people. These include the provision of "inverse care," whereby better-off people consume more care than people with less means and greater health needs; "impoverishing care," in which individuals and families who lack social protection fall into poverty as a result of catastrophic out-of-pocket expenses; "fragmented care" due to overspecialization, which prevents a holistic, continuous approach to people's care; "unsafe care" due to poor system design that fails to ensure safety and hygiene standards; and "misdirected care," whereby resources are allocated disproportionately toward curative care while neglecting prevention and health promotion.

17. The report shows that the primary health care approach addresses all these shortcomings by providing clear direction for a comprehensive and balanced response to health needs. It lays out four areas of primary health care-based reform that are critical for building successful health systems:

18. **Universal coverage.** To reduce health inequities, all people must have access to health care according to need and regardless of their ability to pay. Countries must undertake reforms and interventions that move them toward universal access and social health protection. These include efforts to expand coverage to the entire population for a growing number of services and with decreasing out-of-pocket costs.

19. **Service delivery.** To respond to people's needs and expectations, health care must be "people-centered." Countries must undertake efforts to reorganize and reform their health services to ensure continuous, high-quality care that is locally available. This includes efforts to improve both the technical and the perceived quality of health services.

20. **Public policies.** Many of the most important determinants of health are beyond the reach of the health sector. Countries must pursue cross-cutting and integrated public policies that encourage prevention and health promotion, and that ensure intersectoral collaboration to address the social determinants of health.

21. **Leadership.** Health systems are not evolving on their own toward greater fairness, efficiency and effectiveness. A new direction requires active leadership.

Governments must exercise such leadership by facilitating a participatory dialogue that engages all sectors, by building institutional and individual capacities for leadership in health policymaking, and by improving health information gathering to inform the policy debate.

22. In the Americas, a growing number of countries have embraced the new vision of primary health care and are carrying out initiatives based on these key principles and lines of action. These range from efforts to improve the quality and acceptability of health services to laws and legal frameworks that promote universal health coverage. These include provisions in the new constitutions of Bolivia, Ecuador, and Venezuela that specify health as a basic right of all citizens and assign the State responsibility for guaranteeing inclusion and access to health services (see also Chapter II).

23. Other major examples of progress toward universal health coverage in recent years include:

- Argentina's Maternal-Child Health Insurance Plan ("Plan Nacer") and Compulsory Medical Plan.
- The Bahamas' National Health Insurance.
- Brazil's national public health system (Sistema Único de Saúde) and Family Health Program.
- Chile's Regime of Explicit Health Guarantees ("Plan AUGE").
- The Dominican Republic's Subsidized Regimen of the General System of Social Security in Health.
- El Salvador's Law Creating the National Health System.
- Mexico's Popular Insurance.
- Nicaragua's Model of Family and Community Health.
- Peru's Comprehensive Health Insurance.
- Uruguay's National Integrated Health System and National Health Fund.

24. Countries of the Region are also making important progress through efforts to better integrate and coordinate their health services, expand access to comprehensive care, encourage prevention and health promotion, and address the social determinants of

health. Chapters III through VI of this report highlight a wide range of these efforts in the context of PAHO's technical cooperation during 2008–2009. Together, these efforts reflect meaningful progress in moving the Region of the Americas closer to its collective goal of “Health for All.”

## Chapter II

### Moving toward Universal Coverage

25. Universal access to health services and social protection is fundamental to achieving health equity and central to the renewed vision of primary health care. The concept has wide support among PAHO member countries. Universality is one of the main principles of the Health Agenda for the Americas 2008-2017, and increasing social protection and access to quality health services is one of the agenda's eight priority action areas.

26. In 2008-2009, PAHO Member States made significant progress toward universal access to health through new laws and policy frameworks as well as through concrete programs on the ground. Highlights of PAHO's technical cooperation in support of these advances are presented below.

27. In **Bolivia**, PAHO has provided support for a program that promotes prenatal care for pregnant women without health insurance. The Juana Azurduy de Padilla bond program pays expectant mothers 50 bolivianos (about US\$ 7) for each prenatal checkup they attend and an additional 120 bolivianos if they give birth in a state health center. The women also receive 125 bolivianos for each bimonthly check-up they take their child to, up to the child's second birthday. The initiative began to be implemented in May 2009 in all of the country's municipalities. PAHO is supporting the development of infrastructure and human resources needed to provide the health services offered under the program.

28. In **Colombia**, PAHO is supporting national efforts to expand health coverage through two initiatives that target special populations. In the first, PAHO helped the Ministry of Social Protection form a special technical group (*mesa técnica*) charged with developing alternative and multicultural models of primary health care that guarantee the expansion of social protection and access to quality health services for people living in remote areas. The first models are being implemented in the department of Chocó in 2009-2010, with plans to extend their implementation to Colombia's Pacific Coast areas.

29. In the second, PAHO has promoted the extension of health coverage to people displaced by conflicts, who make up 9–12 percent of the Colombian population. PAHO has supported outreach and training through the Route to Health (Ruta de la Salud)

initiative, which educates authorities and displaced people about their respective rights and duties, and teaches displaced people how to get access to health services in their new locations. PAHO also designed a computer program, SIGA, that tracks government health expenditures on these populations, helping to increase accountability and ensure sustained funding for these efforts.

30. In **Costa Rica**, PAHO provided technical cooperation to help develop a model for guaranteed access to health services and for expanding coverage to formerly excluded populations. It emphasizes a basic package of services that are the responsibility of the state and includes a strategy for providing in-home care as a fundamental element of primary health care and as a way of rationalizing the use of health resources.

### **Health as a Right in Ecuador**

PAHO contributed to the health focus of Ecuador's new constitution, approved in September 2008. It codifies the right of all citizens to *sumac kawsay*, Kichwa for "good living," through access to health care and key social determinants of health such as education, nutrition, and housing. The new constitution is part of a larger legal and development framework known as the National System of Inclusion and Social Equity.

The new constitution specifies that the National Health System must be based on primary health care and must offer a comprehensive public network that operates according to the principles of universality and equity, under the leadership of the national health authority. Article 32 says the system must provide "permanent, timely, and nonexclusive access to programs, actions, and services in health promotion, comprehensive health care, and sexual and reproductive health." The document also says the state must guarantee the right to health through its economic, social, cultural, educational, and environmental policies.

A number of articles in the constitution directly support the implementation of the Sectoral Transformation of Health in Ecuador (TSSE), a government reform effort that seeks to reorganize the health system according to the principles of equity, quality, efficiency, participation, pluralism, solidarity, and universality. Various articles specifically support the TSSE's seven main components: strengthening of the national health authority, administration and management of the national health system, network of public health services and comprehensive care model, financing of the national health system, auditing and monitoring of the national health system, information management in health, and citizen participation and social control. The objective is a national health system that guarantees "universal, progressive and free" access to quality health services based on a comprehensive care model emphasizing health promotion, prevention, and primary care.

31. With financial support from the Canadian International Development Agency (CIDA), PAHO helped the Ministry of Health of **Haiti** develop a strategy to reduce maternal and infant mortality by ensuring free access to prenatal, delivery, neonatal, and post-natal care in 47 health facilities nationwide. Preliminary results show a notable increase in institutional deliveries, a better response to obstetric emergencies, and 70-80 percent satisfaction among beneficiaries regarding the quality of care. These results have helped get a proposed Social Protection in Health policy onto both the domestic and the international cooperation agendas in Haiti.

32. In **Honduras**, PAHO has supported efforts to expand health coverage based on the renewed vision of primary health care and including the decentralization of health services. Using a primary health care framework, the Ministry of Health has reorganized the health services in 20 regions, implementing new models of care in 29 health units in 10 municipalities. By the end of 2008, the third year of the strategy's implementation, 60,000 families in 1,142 rural communities had been served by the reorganized services. PAHO has also signed a letter of understanding to provide a course in development of institutional capacities in primary health care for personnel from the Honduran Social Security Institute, to support its implementation of the program Comprehensive Care in Family and Community Health, which seeks to expand coverage and improve quality of care.

33. In **Panama**, PAHO helped develop and launch a new "Situation Analysis and Health Plan for Indigenous People in Panama." It has a primary health care focus and sets out a five-year strategy for improving indigenous health through a participatory process that includes meetings with indigenous leaders from different ethnic groups throughout the country.

34. In **Paraguay**, PAHO helped the Ministry of Health develop a new National Policy on the Health of Indigenous Peoples to fight exclusion from access to health care. The plan emphasizes primary health care and community participation, and includes the creation of mobile health teams and training of human resources using an intercultural perspective. It is being implemented through alliances with local governments, nongovernmental organizations, and UNICEF.

35. In **Peru**, PAHO is supporting the implementation of a new Law on Universal Insurance, which was passed to complement existing insurance schemes linked to employment with the government or private enterprise. It establishes public health insurance financed with public funds to provide coverage for low-income people. To support the law's implementation, PAHO is spearheading an effort to strengthen the capacities of health workers based on the primary health care model. The law is currently being implemented in seven pilot areas that are among the country's poorest regions.

36. In **Uruguay**, PAHO supported the development and implementation of a new National Integrated Health System, which unifies the private and public subsystems under a single structure, eliminating fragmentation and reducing inequities in access to care. PAHO also supported the creation of Uruguay's new National Health Fund, which incorporates a number of preexisting insurance schemes into a single national health insurance plan, providing coverage to the entire population. As part of its support, PAHO helped Uruguay develop a new model of care based on the primary health care strategy, create a guaranteed portfolio of entitlements (Integral Health Care Plan), and establish mechanisms to implement the new system and the new fund, which have enabled the country to achieve universal coverage.

37. PAHO's Latin American Center for Perinatology and Human Development (CLAP) supported efforts to increase coverage of maternal services and reduce maternal mortality through technical cooperation in the northeastern provinces of **Argentina**, the Sembrando program in **Peru**, Arranque Parejo in **Mexico**, and related initiatives in **Haiti**, **Honduras**, and **Guyana**.

## **Chapter III**

### **Building People-Centered Health Services**

38. To effectively meet the needs of the population, health services must be integrated, accessible, and acceptable and must provide continuous, comprehensive care. PAHO Member States have undertaken major efforts to reorganize their health systems with these objectives in mind, following the principles and elements of primary health care. In 2008-2009, this work ranged from sweeping decentralization efforts to more focused initiatives aimed at improving the quality and acceptability of care. PAHO provided important support for these efforts through its technical cooperation in the countries, as highlighted below.

39. In **Argentina**, PAHO promoted a perinatal care program at the Ramon Sarda Mother-Child Hospital as a model for transforming conventional maternity centers into family-centered maternity services. The program seeks to put expectant and new mothers and their babies at the center of their families through such measures as including family members in prenatal checkups, encouraging them to accompany mothers during labor and delivery, allowing fathers and other family members into neonatal support units, facilitating skin-to-skin contact between babies and their mothers, and providing mothers of hospitalized infants with access to special lodging and meals, with volunteers providing care. PAHO produced a publication presenting the program as a "best practice," citing such indicators as a neonatal death rate of less than 2 per 1,000 (excluding babies with lethal defects and those weighing less than 750 grams) and a 90

percent usage rate for the special lodging and meals. PAHO also facilitated on-site training at the R. Sarda hospital for multidisciplinary teams from other facilities, as well as later visits by R. Sarda health professionals to those same facilities for reinforcement and follow-up.

40. Also in Argentina, PAHO supported the consolidation of the country's National Nursing Development Plan, aimed at increasing the number of nursing professionals and training nursing aides. The initiative emphasizes nursing skills needed in primary health care and will be applied in 42 nursing schools, with the goal of increasing the nursing workforce to 45,000 by 2016.

41. PAHO's Country Office in **Belize** is supporting efforts to integrate HIV prevention, care, and treatment as well as prevention and control of chronic noncommunicable diseases into primary health care. These include efforts to reduce stigma and discrimination as a barrier to effective HIV intervention, as well as support for the development of protocols on diabetes, hypertension, nutritional management, and physical activity for use in primary care settings. In a related effort, PAHO in early 2009 collaborated with the Belize Diabetes Association to provide training to community-based health personnel in foot care for people with diabetes. Plans are in progress for follow-up training in Jamaica.

42. PAHO has also supported efforts in Belize to strengthen community mental health services in the context of primary health care. PAHO's technical cooperation supported capacity building for psychiatric nurse practitioners, development of a mental health policy, development and use of a mental health training manual for police officers, and drafting of a plan for mental health in disasters. Concomitantly with these efforts, Belize has reduced the number of psychiatric hospital admissions and has increased the number of mental health outpatients.

43. In **Bolivia**, PAHO worked in 2008 with the Ministry of Health and Sports to provide graduate-level training for doctors using a new conceptual model called Community, Family and Intercultural Health. The training incorporated the principles of primary health care and focused on the experiences of first-level care in rural and urban areas. The student physicians are expected to eventually hold positions in management and delivery of services at the level of health networks, and the training equips them to improve service delivery and to advocate efforts to address the determinants of health among local authorities.

44. In **Brazil**, PAHO has been supporting the formation of multidisciplinary teams to provide people-centered family health care as part of the country's Family Health Strategy. By early 2009, more than 230,000 health workers in 30,000 teams were providing services to an estimated 50 percent of the population across the national

territory. In areas where the strategy is not yet implemented, primary care services are being provided through a more traditional services-on-demand approach. However, this model is being gradually supplanted by the Family Health Strategy.

45. PAHO also supported the incorporation of a clinical Pharmaceutical Assistance Model into Brazil's Family Health Strategy as part of larger efforts to strengthen policies on rational use of drugs and essential supplies. In addition, PAHO has supported the QualiSUS Project, which is strengthening the health services infrastructure of Brazil's health networks.

46. PAHO's Country Office in **Chile** worked with the Latin American Center for Perinatology and Human Development (CLAP) to develop a country-to-country technical cooperation project promoting maternal, neonatal, and child health. The project was the first line of action of the "Let's Act Now for Mothers and Children" launched in September 2008 by Chilean President Michelle Bachelet. The project will be carried out in Bolivia, Ecuador, and Paraguay.

47. Also in **Chile**, the PAHO/WHO Collaborating Center for Primary Health Care, in the School of Nursing at the Pontifical Catholic University of Chile, developed an innovative program to provide "distance care" via telephone for patients with diabetes and other chronic conditions. The program, ATAS-UC (Spanish acronym for Telephone Support for Self-Care in Health-University of Chile) focuses especially on self-management for patients with diabetes type 2.

48. In **Colombia**, PAHO supported the Ministry of Social Protection's efforts to expand coverage and strengthen the model of care for tuberculosis patients in eight departments with high proportions of indigenous people. The care model is based on the principles of primary health care and includes specific intercultural approaches for each ethnic group. A central aim is to gain acceptance from the indigenous population through intercultural dialogue and the participation of indigenous organizations as leaders and effective channels for communication and implementation of actions in health. A new investment of US\$500,000 will facilitate the expansion of the model to an additional 15 ethnic groups.

49. Also in Colombia, PAHO supported the design of a model for providing child health services in areas with little access to health care or high concentrations of displaced people, where infant mortality rates are high. The model provides curative and preventive health care through mobile teams, with costs absorbed by the country's social security system. In a related effort, PAHO is working with health authorities, insurers, and providers to apply the Integrated Management of Childhood Diseases (IMCI) strategy to achieve comprehensive care for pregnant women and children under 5 in the three provinces of Colombia's "Coffee Belt."

50. In **Cuba**, PAHO has focused its technical cooperation on consolidating the country's notable achievements in primary health care. In 2008-2009, PAHO worked with the Ministry of Health to strengthen municipal health departments and the nearly 500 polyclinics that provide preventive and curative care services throughout the country. So far, more than two thirds of the polyclinics have benefitted from new equipment and personnel training in areas including sonography, radiography, endoscopy, ophthalmology, optometry, rehabilitation, urgent care, laboratory capacity, and information systems. PAHO also helped strengthen the National Health System's statistical network and health surveillance system to support situation analysis for primary health care.

51. In the **Dominican Republic**, PAHO has supported the development of a network of regional health services, including the rehabilitation and construction of new health centers, acquisition of equipment, and needs evaluations to ensure that population demands can be met. PAHO also supported efforts to strengthen human resources for primary health care through the training of 55 national- and regional-level facilitators who in turn will train health professionals in first-level care. Other Dominican health professionals are taking courses through PAHO's Virtual Campus in Public Health.

52. PAHO helped organize the first **Eastern Caribbean** Conference for Health Services Managers and Clinical Engineers, in October 2008, which brought together hospital administrators, health services managers, clinical supervisors, and clinical engineers from 10 countries to share state-of-the-art information about health systems development, technology management, and clinical engineering. PAHO is also supporting training on management of diabetes and hypertension for health teams and other health partners.

53. In **El Salvador**, PAHO supported improvements in the quality of health services in metropolitan San Salvador through the strengthening of providers' capacities and skills, and through the provision of basic equipment for perinatal care. PAHO also supported the reorganization of family and community care with a participatory focus, including the empowerment of women and involvement of other sectors besides health.

### **Faces, Voices, and Places of the MDGs**

PAHO's Faces, Voices, and Places regional initiative provides leadership for primary health care renewal by modeling health promotion interventions that address the social determinants of health. The initiative was conceived to showcase efforts to advance the Millennium Development Goals (MDGs), especially those related to health, in the poorest and most vulnerable communities of Latin America and the Caribbean. The specific interventions are based on an analysis of local realities and are being developed and carried out by the communities themselves with technical assistance from PAHO and other agencies of the United Nations system.

Activities during 2008 in two towns in El Salvador illustrate the initiative's promotion of primary health care through an intersectoral, multiprogrammatic approach to integrating health services. In 2008, PAHO helped carry out participatory local health assessments (*diagnósticos*) in the towns of Rosario de Mora and Santiago Texacuangos, in the country's south. The work included situation analyses, identification of problems, and support for the design of local health plans based on the new vision of primary health care, with a focus on reducing inequities and extending social protection using a family health model. The assessments were carried out with the active participation of local residents and all sectors involved in health, under the leadership of the Ministry of Public Health and Social Assistance and the municipal governments.

Similar work is being carried out as part of the Faces, Voices, and Places initiative in more than 30 communities in 17 countries of the Region (see box). The initiative also supports MDG-promoting interventions in Guyana and Haiti through a PAHO–European Community partnership and has shared its tools and methodologies for participatory research and community capacity-building with Argentina, for its Healthy Municipalities Network, and with Colombia, which is promoting healthy environments and intersectoral alliances in 100 of its most vulnerable communities.

### **Communities of the Faces, Voices, and Places Initiative**

<b>Brazil:</b>	Duque de Caxias (Rio De Janeiro), Fortaleza (Ceará), Guarulhos (São Paulo), Olinda (Pernambuco)
<b>Bolivia:</b>	Betanzos, Potosí (Saavedra); Chacaltaya, La Paz (La Paz); Chaco (Gran Chaco); Huacullani (Altiplano); Pampas Aullaga (Oruro); Brecha, Cordillera, Kuarirenda, and Yapiroa (Santa Cruz); San Silvestre (Pando)
<b>Costa Rica:</b>	Corredores (Puntarenas)
<b>Chile:</b>	Cerro Navia and San Joaquín (Santiago de Chile), Molina (Curicó, 7 <sup>th</sup> Region Maule)
<b>Cuba:</b>	Cotorro and Old Havana (Havana)
<b>Ecuador:</b>	Nabón (Azuay), Alausí, Colta, and Guamate (Chimborazo)
<b>El Salvador:</b>	Panchimalco, Rosario de Mora, Santiago Texacuangos, Santo Tomás, Villa Centenario (San Salvador)
<b>Guatemala:</b>	El Bongo and Los Angeles Mancalá, El Estor (Izabal), San Juan Ermita (Chiquimula), Los Encuentros (Sololá)
<b>Honduras:</b>	Puerto Lempira, La Mosquitia (Gracias a Dios)

<b>Nicaragua:</b>	San Carlos and Río San Juan (Río San Juan)
<b>Panama:</b>	Santa Fe de Veraguas (Veraguas)
<b>Paraguay:</b>	Caazapá and Yuty (Caazapá), Laurelty (Asunción), Reducto and San Lorenzo (Central), Campo Loa and Villa Boquerón (Boquerón), San Miguel (Chaco)
<b>Peru:</b>	Ventanilla (Callao), Belén, Iquitos (Maynas)
<b>Uruguay:</b>	Canelones (Canelones)

54. PAHO is working with the Hospitals Cooperative of Antioquia, **Colombia** (COHAN), a PAHO/WHO Collaborating Center for Essential Drugs and Hospital Supplies, to promote a new tool for improving health services management known as PERC (from the Spanish for “production, efficiency, performance, and costs”). The effort includes the development of manuals and virtual courses as well as training for managers and other users. PERC builds on and replaces the WinSIG information management system, also developed by PAHO.

55. In **Honduras**, PAHO helped the Civic Council of Popular Indigenous Organizations (COPINH) develop the Utopia Center, which serves as a “meeting and friendship center” for the Lenca community of La Esperanza, Intibucá. It will serve as a venue for training and capacity building in areas including natural and traditional medicine, sustainable agriculture, alternative credit and savings, integrated farming, gender issues, and solutions to health problems that affect indigenous people. The center, funded by the Lydia Behm trust, includes a museum on Lenca culture, a library, a radio transmitter, a study and computing area, a kitchen, an administrative area, and four dormitories. The 7-hectare compound also has a fruit grove and vegetable garden.

56. PAHO’s Latin American Center for Perinatology and Human Development (CLAP) produced and disseminated new *Guidelines for the Continuum of Care of Mothers and Newborns in the Context of Primary Health Care*, along with a series of practical manuals, training materials, and other publications covering such subjects as perinatal infections, utilization of the Perinatal Information System, family planning, and child health promotion. During 2008-2009, the center organized 30 workshops in 12 countries, training more than 800 participants from throughout the Region in maternal and child care. It also supported long-distance training courses on community and clinical application of the Integrated Management of Childhood Diseases (IMCI) strategy, covering such areas as case management, health promotion, organizational skills in the delivery of appropriate care, and key family practices in hard-to-reach and vulnerable areas.

### **Primary Health Care and the Pandemic (H1N1) 2009**

Since before the start of the H1N1 influenza pandemic, PAHO provided technical cooperation to Member States in Latin America and the Caribbean to foster an efficient response from the primary health care services in the event of a pandemic. As part of pandemic preparedness efforts, PAHO provided specific recommendations on preparing health facilities for unusual or unexpected cases of acute respiratory illness and guidelines on case identification and triage of patients with respiratory symptoms, with emphasis on the need for early detection and reporting of unusual cases.

Following the outbreaks, PAHO produced and disseminated a technical document on the primary health care strategy and the response to the pandemic, which encourages a comprehensive, integrated approach that focuses not only on hospitals but on all levels of care, that facilitates family and community participation in prevention and home care, and that involves other sectors, including educators and faith-based groups.

PAHO also provided specific recommendations and training on infection control in health facilities and helped countries throughout the Region procure personal protective equipment for health workers, with special support for lower-income countries. PAHO also provided guidelines on clinical management of cases, risk communication for health service managers, the organization of health services in countries where the virus has and has not yet been reported, and responding to a second emergency (such as a natural disaster) during an influenza pandemic.

PAHO is also working to ensure equitable access for its Member States to antiviral drugs and vaccines for novel H1N1.

### **Primary care and communicable diseases**

PAHO carried out a number of initiatives in 2008-2009 targeting communicable diseases that also helped to strengthen primary health care in Member States.

PAHO supported the implementation of an Integrated Management Strategy for the Prevention and Control of Dengue (EGI-dengue) in member countries, with a strong focus on primary health and environmental care. Strategies developed for **Bolivia** and **Chile**, and currently under development for **Puerto Rico** and the **Caribbean**, address the disease at all levels of patient care, with emphasis on primary care, which offers the best opportunities to prevent deaths from the disease. Among the goals in these strategies is to have 100 percent of health units in each country using established standards for dengue care.

PAHO collaborated with the Department of Health in Chiapas, **Mexico**, to develop an integrated action plan for the control and elimination of neglected infectious diseases (onchocerciasis, trachoma, Chagas' disease, and leishmaniasis) with a focus on primary health care services and improved water supply.

PAHO is also carrying out a number of efforts centered on tuberculosis treatment and control that serve to strengthen primary health care. These include efforts to improve comprehensive care of patients with TB through training of health workers in HIV testing and counseling and in health education for patients, the family, and the community, and through better clinical management of the disease; the promotion of community participation in the DOTS strategy; strengthening of laboratory networks; capacity building for management of medicines; training in basic epidemiology; and work with the public and private sectors to incorporate service providers into the network of primary health care services.

PAHO continued its support for efforts to scale up and reorient health services for HIV prevention and care based on the principles of the renewed primary health care strategy. An important initiative was the insertion of comprehensive HIV care into curricula for nursing, psychology, and medical schools in the **Andean Region**. The program also adapted specific HIV modules from the Integrated Management of Adult Illnesses (IMAI) strategy for use in Latin America and the Caribbean, organized a three-day regional discussion with national AIDS and tuberculosis program managers on enhancing comprehensive services for HIV and TB treatment and control, and produced interim guidelines for TB/HIV care and related training modules, job aids, and posters for health care providers.

PAHO also worked in 2008-2009 to raise awareness of the effectiveness, feasibility, and safety of the “screen and treat” approach to cervical cancer in primary health care. PAHO has helped implement the approach in **Guatemala** and **Peru**, and began similar work in **Paraguay** as part of an integrated primary health care package. PAHO also worked with the Ministry of Health in **Nicaragua** to train providers and improve the quality and coverage of cervical cancer screening services in primary health care.

57. In **Nicaragua**, PAHO supported an evaluation effort by the Ministry of Health that assessed progress and challenges in the implementation of health policies based on primary health care. Through a process known as JABA, evaluations were carried out in 149 of the country’s 153 municipalities. They identified a number of major advances including the provision of free health services, improvement in the provision of medicines in the ministry’s health units, the development of special health days and health fairs, and non-denial of requested services. The JABA process is designed to enhance public accountability.

58. Also in Nicaragua, PAHO supported the implementation of a Family and Community Health Model in 11 departments to improve the delivery of health services and to expand immunization coverage in remote communities. As part of these efforts, PAHO worked with the Ministry of Health to strengthen supervision of immunization services at all levels, to evaluate the quality and capacity of the cold chain, to introduce

the new pneumococcal vaccine, and to support the decentralization of antiretroviral treatment to 23 health establishments.

59. In **Panama**, PAHO helped the Ministry of Health develop and disseminate new guides for comprehensive care for patients with diabetes, obesity, and hypertension. The guides, which are part of Panama's renewed primary health care strategy, promote prevention and control of these conditions in first-level care settings, with a focus on community participation.

#### **Decentralization in Peru**

In **Peru**, PAHO has provided support for decentralization of the health system, strengthening of primary care, and efforts to ensure universal access to health.

Peru's decentralization efforts have transferred 125 functions of the health system from the central level to the departmental level. To support this process, PAHO has provided technical cooperation for the organization and development of health services based on the principles of primary health care, with a focus on such areas as referral and cross-referral systems, accreditation of services, guaranteed quality, planning, and financing. In addition, PAHO has helped develop a new family health strategy aimed at expanding health services and strengthening primary care with an emphasis on prevention and health promotion, particularly for low-income people. In implementing the family health strategy, Peru has reoriented its health care model from a focus on comprehensive care for individuals to comprehensive family care.

60. PAHO is helping Member States improve the quality of health services through a regional initiative to improve the health and safety of health workers. Highlights of this initiative in 2008-2009 included an effort to vaccinate 1.5 million health workers in **Peru** against infectious diseases acquired through occupational transmission, including hepatitis B.

61. In **Suriname**, PAHO is supporting a Health Sector Plan that aims to improve health coverage, strengthen primary care, and improve the efficiency, equity, and quality of health services. As part of this support, PAHO has participated in a Community Primary Health Care Steering Committee that conducted a rapid assessment of existing health services in the interior, to serve as the basis for the introduction of comprehensive and integrated health services delivery throughout the country's health system. PAHO is also collaborating with UNICEF and the United Nations Population Fund (UNFPA) to introduce comprehensive primary health care through an integrated management approach in 57 clinics that are part of Suriname's private, faith-based Medical Mission network. With adaptations, the approach is expected to become the national standard for

primary clinics in the public sector as well. In addition, PAHO has helped adapt algorithms and protocols from the Integrated Management of Childhood Diseases (IMCI) approach to Suriname's particular needs and standards.

62. In **Trinidad and Tobago**, PAHO has supported a primary health care approach through the promotion of integrated delivery systems and the integration of mental health services into community-based primary health care. PAHO helped organize three initiatives in these areas: a National Forum on Mental Health Promotion and Mental Disease Prevention and a National Consultation on Integrated Delivery Systems, both in October 2008, and a workshop on Strengthening the Mental Health System in March 2009. The consultation on Integrated Delivery Systems provided feedback for a PAHO regional proposal on integrated delivery systems that grew out of the process of renewal of primary health care.

63. As part of its support for health reform in **Uruguay**, PAHO helped develop a training program on primary health care that hopes to reach 3,000 physicians from both the public and private sectors and from throughout the country. PAHO's country office developed the curriculum for the program, with the participation of public and private institutions, including the University of the Republic of Uruguay. The goal is to provide a professional reorientation for the participants so they can better respond to the demands of a primary health care-based system. PAHO has also promoted similar activities in other departments.

64. Also in support of health reform in Uruguay, PAHO helped carry out a pilot project on primary oral health care in the department of Canelones. The project promoted use of the Atraumatic Restorative Treatment (ART), a procedure for removing dental caries with hand instruments, which can be used by nondental personnel and primary health care workers. The pilot project carried out sociological and anthropological studies to assess local community oral health conditions and needs, including a survey using the DMF (decayed, missing, filled) index, which allows for comparisons of the oral health of different groups and across countries.

65. In the **Turks and Caicos Islands**, PAHO provided training in contact tracing and counseling for nurses and medical practitioners caring for HIV/STI patients. PAHO also provided support for an assessment of the island's mental health services, utilizing the WHO's Assessment Instrument for Mental Health Systems (WHO-AIMS). The findings are being used to develop a draft mental health plan that will focus on primary health care.

66. PAHO in 2008 provided support for **Venezuela's** Barrio Adentro ("Inside the Neighborhood") initiative, which has installed 8,000 "consultation points" in people's homes and has constructed 3,580 clinics whose main priority is care for low-income

people who have traditionally lacked access to rural and urban health services. The initiative has led to the expansion of primary health care to some 17 million people throughout the country and has formed the basis for the creation of Comprehensive Community Health Areas as operating units for the health system, providing health care in conjunction with local governments and the citizenry.

67. Also in Venezuela, PAHO supported efforts to incorporate a Plan of Universal Access to Treatment for Tobacco Dependency into the National Public Health System, through a network of primary care facilities. The initiative has trained 1,125 doctors, nurses, psychologists, and psychiatrists. Between July 2008 and February 2009, the initiative reached some 3,000 smokers, with a smoking cessation rate of 16 percent at the end of treatment. The cost-free treatment includes the use of bupropion and nicotine patches.

68. In late 2008, PAHO's **Virtual Campus in Public Health** offered its first course on capacity building for the renewal of primary health care, and 59 students from 17 countries in the Region completed the course.

69. In **Puerto Rico**, PAHO began discussions with the Department of Health to establish a node of the Virtual Campus of Public Health at the School of Public Health of the University of Puerto Rico. PAHO recently assigned five virtual rooms of the campus to work in coordination with the university.

70. PAHO worked with a C\$12 million grant from Canada through the Canadian International Development Agency (CIDA) to promote an integrated and intersectoral approach to communicable diseases, with emphasis on reducing inequities in access to health services and addressing the priority health needs of vulnerable and marginalized populations. The program targets selected areas in **Colombia, Ecuador, Paraguay, and Peru** and follows the principles of primary health care, with special emphasis on community disease surveillance, health promotion and education, and building local capacity to increase community participation and empowerment.

71. In addition, during 2008-2009 PAHO worked with nearly €2 million from the Government of Spain to improve the organization, management, and delivery of health services in Latin America and the Caribbean as part of efforts to reduce illness, disability, and premature mortality in the Region. The funds supported efforts to strengthen organizational and management capacity in health institutions and health service delivery networks, based on the principles of primary health care, as well as improvements in primary care and promotion of policies and strategies for integrating health services networks. The funds also supported efforts to strengthen emergency medical services; the development of a regional strategy to improve safety and quality of care, including the establishment of a Regional Observatory on Patient Safety and Quality of Care; efforts to

fight chronic noncommunicable diseases in the Caribbean and elsewhere; and efforts to improve screening and treatment for cervical cancer in **Bolivia, Haiti, and Paraguay**.

72. PAHO helped organize the first Regional Colloquium on Organization and Management of Emergency Health Services, held in Medellin, Colombia, in November 2008. The meeting brought together experts from **Argentina, Brazil, Costa Rica, Colombia, Chile, Mexico, Panama, Peru, Spain, Trinidad and Tobago**, and the **United States** to develop collective lines of action for improving emergency health services throughout the Region. Discussions covered issues such as legal frameworks for health policy, organization and management of pre-hospital care, emergency room management, human resources and equipment for emergency services, and emergency medical services and disaster response. Participants in the colloquium pledged to form a team of experts to help PAHO design a regional strategy for strengthening emergency medical services in the Americas.

### **From Fragmentation to Integrated Networks**

One of PAHO's most important technical cooperation initiatives during 2008-2009 was the development of recommendations for integrating health care delivery networks, including public and private providers, as a primary health care-based solution to the fragmentation of health systems. The initiative is based on evidence that poorly integrated health services are a major cause of weak health system performance, resulting in inefficient use of resources, poor quality of services, lack of continuity in care, high costs, and low user satisfaction.

Fragmentation is closely related to, and partly the result of, institutional segmentation, in which different subsystems provide health services for different groups depending on their ability to pay or their employment status (public or private sector employee or unemployed). Segmentation produces fragmentation when the infrastructure and capacities of these subsystems are not coordinated or integrated. Fragmentation can also result from other trends, including the decentralization of health services without adequate coordination of levels of care; the prevalence of programs focused on specific diseases, risks, or population groups; overspecialization and overemphasis on curative rather than preventive care; poor organizational models; and the proliferation of "vertical" and other narrowly focused programs funded by international donors and cooperation agencies. Symptoms of fragmented health systems include low rates of case resolution at the first level of care, the use of emergency services to obtain specialized care, the hospitalization of patients who could have been treated on an outpatient basis, and extended hospital stays because of difficulties in discharging patients who lack social support.

To address these problems, PAHO developed a proposal for a regional policy on integrated health services delivery networks (IHSDN), defined as networks of organizations that provide—or make arrangements to provide—comprehensive health services to a particular population and that are willing to be held accountable for their clinical and economic outcomes and the health status of the population they serve. The concept allows for contractual arrangements or strategic

partnerships between different providers, including public and private (and even in different countries), that offer complementary services. The networks can be based on a number of models, provided they meet a few key requirements, including having:

- Extensive knowledge of the health needs of the target population
- The ability to provide the full range of personal and public health services, from prevention to treatment and rehabilitation
- The ability to provide first-level care to the entire target population, with good systems for referral toward more specialized care
- An integrated information system that links all members of the network and disaggregates data by key variables, including sex and ethnicity
- Adequate funding mechanisms as well as financial incentives that are aligned with network goals.

A “roadmap” for developing IHSDN throughout the Region was presented to the PAHO Executive Committee in June 2009 for consideration by the 49<sup>th</sup> Directing Council in September–October. PAHO has formed partnerships with the Ministry of Health of Brazil, the German Agency for Technical Cooperation (GTZ), the Hospital Consortium of Catalonia (Spain), and the Hospital Cooperative of Antioquia (Colombia), and is seeking additional partners to support the initiative.

## Chapter IV

### Promoting Public Policy for Health

73. Public policies are an important complement to efforts to expand coverage and improve health services. PAHO Member States have, with PAHO support, been developing and implementing policies that support the goals of renewed primary health care, particularly cross-cutting policies that involve other sectors in prevention, health promotion, and action on the social determinants of health. Much of this work has been aimed at reducing risk factors for chronic noncommunicable diseases. Below are some highlights of PAHO technical cooperation in this area during 2008-2009.

74. In **Brazil**, PAHO supported the implementation of the National Health Promotion Plan, which promotes behavior change toward healthy lifestyles. Among Brazil’s most notable efforts in this area is its pioneering work in tobacco control. In 2008-2009, PAHO carried out important work in support of Brazil, in partnership with the Bloomberg Foundation and WHO’s Global Program on Tobacco Control, including studies to

support regulation of tobacco advertising and packaging and labeling of tobacco products. In addition, PAHO spearheaded an assessment of Brazil's national capacity for tobacco control, in partnership with the Ministry of Health and the National Cancer Institute.

75. PAHO's Caribbean Food and Nutrition Institute (CFNI) has vigorously promoted a public policy approach to the **Caribbean's** food and health problems. Initiatives in 2008-2009 included advocacy for the inclusion of nutrition and health in agricultural sector policies, developing public policies to address chronic noncommunicable diseases and their risk factors through good nutrition and healthy lifestyle behaviors, and raising awareness of the risks to food security in the Caribbean due to rapid inflation on food prices. The institute provided advice to CARICOM's Council on Trade and Economic Development on the negative impact of high prices on household food security. It also partnered with the Food and Agriculture Organization (FAO) to organize a Symposium on Food Security in the Caribbean: Risks and Responses. In addition, CFNI continued efforts to strengthen intersectoral cooperation with various partners (IICA, FAO, USDA, and others) on food safety, quality, and security.

76. In **Barbados** and the **Eastern Caribbean** (Anguilla, Antigua and Barbuda, Barbados, the British Virgin Islands, Dominica, French Guiana, Grenada, Guadeloupe, Martinique, Montserrat, Saint Kitts and Nevis, Saint Martin and Saint Bartholomew, Saint Lucia, and Saint Vincent and the Grenadines), PAHO is supporting efforts to follow up on the Port of Spain Declaration, "Uniting to Stop the Epidemic of Chronic Noncommunicable Diseases." Activities supported by PAHO include the annual observance of Caribbean Wellness Day, the development of healthy public policies, the formation of National Commissions on NCDs, and efforts to mobilize civil society and academic institutions.

77. Also in follow-up to the Port of Spain Declaration, PAHO is working closely with **Belize's** Ministry of Health to develop a National Plan of Action for chronic disease prevention and control, with a primary health care focus.

78. PAHO supported Mexican officials in organizing the First Meeting of Ministers of Health and Education to Stop HIV in Latin America and the Caribbean, held in Mexico City in August 2008. Participants included 56 ministers of health and education from 30 countries in the Americas. The meeting's final declaration called for a 75 percent reduction in the number of schools under the jurisdiction of the Region's ministries of education that do not offer comprehensive sex education, and a 50 percent reduction in the number of youths in the Americas who do not have access to health services that meet their sexual and reproductive needs. PAHO provided logistical and promotional support for the meeting and technical support for the drafting of the declaration. PAHO is also a

member of the intersectoral group (led by Mexico) responsible for supporting the declaration's implementation through collaborative action.

79. At the request of **Ecuador's** Ministry of Health and Ministry of Urban Development and Housing, PAHO studied the living conditions in resettlement camps for people displaced by eruptions of the Tungurahua volcano and examined proposed areas for resettling people from Guayaquil neighborhoods affected by floods in early 2008. On the basis of the observations, PAHO developed a series of recommendations on how to minimize the adverse health impacts of resettlement efforts, how to empower people to reduce risks in their own dwellings, and how to develop a framework based on PAHO's Faces, Voices, and Places initiative to guide the process of adaptation to new settlements for the displaced.

80. In **Guatemala**, PAHO worked with members of Congress to obtain approval of the Framework Convention on Tobacco Control (FCTC) and passage of a new Law on Smoke-Free Environments. PAHO also worked with the Ministry of Public Health and Social Assistance to develop an Information, Education, and Communication plan and mechanisms for monitoring and inspection to support the law's implementation.

81. In **Paraguay**, PAHO has supported the development of a Policy on Health Promotion that includes a healthy housing strategy. The initiative is developing intersectoral agreements with the National Housing Council (CONAVI) to incorporate health promotion components into national housing plans.

### **Promoting and Protecting Health as a Human Right**

Among the most important areas of PAHO's support for policymaking on primary health care is its efforts to promote and protect health as a human right. This work focuses on using existing treaties, recommendations, and other national and international commitments to advocate for and shape reform of public policy and national legislation in PAHO Member States.

During 2008–2009, PAHO reached out to health workers, the general public, staff of national human rights ombudsperson's offices, judicial system staff, and professionals who work in hospitals and other public institutions in 17 Member States to disseminate general human rights norms and specific regional and international standards that protect the right to the enjoyment of the highest attainable standard of health ("right to health") and other associated rights for people with mental disorders, people with disabilities, older persons, people with HIV, indigenous people, and patients (patient safety).

PAHO also helped seven Member States—Argentina, Belize, Chile, El Salvador, Guatemala, Paraguay, and Peru—incorporate regional and international human rights norms into policies and legislation on aging, HIV, disability, mental health, sexual and reproductive health.

In addition, PAHO worked closely in 2008 with regional and global human rights bodies including the Inter-American Commission on Human Rights (IACHR) and committees created by United Nations human rights treaties (Committee on the Rights of Women and the Committee on Economic, Social and Cultural Rights, among others). PAHO provided technical briefings for the IACHR and other committees on the right to health and other human rights of people with disabilities, people with HIV, and people with mental disorders, as well as on malnutrition in indigenous children.

## Chapter V

### New Leadership for Health

82. Effective leadership is crucial to reforming health systems along the lines of the new vision of primary health care. Ministries of health must play a strong steering role vis-à-vis their health systems and mobilize additional advocates to present a strong, evidence-based case for needed reforms in dialogue with all sectors of government and society.

83. During 2008-2009, PAHO and its member countries carried out a number of initiatives aimed at promoting a primary health care orientation through cross-sector advocacy and dialogue, building of leadership capacity, and improvements in health information gathering.

84. In **Argentina**, PAHO has helped build support for health promotion and efforts that address the social determinants of health through the National Healthy Municipalities and Communities Program. The program mobilizes local actors to support and carry out actions that increase access to essential health services, promote environmental health, expand opportunities for education and employment, and encourage healthy lifestyles. PAHO has worked to strengthen the technical and institutional capacity of the program to build intergovernmental and intersectoral alliances that advocate for healthy public policies and actions at the national and local levels.

85. In the **Bahamas**, PAHO continued its support in 2008-2009 for the development of a Public Health Information System that will help standardize and computerize all medical records at the primary care level. The system will provide a consolidated patient database to facilitate analyses of morbidity, mortality, and other indicators to provide evidence for better decision-making at the national, community, and health facility levels. PAHO has also worked actively with the Ministry of Health to strengthen management of the national pharmaceutical system, helping develop a new regulatory framework for

pharmaceutical supplies and providing critical review of a newly developed Pharmacy Act.

86. In **Belize**, the Ministry of Health has improved its health information collection, collecting and disaggregating data by age, sex, and geographical location. The Belize Health Information System was rolled out nationally in 2008, with technical cooperation from PAHO, the Health Metrics Network, and other partners, and is a model for an affordable, efficient, effective, and confidential computer system that will provide evidence for health decision-making. The system creates an electronic health record for every patient using the country's primary care services and facilitates the identification and reduction of inequities. In 2008, PAHO provided special support for the application of gender analysis to health data, using HIV and road traffic injuries as examples.

87. As part of a five-year effort to help Member States reduce gender inequalities in health, PAHO organized a series of workshops in 2008-2009 for ministry of health personnel and members of civil society from the **Caribbean, Central America**, and the **Andean Region** on how to incorporate a gender approach into health analysis and planning for their countries' health systems. PAHO also developed a series of information products and guides on disaggregation of data and other aspects of gender- and ethnic-based analysis. A related workshop in **Colombia** focused on indigenous populations and Afro-descendants. Examples of noteworthy progress during 2008-2009 in incorporating gender and ethnic perspectives included efforts involving the Integrated Management of Childhood Diseases (IMCI) strategy in **Ecuador** and the national health system of **Paraguay**. Also during 2008, PAHO organized a best-practices contest to highlight and disseminate efforts to integrate ethnicity and gender into health systems.

88. In the **Dominican Republic**, PAHO helped the Ministry of Public Health and Social Assistance organize the 2008 Dominican Forum on Primary Health Care, which brought representatives of the health sector together with political and community leaders to reach agreement on how to strengthen primary health care. PAHO also supported the ministry's launch of a new Regional Strategy on Neonatal Health, in which 17 organizations committed themselves to the strategy as a way of advancing the Millennium Development Goals. The strategy includes a Plan of National Action and Profile of Child Health that uses data disaggregated at the provincial level to identify gaps and inequities in newborn health at the local level. PAHO also helped the ministry strengthen its Health Accounting Unit, by developing indicators for total health spending in 2008 and accounting methods to track spending on HIV/AIDS, medicines, and the country's cost-free Health Risk Insurance program.

89. In **Barbados** and the **Eastern Caribbean**, PAHO is supporting the implementation of the Pan American Stepwise Survey for Chronic Noncommunicable Diseases and their Risk Factors to gather evidence to inform policy development and

enhancement of health services. **Dominica, Saint Kitts and Nevis,** and **Barbados** have implemented the survey, and the **British Virgin Islands** and **Grenada** have begun the process.

90. To improve the evidence base for developing violence prevention programs, PAHO in 2008-2009 worked with the PAHO/WHO Collaborating Center for Violence and Health (CISALVA) at the Universidad del Valle in Cali, Colombia, to help establish violence and crime “observatories” in **Colombia, El Salvador, Honduras, Nicaragua,** and **Panama**. PAHO helped establish similar observatories for gender-based violence in **Barbados, Bolivia, Chile, El Salvador, Grenada, Honduras, Nicaragua, St. Vincent, and Uruguay,** to support analysis of and awareness-raising about violence against women, as well as the development of care models for battered women. In **Mexico,** PAHO worked with the PAHO/WHO Collaborating Center for Injuries and Violence Research at the National Institute for Public Health to develop interventions for battered women and male aggressors.

91. In addition, PAHO helped draft the 2008 Declaration of Ministers of Health on Violence and Injuries in the Americas, issued in Mérida, **Mexico,** which formed the basis for a resolution (CD48.R11) of the 48th PAHO Directing Council. The declaration calls for stronger action by governments and civil society to prevent and control violence and injuries, particularly through the construction of safe, healthy, and sustainable environments. The declaration also calls for better treatment for victims of violence and injuries and comprehensive care that includes health promotion and incorporates human rights, gender, and intercultural approaches. It also calls for improved emergency services, trauma care, and rehabilitation services and for more legal and social services for violence and injury victims. PAHO, in conjunction with other United Nations agencies, is also working with national and local governments in **Brazil, Colombia, El Salvador, Honduras, Guatemala,** and **Suriname** to develop programs to improve human safety and prevent violence.

92. In **Ecuador,** PAHO has helped the Ministry of Public Health evaluate and strengthen its steering role as part of a Health Sector Transformation process aimed at expanding access to quality care and reducing out-of-pocket spending on health. Areas identified as needing reinforcement included capacities for health policymaking, sectoral management and regulation, quality assurance systems, public health surveillance, integrated management of national and international cooperation resources, promotion of technological research and development in health, and implementation of a national health information system. The findings were incorporated as a key component of a proposal for health sector transformation that was approved in a national consultation.

93. In **El Salvador,** PAHO worked with the Ministry of Public Health and Social Assistance to develop a new Law on the National Health System, which seeks to

strengthen the steering role of the ministry. The new National Health System places priority on family health and is based on a comprehensive primary health care model that has now been implemented in 40 percent of the country's health units.

94. PAHO continued its support for efforts by **Guatemala, Honduras, and Nicaragua** to improve information for decision-making on access to medicines. The efforts began in 2007 when PAHO experts in essential medicines and health systems and social protection helped the three countries' ministries of health carry out surveys in homes and pharmaceutical services to assess access to health services and essential medicines, using methodologies developed by PAHO and WHO to measure exclusion in health. The results of the surveys, analyzed during 2008-2009, showed a strong correlation between access to services and access to medicines, challenging the presumption that people can access medicines through free markets without having access to health care. The results pointed to the importance of creating health care networks that are accessible to people in their daily lives, through facilities near their homes that offer quality health care.

#### **Primary Health Care and Global Health Initiatives**

PAHO collaborated with WHO during 2008-2009 to promote synergies between global health initiatives (e.g., the GAVI Alliance and the Global Fund for AIDS, Tuberculosis and Malaria) and efforts to strengthen health systems based on primary health care. The work recognizes that the structure of international health cooperation has a clear effect on health systems and that the flow of investments and financial and human resources from these initiatives does not always contribute to strengthening the key functions of health systems. In fact, international health cooperation has in some cases contributed directly or indirectly to the fragmentation and segmentation of health systems by focusing on specific diseases, products, or populations. In some cases, global initiatives have actually weakened national capacities by promoting actions that are ineffective in the context of a particular country's needs and priorities.

In May 2008, WHO launched a process of international consultation to promote new orientations for global health initiatives toward a positive role in strengthening national health systems and capacities and in contributing to universal and equitable access to health care. The primary health care strategy serves as a point of departure for this effort and as the basis for recommendations on the design of interventions that take account of and support national strategies and plans for health systems strengthening.

As part of these efforts, PAHO is helping GAVI-eligible countries (Bolivia, Cuba, Guyana, Haiti, Honduras, and Nicaragua) formulate and implement proposals to strengthen their health systems as a way of achieving and sustaining higher levels of immunization coverage.

95. In **Jamaica**, PAHO in 2008 became a member of a task force set up by the Ministry of Health and the Environment to define strategies and plans to strengthen primary health care in the country. PAHO helped develop the first draft of these plans and is collaborating in a second stage of the process. PAHO is also working with the Inter-American Development Bank, the Ministry of Health, and the Planning Institute of Jamaica to analyze the impact of the global financial crisis on the health system, particularly on the recent abolition of user fees, increased demand for health services, and potential pressure on health care services.

96. PAHO is supporting **Mexico's** efforts to integrate its highly segmented health system based on the principles of primary health care through advocacy, facilitation, mediation, and participation in negotiations and consultations in the National Health Council. During 2008, the council signed three agreements related to PAHO technical cooperation that focus on the development of integrated health services networks (RISS) based on primary health care. As part of these agreements, Mexico held a national consultation on RISS, and a delegation from the Mexican Ministry of Health, the Mexican Social Security Institute (IMSS), and two cabinet ministers participated in a regional consultation held in Belo Horizonte, Brazil. Additional events are planned for this year to facilitate debate on the conceptual and strategic foundations of these efforts. PAHO has also signed technical cooperation agreements focused on primary health care renewal with the IMSS and the Institute for Social Security and Services for State Workers (ISSSTE).

#### **Promoting Primary Health Care in Subregional Cooperation**

During 2008-2009, PAHO emphasized the renewed primary health care approach in providing technical cooperation to support the health agendas of the Caribbean Community (CARICOM), the Central American Integration System (SICA), the Andean Community, and the Southern Cone Common Market (MERCOSUR).

For CARICOM, PAHO supported the completion of the Caribbean Cooperation in Health III initiative, which provides the main framework for collective efforts to advance health and development in the subregion. Approved by CARICOM ministers of health at their 28th Council for Health and Social Development in June 2009, CCH III reflects the subregion's commitment to equity in access to prevention and treatment as well as its intersectoral approach to health.

In support of Central American integration, PAHO helped develop the Health Agenda and Strategic Health Plan of Central America and the Dominican Republic. The agenda and plan both seek to improve coordination of cooperation agencies and alignment of subregional priorities within the renewed primary health care framework.

For MERCOSUR, PAHO developed actions to strengthen primary health care in border communities, within the framework of an integrated healthcare network, and to address the social determinants of health, particularly through food safety and security and environmental health.

Similar efforts were focused on border populations of the Andean Region, through PAHO collaboration with the Andean Health Agency (ORAS/CONHU). In addition, PAHO supported the Andean Observatory on Human Resources in Health and the Andean Network of National Public Health Laboratories, as well as negotiations toward a joint Andean Policy on Access to Essential Medicines.

97. **Paraguay's** Ministry of Health took important steps in 2008, with PAHO support and technical cooperation, to strengthen implementation of its primary health care strategy. In August 2008, the ministry launched a new national health policy known by its slogan, "Quality of Life and Health with Equity in Paraguay." The policy is aimed at strengthening the health system according to the principles and elements of primary health care, including expanded coverage, guaranteed equity in access, improved quality of care, promotion of community participation, and better coordination among levels of care. To lead this process, the ministry created a new General Directorate for Primary Health Care.

98. Also with PAHO support, the ministry developed a six-month "contingency plan" aimed at increasing health coverage and combating exclusion, reducing out-of-pocket expenditures, improving quality of health services, fighting corruption, and reducing red tape. The plan included progressive implementation of a policy of free health services, carried out through resolutions and decrees. As part of this process, Paraguay in 2008 began developing structural reforms aimed at building a decentralized national health system. Among the first measures was the implementation of 38 Family Health Units, which are providing comprehensive health services to 133,000 people.

99. PAHO's United States–Mexico Border Office in El Paso, Texas, spearheaded the formation of a technical advisory group that will develop intersectoral policies and lines of action to address the social determinants of health along the U.S.–Mexico border. The new advisory group grew out of a meeting in August 2008 that brought together experts from both countries to discuss the recently released report of the Commission on the Social Determinants of Health. The group will develop a conceptual framework for addressing the special challenges of the border area and will set out priority goals for work in this area, including strengthening knowledge and understanding of the dynamics of the social determinants of health in the border region.

100. PAHO collaborated with the United Nations Economic Commission for Latin America and the Caribbean (ECLAC) during 2008-2009 in two areas to strengthen the

evidence base for regional policymaking on primary health care. In the first area, “strengthening of vital and health statistics,” work focused on incorporating an ethnic focus into health data and vital statistics and increasing the participation of indigenous people and Afro-descendants in upcoming censuses for 2010. In the second area, “evaluating progress on the Millennium Development Goals related to health,” the collaboration included a study on indigenous peoples and Afro-descendants in Latin America and a project on territorial inequalities and the MDGs.

101. PAHO’s Latin American Center for Perinatology and Human Development (CLAP) worked to strengthen interagency coordination and develop alliances and networks at the global and regional levels, among partners including the Spanish Agency for International Development Cooperation (AECID), IPAS, ACDI/VOCA, the European Union, UNICEF, UNFPA, and the March of Dimes. CLAP also promoted the establishment of networks of perinatal institutions in a growing number of countries, including **Argentina, Bolivia, Colombia, Ecuador, El Salvador, Honduras, Nicaragua, Peru, Paraguay and Uruguay.**

102. In 2008, PAHO promoted discussions in Member States on the recently released report of the Commission on the Social Determinants of Health and on how to address social determinants through synergistic policies and actions combining environmental health with the renewal of primary health care. A number of countries have already formed national commissions to develop policies in these areas, while others are beginning to implement programs that address the multiple conditions that affect the well-being of their populations.

103. PAHO’s immunization program once again spearheaded what has become the hemisphere’s flagship Pan American health initiative, Vaccination Week in the Americas. The 2008 initiative was kicked off with multiple launching events in border areas of the **United States and Mexico, Central America and Panama, Brazil, Colombia, Peru, and Guyana.** Participants included presidents, ministers and other high-level dignitaries, and celebrities Ricardo Montaner and Jerry Rivera. The initiative mobilized thousands of health workers and volunteers and used mass communication campaigns to expand vaccine coverage throughout the Region. Forty-five countries and territories took part, vaccinating nearly 60 million people against diseases including polio, measles, rubella, tetanus, yellow fever, and influenza. Many countries also took the opportunity to offer additional health services, including Pap smears, vitamin A supplementation, and tuberculosis screening.

104. PAHO partnered with UNAIDS and UNICEF to produce a report on HIV/AIDS that highlighted specific vulnerable populations, such as men who have sex with men, sex workers, and drug users, to better address gender vulnerabilities, human rights, and challenges to achieving universal access to treatment and prevention services for HIV.

105. PAHO also undertook a mapping initiative to gather data on the availability of sexual and reproductive health services as well as HIV prevention services and coverage for the adolescent population, to identify needs for primary care services in the Region for policy development and decision-making.

106. PAHO supported the creation of a new Pan American Alliance for Nutrition and Development by the United Nations Regional Directors for Latin America. The alliance aims to advance the Millennium Development Goals by strengthening and integrating international and national responses to nutrition, health, and development, through intersectoral and interprogrammatic strategies, interventions and tools in areas including health, nutrition, education, water and sanitation, agriculture, trade, labor, social participation, gender, and human rights.

107. In 2008-2009, PAHO intensified its collaboration with faith-based organizations including the Latin American Episcopal Conference (CELAM), the Church of Jesus Christ of Latter-day Saints, and the Health Ministries of the General Conference of Seventh-Day Adventists (SDA), which has 15 million members and over 6,000 hospitals, clinics, and health centers worldwide. With support from PAHO and WHO, SDA organized a Global Conference on Health and Lifestyle in mid-2009 in Geneva, where participants shared knowledge and experiences about adopting WHO global health care norms in efforts to advance the health-related MDGs. More than 700 people participated.

108. PAHO worked during 2008-2009 to mobilize financial and technical resources and to facilitate country-level multisectoral coordination on child health. In partnership with international and national agencies including WHO, USAID, UNICEF, as well as nongovernmental and faith-based organizations, the private sector, and civil society, PAHO promoted the expansion of the Integrated Management of Childhood Illness strategy and other child health initiatives.

109. PAHO worked with the United Nations Development Program (UNDP) to channel part of a €528 million grant in support of U.N. reform and the achievement of the Millennium Development Goals (MDG Achievement Fund). By late 2008, PAHO/WHO had received approval for projects totaling US\$3.7 million. PAHO Country Offices are participating in projects in **Colombia, Costa Rica, Guatemala, Honduras, Panama,** and **Peru** and elsewhere by preparing concept notes and joint U.N. program documents.

110. PAHO during 2008-2009 continued work under a four-year US\$4 million grant from the U.S. Agency for International Development (USAID) to strengthen health systems and services in the context of primary health care and to improve the quality of health services throughout the Region. As part of the grant's management, a technical coordinator helped identify synergies, maximize results, and promote a common vision among the multiple actors and projects involved in the umbrella agreement.

## **Chapter VI**

### **Facing Future Challenges**

111. Chapters I through IV of this report illustrate both the growing commitment to primary health care renewal in Latin America and the Caribbean and concrete progress by PAHO and its Member States in implementing the approach.

112. But the challenge of achieving “Health for All” will not be met easily or soon. Many countries in the Region still do not have broad health protection schemes, and significant numbers of people—some 125 million regionwide—continue to lack access to basic health services. Countries that do have health protection schemes are struggling to expand them to cover more people and more conditions and to finance these schemes in ways that are both sustainable and equitable. For all the countries, the work of reorganizing health systems to overcome fragmentation and segmentation and improve quality, efficiency, and equity is an ongoing challenge.

113. Some countries also face the special challenge of recovering lost ground. Some countries that made real progress in primary health care in past decades have neglected the referral systems and back-up needs of their primary-level services to such an extent that patients now face waiting lists of several months or even years to receive certain types of care. Others have fallen back into the overmedicalization of health services and an undervaluation of the role of nurses, medical technicians, community health workers, nutritionists, midwives, social workers and of the importance of individuals, their families, and communities protecting and promoting their own health.

114. A related problem is an overemphasis on the latest equipment and technology when less expensive alternatives might be equally adequate and even better in terms of ensuring the financial sustainability of health services. Equally important is the problem of excessive spending on second- and third-level care not articulated with, or at the expense of, first-level care and efforts to implement the primary health care strategy throughout all levels of the health care system.

115. These inherently difficult challenges have been made more urgent and more taxing by the global economic crisis, which is threatening health and other development gains throughout the Region. During 2008, increasing food and fuel prices and declining remittances had already increased poverty and food insecurity in a number of PAHO Member States. By mid-2009, in the midst of the global economic downturn, the U.N. Economic Commission for Latin America and the Caribbean (ECLAC) was predicting a

1.7 percent decline in GDP in the Region for 2009, producing a drop in per capita income for the first time in nearly a decade.

116. Absent mitigating measures, these trends could impact heavily on health. A decline in personal income and increasing unemployment will mean growing numbers of vulnerable people as well as lower individual contributions to social security systems and reduced enrollment in public and private health insurance plans. This in turn is likely to induce more people to utilize free public services and those provided by voluntary (including faith-based and charity) organizations, which are already overburdened. It may also lead people to delay seeking health care and reduce compliance with medication and diet, increasing the risk of complications and producing catastrophic health expenses that can push entire families into poverty.

117. For governments, the global downturn has already affected overall economic activity and lowered export prices, resulting in reduced government revenues. If the Region's historic pattern of procyclical public spending holds, government funding for health will drop below the average 3.4 percent of GDP experienced during the past five years, a figure that was already lower than average spending in countries with broad social protection in health. While some of the Region's countries are now developing anticyclical fiscal policies to mitigate the impact of the crisis, most of these policies focus on employment generation and infrastructure investments rather than social or health spending. Indeed, countries that have already made cuts in public spending have reduced their health sector spending disproportionately.

118. Despite these trends, the global economic crisis also presents an opportunity to promote the new vision of primary health care as a way of safeguarding health gains while increasing efficiency in health systems and lowering overall health care costs. Toward this end, PAHO's Strategic Plan 2008-2012 (amended) incorporates primary health care as the guiding strategy for health systems organization and management, adolescent health, family and community health, and pharmaceutical services, and as a central focus of technical cooperation in disease prevention and control, human resources development, and extension of social protection. The approach has also been identified as a "cross-cutting priority" for mainstreaming into PAHO's Biennial Work Plan for 2010-2011, planning guidelines, strategies, and special courses made available to help PAHO staff incorporate the approach into their work.

119. For PAHO Member States, the PAHO Strategic Plan 2008-2012 identifies a number of near-term challenges for the implementation of the renewed vision of primary health care. These include:

- Continuing to promote of the concept of primary health care–based health systems and encouraging greater participation by communities and other stakeholders in these systems’ development.
- Applying the renewed primary health care approach to population-based programs and priority disease control initiatives.
- Creating specific mechanisms to strengthen intersectoral collaboration, including new networks and partnerships.
- Implementing PAHO/WHO policy recommendations on the integration of health services networks that include both public and private providers.
- Integrating an intercultural approach into the development of policies and health systems based on primary health care.
- Carrying out programs to improve quality of care, including patient safety.
- Ensuring the availability and sustainability of financial, physical, and technological resources required for successful implementation of primary health care.
- Developing specific competencies in health workers throughout the Region to support the implementation of primary health care.

120. PAHO’s technical cooperation for 2009-2012 focuses in large measure on supporting country efforts to meet these challenges. In addition to the tools and strategies detailed in the Strategic Plan 2008-012, PAHO is spearheading other initiatives to support the renewal of primary health care. Among the most important is the new regional policy on integrated health services delivery networks (IHSDN, see Chapter V), which is being presented to the 49th Directing Council for adoption as a common strategy to improve health services by creating economies of scale, reducing duplication of efforts, encouraging cooperation and responsibility among providers, sharing expenses and investments, and improving the management of risk factors.

121. Other initiatives include a virtual course “Developing Capacities for the Renewal of Primary Health Care,” available on the Virtual Campus in Public Health, and a new Regional Thematic Network for Primary Health Care, which will promote the dissemination of best practices.

122. In addition, PAHO is developing a series of publications with guidelines and strategies for the implementation of primary health care. The series includes the PAHO/WHO position paper *Renewing Primary Health Care in the Americas* as well as *Strategies for the Development of Primary Health Care Teams* and *Medical Training Oriented toward Primary Health Care (La Formación en medicina orientada hacia la atención primaria de salud*, currently available only in Spanish). A third publication,

*Integrated Delivery Networks*, will incorporate feedback from the 49th Directing Council and is expected to be published in early 2010.

123. These initiatives come at a critical but opportune time for the Americas. While the Region faces serious economic, political, and social challenges, it also enjoys a nearly universal consensus that the highest attainable level of health is an inalienable human right and a necessary condition for economic and social development. In accords ranging from the Health Agenda for the Americas to the Declaration of Montevideo, the Iquique Consensus of the 9th Ibero-American Conference of Ministers of Health, the constitution of the South American Health Council (UNASUR-SALUD), and the Declaration of Commitment of Port of Spain (Fifth Summit of the Americas), governments throughout the Region have acknowledged their responsibility for guaranteeing the right to health and their conviction that primary health care-based systems are the best way to realize that right.

124. In this context, the renewal of primary health care is needed “now more than ever” throughout the Americas. Through its technical cooperation programs and advocacy efforts, PAHO will continue to support this process to ensure that the vision of “Health for All” becomes a reality throughout its Member States.

- - -