

A century in public health



PAHO

Dr Mirta Roses Periago

Dr Mirta Roses Periago earned her medical degree in 1969 from the National University of Córdoba in her native Argentina. She subsequently obtained a diploma in tropical medicine from the Federal University of Bahia, Brazil, in 1971 and diplomas in public health and infectious diseases from the State University of Buenos Aires in 1974. She started her career as a resident at the Rawson Hospital in Córdoba and as a teaching assistant in preventive medicine and infectious diseases at the National University of Córdoba. In 1984 she joined the Pan American Health Organization (PAHO) as head of the surveillance unit in the Caribbean Epidemiology Center in Trinidad and Tobago. After serving in a number of positions at WHO, Dr Roses became Director of PAHO and WHO Regional Director for the Americas in January 2003.

The Pan American Health Organization (PAHO) was founded in 1902 in Washington, DC, where it has since had its headquarters. In 1949, it became WHO Regional Office for the Americas (AMRO). PAHO/AMRO has achieved major public health successes in polio and smallpox eradication and in the elimination of measles. It has pioneered internal control and good governance. Nevertheless, the Americas Region, which stretches from the Arctic to the Antarctic, continues to face health challenges. These include significant inequalities in terms of income and access to health care, and the threat of hurricanes, earthquakes and volcanic eruptions that can wipe out health and development progress in an instant. Dr Mirta Roses Periago is the first woman to lead a WHO Regional Office — as well as the first WHO Regional Director to write a blog (<http://www.paho.org/>). In this interview, she describes her efforts to tackle inequality in her continent and to share PAHO's century of expertise in international public health with other WHO Regions.

Q: When you became Regional Director in 2003, it was a major coup for women in public health. How do you see yourself as a role model and why are there not more women in similar public health positions to yours?

A: At the decision-making level there are men, and they tend to select men. To break that circle, it takes a lot of time and effort. If a man fails they say "let's try another one". If a woman fails they say "you can't trust a woman". We have to bring more women into international delegations, to expose them to high office and international work. At WHO and PAHO we have a health leadership programme. In PAHO, we have had it for 20 years. We select about 10 people under 35 years of age to spend one year in the office in Washington, DC. Most of them are women, so, increasingly,

we have to be careful to have some men among them! We hope that these women will go on to take leadership positions and that having a woman as PAHO Director will open up more possibilities for them.

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Q: How does PAHO, as the world's first regional public health organization, see itself in relation to the rest of WHO? Does it see itself more as the Sanitary Bureau of the Organization of American States or as AMRO?

A: Our Member States invest double, paying a quota to PAHO and a quota to WHO. Some people may say we have divided loyalties, but for us it has never posed any difficulty. We feel

our role as Regional Office of WHO to be in increasing demand because, in a globalized world, Member States really value the international connections this brings. At the same time, we also have a

role in the inter-American system, which has existed since the latter part of the 19th century. We are the only intergovernmental body concerned with health in our Region.

Q: Your Region is incredibly diverse. How do you reconcile the need to address public health in the United States of America and Canada, two of the world's most developed countries, with some of the poorest: Bolivia, Guyana, Haiti, Honduras and Nicaragua?

A: When PAHO was founded more than 100 years ago with 11 members, it was based on the principles of solidarity and cooperation. These principles still hold true even as we have expanded to include all 35 countries in the Americas among our members. In this spirit, over the last three years, we have moved away from addressing specific diseases and instead identified health problems that all our Member States must solve, the most important of which is inequity. Every country in PAHO faces significant inequalities of income and access to health care. Even if you take the United States, you have about 40 million people without

health insurance. So everybody has an unfinished agenda. Another key issue is the threat posed by the natural environment, most notably hurricanes, earthquakes and volcanic eruptions. These can wipe out any progress we might have made in health and development, and of course, they create their own problems as well, as New Orleans discovered after Hurricane Katrina in 2005.

Q: How do you cope in your Region with four official languages — Spanish, English, Portuguese and French.— plus dozens of indigenous languages?

A: Intergovernmental meetings encourage us to speak each others' languages and most of our officials have no problems conversing in Spanish or English. At smaller meetings, discussion and documents are in Spanish and English. Official documents and a good number of technical documents are also translated into Portuguese and French, sometimes with the support of Brazil and France. In larger meetings we have simultaneous interpretation into and out of our four official languages. In addition, we have Creole in the Caribbean and about 30 indigenous languages, such as Quechua, which are spoken by millions of people in Central and South America. We work with governments and NGOs [nongovernmental organizations] to produce advocacy material in these indigenous languages. These include radio broadcasts, brochures and banners for raising awareness about health.

Q: How do you describe the achievements and international recognition of BIREME and its Virtual Health Library and SciELO in the dissemination of health sciences information in the Region? Can these services help other WHO regions as well?

A: BIREME was created as a regional library of medicine almost 45 years ago. The idea was to catalogue research publications in medicine and health written in Spanish and Portuguese. The Virtual Health Library was a natural progression with the advent of the Internet. SciELO is simply an agreement by scientific publishers to make their products freely available on the web. It provides information to health professionals and scientists throughout the Spanish- and Portuguese-speaking worlds. Countries that use these official

languages in other WHO regions are also accessing the materials.

Q: How does PAHO manage to stick to its priorities when it is based in, and largely financed by, the most powerful country in the world, the United States of America? How does PAHO avoid undue political influence in its public health programmes?

A: The United States is the main contributor to our regular budget. It also makes the largest voluntary contribution. But in PAHO all the countries work by political consensus and mutual respect. Every Member State subscribes to the ideals of equity, solidarity and Pan-Americanism. For instance, PAHO is the only intergovernmental institution in the Americas where the United States and Cuba work together. Protecting people's health is clearly the common goal.

Q: What are PAHO's mechanisms for transparency and accountability?

A: Donors want accountability and transparency, so does the general public we serve, and so do we. There was also a strong push from Member States for us to decentralize, and modernize our mechanisms. In the last year, we created two new positions: an ombudsperson and an ethics officer. We developed rigorous auditing and internal oversight. This is very similar to what WHO is doing now with the Global Management System. Transparency has been greatly helped by early implementation of information technology. Since 1990, a financial system for the field offices has been fully integrated with the programming and budgeting system.

Q: Can you describe the Region's contribution to global action on immunization for polio, measles and rubella. What is the secret of your success of the Vaccination Week in the Americas. Can other WHO regions learn from your experience?

A: In 1973, smallpox was eradicated from the Americas. Then we started

dreaming about eradicating other diseases through vaccination. It seemed completely fantastic from an operational point of view, but the countries decided to move forward, and they launched the Regional Immunization Program in 1976. PAHO created the first-ever revolving fund for vaccine procurement over 25 years ago. That was key to PAHO's efforts to eliminate and control vaccine-preventable diseases. In 1994, we eradicated polio in the Americas. The key to our success is the strong scientific evidence base backed by the Technical Advisory Group. Another factor is that we have been blessed with creative, visionary people. Most of them were personal friends and prestigious colleagues, and they knew

how to work together and how to convince the politicians and the donors.

Q: How far are countries in your Region from achieving the Millennium Development Goals (MDGs)?

A: Our governments have taken the target indicators of the MDGs into consideration while framing their national development plans. The key message in our Region

is "don't stop with the national average figures, go deeper." When the MDG declaration was signed by UN Member States in 2000, the national figures in our Region looked good. But in fact there was widespread inequality between different sections of the population in many countries in the Americas. In the last 20 years, the income gap between rich and poor has increased, right across our continent. Most countries have now identified the poorest sections of the population and are trying to help them achieve the MDG targets. We have been able to move the focus of the MDGs from poor countries to poor people.

Q: Why is your Region arguably the most protected from the threat of avian flu and how does this affect the Regional pandemic influenza preparedness plan?

A: Although our continent is geographically isolated, cholera re-entered Peru

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in 1991 and spread across the continent in just three years. So we know we are not really isolated. We have five very important poultry-producing countries, namely Argentina, Brazil, Canada, Chile and the United States, and they all have high standards of hygiene and surveillance in place. We have a very strong veterinary public health programme. We have had for the past 30 years a biennial meeting of national agriculture and health departments, at the ministerial level. But we also have a number of countries with very weak and vulnerable health systems. So we have started to get ready. We were one of the first WHO regions

to have a Regional plan for pandemic influenza. It was presented to our Executive Committee in September 2005, and we have been implementing it ever since.

Q: What is your vision for the near future? What are the main achievements in your Region? What are the new challenges in your Region? How are you intending to meet them?

A: With 100 years of history behind us, we have lots of experience. My vision is that we should continue to help our Member States work together, sharing their resources and expertise. But we must also begin to share our

knowledge with, and learn more readily from, other [WHO] regions. Just as some countries work together on trade and manufacturing, we should work together in health care. The islands of the Caribbean share common problems with the small islands of the Pacific. The natural hazards we face, the world faces. To give two recent examples, in 2004 we supported the WHO Regional Offices and affected countries after the Asian Tsunami, and in 2005, after the earthquake in Pakistan. Not only did we provide relief as an expression of solidarity and generosity, but we also learned how to deal with similar situations in our own continent. ■

WHO response to the humanitarian crisis in Lebanon

WHO, other UN agencies, 45 local and international partners and the Lebanese Red Cross have been supporting Lebanese authorities in meeting the health needs of people caught in the conflict across the border between Lebanon and Israel.

The crisis, which affects the lives of one million people in Lebanon, Israel and surrounding countries, forced large numbers of people to flee their homes.

WHO's main task has been to coordinate the relief effort in all areas related to health care. The organization also filled unmet gaps — for example, by providing essential medicines, in particular for

the chronically ill, and monitoring the quality of drinking-water.

WHO set up an effective reporting system for disease outbreaks in 60 public buildings in Beirut where people sought refuge. The aim was to detect any outbreak of disease and contain it at an early stage.

WHO, in collaboration with UNICEF, the Lebanese Ministry of Health and other agencies participated in two measles and polio immunization campaigns in greater Beirut, targeting children displaced by the fighting. About 10 000 children were vaccinated in five days at the height of the crisis.

When the conflict was at a peak

in late July and early August, access to southern Lebanon was severely hampered — due to security concerns and badly damaged roads and bridges — making it extremely difficult for UN agencies to deliver humanitarian relief supplies.

Nevertheless, WHO was able to send supplies which met the needs of Lebanese health care workers, including 20 Emergency Health Kits to hospitals. One kit meets the basic health needs of 10 000 people for three months.

Hospitals and other health facilities were also dangerously close to running out of fuel. Fuel is essential to keep the back-up generators running that supply electricity to hospital operating theatres, incubators for newborn babies and refrigerators containing vaccines and drugs. WHO warned that more than half the hospitals would close without fuel delivery.

However, with the cessation of hostilities on 14 August, freedom of movement over the whole of Lebanon was restored. "We are glad access is now allowed. We can move experts and supplies more easily to many places, especially in the southern part of the country," said Dr Ala Alwan, WHO Representative of the Director-General for Health Action in Crises.

In mid-August, WHO sent 67 tonnes of fuel to southern Lebanon, enough to meet the needs of 18 hospitals for 10 days. The ceasefire also allowed WHO to visit dozens of hospitals and health centres to assess the damage and the needs for early recovery. ■



Christopher Black, WHO

Dr Ziad Mansour, from the WHO Country Office in Lebanon, helping out in Beirut.