Official Document
of the
Pan American Health Organization
No. 239

PROGRAM BUDGET

PROPOSED FOR THE PAN AMERICAN HEALTH ORGANIZATION, 1992-1993
WORLD HEALTH ORGANIZATION, REGION OF THE AMERICAS, 1992-1993
PAN AMERICAN HEALTH ORGANIZATION, PROVISIONAL DRAFT, 1994-1995
WORLD HEALTH ORGANIZATION, REGION OF THE AMERICAS, PROVISIONAL DRAFT, 1994-1995

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PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

May 1991

ISBN 92 75 17239 0

LETTER OF TRANSMITTAL

THE DIRECTOR OF THE PAN AMERICAN SANITARY BUREAU, REGIONAL OFFICE OF THE WORLD HEALTH ORGANIZATION, HAS THE HONOR TO PRESENT THE FOLLOWING FOR CONSIDERATION:

1. THE PROPOSED PROGRAM BUDGET OF THE PAN AMERICAN HEALTH ORGANIZATION FOR THE FINANCIAL PERIOD 1992-1993.

2. THE PROGRAM BUDGET OF THE WORLD HEALTH ORGANIZATION FOR THE REGION OF THE AMERICAS FOR THE FINANCIAL PERIOD 1992-1993.

3. THE PROVISIONAL DRAFT OF THE PROGRAM BUDGET OF THE PAN AMERICAN HEALTH ORGANIZATION FOR THE FINANCIAL PERIOD 1994-1995.

4. THE PROVISIONAL DRAFT OF THE PROGRAM BUDGET OF THE WORLD HEALTH ORGANIZATION FOR THE REGION OF THE AMERICAS FOR THE FINANCIAL PERIOD 1994-1995.

CARLYLE GUERRA DE MACEDO
DIRECTOR

SOURCES OF FUNDS

PAHO — PR - PAHO REGULAR BUDGET

PA - INCAP MEMBERSHIP AND MISCELLANEOUS FUNDS
PN - INCAP GRANTS AND CONTRACTUAL AGREEMENTS
PC - CAREC MEMBERSHIP AND MISCELLANEOUS FUNDS
PJ - CAREC GRANTS AND CONTRACTUAL AGREEMENTS

PB - BUILDING FUND
PD - NATURAL DISASTER RELIEF VOLUNTARY FUND
PG - GRANTS AND CONTRACTUAL AGREEMENTS
PK - SPECIAL FUND FOR HEALTH PROMOTION
PL - SPECIAL FUND FOR ASSOCIATED AGENCY: UNDP AGREEMENTS
PU - SPECIAL FUND FOR ANIMAL HEALTH RESEARCH
PX - PROGRAM SUPPORT COSTS

HP - PAN AMERICAN HEALTH AND EDUCATION FOUNDATION TRUST FUNDS
HT - TEXTBOOKS AND INSTRUCTIONAL MATERIALS

WHO — WR - WHO REGULAR BUDGET

INCOME FROM UNITED NATIONS SOURCES:

DP - UNITED NATIONS DEVELOPMENT PROGRAM
DI - UNDP COST-INCURRED ACCOUNT
FB - ASSOCIATE PROFESSIONAL OFFICERS
FD - UNITED NATIONS FUND FOR DRUG ABUSE CONTROL
FP - UNITED NATIONS POPULATION FUND

TRUST FUNDS:

FA - SPECIAL PROGRAM FOR RESEARCH AND TRAINING IN TROPICAL DISEASES
FX - GLOBAL PROGRAM ON AIDS
ST - SASAKAWA HEALTH FUND

VOLUNTARY FUND FOR HEALTH PROMOTION:

VC - SPECIAL ACCOUNT FOR DIARRHEAL DISEASES INCLUDING CHOLERA
VD - SPECIAL ACCOUNT FOR MISCELLANEOUS DESIGNATED CONTRIBUTIONS (OTHER)
VG - SPECIAL ACCOUNT FOR MEDICAL RESEARCH (SPECIFIED)
VI - SPECIAL ACCOUNT FOR THE EXPANDED PROGRAM ON IMMUNIZATION
VW - SPECIAL ACCOUNT FOR COMMUNITY WATER SUPPLY

AS - SPECIAL ACCOUNT FOR SERVICING COSTS
EF - REAL ESTATE FUND

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I. INTRODUCTION AND SUMMARY TABLES

1. The 1992-1993 program budget proposal of the Pan American Health Organization, Regional Office of the Americas of the World Health Organization, is the initial expression of a profound revision of the mission and functions that the institution must undertake in the 1990s. It has been drawn up in light of the economic, political, and social context of the Region and the world, which today frames the work of the institution in its efforts to attain better health for the inhabitants of the Americas.

2. The long-term perspective on which this proposal is fundamentally based, is characterized by the search for health for all in the Hemisphere. A medium-term frame of reference is provided by the Strategic Orientations and Program Priorities during the Quadrennium 1991-1994 that were approved by the XXIII Pan American Sanitary Conference in September 1990. The principles governing the activities proposed here emanate from both the Managerial Strategy for the Optimal Use of PAHO/WHO Resources in Direct Support of Member Countries, and from the Regional Budget Policy, both of which were approved by the Governing Bodies in the early 1980s.

3. The fundamental logic of the proposal rests on making progress, during the 1992-1993 biennium, towards a greater concentration of resources on very effective areas that have a high impact on scientific and technical cooperation for health. It is based on the explicit mandates to this effect by the Governing Bodies of the Organization which seek to harmonize the priority health cooperation needs of the Member States with the collective mandates that imbue the institution's activities with cohesiveness.

4. The above has only been possible thanks to a process of extensive and frank dialogue with the Member Countries; a detailed analysis of the situation at the level of each country, each subregion, and the various regional spheres of operation; a careful revision of the technical, political, and administrative efficiency of the proposal for action formulated by each organizational unit of the institution; and a detailed examination of the unfavorable economic circumstances that restrict the Organization's expansion and have led it to implement painful adjustments, in spite of the growing number of problems and challenges faced in the struggle for health in the Americas.

GENERAL SITUATION

5. This proposal was drawn up in the context of a continuing deep economic crisis, which is more pronounced in the countries of Latin America and the Caribbean, but is also felt in the more developed countries of North America. The economic stage of the Region is still set with the problems of economic recession, structural maladjustment, and a build-up of external debt resulting in national economies that are overburdened by debt service payments, reduced rates of investment, increased unemployment, runaway inflation, and persistent or growing fiscal deficits.

6. This has happened at the same time that there have been marked transformations in the world arena. On the one hand, there have been political changes which have yielded an easing of traditional tensions between the East and the West; on the other, there have been economic changes that have further internationalized production and markets, and have increased the interdependence of national economies. The result of all of this is a new world stage in which multipolarity is increasingly pronounced and ever broader spaces are opened for an era of enhanced international cooperation, in spite of the recent military conflict in the Persian Gulf that for a time clouded the dawning of this stage of peace, understanding, and cooperation.

7. The 1990s are beginning, however, with a real drop in per capita income in Latin America and the Caribbean of almost 10% compared to 1980. The external debt, for its part, which stands at $430 billion, continues to weigh on the national economies, despite the fact that from 1983 to 1990 around $200 billion were paid to service that debt. In fact, the debt of the countries of Latin America and the Caribbean grew during that same period by more than $120 billion. During the last eight years, net transfers of capital abroad have averaged more than $20 billion annually. This has meant the passage of around $170 billion from Latin America and the Caribbean to the countries of the First World. On the other hand, gross investment rates have fallen. Before the crisis they represented close to 24% of gross domestic product; now they are around 16%.

8. Regarding domestic price increases, last year Latin America experienced the highest inflation rate of all time in the Region: an average of 1500% once statistical weighting is done for the size of the national economies. In the area of foreign trade, on the other hand, in spite of the uncommon efforts made to generate surplus resources in the trade balance, the countries have faced a constant decline in their terms of trade and an overall drop in the prices of their exports.

9. One of the consequences of all of these structural imbalances has been the need to introduce policies of adjustment with different variations, some at an extremely high social cost for the respective populations. In terms of the health sector, particularly the public subsector of health, this has meant a reduction, or at least freeze, of resources available to meet growing and increasingly pressing needs.

10. Fortunately, the economic crisis and its social impact have not been paralleled in the political life of the countries. In the past few years, the Member States have managed to consolidate more and more the institutional development of their forms of government, making possible a gradual strengthening of democracy in the Hemisphere.

11. When all things are considered--the elements of the economic crisis, the elements of the global transformations, the extraordinary progress made in the institutional public life of the countries, particularly as expressed in the consolidation of democracy--it is clear that the Region is up against tremendous challenges that carry the consequences of numerous encumbrances on the activity of the health sector.

12. Without a doubt, the main challenge facing the Region in the nineties, the last decade of this century, is the need to create, promote, and put into operation new models of development. This should not only mark the surmounting of the current crisis in production terms, but also imply real changes in addressing unmet social needs. This new type of development that needs to be put into effect in the countries of the Region, should have some basic features that are particularly important to the field of health.

13. The first is recognition that in order for such development to be viable, conditions must be created to resume the pace of economic growth. This implies stabilizing or correcting the tremendous macroeconomic imbalances that the countries have been experiencing. That means creating the conditions of trust and economic stability that will make it possible to recover investment levels, and to resolve the problems stemming from the sizeable transfer of resources out of the countries.

14. But economic growth is not synonymous with development. It is a condition for development, as long as that development is positioned to serve the well-being of the populations. From there emerges the second feature necessary for the new models of development of the Region: the ultimate objective of economic growth should be satisfaction of the basic needs of the populations of the countries in the most equitable way possible. This consideration is not taken into account during economic policy-making. Or if it is, it tends to be in the form of social compensation measures which are often fragmentary, and are aimed at mitigating the adverse effects of the economic policies that are implemented as part of the adjustment packages for the national economies.

15. The third feature of the new process that is to be undertaken, is based on the fact that development should establish or strengthen social participation and democratic practices in political life. The latter implies not only holding free elections, but also strengthening the system of social coexistence in which all members of a society exercise the right to participation in the decisions that affect their lives; in other words, the real rights of citizens.

16. No economy in today's world where economic activity and productive processes are increasingly internationalized, can function in isolation. Therefore, the fourth feature of the necessary process of development is that the countries of the Region should find instruments or paths through which they can most effectively gain a foothold in the world economy, from the economic, political, and social point of view. The stepping up of efforts for regional and subregional integration will play a decisive role in this.

17. The fifth feature of the new type of development the countries of the Region should seek implies a redefining of the role of the State. That entails placing emphasis on its social responsibilities; its dimension as an instrument to promote harmony and equity among the members of society; and the quality of guarantor of the basic rights of the population, including the right to health.

18. Finally, the sixth feature that should be present in the new type of development being launched is that it does not suffice to create transitory conditions to periodically reactivate the process of growth. Conditions of sustainability must be created to support the overall process of development, to make it permanent and not the mere result of certain passing economic trends that are favorable. Included in the factors defining sustainability, in addition to the features described above, are: a commitment to institutional development; a redefining of the role of the State and its relations with civilian society under the new types of economy and development sought; a profound change in the cultural bases that establish the essential values that should prevail in coexistence and social life; and the defense, protection, and rational use of natural resources as an effective way to protect the environment.

SECTORAL CHALLENGES AND INSTITUTIONAL RESPONSES

19. The proposed program budget for the 1992-1993 biennium that is presented here stems from an all-encompassing observation. In most cases, health activities and the challenges that must be faced in the sector, are intimately related and conditioned by the forms of development that are adopted, and by the way in which the countries of the Region handle the opportunities and problems arising from them.

20. This is completely within the approach that was handed down by the Pan American Sanitary Conference in September 1990, which was contained in the Strategic Orientations and Program Priorities (SOPPs) of PAHO for the quadrennium. That document defines the challenges to health and the transformation of the sector which the Region will have to face in the upcoming years, and the Pan American Health Organization's response to them.

21. The other mandates still in effect that have been issued by the Governing Bodies of both the Pan American Health Organization and the World Health Organization, were taken into account when defining the lines of action that should be implemented during the next biennium. Also, the proposed program budget of the WHO for the same period, 1992-1993, which will be presented to the

44th World Health Assembly meeting in May of this year, was also taken into consideration.

22. The "Strategic Orientations and Program Priorities of the Pan American Health Organization during the Quadrennium 1991-1994" draw the lines of action on which the Organization should concentrate its efforts during the next quadrennium. They represent a renewed commitment to the strategic orientations and program priorities set forth in 1986 at the XXII Pan American Sanitary Conference and approved for the 1987-1990 quadrennium that has just ended. They have taken into account the emergence of new problems that require the activation of new solutions: the persistence of inequalities, inefficiencies, and ineffectiveness in health care in the Region; the possibility of health contributing to a process of sustained human development; the need to improve the capacity of institutions to respond to health problems; and the importance of promoting, in the political arena and in the eyes of the public, the need to reorganize the sector in order to make progress towards a real transformation of the national health systems.

23. The strategic orientations and program priorities for the 1991-1994 quadrennium constitute a frame of reference designed to encourage the Member Countries in their efforts to transform their national health systems. They should serve to guide the Secretariat's technical cooperation work, as expressed in the biennial program budget proposals drafted during that period, which contain the cooperation activities to be carried out at the country and intercountry levels.

24. The overall context of the Region of the Americas in the beginning of the nineties, described in the above paragraphs, has caused the stagnation of economic growth to be accompanied by a buildup of unmet social needs. Levels of poverty have risen in both absolute and relative terms, causing a decline in standards of living which may endanger social peace and the stability of the increasingly democratic political processes. The matter of development is, therefore, the Region's greatest issue for the 1990s. The fundamental challenges are to make progress in overcoming the difficulties faced in the economic, political, cultural, and social spheres in order to attain levels of real progress; and to give priority attention to the unmet essential human needs.

25. As for the health situation of the Region at the beginning of the nineties, it bears noting that the crisis and the policies of adjustment have had a considerable impact on the health situation and the availability of resources to the sector. This comes on top of the changes in the structure and dynamics of the population, the overlapping of epidemiological profiles in which preventable diseases and deaths predominate on the one hand, and noncommunicable diseases predominate on the other. Also, the health services have been chronically insufficient in providing an adequate solution to the health problems of the population.

26. The regional health agenda for the upcoming years is marked by the seven great challenges to the transformation of the national health systems of the countries of the Americas: the need to attribute more importance to health within social policy and the process of development; the need to improve the capacity to analyze the situation and identify high risk groups; the need to formulate policies and programs that pursue equity in health and fight the growing deficit in service coverage; the need to concentrate resources on effective interventions against health problems and risks; the need to enhance the efficiency of the sector; the need to redefine the sector's forms of leadership and organization; and the need to overcome the imbalances between the work force and the needs of the services.

27. The response demanded by the current time of crisis and changes in the great health community of the countries of the Americas, must be marked by a series of strategic orientations that constitute the main paths to be followed for an effective process to transform the national health systems. It also must have a set of program priorities that, within the broad spectrum of lines of action of the Organization laid out in the Eighth General Program of Work of the WHO for the period 1990-1995, indicate the actions that should be given priority and which require preferential attention, a greater concentration of efforts, and a larger allocation of resources during the new quadrennium.

28. The Pan American Sanitary Conference has approved nine strategic orientations that can favor substantial progress towards the recovery and modernization of the sector in the countries of the Hemisphere. They may also help generate more efficient and effective responses to the health needs of the peoples of the Americas. These strategic orientations are: health in development; reorganizing the health sector; focusing action on high risk groups; health promotion; using social communication; integrating women into health and development; management of knowledge; mobilizing resources; and cooperation among countries.

29. The program priorities that both the countries and the Secretariat will have to take up over the next four years in order to enhance the sector's response capacity to the old and new problems that must be addressed, fall into two main areas. The first regards development of the health services infrastructure, and it includes five sub-priorities: sector and resource allocation analysis; sectoral financing; management of local health systems and local programming; technological development; and development of human resources. The second area of program priorities refers to the development of health programs. Eight priority lines of action are identified within it: health and the environment; food and nutrition; lifestyles and risk factors; control and/or elimination of preventable diseases; maternal and child health; workers' health; drug addiction; and AIDS.

DEVELOPMENT AND ANALYSIS OF THE PROGRAM BUDGET FOR 1992-1993

30. In drafting the program budget of PAHO/WHO for the 1992-1993 biennium, there has been an attempt to make it a catalyst for the processes of transformation of the health sector under way to differing degrees in the Member Countries. Therefore, it is important to envision it as a proposal for institutional action designed to trigger the mobilization of national resources for the modernization of the sector. It should not be viewed as the sole formula for implementation of the strategic orientations and program priorities (SOPPs) of PAHO during the 1991-1994 quadrennium.

31. At the same time, it should be remembered that the 1992-1993 program budget was drawn up with the intention that it be executed with sufficient flexibility to adapt to the changing health requirements that the countries of the Region may have. This is the only way to be able to guarantee a timely and effective response capacity to unforeseen situations, such as the current cholera epidemic.

32. After the approval of the 1991-1994 SOPPs by the Pan American Sanitary Conference in September 1990, all of the organizational units in the field and at Headquarters were instructed to draw up their annual program budgets (APBs) for 1991. They were told to take into consideration the basic criteria set forth in the document and approved by the Governing Bodies, aimed at concentrating efforts on priority areas of action that can have a high impact on the development of health in the countries of the Region. During the internal review of the APB proposals for 1991, which was conducted in December 1990, criteria of analysis and resource allocation were established. These are based on the degree of implementation of the 1991-1994 SOPPs, as reflected in the program budgets drawn up between September and November. This initial formula was used to encourage the Organization's technical cooperation to adjust to the quadrennial mandate bestowed by the Governing Bodies. Later, instructions were issued for preparation of the biennial program budget (BPB) for 1992-1993; all units in the field and at Headquarters were emphatically told that the analysis of the situation and dialogue on priority cooperation needs they would establish with the national health authorities in each one of the Member Countries, as well as the proposals for biennial activities, should take into consideration, as much as possible, the mandates contained in the SOPPs. The 1992-1993 BPB proposal, presented with this document, shows the results of the aforementioned activity.

33. Having established this characterization of the general conditions placing limitations on the Organization, it is important to make some reference to how costs were determined in drawing up the program budget. The cost increases to be faced in the upcoming biennium are sizeable, and they must be incorporated into this program budget. The magnitude of this phenomenon has reached surprising proportions. Although a greater cost increase was anticipated than that of two years ago, it was not expected to be so high. This is primarily due to the three factors described below.

34. The first factor was increases prescribed by the United Nations System, which essentially affect various aspects of personnel costs: health insurance, wage increases, and benefits increases. This has caused an overall increase in personnel costs of approximately 30% over what was budgeted for the present biennium.

35. The second factor was the increases in consumer price indexes in the economies based on the United States dollar. Cost increases are customarily projected based on inflationary factors observed during the current biennium. Last year, the United States experienced an annual inflation rate of 6.1%, and it has been estimated that in 1991 the rate will be 4.9%. Together it will be close to 11.2% for the current biennium.

36. The third and most surprising factor is the relationship between inflation rates or the increase in domestic prices in the countries of Latin America and the Caribbean, and their relationship to the exchange rates of the national currencies with the United States dollar. Generally in the past, domestic inflation rates in Latin America and the Caribbean were somewhat compensated by the performance of rates of exchange for the national currencies to the United States dollar. The two tended to neutralize each other, causing overall cost increases for the Organization's operations to be more or less identical to domestic inflation in the United States as defined in United States dollars. However, in the last two years, a new, widespread phenomena has emerged. The United States dollar has devalued not only vis-a-vis the so-called hard currencies (the yen, the deutsche mark, the Swiss franc, etc.), but also, to an extraordinary degree, vis-a-vis many Latin American currencies.

37. When statistical weighting is done for the volume of spending that the Organization does in each of these countries, the impact of cost increases stemming from devaluation of the dollar is considerable. In 1990 alone, devaluation of the dollar compared to Latin American currencies caused an 18.7% increase in overall costs to the Organization.

38. With all of these factors in mind, an individual analysis was conducted country-by-country and post-by-post, not through averages or estimates as had been done in the past. This produced an estimate of overall cost increases to the Organization of 19.7%, which is presented in the attached budget proposal.

39. The part of the budget of the World Health Organization (WHO) corresponding to the Regional Office of the Americas came with a fixed increase of only 9.9%. Therefore, starting with the part of our budget funded by WHO we already had an uncovered cost increase of approximately $6,346,300.

40. In the case of PAHO, in order to maintain zero growth, we would have had to increase the budget by 19.7%, based on the very conservative cost estimate we have done. Instead of being $152,576,000, the budget would have had to be approximately $155,637,500. This means we have another $3,061,500 in costs uncovered inasmuch as we applied the 17.3% increase that we are requesting for the PAHO budget.

41. The above facts indicate an accumulated difference in costs of $9,407,800, which has been absorbed. But more than being absorbed, this has implied a real reduction in the Organization's program of activities. That is, it has been necessary to cut back activities in the amount of $9,371,400, which signifies a considerable reduction of programs. In sum, taking into account the deficit not covered by WHO, and real cost increases, in order for the PAHO/WHO combined budget to have overall zero growth, the PAHO portion would have had to increase by 24.6%. We have deemed it inappropriate, in light of the situation of crisis and the restrictions mentioned previously, to ask the Member Countries for an increase of the magnitude that would be required to maintain operations at the same level as the current biennium, even though this would be consistent with the policy of zero growth. For that reason, we have carefully studied all of the policy options for financing the 1992-1993 program budget so as to minimize the impact on the country assessments. Consequently, a 17.3% increase in the PAHO budget has been set, which means that 7.3% of the 24.6% increase that would have been required is absorbed. In other words, almost 30% of the increase necessary to maintain the program budget with zero growth has been absorbed by the Organization through a cut in programs.

42. The previous paragraphs show that the program budget has been drafted based on a 7.3% reduction in programs for PAHO, and 4.8% for the combined PAHO/WHO funds. Also, since part of the cost increases are financed by using miscellaneous income, we are in a position to propose an increase in the assessments for the Member Countries of only 14.55%, that is, approximately 7% per annum.

43. Two aspects must be pointed out regarding the funding of the program budget. First, it must be emphasized that our share of the WHO budget has diminished. WHO's contribution to the regional programs is now equivalent to less than 32% of the total, while PAHO takes over more than 68% of the total. Our share of the overall WHO budget has dropped to around 9.3% of its total. Secondly, it must be stressed that we are proposing a total increase in country assessments of 14.55%, but that this is not applied uniformly across-the-board to all of the countries. Since the Organization of American States (OAS) took Canada in as a member, it is establishing a new assessment scale, whose final conformation for the 1992-1993 period should be decided upon by the OAS General Assembly to be held in early June 1991 in Santiago, Chile, a few weeks before our Executive Committee is to meet.

44. In spite of the adverse circumstances described in the above paragraphs, it is important to mention that in drawing up and revising this proposed program budget for 1992-1993, special emphasis was placed on concentrating the resources allocated to classified programs that include activities closely linked to the implementation of the strategic orientations and program priorities. In fact, allocations for the priority programs increased by 23.9% over the previous biennium, while the overall increase was only 14.9%.

45. The 1992-1993 PAHO regular proposal is $152,576,000 which reflects an increase of $22,553,000 or 17.3% over 1990-1991. The 1992-1993 WHO regular proposal is $71,491,000 which reflects an increase of $6,464,000 or 9.9% over 1990-1991. The combined PAHO/WHO regular proposal is $224,067,000 which reflects an increase of $29,017,000 or 14.9% over 1990-1991.

46. These various and imbalanced increases are caused by several related factors. The imbalance in the increases between the two regular funds is caused by the timing of the original WHO regular proposal, and the increase restrictions placed upon Regional proposals by the Director-General of WHO, even though the global WHO proposal increases 16.8% and 24.27% for the portion related to WHO/Geneva Headquarters.

47. The other cost increases, exacerbated by the imbalance, have caused the largest overall budget increase in this Region since 1984-1985 when it was 15.2%, and the largest program reduction in memory ($9,371,400 or 4.8%). The other cost increases have been caused by inflation rates, which have not been offset by increases in the exchange rates (real devaluation of the US dollar), and the salary and allowance increases mandated by the United Nations. The base salary increase of approximately 5.0% for professional staff which was effective in mid-1990 was the first since January 1975. Other increases for pensions and health insurance also required additional contributions from employees and the Organization. The Organization's share of health insurance has increased from 60.0% to over 66.0%, and the Organization's share of retirees' health insurance costs in 1992-1993 is estimated to be $3,650,000, compared to a 1990-1991 budgeted amount of $700,000. The actual estimated cost for 1990-1991 is expected to be $3,300,000. The education grant base has increased from $6,750 to $8,250 currently--an increase of 22.2%.

48. Local salary averages, which were calculated in early 1989 for 1990-1991 and recalculated for 1992-1993 in early 1991, have increased from 5.0% to 85.0%. Almost without exception, the higher increases are in those countries with inflation rates not offset by increased exchange rates. In addition, the Organization has the largest concentration of staff in these countries.

49. The above general information is given as background to the understanding of the progression from the original proposals received in late 1990 to the current proposal. During the latter half of 1990, the countries and regional program coordinations were requested to make 1992-1993 proposals and 1994-1995 projections related to the combined PAHO/WHO regular-funded programs. These proposals were extensively reviewed by the Director's Advisory Committee during March 1991. The proposals, originally received from the countries and regional program coordinations and prepared within the instructions given of no program growth, would have required PAHO/WHO regular funds of approximately $244,200,000, representing an increase of 25.2% over 1990-1991. Since the WHO regular portion of this original proposal remains at $71,491,000 (9.9% increase) for the consideration of the May 1991 World Health Assembly, PAHO regular funds would have to increase by 32.8% instead of the 17.3% increase now being proposed.

50. The proposal contained in this document has been carefully reviewed and extensive revisions have been made to the original proposals while, at the same time, taking into consideration the program priorities approved by the Governing Bodies. The Subcommittee on Planning and Programming favorably reviewed the proposal in April 1991 and, subsequently, the Director further increased some of the program priorities.

51. Cost increases of 19.7% overall require a program decrease of $9,371,400 or 4.8% in order to remain within the net increase of 14.9%. The PAHO regular budget would have had to increase by 24.6% in order to compensate for the difference between the 19.7% cost increase and the limited cost increase of 9.9% provided by WHO. The real reduction in the PAHO regular budget is, therefore, 7.3% (24.6% increase required minus 17.3% increase proposed). Of the overall program decrease of $9,371,400, only $1,638,600 or 17.5% occurs in country programs, despite the fact that country programs are maintained at 37.1% of the total program.

52. To arrive at the current reduced proposal, the original proposal has been reduced by over $20,000,000. The proposal contains an overall reduction of 74 posts--34 professional posts and 40 local posts. Due to this reduction, a lapse factor for vacant posts has not been applied since short-term consultants, contractual services, and temporary local staff may be used pending the filling of the vacant posts. Of the overall 74 post reduction, only 5 posts were reduced in country programs. Despite this reduction and a 10.0% reduction in funds for short-term consultants, the personnel costs increase by 15.3%.

53. The Region-wide average cost for short-term consultants and fellowships used in the budget increases by less than 2.6% annually. The overall cost increase factors used for all other elements in the proposal are less than 5.5% annually in Washington and less than 8.0% annually in field locations.

54. Following this Introduction, there are several tables and graphs which present the program budget in the various ways requested by the Governing Bodies, and explanations of these tables and graphs are in the following paragraphs.

55. Table A on page 8 summarizes the PAHO and WHO regular regional budget history since 1970. The PAHO regular portion of the $224,067,000 proposal is $152,576,000, which requires an increase of 17.3% over 1990-1991 due to the fact that the WHO regular portion of $71,491,000 was limited to an increase of 9.9%. After the reductions of over $20,000,000, the combined PAHO/WHO regular increase is 14.9%. The PAHO regular share of the overall proposal has risen to 68.1% compared to its 1990-1991 share of 66.7%. The WHO regular share has decreased to 31.9% compared to 33.3% in 1990-1991. This Region's portion of the global WHO regular program budget decreases to 9.36% in 1992-1993 from 9.95% in 1990-1991. This percentage decrease may seem small, but it amounts to over $4,500,000. Had the 1992-1993 portion been maintained at 9.95%, the regional WHO regular proposal could have increased by 16.8%, which is the amount of the increase in the global WHO regular proposal. The PAHO regular increase could have been 13.9%, and/or the overall program decrease of $9,371,400 could have been reduced accordingly.

56. Table B starting on page 9 is divided between posts on PAHO/WHO regular funds (Table B-1, page 9) and posts on extrabudgetary funds (Table B-2, page 10). As mentioned previously, there is an overall reduction of 74 posts on PAHO/WHO regular funds between 1990-1991 and 1992-1993. Only 5 posts were reduced in country programs. Of the 1,093 posts in the 1992-1993 proposal, 614 posts or 56.0% are stationed in the field and 479 posts or 44.0% are stationed in Washington. The decline in posts on extrabudgetary funds shown in Table B-2 is caused by the inability to predict commitments in future years. Using the most up-to-date figures for 1990-1991, 144 posts or 57.0% are stationed in the field and 110 posts or 43.0% are stationed in Washington.

57. Starting on page 11, the various charts and Table C provide an analysis of the PAHO/WHO regular program budget by location categories and by program and cost increase or decrease. Since there are no program increases in the 1992-1993 proposal, program decreases of $9,371,400 or 4.8% relate to the items which were included in the 1990-1991 program but could not be included in the 1992-1993 proposal. Cost increase of $38,388,400 or 19.7% are related to estimates of inflation and United Nations mandated increases such as salaries and allowances, post adjustments, per diem rates, etc.

58. Table C also shows the percentage of the total PAHO/WHO regular program budget assigned to each of the location categories. In compliance with resolutions of the Governing Bodies, at least 35.0% of the PAHO/WHO regular funds are to be budgeted in country programs. The per cent in 1992-1993 is 37.1 of the total, which maintains the 1990-1991 level, despite the overall program reductions which were made. As mentioned previously, only 17.5% of the reductions were made in country programs or 2.3% within country programs. Reductions of 58.2% were made in regional and center programs and technical and administrative direction. Technical and administrative direction continues to decline as a per cent of the total budget. In 1984-1985, it was 17.2% of the total, and it is 15.6% of the total in 1992-1993.

59. The largest increase is for Retirees' Health Insurance which is shown separately on line D at the bottom of the table. The $3,650,000 for 1992-1993 is made up of $2,250,000 for the Organization's contribution and $1,400,000 to pay off the past deficit in the fund by the year 2000. The budgeted amount of $700,000 shown for 1990-1991 is actually estimated to be $3,300,000, meaning that the budget will have to absorb $2,600,000.

60. Table D on pages 14 and 15 is a summary of all the various funds committed to the Organization for 1990-1991 at this time, and an estimate of the funds for 1992-1993 and 1994-1995. As in past program budget documents, the

future periods show decreases in extrabudgetary funds since future commitments from external sources cannot be predicted at this time. The amounts shown for 1992-1993 and 1994-1995 on extrabudgetary funds, therefore, should not be considered as formal commitments.

61. The PAHO and WHO regular funds are shown separately at the top of the table with the proposed increases between 1990-1991 and 1992-1993. It should also be noted in 1990-1991 that for the first time the two regular funds amount to only 50.1% of the total funds. Before the end of 1991, this percentage may fall below 50.0% as additional extrabudgetary commitments are received. The budget on extrabudgetary funds was $69,778,445 in 1982-1983. The 1990-1991 extrabudgetary funds known at this time amount to $193,921,332 representing an increase of 177.9%.

62. The various charts and tables under Table E between pages 16 and 32 present the proposal, separated by funding source, in the program classification structure with the addition of programs for Women, Health, and Development (WHD) which had been included previously within Health Services Development (DHS), and Research and Development in the Field of Vaccines (RDV), which had been included previously within Essential Drugs and Vaccines (EDV).

63. The most logical presentation of the program is shown under Table E-3 starting on page 24 which combines the PAHO and WHO regular funds since these two funds constitute the core program of the Organization. Part I, Direction, Coordination, and Management, and Part IV, Program Support, increase by 9.1% and account for 20.6% of the total 1992-1993 proposal. Part II, Health System Infrastructure, and Part III, Health Science and Technology, increase by 16.9% and account for 79.4% of the total 1992-1993 proposal. While the overall increase between 1990-1991 and 1992-1993 is limited to 14.9%, the priority programs approved by the Governing Bodies have increased by 23.9%. All other programs increase by 6.6%.

64. Part IV, Program Support, frequently referred to as "overhead", accounts for 11.1% of the proposal, decreasing from 11.3% in 1990-1991. While this percentage for administrative support is the lowest of any international organization, when combined with the current level of extrabudgetary funds, Program Support amounts to only 7.2% of the total.

65. The several tables under Table F show the budget in the traditional object of expenditure allocations (personnel, duty travel, fellowships, etc.). Despite the reduction of 74 posts and 185 short-term consultant months, the personnel costs increase by 15.3%. The remaining elements increase by 14.2%.

66. Section II (yellow tab) of this document contains a general analysis and description of the classified list of programs. Each program category has a narrative description together with a presentation of the funds devoted to the program.

67. Section III (green tab) of the document contains subsections related to the main locations of the programs (Country Programs, Multicountry Programs, etc.). These subsections by location categories are an elaboration of the overall summary shown previously under Table C on page 13.

68. Section IV (pink tab) provides a description of the organizational structure and the funds related to it.

69. The last part of the document includes an annex which presents the entire program budget by fund category in the structure of the WHO classified list of programs.

70. This document and the related proposal are presented for the consideration of the June 1991 Executive Committee. Specifically, it is the responsibility of the Executive Committee to make recommendations on the PAHO regular program budget proposal of $152,576,000 for 1992-1993 to the September 1991 Directing Council. The Executive Committee's recommendations will be taken into consideration by the Director, and the document will be revised accordingly.

71. The PAHO regular proposal of $152,576,000, representing an increase of $22,553,000 or 17.3%, is proposed to be funded by an 83.0% increase in Miscellaneous Income (from $5,300,000 in 1990-1991 to $9,700,000 in 1992-1993) and an assessment increase of $18,153,000 or 14.6%.

72. Finally, it is the responsibility of the September 1991 Directing Council to approve a PAHO regular program budget for 1992-1993. Draft appropriation and assessment resolutions will be distributed at the June 1991 Executive Committee meeting since the Organization of American States (OAS) will determine quota assessment percentages during its General Assembly meeting in early June 1991.

TABLE A

PAHO REGULAR AND WHO REGULAR REGIONAL BUDGET HISTORY

BUDGET PERIOD	PAHO REGULAR	% OF TOTAL	% INCREASE	WHO REGULAR	% of TOTAL	% INCREASE	TOTAL PAHO AND WHO REGULAR	% INCREASE
1970-71	30,072,442*	68.2	-	14,053,685	31.8	-	44,126,127	-
1972-73	37,405,395	68.6	24.4	17,150,800	31.4	22.0	54,556,195	23.6
1974-75	45,175,329	68.8	20.8	20,495,900	31.2	19.5	65,671,229	20.4
1976-77	55,549,020	69.3	23.0	24,570,200	30.7	19.9	80,119,220	22.0
1978-79	64,849,990	67.8	16.7	30,771,500	32.2	25.2	95,621,490	19.3
1980-81**	76,576,000	67.1	18.1	37,566,200	32.9	22.1	114,142,200	19.4
1982-83	90,320,000	67.2	17.9	44,012,000	32.8	17.2	134,332,000	17.7
1984-85	103,959,000	67.2	15.1	50,834,000	32.8	15.5	154,793,000	15.2
1986-87	112,484,000	66.0	8.2	57,856,000	34.0	13.8	170,340,000	10.0
1988-89***	121,172,000	66.8	7.7	60,161,000	33.2	4.0	181,333,000	6.5
1990-91	130,023,000	66.7	7.3	65,027,000	33.3	8.1	195,050,000	7.6
1992-93****	152,576,000	68.1	17.3	71,491,000	31.9	9.9	224,067,000	14.9

* INCLUDES THE SUPPLEMENTAL BUDGET OF $982,992 WHICH REPRESENTS THE ASSESSMENT OF CANADA WHEN IT JOINED PAHO IN 1971.

** FIRST BIENNIAL BUDGET PERIOD. THE PAHO REGULAR AMOUNT INCLUDES THE SUPPLEMENTAL BUDGET OF $1,041,400 FOR 1980.

*** THE WHO REGULAR AMOUNT REFLECTS THE $2,470,000 REDUCTION IN THIS REGION RELATED TO THE $25,000,000 GLOBAL REDUCTION.

**** THE PAHO REGULAR AMOUNT FOR 1992-93 IS PROPOSED. THE WHO REGULAR AMOUNT FOR 1992-93 WILL BE CONSIDERED WITHIN THE OVERALL WHO REGULAR PROPOSAL BY THE MAY 1991 WORLD HEALTH ASSEMBLY.

TABLE B-1

POST ANALYSIS - PAHO AND WHO REGULAR FUNDS

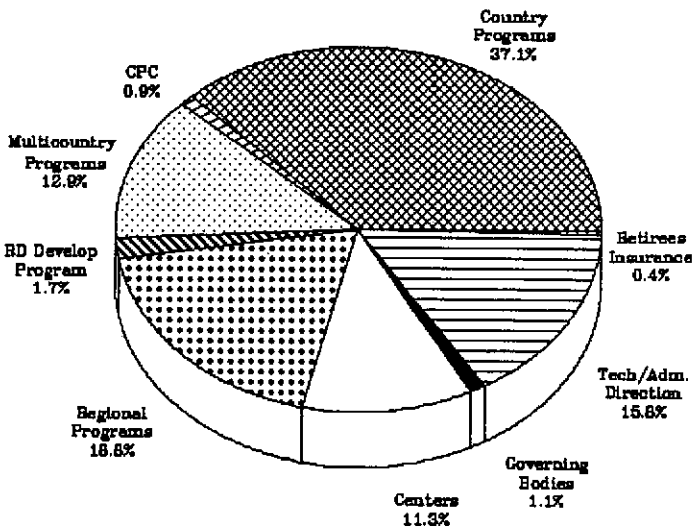
LOCATION	1990 - 1991			1992 - 1993			1994 - 1995		
	PROFESSIONAL	LOCAL	TOTAL	PROFESSIONAL	LOCAL	TOTAL	PROFESSIONAL	LOCAL	TOTAL
A.1 COUNTRY PROGRAMS	140	164	304	136	163	299	132	163	295
A.2 CARIBBEAN PROGRAM COORDINATION	3	8	11	3	9	12	3	9	12
A.3 MULTICOUNTRY PROGRAMS	43	11	54	32	10	42	32	10	42
SUBTOTAL, DIRECT COOPERATION WITH COUNTRIES	186	183	369	171	182	353	167	182	349
A.4 REGIONAL PROGRAMS	150	136	286	139	130	269	135	130	265
A.5 CENTERS	68	225	293	60	201	261	58	201	259
A. COOPERATION WITH COUNTRIES	404	544	948	370	513	883	360	513	873
B. TECHNICAL AND ADMINISTRATIVE DIRECTION	73	139	212	73	130	203	71	130	201
C. GOVERNING BODIES	3	4	7	3	4	7	3	4	7
GRAND TOTAL	480	687	1,167	446	647	1,093	434	647	1,081

TABLE B-2

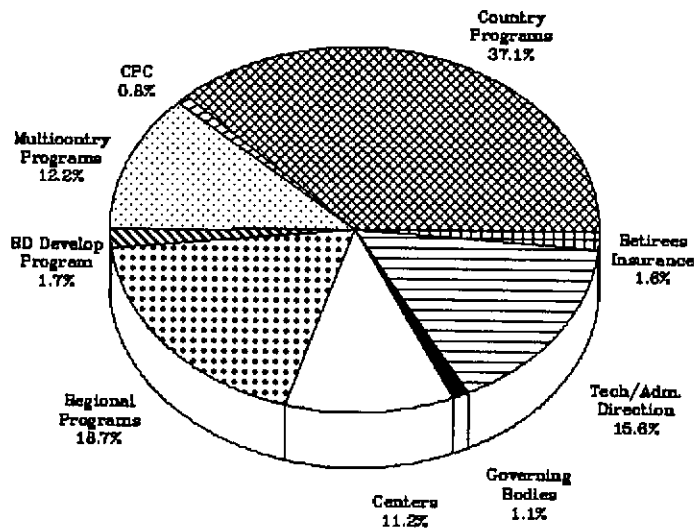
POST ANALYSIS - EXTRABUDGETARY FUNDS

LOCATION	1990 - 1991			1992 - 1993			1994 - 1995		
	PROFESSIONAL	LOCAL	TOTAL	PROFESSIONAL	LOCAL	TOTAL	PROFESSIONAL	LOCAL	TOTAL
A.1 COUNTRY PROGRAMS	21	14	35	7	13	20	3	13	16
A.2 CARIBBEAN PROGRAM COORDINATION	0	0	0	0	0	0	0	0	0
A.3 MULTICOUNTRY PROGRAMS	21	6	27	16	6	22	6	3	9
SUBTOTAL, DIRECT COOPERATION WITH COUNTRIES	42	20	62	23	19	42	9	16	25
A.4 REGIONAL PROGRAMS	26	50	76	25	49	74	10	35	45
A.5 CENTERS	10	72	82	9	69	78	5	67	72
A. COOPERATION WITH COUNTRIES	78	142	220	57	137	194	24	118	142
B. TECHNICAL AND ADMINISTRATIVE DIRECTION	7	27	34	8	26	34	8	26	34
C. GOVERNING BODIES	0	0	0	0	0	0	0	0	0
GRAND TOTAL	85	169	254	65	163	228	32	144	176

Approved 1990-1991 Vs Proposed 1992-1993 PR/WR Program Budget by Location



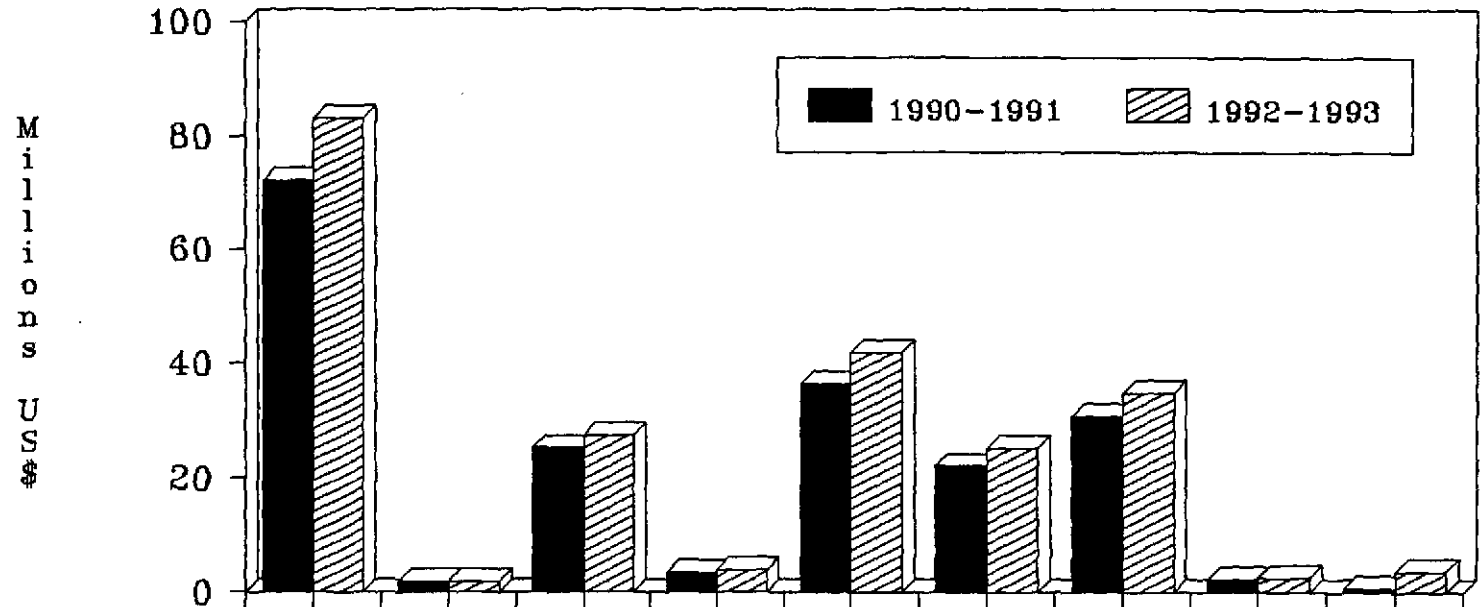
Approved 1990-1991



Proposed 1992-1993

GRAPH II

Comparison: 1990-1991 and 1992-1993 PR/WR Program Budget by Location



	Country Programs 15.1%	Caribbean Program Coord. -2.6%	Multi-country Programs 8.3%	Director's Development Program 11.2%	Regional Programs 14.4%	Centers 13.5%	Technical & Admin. Direction 13.3%	Governing Bodies 15.0%	Retirees' Health Insurance 421.4%
1990-1991	72.289	1.804	25.246	3.35	36.585	22.089	30.782	2.205	0.7
1992-1993	83.237	1.756	27.332	3.725	41.863	25.081	34.886	2.536	3.65

TABLE C

1992-1993 PAHO/WHO REGULAR BUDGET ANALYSIS OF PROGRAM AND COST INCREASES/(DECREASES) BY LOCATION

LOCATION	1990-1991 APPROPRIATION AMOUNT	1990-1991 APPROPRIATION % OF TOTAL	1992-1993 PROGRAM AT 1990-1991 AVERAGES	PROGRAM INCREASE/ (DECREASE)	COST INCREASE/ (DECREASE)	TOTAL INCREASE/ (DECREASE)	1992-1993 PROPOSAL AMOUNT	1992-1993 PROPOSAL % OF TOTAL
A.1 COUNTRY PROGRAMS	72,289,400	37.1	70,650,800	(1,638,600) (2.3)	12,586,300 17.4	10,947,700 15.1	83,237,100	37.1
A.2 CARIBBEAN PROGRAM COORDINATION	1,803,500	.9	1,649,800	(153,700) (8.5)	105,900 5.9	(47,800) (2.6)	1,755,700	.8
A.3 MULTICOUNTRY PROGRAMS	25,246,100	12.9	23,125,800	(2,120,300) (8.4)	4,206,200 16.7	2,085,900 8.3	27,332,000	12.2
A.4 REGIONAL DIRECTOR'S DEVELOPMENT PROGRAM IN SUPPORT OF COUNTRY ACTIVITIES	3,350,000	1.7	3,350,000	- 0.0	375,200 11.2	375,200 11.2	3,725,200	1.7
SUBTOTAL, DIRECT COOPERATION WITH COUNTRIES	102,689,000	52.6	98,776,400	(3,912,600) (3.8)	17,273,600 16.8	13,361,000 13.0	116,050,000	51.8
A.5 REGIONAL PROGRAMS	36,584,800	18.8	34,468,600	(2,116,200) (5.8)	7,394,900 20.2	5,278,700 14.4	41,863,500	18.7
A.6 CENTERS	22,089,100	11.3	19,967,200	(2,121,900) (9.6)	5,113,500 23.1	2,991,600 13.5	25,080,700	11.2
A. COOPERATION WITH COUNTRIES	161,362,900	82.7	153,212,200	(8,150,700) (5.0)	29,782,000 18.4	21,631,300 13.4	182,994,200	81.7
B. TECHNICAL AND ADMINISTRATIVE DIRECTION	30,781,800	15.8	29,561,100	(1,220,700) (4.0)	5,325,200 17.3	4,104,500 13.3	34,886,300	15.6
C. GOVERNING BODIES	2,205,300	1.1	2,205,300	- 0.0	331,200 15.0	331,200 15.0	2,536,500	1.1
D. RETIREES' HEALTH INSURANCE	700,000	.4	700,000	- 0.0	2,950,000 421.4	2,950,000 421.4	3,650,000	1.6
TOTAL	195,050,000	100.0	185,678,600	(9,371,400) (4.8)	38,388,400 19.7	29,017,000 14.9	224,067,000	100.0

TABLE D

ALL FUNDS

		1990-1991 BIENNIUM APPROVED		INCREASE (DECREASE) 1992-1993 OVER 1990-1991	1992-1993 BIENNIUM PROPOSED		INCREASE (DECREASE) 1994-1995 OVER 1992-1993	1994-1995 BIENNIUM PROVISIONAL	
		AMOUNT $	% OF TOTAL		AMOUNT $	% OF TOTAL		AMOUNT $	% OF TOTAL
	REGULAR BUDGET	195,050,000	50.1	14.9	224,067,000	61.8	12.4	251,825,000	77.8
PR	PAHO REGULAR BUDGET	130,023,000	33.4	17.3	152,576,000	42.1	12.3	171,316,000	52.9
WR	WHO REGULAR BUDGET	65,027,000	16.7	9.9	71,491,000	19.7	12.6	80,509,000	24.9
	EXTRABUDGETARY FUNDS:								
	PAN AMERICAN HEALTH ORGANIZATION	141,026,293	36.3	(29.7)	99,203,794	27.4	(44.9)	54,626,036	16.9
PA	INCAP MEMBERSHIP AND MISCELLANEOUS FUNDS	1,100,000	.3	9.1	1,200,000	.3	-	1,200,000	.4
PN	INCAP GRANTS AND CONTRACTUAL AGREEMENTS	12,500,000	3.2	4.0	13,000,000	3.6	-	13,000,000	4.0
PC	CAREC MEMBERSHIP AND MISCELLANEOUS FUNDS	1,599,180	.4	19.9	1,917,300	.5	6.7	2,045,000	.6
PJ	CAREC GRANTS AND CONTRACTUAL AGREEMENTS	2,665,276	.7	(56.8)	1,150,324	.3	(100.0)	-	
PB	BUILDING FUND	2,157,716	.6	20.5	2,600,000	.7	(45.4)	1,420,000	.4
PD	NATURAL DISASTER RELIEF VOLUNTARY FUND	1,483,109	.4	(42.2)	857,000	.2	4.7	897,000	.3
PG	GRANTS AND CONTRACTUAL AGREEMENTS	107,710,742	27.7	(36.4)	68,470,284	18.9	(59.4)	27,817,120	8.6
PK	SPECIAL FUND FOR HEALTH PROMOTION	216,216	.1	-	216,216	.1	-	216,216	.1
PL	SPECIAL FUND FOR ASSOCIATED AGENCY: UNDP AGREEMENTS	2,513,231	.6	(.9)	2,491,370	.7	(100.0)	-	-
PU	SPECIAL FUND FOR ANIMAL HEALTH RESEARCH	16,332	.*	(8.2)	15,000	.*	-	15,000	.*
PX	PROGRAM SUPPORT COSTS	8,007,891	2.1	(25.1)	5,997,100	1.7	9.5	6,567,300	2.0
HP	PAN AMERICAN HEALTH AND EDUCATION FOUNDATION TRUST FUNDS	146,400	.*	16.9	171,100	.1	12.0	191,600	.1
HT	TEXTBOOKS AND INSTRUCTIONAL MATERIALS	910,200	.2	22.8	1,118,100	.3	12.4	1,256,800	.4

TABLE D (CONT.)

ALL FUNDS (CONT.)

		1990-1991 BIENNIUM APPROVED		INCREASE (DECREASE) 1992-1993 OVER 1990-1991	1992-1993 BIENNIUM PROPOSED		INCREASE (DECREASE) 1994-1995 OVER 1992-1993	1994-1995 BIENNIUM PROVISIONAL	
		AMOUNT $	% OF TOTAL		AMOUNT $	% OF TOTAL		AMOUNT $	% OF TOTAL
	WORLD HEALTH ORGANIZATION	52,895,039	13.6	(25.7)	39,296,845	10.8	(56.3)	17,156,902	5.3
	INCOME FROM UNITED NATIONS SOURCES:								
DP	UNITED NATIONS DEVELOPMENT PROGRAM	2,039,977	.5	(65.7)	699,737	.2	(85.7)	100,000	.*
DI	UNDP COST-INCURRED ACCOUNT	10,288	.*	(100.0)	-	-	-	-	-
FB	ASSOCIATE PROFESSIONAL OFFICERS	757,795	.2	(90.9)	68,846	.*	(100.0)	-	-
FD	UNITED NATIONS FUND FOR DRUG ABUSE CONTROL	278,384	.1	(100.0)	-	-	-	-	-
FP	UNITED NATIONS POPULATION FUND	15,760,849	4.0	(17.0)	13,080,224	3.6	(29.0)	9,288,982	2.9
	TRUST FUNDS:								
FA	SPECIAL PROGRAM FOR RESEARCH AND TRAINING IN TROPICAL DISEASES	264,800	.1	(100.0)	-	-	-	-	-
FX	GLOBAL PROGRAM ON AIDS	22,290,064	5.7	(20.3)	17,765,284	4.9	(99.1)	165,000	.*
ST	SASAKAWA HEALTH FUND	43,556	.*	(100.0)	-	-	-	-	-
	VOLUNTARY FUND FOR HEALTH PROMOTION:								
VC	SPECIAL ACCOUNT FOR DIARRHEAL DISEASES INCLUDING CHOLERA	1,769,599	.5	19.0	2,104,960	.6	5.7	2,223,970	.7
VD	SPECIAL ACCOUNT FOR MISCELLANEOUS DESIGNATED CONTRIBUTIONS (OTHER)	5,196,879	1.3	(69.9)	1,562,044	.4	(44.0)	874,000	.3
VG	SPECIAL ACCOUNT FOR MEDICAL RESEARCH (SPECIFIED)	19,744	.*	(100.0)	-	-	-	-	-
VI	SPECIAL ACCOUNT FOR THE EXPANDED PROGRAM ON IMMUNIZATION	630,587	.2	(31.0)	435,050	.1	18.2	514,150	.2
VW	SPECIAL ACCOUNT FOR COMMUNITY WATER SUPPLY	21,321	.*	(100.0)	-	-	-	-	-
AS	SPECIAL ACCOUNT FOR SERVICING COSTS	3,591,886	.9	(0.3)	3,580,700	1.0	11.5	3,990,800	1.2
EF	REAL ESTATE FUND	219,310	.1	(100.0)	-	-	-	-	-
	TOTAL BUDGET	388,971,332	100.0	(6.8)	362,567,639	100.0	(10.7)	323,607,938	100.0

* LESS THAN .05 PER CENT

TABLE E-1

PROGRAM BUDGET - PAHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
I. DIRECTION, COORDINATION AND MANAGEMENT		17,332,700	13.4	18,477,600	12.1	20,417,300	11.8
GOVERNING BODIES		1,881,200	1.4	2,176,100	1.4	2,432,100	1.4
GOVERNING BODIES	GOB	1,881,200	1.4	2,176,100	1.4	2,432,100	1.4
GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT		15,451,500	12.0	16,301,500	10.7	17,985,200	10.4
EXECUTIVE MANAGEMENT	EXM	2,448,400	1.9	2,902,600	1.9	3,234,900	1.9
REGIONAL DIRECTOR'S DEVELOPMENT PROGRAM	DGP	3,194,000	2.5	3,569,200	2.3	3,969,000	2.3
GENERAL PROGRAM DEVELOPMENT	GPD	4,235,800	3.3	3,446,800	2.3	3,680,400	2.1
EXTERNAL COORD. FOR HEALTH AND SOCIAL DEVELOPMENT	COR	850,100	.7	1,242,400	.8	1,404,100	.8
INFORMATICS MANAGEMENT	ISS	4,723,200	3.6	5,140,500	3.4	5,696,800	3.3
II. HEALTH SYSTEM INFRASTRUCTURE		58,797,200	45.3	72,564,400	47.7	81,910,600	48.3
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		16,461,400	12.6	24,726,200	16.2	27,990,700	16.7
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	15,609,100	11.9	23,772,700	15.6	26,913,200	16.1
ADMINISTRATIVE ANALYSIS	AAN	852,300	.7	953,500	.6	1,077,500	.6
TECHNICAL COOPERATION AMONG COUNTRIES		2,279,500	1.8	2,645,700	1.7	3,069,700	1.8
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	2,279,500	1.8	2,645,700	1.7	3,069,700	1.8
HEALTH SITUATION AND TREND ASSESSMENT		4,281,900	3.3	4,381,700	2.9	4,962,800	2.9
HEALTH SITUATION AND TREND ASSESSMENT	HST	4,281,900	3.3	4,381,700	2.9	4,962,800	2.9
HEALTH POLICY DEVELOPMENT		3,600,200	2.8	5,744,000	3.8	6,517,400	3.8
HEALTH POLICY ANALYSIS AND DEVELOPMENT	HDP	2,712,500	2.1	3,651,300	2.4	4,147,700	2.4
HEALTH ECONOMICS AND FINANCING	HDE	775,200	.6	992,600	.7	1,129,100	.7
HEALTH LEGISLATION	HLE	112,500	.1	464,200	.3	521,000	.3
WOMEN, HEALTH AND DEVELOPMENT	WHD	0	-	635,900	.4	719,600	.4
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		14,882,000	11.5	15,065,300	9.9	16,995,700	10.0
HEALTH SERVICES DEVELOPMENT	DHS	12,037,400	9.3	12,553,700	8.2	14,149,200	8.3
ESSENTIAL DRUGS AND VACCINES	EDV	691,000	.5	445,500	.3	503,700	.3
ORAL HEALTH	ORH	493,200	.4	430,700	.3	490,600	.3
DISASTER PREPAREDNESS	DPP	470,500	.4	630,300	.4	716,100	.4
CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY	CLR	558,300	.4	560,700	.4	634,800	.4
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	103,500	.1	0	-	0	-
REHABILITATION	RHB	528,100	.4	444,400	.3	501,300	.3

TABLE E-1 (CONT.)

PROGRAM BUDGET - PAHO REGULAR FUNDS (CONT.)

	PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
	HUMAN RESOURCES DEVELOPMENT		7,304,300	5.7	8,997,200	5.9	10,034,900	5.9
	COORDINATION & SUPPORT OF HUMAN RESOURCES DEVELOP.	HMC	3,464,700	2.7	4,062,200	2.7	4,585,000	2.7
	HUMAN RESOURCES ADMINISTRATION	HMA	631,000	.5	530,900	.3	457,200	.3
	HUMAN RESOURCES EDUCATION	HME	3,208,600	2.5	4,404,100	2.9	4,992,700	2.9
	HEALTH INFORMATION SUPPORT		6,455,100	4.9	7,088,000	4.7	7,872,600	4.6
	OFFICIAL AND TECHNICAL PUBLICATIONS	HBP	2,113,000	1.6	2,582,200	1.7	2,896,200	1.7
	PUBLIC INFORMATION	HBF	1,447,000	1.1	1,638,400	1.1	1,742,400	1.0
	LANGUAGE SERVICES	HBL	928,700	.7	642,300	.4	719,300	.4
	SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION	HBD	1,966,400	1.5	2,225,100	1.5	2,514,700	1.5
	RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT		3,532,800	2.7	3,916,300	2.6	4,466,800	2.6
	RESEARCH PROMOTION AND DEVELOPMENT	RPD	3,036,600	2.3	3,039,900	2.0	3,473,800	2.0
	HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT	HDT	496,200	.4	488,800	.3	554,400	.3
	RESEARCH AND DEVELOPMENT IN THE FIELD OF VACCINES	RDV	0	-	387,600	.3	438,600	.3
III.	HEALTH SCIENCE AND TECHNOLOGY		37,820,600	29.0	43,526,300	28.4	48,827,000	28.2
	FOOD AND NUTRITION		4,779,800	3.7	5,462,200	3.6	5,914,300	3.4
	FOOD	FOD	1,557,200	1.2	1,069,600	.7	1,047,500	.6
	NUTRITION	NUT	3,222,600	2.5	4,392,600	2.9	4,866,800	2.8
	ENVIRONMENTAL HEALTH		9,134,100	6.9	9,922,500	6.5	11,188,600	6.5
	COMMUNITY WATER SUPPLY AND SANITATION	CWS	6,694,800	5.1	5,985,800	3.9	6,743,500	3.9
	SOLID WASTES AND HOUSING HYGIENE	RUD	314,800	.2	277,400	.2	312,700	.2
	CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	1,685,000	1.3	3,132,400	2.1	3,636,300	2.1
	WORKERS' HEALTH	OCH	439,500	.3	526,900	.3	597,100	.3
	MATERNAL AND CHILD HEALTH		4,265,000	3.3	5,045,400	3.2	5,509,100	3.1
	GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	3,809,200	2.9	4,565,600	3.0	4,964,200	2.9
	ADOLESCENT HEALTH	ADH	101,400	.1	63,700	.*	70,800	.*
	ACUTE RESPIRATORY INFECTIONS	ARI	147,300	.1	184,600	.1	210,400	.1
	IMMUNIZATION	EPI	141,800	.1	156,800	.1	180,000	.1
	DIARRHEAL DISEASES	CDD	65,300	.1	74,700	.*	83,700	.*
	COMMUNICABLE DISEASES		4,254,000	3.2	4,975,000	3.3	5,666,900	3.3
	GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	2,491,500	1.9	2,998,900	2.0	3,427,100	2.0
	TROPICAL DISEASE RESEARCH	TDR	23,600	.*	119,100	.1	133,000	.1
	TUBERCULOSIS	TUB	422,100	.3	196,200	.1	221,500	.1
	ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	359,400	.3	359,000	.2	406,100	.2
	VECTOR-BORNE DISEASES	VBC	0	-	331,100	.2	384,300	.2
	MALARIA	MAL	957,400	.7	880,400	.6	992,400	.6
	PARASITIC DISEASES	PDP	0	-	90,300	.1	102,500	.1

TABLE E-1 (CONT.)

PROGRAM BUDGET - PAHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
HEALTH PROMOTION		2,618,700	2.0	3,944,300	2.5	4,468,700	2.5
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	2,379,100	1.8	3,662,000	2.4	4,146,800	2.4
TOBACCO OR HEALTH	TOH	68,000	.1	57,700	.*	65,800	.*
CANCER	CAN	0	-	57,000	.*	65,100	.*
ACCIDENT PREVENTION	APR	60,200	.*	50,300	.*	56,900	.*
PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE	ADA	111,400	.1	117,300	.1	134,100	.1
VETERINARY PUBLIC HEALTH		12,769,000	9.9	14,176,900	9.3	16,079,400	9.4
FOOD SAFETY	FOS	498,600	.4	552,000	.4	620,800	.4
FOOT-AND-MOUTH DISEASE	FMD	7,764,900	6.0	8,586,100	5.6	9,720,300	5.7
ZOONOSES	ZNS	4,505,500	3.5	5,038,800	3.3	5,738,300	3.3
IV. PROGRAM SUPPORT		16,072,500	12.3	18,007,700	11.8	20,161,100	11.7
ADMINISTRATION		16,072,500	12.3	18,007,700	11.8	20,161,100	11.7
BUDGET AND FINANCE	BFI	5,371,700	4.1	5,976,500	3.9	6,721,200	3.9
GENERAL SERVICES & HEADQUARTERS OPERATING EXPENSES	PGS	7,655,300	5.9	8,636,700	5.7	9,627,900	5.6
PERSONNEL	PER	1,974,000	1.5	2,260,000	1.5	2,537,400	1.5
PROCUREMENT	SUP	1,071,500	.8	1,134,500	.7	1,274,600	.7
GRAND TOTAL		130,023,000	100.0	152,576,000	100.0	171,316,000	100.0

* LESS THAN .05 PER CENT

TABLE E-2

PROGRAM BUDGET - WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
I. DIRECTION, COORDINATION AND MANAGEMENT		3,108,900	4.7	2,903,100	4.1	3,231,400	4.0
GOVERNING BODIES		324,100	.5	360,400	.5	400,600	.5
GOVERNING BODIES	GOB	324,100	.5	360,400	.5	400,600	.5
GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT		2,784,800	4.2	2,542,700	3.6	2,830,800	3.5
EXECUTIVE MANAGEMENT	EXM	315,600	.5	339,000	.5	373,800	.5
REGIONAL DIRECTOR'S DEVELOPMENT PROGRAM	DGP	156,000	.2	156,000	.2	173,500	.2
GENERAL PROGRAM DEVELOPMENT	GPD	1,453,500	2.2	1,326,600	1.9	1,471,000	1.8
INFORMATICS MANAGEMENT	ISS	859,700	1.3	721,100	1.0	812,500	1.0
II. HEALTH SYSTEM INFRASTRUCTURE		33,005,800	50.7	35,808,900	50.1	40,273,000	50.1
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		4,651,400	7.2	5,532,800	7.7	6,279,200	7.8
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	4,398,700	6.8	5,286,400	7.4	6,004,600	7.5
ADMINISTRATIVE ANALYSIS	AAN	252,700	.4	246,400	.3	274,600	.3
HEALTH SITUATION AND TREND ASSESSMENT		4,851,600	7.5	6,200,200	8.7	6,991,000	8.7
HEALTH SITUATION AND TREND ASSESSMENT	HST	4,851,600	7.5	6,200,200	8.7	6,991,000	8.7
HEALTH POLICY DEVELOPMENT		1,354,100	2.1	574,100	.8	647,800	.8
HEALTH POLICY ANALYSIS AND DEVELOPMENT	HDP	1,080,100	1.7	475,900	.7	538,000	.7
HEALTH ECONOMICS AND FINANCING	HDE	274,000	.4	98,200	.1	109,800	.1
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		13,955,200	21.3	15,296,000	21.4	17,128,300	21.3
HEALTH SERVICES DEVELOPMENT	DHS	11,906,300	18.2	13,232,100	18.5	14,796,600	18.4
ESSENTIAL DRUGS AND VACCINES	EDV	910,400	1.4	858,700	1.2	967,900	1.2
ORAL HEALTH	ORH	209,600	.3	280,000	.4	317,000	.4
CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY	CLR	314,300	.5	312,500	.4	351,200	.4
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	614,600	.9	612,700	.9	695,600	.9
HUMAN RESOURCES DEVELOPMENT		4,118,400	6.3	4,311,200	6.1	4,845,800	6.1
COORDINATION & SUPPORT OF HUMAN RESOURCES DEVELOP.	HMC	1,481,100	2.3	1,483,700	2.1	1,671,200	2.1
HUMAN RESOURCES ADMINISTRATION	HMA	422,100	.6	618,200	.9	697,700	.9
HUMAN RESOURCES EDUCATION	HME	2,215,200	3.4	2,209,300	3.1	2,476,900	3.1

TABLE E-2 (CONT.)

PROGRAM BUDGET - WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
HEALTH INFORMATION SUPPORT		3,359,200	5.2	3,353,500	4.7	3,766,700	4.7
OFFICIAL AND TECHNICAL PUBLICATIONS	HBP	2,138,100	3.3	2,109,800	3.0	2,366,500	2.9
PUBLIC INFORMATION	HBF	100,300	.2	124,900	.2	138,200	.2
LANGUAGE SERVICES	HBL	926,300	1.4	963,700	1.3	1,089,600	1.4
SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION	HBD	194,500	.3	155,100	.2	172,400	.2
RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT		715,900	1.1	541,100	.7	614,200	.7
RESEARCH PROMOTION AND DEVELOPMENT	RPD	434,900	.7	443,000	.6	504,600	.6
HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT	HDT	281,000	.4	98,100	.1	109,600	.1
III. HEALTH SCIENCE AND TECHNOLOGY		22,994,800	35.5	25,681,400	36.1	29,292,800	36.3
FOOD AND NUTRITION		1,757,300	2.7	1,903,400	2.7	2,172,500	2.7
FOOD	FOD	182,500	.3	196,200	.3	221,500	.3
NUTRITION	NUT	1,574,800	2.4	1,707,200	2.4	1,951,000	2.4
ENVIRONMENTAL HEALTH		5,588,300	8.6	6,709,400	9.4	7,582,500	9.4
COMMUNITY WATER SUPPLY AND SANITATION	CWS	4,390,100	6.8	4,475,400	6.3	5,040,900	6.3
SOLID WASTES AND HOUSING HYGIENE	RUD	202,300	.3	259,800	.4	293,800	.4
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	899,300	1.4	1,939,600	2.7	2,208,100	2.7
WORKERS' HEALTH	OCH	96,600	.1	34,600	.*	39,700	.*
MATERNAL AND CHILD HEALTH		3,521,400	5.4	4,395,600	6.1	4,966,300	6.1
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	1,669,300	2.6	2,220,900	3.1	2,509,300	3.1
ACUTE RESPIRATORY INFECTIONS	ARI	153,100	.2	224,800	.3	253,000	.3
IMMUNIZATION	EPI	1,312,500	2.0	1,516,600	2.1	1,714,500	2.1
DIARRHEAL DISEASES	CDD	386,500	.6	433,300	.6	489,500	.6
COMMUNICABLE DISEASES		7,376,600	11.5	7,563,000	10.5	8,575,500	10.6
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	2,310,000	3.6	3,011,000	4.2	3,430,200	4.3
TROPICAL DISEASE RESEARCH	TDR	247,800	.4	0	-	0	-
TUBERCULOSIS	TUB	181,700	.3	232,400	.3	261,800	.3
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	51,100	.1	15,700	.*	17,300	.*
VECTOR-BORNE DISEASES	VBC	3,229,900	5.0	2,668,200	3.7	3,016,400	3.7
MALARIA	MAL	1,055,200	1.6	952,100	1.3	1,080,000	1.3
PARASITIC DISEASES	PDP	0	-	286,400	.4	322,000	.4
LEPROSY	LEP	257,300	.4	349,300	.5	394,900	.5
SEXUALLY TRANSMITTED DISEASES	VDT	43,600	.1	47,900	.1	52,900	.1

TABLE E-2 (CONT.)

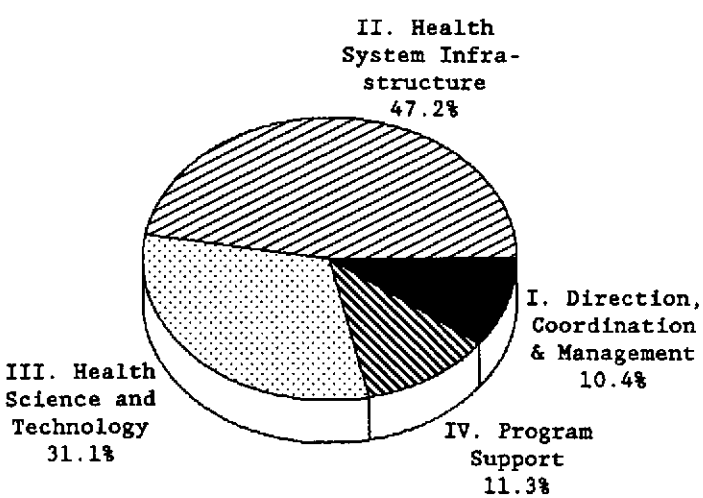
PROGRAM BUDGET - WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
HEALTH PROMOTION		1,800,300	2.8	2,504,800	3.5	2,825,700	3.6
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	710,300	1.1	1,212,700	1.7	1,368,800	1.7
PREV/TREAT. OF MENTAL AND NEUROLOGICAL DISORDERS	MND	384,000	.6	464,900	.7	524,100	.7
HEALTH OF THE ELDERLY	HEE	402,100	.6	464,000	.6	523,400	.7
PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE	ADA	247,800	.4	299,500	.4	336,700	.4
OCULAR HEALTH	PBD	56,100	.1	63,700	.1	72,700	.1
VETERINARY PUBLIC HEALTH		2,950,900	4.5	2,805,200	3.9	3,170,300	3.9
FOOD SAFETY	FOS	926,600	1.4	924,200	1.3	1,041,800	1.3
ZOONOSES	ZNS	2,024,300	3.1	1,881,000	2.6	2,128,500	2.6
IV. PROGRAM SUPPORT		5,917,500	9.1	6,897,600	9.7	7,711,800	9.6
ADMINISTRATION		5,917,500	9.1	6,897,600	9.7	7,711,800	9.6
BUDGET AND FINANCE	BFI	1,364,800	2.1	1,672,900	2.3	1,881,600	2.3
GENERAL SERVICES & HEADQUARTERS OPERATING EXPENSES	PGS	3,405,700	5.2	3,772,200	5.3	4,198,200	5.2
PERSONNEL	PER	822,800	1.3	1,053,400	1.5	1,184,700	1.5
PROCUREMENT	SUP	324,200	.5	399,100	.6	447,300	.6
GRAND TOTAL		65,027,000	100.0	71,491,000	100.0	80,509,000	100.0

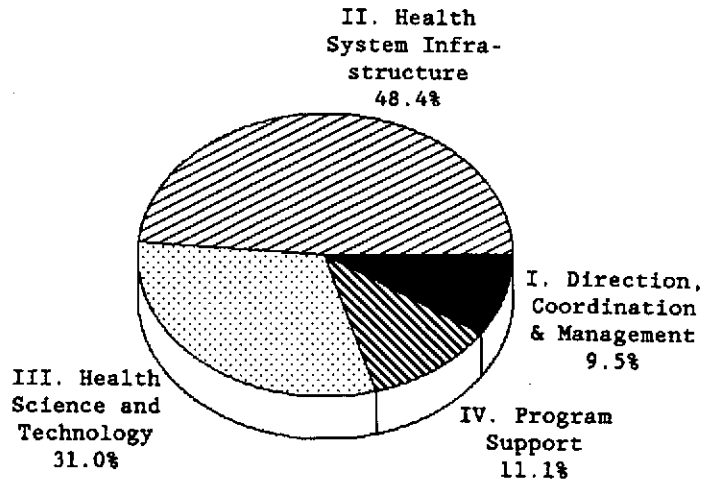
* LESS THAN .05 PER CENT

GRAPH III

Approved 1990-1991 Vs Proposed 1992-1993 PR/WR Program Budget by Appropriation Section

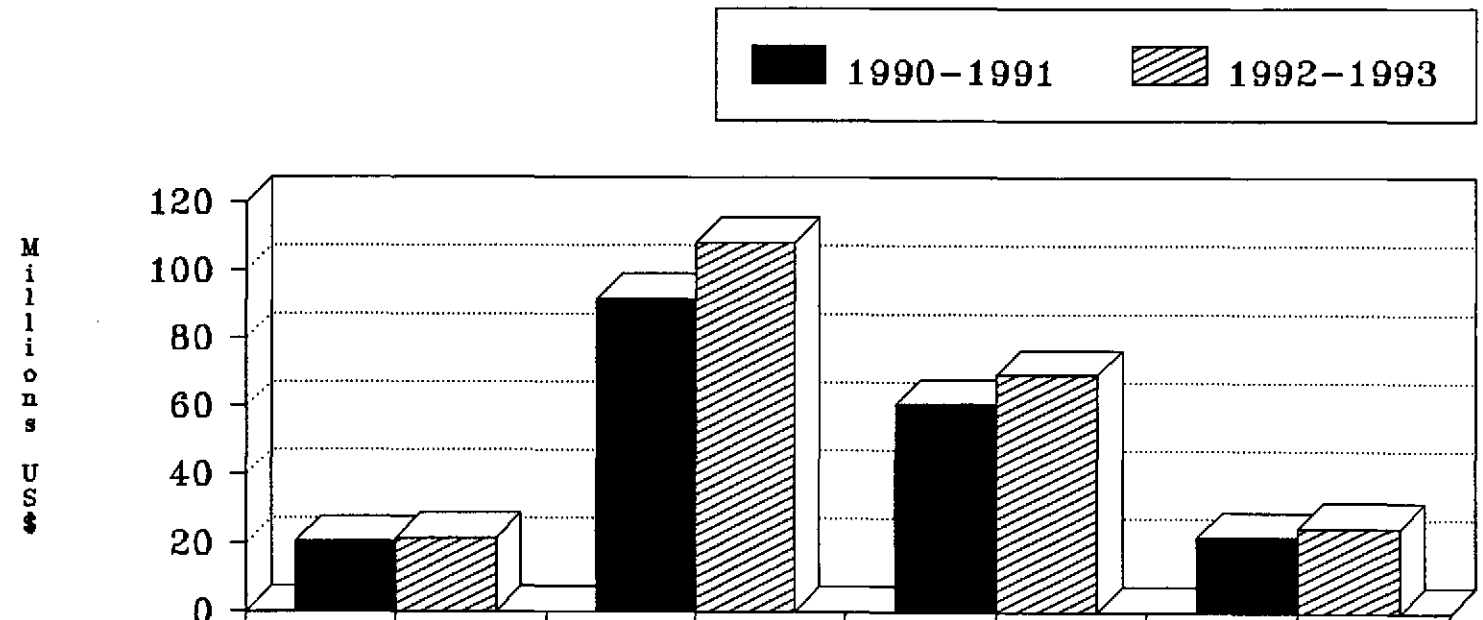


Approved 1990-1991



Proposed 1992-1993

Comparison: 1990-1991 and 1992-1993 PR/WR Program Budget by Appropriation Section



	I. Direction, Coordination & Management	II. Health System Infra-structure	III. Health Science and Technology	IV. Program Support
1990-1991	20.442	91.803	60.815	21.99
1992-1993	21.381	108.373	69.408	24.905

TABLE E-3

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
I. DIRECTION, COORDINATION AND MANAGEMENT		20,441,600	10.4	21,380,700	9.5	23,648,700	9.3
GOVERNING BODIES		2,205,300	1.1	2,536,500	1.1	2,832,700	1.1
GOVERNING BODIES	GOB	2,205,300	1.1	2,536,500	1.1	2,832,700	1.1
GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT		18,236,300	9.3	18,844,200	8.4	20,816,000	8.2
EXECUTIVE MANAGEMENT	EXM	2,764,000	1.4	3,241,600	1.4	3,608,700	1.4
REGIONAL DIRECTOR'S DEVELOPMENT PROGRAM	DGP	3,350,000	1.7	3,725,200	1.7	4,142,500	1.6
GENERAL PROGRAM DEVELOPMENT	GPD	5,689,300	2.9	4,773,400	2.1	5,151,400	2.0
EXTERNAL COORD. FOR HEALTH AND SOCIAL DEVELOPMENT	COR	850,100	.4	1,242,400	.6	1,404,100	.6
INFORMATICS MANAGEMENT	ISS	5,582,900	2.9	5,861,600	2.6	6,509,300	2.6
II. HEALTH SYSTEM INFRASTRUCTURE		91,803,000	47.2	108,373,300	48.4	122,183,600	48.4
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		21,112,800	10.9	30,259,000	13.3	34,269,900	13.3
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	20,007,800	10.3	29,059,100	12.8	32,917,800	12.8
ADMINISTRATIVE ANALYSIS	AAN	1,105,000	.6	1,199,900	.5	1,352,100	.5
TECHNICAL COOPERATION AMONG COUNTRIES		2,279,500	1.2	2,645,700	1.2	3,069,700	1.2
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	2,279,500	1.2	2,645,700	1.2	3,069,700	1.2
HEALTH SITUATION AND TREND ASSESSMENT		9,133,500	4.7	10,581,900	4.7	11,953,800	4.7
HEALTH SITUATION AND TREND ASSESSMENT	HST	9,133,500	4.7	10,581,900	4.7	11,953,800	4.7
HEALTH POLICY DEVELOPMENT		4,954,300	2.5	6,318,100	2.8	7,165,200	2.9
HEALTH POLICY ANALYSIS AND DEVELOPMENT	HDP	3,792,600	1.9	4,127,200	1.8	4,685,700	1.9
HEALTH ECONOMICS AND FINANCING	HDE	1,049,200	.5	1,090,800	.5	1,238,900	.5
HEALTH LEGISLATION	HLE	112,500	.1	464,200	.2	521,000	.2
WOMEN, HEALTH AND DEVELOPMENT	WHD	0	-	635,900	.3	719,600	.3
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		28,837,200	14.8	30,361,300	13.6	34,124,000	13.6
HEALTH SERVICES DEVELOPMENT	DHS	23,943,700	12.3	25,785,800	11.5	28,945,800	11.5
ESSENTIAL DRUGS AND VACCINES	EDV	1,601,400	.8	1,304,200	.6	1,471,600	.6
ORAL HEALTH	ORH	702,800	.4	710,700	.3	807,600	.3
DISASTER PREPAREDNESS	DPP	470,500	.2	630,300	.3	716,100	.3
CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY	CLR	872,600	.4	873,200	.4	986,000	.4
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	716,100	.4	612,700	.3	695,600	.3
REHABILITATION	RHB	528,100	.3	444,400	.2	501,300	.2

TABLE E-3 (CONT.)

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
HUMAN RESOURCES DEVELOPMENT		11,422,700	5.8	13,308,400	6.0	14,880,700	6.0
COORDINATION & SUPPORT OF HUMAN RESOURCES DEVELOP.	HMC	4,945,800	2.5	5,545,900	2.5	6,256,200	2.5
HUMAN RESOURCES ADMINISTRATION	HMA	1,053,100	.5	1,149,100	.5	1,154,900	.5
HUMAN RESOURCES EDUCATION	HME	5,423,800	2.8	6,613,400	3.0	7,469,600	3.0
HEALTH INFORMATION SUPPORT		9,814,300	5.1	10,441,500	4.7	11,639,300	4.6
OFFICIAL AND TECHNICAL PUBLICATIONS	HBP	4,251,100	2.2	4,692,000	2.1	5,262,700	2.1
PUBLIC INFORMATION	HBF	1,547,300	.8	1,763,300	.8	1,880,600	.7
LANGUAGE SERVICES	HBL	1,855,000	1.0	1,606,000	.7	1,808,900	.7
SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION	HBD	2,160,900	1.1	2,380,200	1.1	2,687,100	1.1
RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT		4,248,700	2.2	4,457,400	2.1	5,081,000	2.1
RESEARCH PROMOTION AND DEVELOPMENT	RPD	3,471,500	1.8	3,482,900	1.6	3,978,400	1.6
HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT	HDT	777,200	.4	586,900	.3	664,000	.3
RESEARCH AND DEVELOPMENT IN THE FIELD OF VACCINES	RDV	0	-	387,600	.2	438,600	.2
III. HEALTH SCIENCE AND TECHNOLOGY		60,815,400	31.1	69,407,700	31.0	78,119,800	31.2
FOOD AND NUTRITION		6,537,100	3.4	7,365,600	3.3	8,086,800	3.2
FOOD	FOD	1,739,700	.9	1,265,800	.6	1,269,000	.5
NUTRITION	NUT	4,797,400	2.5	6,099,800	2.7	6,817,800	2.7
ENVIRONMENTAL HEALTH		14,722,400	7.6	16,631,900	7.5	18,771,100	7.5
COMMUNITY WATER SUPPLY AND SANITATION	CWS	11,084,900	5.7	10,461,200	4.7	11,784,400	4.7
SOLID WASTES AND HOUSING HYGIENE	RUD	517,100	.3	537,200	.2	606,500	.2
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	2,584,300	1.3	5,072,000	2.3	5,743,400	2.3
WORKERS' HEALTH	OCH	536,100	.3	561,500	.3	636,800	.3
MATERNAL AND CHILD HEALTH		7,786,400	4.0	9,441,000	4.1	10,475,400	4.2
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	5,478,500	2.8	6,786,500	3.0	7,473,500	3.0
ADOLESCENT HEALTH	ADH	101,400	.1	63,700	.*	70,800	.*
ACUTE RESPIRATORY INFECTIONS	ARI	300,400	.2	409,400	.2	463,400	.2
IMMUNIZATION	EPI	1,454,300	.7	1,673,400	.7	1,894,500	.8
DIARRHEAL DISEASES	CDD	451,800	.2	508,000	.2	573,200	.2
COMMUNICABLE DISEASES		11,630,600	5.9	12,538,000	5.7	14,242,400	5.8
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	4,801,500	2.5	6,009,900	2.7	6,857,300	2.7
TROPICAL DISEASE RESEARCH	TDR	271,400	.1	119,100	.1	133,000	.1
TUBERCULOSIS	TUB	603,800	.3	428,600	.2	483,300	.2
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	410,500	.2	374,700	.2	423,400	.2
VECTOR-BORNE DISEASES	VBC	3,229,900	1.7	2,999,300	1.3	3,400,700	1.4
MALARIA	MAL	2,012,600	1.0	1,832,500	.8	2,072,400	.8
PARASITIC DISEASES	PDP	0	-	376,700	.2	424,500	.2
LEPROSY	LEP	257,300	.1	349,300	.2	394,900	.2
SEXUALLY TRANSMITTED DISEASES	VDT	43,600	.*	47,900	.*	52,900	.*

TABLE E-3 (CONT.)

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
HEALTH PROMOTION		4,419,000	2.2	6,449,100	2.8	7,294,400	2.8
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	3,089,400	1.6	4,874,700	2.2	5,515,600	2.2
TOBACCO OR HEALTH	TOH	68,000	.*	57,700	.*	65,800	.*
PREV/TREAT. OF MENTAL AND NEUROLOGICAL DISORDERS	MND	384,000	.2	464,900	.2	524,100	.2
CANCER	CAN	0	-	57,000	.*	65,100	.*
ACCIDENT PREVENTION	APR	60,200	.*	50,300	.*	56,900	.*
HEALTH OF THE ELDERLY	HEE	402,100	.2	464,000	.2	523,400	.2
PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE	ADA	359,200	.2	416,800	.2	470,800	.2
OCULAR HEALTH	PBD	56,100	.*	63,700	.*	72,700	.*
VETERINARY PUBLIC HEALTH		15,719,900	8.0	16,982,100	7.6	19,249,700	7.7
FOOD SAFETY	FOS	1,425,200	.7	1,476,200	.7	1,662,600	.7
FOOT-AND-MOUTH DISEASE	FMD	7,764,900	4.0	8,586,100	3.8	9,720,300	3.9
ZOONOSES	ZNS	6,529,800	3.3	6,919,800	3.1	7,866,800	3.1
IV. PROGRAM SUPPORT		21,990,000	11.3	24,905,300	11.1	27,872,900	11.1
ADMINISTRATION		21,990,000	11.3	24,905,300	11.1	27,872,900	11.1
BUDGET AND FINANCE	BFI	6,736,500	3.5	7,649,400	3.4	8,602,800	3.4
GENERAL SERVICES & HEADQUARTERS OPERATING EXPENSES	PGS	11,061,000	5.7	12,408,900	5.5	13,826,100	5.5
PERSONNEL	PER	2,796,800	1.4	3,313,400	1.5	3,722,100	1.5
PROCUREMENT	SUP	1,395,700	.7	1,533,600	.7	1,721,900	.7
GRAND TOTAL		195,050,000	100.0	224,067,000	100.0	251,825,000	100.0

* LESS THAN .05 PER CENT

TABLE E-4

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
I. DIRECTION, COORDINATION AND MANAGEMENT		941,179	.4	788,700	.5	843,600	1.2
GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT		941,179	.4	788,700	.5	843,600	1.2
EXECUTIVE MANAGEMENT	EXM	52,226	.*	0	-	0	-
GENERAL PROGRAM DEVELOPMENT	GPD	247,825	.1	64,100	.*	71,300	.1
EXTERNAL COORD. FOR HEALTH AND SOCIAL DEVELOPMENT	COR	431,063	.2	464,600	.3	484,300	.7
INFORMATICS MANAGEMENT	ISS	210,065	.1	260,000	.2	288,000	.4
II. HEALTH SYSTEM INFRASTRUCTURE		56,583,689	29.1	33,947,054	24.5	9,299,916	12.8
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		1,803,688	.9	1,221,263	.9	947,900	1.3
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	1,541,729	.8	935,063	.7	625,900	.9
ADMINISTRATIVE ANALYSIS	AAN	261,959	.1	286,200	.2	322,000	.4
TECHNICAL COOPERATION AMONG COUNTRIES		3,090,549	1.6	1,302,950	.9	0	-
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	3,090,549	1.6	1,302,950	.9	0	-
HEALTH SITUATION AND TREND ASSESSMENT		4,678,451	2.4	3,067,624	2.2	2,045,000	2.8
HEALTH SITUATION AND TREND ASSESSMENT	HST	4,678,451	2.4	3,067,624	2.2	2,045,000	2.8
HEALTH POLICY DEVELOPMENT		386	.*	1,100,000	.8	0	-
HEALTH POLICY ANALYSIS AND DEVELOPMENT	HDP	386	.*	0	-	0	-
WOMEN, HEALTH AND DEVELOPMENT	WHD	0	-	1,100,000	.8	0	-
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		39,665,003	20.5	20,609,698	14.9	1,090,000	1.5
HEALTH SERVICES DEVELOPMENT	DHS	24,543,096	12.7	12,237,420	8.8	138,000	.2
ESSENTIAL DRUGS AND VACCINES	EDV	5,300,294	2.7	2,061,044	1.5	0	-
ORAL HEALTH	ORH	542,937	.3	71,000	.1	0	-
DISASTER PREPAREDNESS	DPP	7,564,070	3.9	4,310,234	3.1	952,000	1.3
CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY	CLR	10,052	.*	0	-	0	-
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	153,950	.1	0	-	0	-
REHABILITATION	RHB	1,550,604	.8	1,930,000	1.4	0	-
HUMAN RESOURCES DEVELOPMENT		4,089,584	2.1	3,317,956	2.4	1,664,616	2.3
COORDINATION & SUPPORT OF HUMAN RESOURCES DEVELOP.	HMC	1,515,777	.8	1,505,416	1.1	1,664,616	2.3
HUMAN RESOURCES EDUCATION	HME	2,573,807	1.3	1,812,540	1.3	0	-

TABLE E-4 (CONT.)

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
HEALTH INFORMATION SUPPORT		3,204,418	1.6	3,267,563	2.4	3,484,400	4.8
OFFICIAL AND TECHNICAL PUBLICATIONS	HBP	428,168	.2	429,000	.3	466,000	.6
PUBLIC INFORMATION	HBF	673,575	.3	655,500	.5	718,400	1.0
LANGUAGE SERVICES	HBL	16,037	.*	0	-	0	-
SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION	HBD	2,086,638	1.1	2,183,063	1.6	2,300,000	3.2
RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT		51,610	.*	60,000	.*	68,000	.1
RESEARCH PROMOTION AND DEVELOPMENT	RPD	30,610	.*	0	-	0	-
HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT	HDT	21,000	.*	60,000	.*	68,000	.1
III. HEALTH SCIENCE AND TECHNOLOGY		130,503,457	67.5	97,298,485	70.3	55,957,022	78.1
FOOD AND NUTRITION		16,611,907	8.5	14,948,200	10.8	15,017,400	21.2
FOOD	FOD	56,400	.*	56,500	.*	62,800	.1
NUTRITION	NUT	16,555,507	8.5	14,891,700	10.8	14,954,600	21.1
ENVIRONMENTAL HEALTH		8,796,656	4.5	5,181,632	3.7	1,392,200	1.9
COMMUNITY WATER SUPPLY AND SANITATION	CWS	6,180,335	3.2	1,443,321	1.0	822,600	1.1
SOLID WASTES AND HOUSING HYGIENE	RUD	33,537	.*	0	-	0	-
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	2,498,279	1.3	3,721,343	2.7	569,600	.8
WORKERS' HEALTH	OCH	84,505	.*	16,968	.*	0	-
MATERNAL AND CHILD HEALTH		47,804,016	24.7	33,521,255	24.2	25,985,522	36.2
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	23,228,767	12.0	18,522,659	13.4	11,791,600	16.4
ADOLESCENT HEALTH	ADH	480,761	.2	145,945	.1	64,582	.1
ACUTE RESPIRATORY INFECTIONS	ARI	1,281,992	.7	1,219,700	.9	1,095,000	1.5
IMMUNIZATION	EPI	19,549,262	10.1	11,527,265	8.3	10,810,370	15.1
DIARRHEAL DISEASES	CDD	3,263,234	1.7	2,105,686	1.5	2,223,970	3.1
COMMUNICABLE DISEASES		39,361,257	20.6	30,519,812	22.1	409,300	.5
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	2,152,330	1.1	0	-	0	-
TROPICAL DISEASE RESEARCH	TDR	264,800	.1	0	-	0	-
TUBERCULOSIS	TUB	100,238	.1	33,456	.*	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	30,095,451	15.9	23,262,536	16.8	234,300	.3
VECTOR-BORNE DISEASES	VBC	419,744	.2	940,000	.7	0	-
MALARIA	MAL	5,882,430	3.0	6,204,564	4.5	100,000	.1
PARASITIC DISEASES	PDP	262,908	.1	75,000	.1	75,000	.1
LEPROSY	LEP	64,312	.*	0	-	0	-
SEXUALLY TRANSMITTED DISEASES	VDT	119,044	.1	4,256	.*	0	-

TABLE E-4 (CONT.)

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
HEALTH PROMOTION		2,212,122	1.1	222,140	.2	0	-
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	65,375	.*	0	-	0	-
TOBACCO OR HEALTH	TOH	222,054	.1	0	-	0	-
PREV/TREAT. OF MENTAL AND NEUROLOGICAL DISORDERS	MND	74,409	.*	0	-	0	-
CANCER	CAN	617,461	.3	0	-	0	-
HEALTH OF THE ELDERLY	HEE	421,966	.2	0	-	0	-
PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE	ADA	500,151	.3	0	-	0	-
OCULAR HEALTH	PBD	310,706	.2	222,140	.2	0	-
VETERINARY PUBLIC HEALTH		15,717,499	8.1	12,905,446	9.3	13,152,600	18.3
FOOD SAFETY	FOS	3,114	.*	0	-	0	-
FOOT-AND-MOUTH DISEASE	FMD	10,298,855	5.3	8,165,651	5.9	7,975,000	11.1
ZOONOSES	ZNS	5,415,530	2.8	4,739,795	3.4	5,177,600	7.2
IV. PROGRAM SUPPORT		5,893,007	3.0	6,466,400	4.7	5,682,400	7.9
ADMINISTRATION		5,893,007	3.0	6,466,400	4.7	5,682,400	7.9
BUDGET AND FINANCE	BFI	1,623,058	.8	1,830,500	1.3	2,006,800	2.8
GENERAL SERVICES & HEADQUARTERS OPERATING EXPENSES	PGS	3,532,261	1.8	3,543,900	2.6	2,468,300	3.4
PERSONNEL	PER	231,588	.1	259,000	.2	294,600	.4
PROCUREMENT	SUP	506,100	.3	833,000	.6	912,700	1.3
GRAND TOTAL		193,921,332	100.0	138,500,639	100.0	71,782,938	100.0

* LESS THAN .05 PER CENT

TABLE E-5

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS WITH PER CENT INCREASES/(DECREASES)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	INCREASE/DECREASE 1992-1993 OVER 1990-1991	1992-1993 AMOUNT	1992-1993 % OF TOTAL
I. DIRECTION, COORDINATION AND MANAGEMENT		20,441,600	10.4	4.6	21,380,700	9.5
GOVERNING BODIES		2,205,300	1.1	15.0	2,536,500	1.1
GOVERNING BODIES	GOB	2,205,300	1.1	15.0	2,536,500	1.1
GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT		18,236,300	9.3	3.3	18,844,200	8.4
EXECUTIVE MANAGEMENT	EXM	2,764,000	1.4	17.3	3,241,600	1.4
REGIONAL DIRECTOR'S DEVELOPMENT PROGRAM	DGP	3,350,000	1.7	11.2	3,725,200	1.7
GENERAL PROGRAM DEVELOPMENT	GPD	5,689,300	2.9	(16.1)	4,773,400	2.1
EXTERNAL COORD. FOR HEALTH AND SOCIAL DEVELOPMENT	COR	850,100	.4	46.1	1,242,400	.6
INFORMATICS MANAGEMENT	ISS	5,582,900	2.9	5.0	5,861,600	2.6
II. HEALTH SYSTEM INFRASTRUCTURE		91,803,000	47.2	18.0	108,373,300	48.4
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		21,112,800	10.9	43.3	30,259,000	13.3
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	20,007,800	10.3	45.2	29,059,100	12.8
ADMINISTRATIVE ANALYSIS	AAN	1,105,000	.6	8.6	1,199,900	.5
TECHNICAL COOPERATION AMONG COUNTRIES		2,279,500	1.2	16.1	2,645,700	1.2
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	2,279,500	1.2	16.1	2,645,700	1.2
HEALTH SITUATION AND TREND ASSESSMENT		9,133,500	4.7	15.9	10,581,900	4.7
HEALTH SITUATION AND TREND ASSESSMENT	HST	9,133,500	4.7	15.9	10,581,900	4.7
HEALTH POLICY DEVELOPMENT		4,954,300	2.5	27.5	6,318,100	2.8
HEALTH POLICY ANALYSIS AND DEVELOPMENT	HDP	3,792,600	1.9	8.8	4,127,200	1.8
HEALTH ECONOMICS AND FINANCING	HDE	1,049,200	.5	4.0	1,090,800	.5
HEALTH LEGISLATION	HLE	112,500	.1	312.6	464,200	.2
WOMEN, HEALTH AND DEVELOPMENT	WHD	0	-	-	635,900	.3
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		28,837,200	14.8	5.3	30,361,300	13.6
HEALTH SERVICES DEVELOPMENT	DHS	23,943,700	12.3	7.7	25,785,800	11.5
ESSENTIAL DRUGS AND VACCINES	EDV	1,601,400	.8	(18.6)	1,304,200	.6
ORAL HEALTH	ORH	702,800	.4	1.1	710,700	.3
DISASTER PREPAREDNESS	DPP	470,500	.2	34.0	630,300	.3
CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY	CLR	872,600	.4	0.1	873,200	.4
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	718,100	.4	(14.7)	612,700	.3
REHABILITATION	RHB	528,100	.3	(15.8)	444,400	.2

TABLE E-5 (CONT.)

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS WITH PER CENT INCREASES/(DECREASES) (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	INCREASE/(DECREASE) 1992-1993 OVER 1990-1991	1992-1993 AMOUNT	1992-1993 % OF TOTAL
HUMAN RESOURCES DEVELOPMENT		11,422,700	5.8	16.5	13,308,400	6.0
COORDINATION & SUPPORT OF HUMAN RESOURCES DEVELOP.	HMC	4,945,800	2.5	12.1	5,545,900	2.5
HUMAN RESOURCES ADMINISTRATION	HMA	1,053,100	.5	9.1	1,149,100	.5
HUMAN RESOURCES EDUCATION	HME	5,423,800	2.8	21.9	6,613,400	3.0
HEALTH INFORMATION SUPPORT		9,814,300	5.1	6.4	10,441,500	4.7
OFFICIAL AND TECHNICAL PUBLICATIONS	HBP	4,251,100	2.2	10.4	4,692,000	2.1
PUBLIC INFORMATION	HBF	1,547,300	.8	14.0	1,763,300	.8
LANGUAGE SERVICES	HBL	1,855,000	1.0	(13.4)	1,606,000	.7
SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION	HBD	2,160,900	1.1	10.1	2,380,200	1.1
RESEARCH PROMOTION AND DEVELOPMENT		4,248,700	2.2	4.9	4,457,400	2.1
RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT	RPD	3,471,500	1.8	0.3	3,482,900	1.6
RESEARCH AND DEVELOPMENT IN THE FIELD OF VACCINES	RDV	0	-	~	387,600	.2
HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT	HDT	777,200	.4	(24.5)	586,900	.3
III. HEALTH SCIENCE AND TECHNOLOGY		60,815,400	31.1	14.1	69,407,700	31.0
FOOD AND NUTRITION		6,537,100	3.4	12.7	7,365,600	3.3
FOOD	FOD	1,739,700	.9	(27.2)	1,265,800	.6
NUTRITION	NUT	4,797,400	2.5	27.1	6,099,800	2.7
ENVIRONMENTAL HEALTH		14,722,400	7.6	13.0	16,631,900	7.5
COMMUNITY WATER SUPPLY AND SANITATION	CWS	11,084,900	5.7	(5.6)	10,461,200	4.7
SOLID WASTES AND HOUSING HYGIENE	RUD	517,100	.3	3.9	537,200	.2
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	2,584,300	1.3	96.3	5,072,000	2.3
WORKERS' HEALTH	OCH	536,100	.3	4.7	561,500	.3
MATERNAL AND CHILD HEALTH		7,786,400	4.0	21.2	9,441,000	4.1
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	5,478,500	2.8	23.9	6,786,500	3.0
ADOLESCENT HEALTH	ADH	101,400	.1	(37.2)	63,700	.*
ACUTE RESPIRATORY INFECTIONS	ARI	300,400	.2	36.3	409,400	.2
IMMUNIZATION	EPI	1,454,300	.7	15.1	1,673,400	.7
DIARRHEAL DISEASES	CDD	451,800	.2	12.4	508,000	.2

TABLE E-5 (CONT.)

PROGRAM BUDGET - PAHC AND WHO REGULAR FUNDS WITH PER CENT INCREASES/(DECREASES) (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	INCREASE/(DECREASE) 1992-1993 OVER 1990-1991	1992-1993 AMOUNT	1992-1993 % OF TOTAL
COMMUNICABLE DISEASES		11,630,600	5.9	7.8	12,538,000	5.7
COMMUNICABLE DISEASE PREVENTION AND CONTROL	OCD	4,801,500	2.5	25.2	6,009,900	2.7
TROPICAL DISEASE RESEARCH	TDR	271,400	.1	(56.1)	119,100	.1
TUBERCULOSIS	TUB	603,800	.3	(29.0)	428,600	.2
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	410,500	.2	(8.7)	374,700	.2
VECTOR-BORNE DISEASES	VBC	3,229,900	1.7	(7.1)	2,999,300	1.3
MALARIA	MAL	2,012,600	1.0	(8.9)	1,832,500	.8
PARASITIC DISEASES	PDP	0	-	~	376,700	.2
LEPROSY	LEP	257,300	.1	35.8	349,300	.2
SEXUALLY TRANSMITTED DISEASES	VDT	43,600	.*	9.9	47,900	.*
HEALTH PROMOTION		4,419,000	2.2	45.9	6,449,100	2.8
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	3,089,400	1.6	57.8	4,874,700	2.2
TOBACCO OR HEALTH	TOH	68,000	.*	(15.1)	57,700	.*
MENTAL AND NEUROLOGICAL DISORDERS	MND	384,000	.2	21.1	464,900	.2
CANCER	CAN	0	-	~	57,000	.*
ACCIDENT PREVENTION	APR	60,200	.*	(16.4)	50,300	.*
HEALTH OF THE ELDERLY	HEE	402,100	.2	15.4	464,000	.2
PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE	ADA	359,200	.2	16.0	416,800	.2
OCULAR HEALTH	PBD	56,100	.*	13.5	63,700	.*
VETERINARY PUBLIC HEALTH		15,719,900	8.0	8.0	16,982,100	7.6
FOOD SAFETY	FOS	1,425,200	.7	3.6	1,476,200	.7
FOOT-AND-MOUTH DISEASE	FMD	7,764,900	4.0	10.6	8,586,100	3.8
ZOONOSES	ZNS	6,529,800	3.3	6.0	6,919,800	3.1
IV. PROGRAM SUPPORT		21,990,000	11.3	13.3	24,905,300	11.1
ADMINISTRATION		21,990,000	11.3	13.3	24,905,300	11.1
BUDGET AND FINANCE	BFI	6,736,500	3.5	13.6	7,649,400	3.4
GENERAL SERVICES & HEADQUARTERS OPERATING EXPENSES	PGS	11,061,000	5.7	12.2	12,408,900	5.5
PERSONNEL	PER	2,796,800	1.4	18.5	3,313,400	1.5
PROCUREMENT	SUP	1,395,700	.7	9.9	1,533,600	.7
GRAND TOTAL		195,050,000	100.0	14.9	224,067,000	100.0

* LESS THAN .05 PER CENT

TABLE F-1

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	130,023,000	7224	13306	22725	78,858,600	4,757,800	1791	3,402,900	8,895,500	6,019,600	2,803,200	25,285,400
WHO - WR	65,027,000	4218	3168	15055	40,025,600	2,294,500	2012	3,822,800	5,145,700	3,458,400	462,500	9,817,500
TOTAL	195,050,000	11442	16474	37780	118,884,200	7,052,300	3803	7,225,700	14,041,200	9,478,000	3,265,700	35,102,900
% OF TOTAL	100.0				60.9	3.6		3.7	7.2	4.9	1.7	18.0
1992-1993												
PAHO - PR	152,576,000	6654	12432	19842	91,792,600	6,094,000	1522	3,044,000	10,910,500	7,663,700	2,161,800	30,909,400
WHO - WR	71,491,000	3904	3096	12395	45,320,200	2,506,600	1418	2,836,000	5,542,800	3,361,600	61,100	11,862,700
TOTAL	224,067,000	10558	15528	32237	137,112,800	8,600,600	2940	5,880,000	16,453,300	11,025,300	2,222,900	42,772,100
% OF TOTAL	100.0				61.3	3.8		2.6	7.3	4.9	1.0	19.1
1994-1995												
PAHO - PR	171,316,000	6528	12432	19842	101,870,400	7,031,600	1522	3,196,200	12,647,600	8,798,500	2,507,900	35,263,800
WHO - WR	80,509,000	3886	3096	12300	50,700,900	2,899,500	1418	2,977,800	6,430,400	3,887,300	71,000	13,542,100
TOTAL	251,825,000	10416	15528	32142	152,571,300	9,931,100	2940	6,174,000	19,078,000	12,685,800	2,578,900	48,805,900
% OF TOTAL	100.0				60.6	3.9		2.5	7.6	5.0	1.0	19.4

TABLE F-2

ALLOCATION BY OBJECT OF EXPENDITURE / ANALYSIS OF BUDGET ELEMENTS - PAHO AND WHO REGULAR FUNDS

BUDGET ELEMENTS	1990-1991 AMOUNT	1990-1991 % OF TOTAL	PER CENT INCREASE (DECREASE)	1992-1993 AMOUNT	1992-1993 % OF TOTAL
PERSONNEL:					
POSTS	104,851,700	53.6	14.9	120,469,700	53.8
CONSULTANTS	9,559,800	4.9	(10.0)	8,606,400	3.8
LOCAL CONDITIONS STAFF	743,300	.4	65.7	1,231,500	.6
RETIREES' HEALTH INSURANCE	700,000	.4	421.4	3,650,000	1.6
TEMPORARY ASSISTANCE	3,029,400	1.6	4.2	3,155,200	1.4
TOTAL, PERSONNEL	118,884,200	60.9	15.3	137,112,800	61.2
DUTY TRAVEL	7,052,300	3.6	22.0	8,600,600	3.8
FELLOWSHIPS	7,225,700	3.7	(18.6)	5,880,000	2.6
COURSES AND SEMINARS	14,041,200	7.2	17.2	16,453,300	7.3
SUPPLIES AND EQUIPMENT	9,478,000	4.9	16.3	11,025,300	4.9
GRANTS	3,265,700	1.7	(31.9)	2,222,900	1.0
OTHER:					
CONFERENCE SERVICES	1,260,600	.6	11.9	1,410,200	.6
CONTRACTUAL SERVICES	12,271,700	6.3	35.4	16,619,100	7.4
EXTERNAL AUDIT COSTS	409,100	.2	11.2	454,900	.2
GENERAL OPERATING EXPENSES	15,213,400	7.9	14.6	17,439,400	7.8
HOSPITALITY	44,900	.*	13.8	51,100	.*
INTERNAL AUDIT COSTS	132,200	.1	11.2	147,000	.1
REGIONAL DIRECTOR'S DEVELOPMENT PROGRAM	3,350,000	1.7	11.2	3,725,200	1.7
REPAYMENT OF TEXTBOOK LOAN	247,700	.1	(12.7)	216,200	.1
STAFF RELATIONS	55,900	.*	13.2	63,300	.1
TECHNICAL COOPERATION	2,117,400	1.1	25.0	2,645,700	1.2
TOTAL, OTHER	35,102,900	18.0	21.8	42,772,100	19.2
GRAND TOTAL	195,050,000	100.0	14.9	224,067,000	100.0

* LESS THAN .05 PER CENT

TABLE F-3

ALLOCATION BY OBJECT OF EXPENDITURE - EXTRABUDGETARY FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PA	1,100,000	0	0	0	1,100,000	0	0	0	0	0	0	0
PN	12,500,000	0	0	0	12,500,000	0	0	0	0	0	0	0
PC	1,599,180	36	0	0	914,462	65,718	0	0	21,303	493,208	0	104,489
PJ	2,665,276	36	0	0	1,096,912	329,886	0	0	20,000	484,689	0	733,789
PB	2,157,716	0	0	0	0	0	0	0	0	0	0	2,157,716
PD	1,483,109	0	0	0	7,635	30,073	0	0	8,000	1,144,380	10,000	283,021
PG	107,710,742	613	2074	0	21,772,766	2,014,991	0	833,259	14,788,198	28,030,658	2,905,346	37,365,524
PK	216,216	0	0	0	0	0	0	0	0	0	216,216	0
PL	2,513,231	0	0	0	312,300	20,000	0	10,000	325,533	1,421,260	0	424,138
PU	16,332	0	0	0	12,917	2,000	0	0	0	1,415	0	0
PX	8,007,891	136	837	0	4,139,396	355,521	0	18,640	278,448	460,751	71,592	2,683,543
HP	146,400	0	48	0	146,400	0	0	0	0	0	0	0
HT	910,200	72	168	0	910,200	0	0	0	0	0	0	0
DI	10,288	0	0	0	10,288	0	0	0	0	0	0	0
DP	2,039,977	0	0	12	656,976	45,554	0	52,132	560,744	460,403	0	264,168
FB	757,795	167	0	0	621,324	57,984	0	0	0	0	0	78,487
FD	278,384	0	0	0	65,760	15,939	0	19,500	13,000	64,659	0	99,526
FP	15,760,849	126	24	11	2,642,821	742,548	0	614,537	3,993,168	3,979,485	287,620	3,500,670
FA	264,800	0	0	0	259,800	5,000	0	0	0	0	0	0
FX	22,290,064	206	155	0	4,427,008	661,321	0	54,491	3,103,918	5,598,230	1,318,078	7,127,018
ST	43,556	0	0	0	15,001	3,488	0	5,027	3,199	3,783	0	13,058
VC	1,769,599	89	21	0	782,591	139,625	0	0	371,568	158,214	4,500	313,101
VD	5,196,879	18	0	0	675,348	139,814	0	26,388	1,286,204	1,487,909	46,226	1,534,990
VG	19,744	0	0	0	0	0	0	0	0	12,350	0	7,394
VI	630,587	47	0	0	448,007	20,000	0	0	4,000	18,036	0	140,544
VW	21,321	0	0	0	8,899	1,602	0	0	8,367	0	0	2,453
AS	3,591,886	24	441	0	1,681,830	210,012	0	0	358,893	52,882	30,000	1,258,269
EF	219,310	0	0	0	0	0	0	0	0	0	0	219,310
TOTAL	193,921,332	1570	3768	23	55,208,641	4,861,076	0	1,633,974	25,144,543	43,872,312	4,889,578	58,311,208
% OF TOTAL	100.0				28.5	2.5		.8	13.0	22.6	2.5	30.1

TABLE F-3 (CONT.)

ALLOCATION BY OBJECT OF EXPENDITURE - EXTRABUDGETARY FUNDS (CONT.)

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL PROF. MONTHS	PERSONNEL LOCAL MONTHS	PERSONNEL CONS. DAYS	PERSONNEL AMOUNT	DUTY TRAVEL AMOUNT	FELLOWSHIPS MONTHS	FELLOWSHIPS AMOUNT	SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
	$				$	$		$	$	$	$	$
1992-1993												
PA	1,200,000	0	0	0	1,200,000	0	0	0	0	0	0	0
PN	13,000,000	0	0	0	13,000,000	0	0	0	0	0	0	0
PC	1,917,300	72	0	0	1,197,900	69,000	0	0	22,400	517,700	0	110,300
PJ	1,150,324	0	0	0	358,826	322,700	0	0	0	54,248	0	414,550
PB	2,600,000	0	0	0	0	0	0	0	0	0	0	2,600,000
PD	857,000	0	0	0	7,000	20,000	0	0	0	710,000	0	120,000
PG	68,470,284	452	1959	0	19,450,860	859,971	0	220,643	12,831,704	16,653,966	708,620	17,744,520
PK	216,216	0	0	0	0	0	0	0	0	0	216,216	0
PL	2,491,370	0	0	0	287,000	20,000	0	15,000	322,184	1,442,210	0	404,976
PU	15,000	0	0	0	10,000	3,000	0	0	0	2,000	0	0
PX	5,997,100	204	936	0	4,727,100	140,000	0	0	0	185,000	0	945,000
HP	171,100	0	48	0	171,100	0	0	0	0	0	0	0
HT	1,118,100	72	168	0	1,118,100	0	0	0	0	0	0	0
DP	699,737	0	0	0	167,937	0	0	0	302,010	198,690	0	31,100
FB	68,846	17	0	0	60,950	0	0	0	0	0	0	7,896
FP	13,080,224	84	24	0	1,918,882	588,280	0	268,428	4,067,136	2,763,573	195,000	3,278,925
FX	17,765,284	276	168	0	4,140,661	395,000	0	44,247	2,419,640	4,233,298	568,478	5,963,960
VC	2,104,960	96	24	0	897,000	122,035	0	0	663,761	107,065	0	315,099
VD	1,562,044	0	0	0	370,796	50,000	0	0	536,543	300,000	0	304,705
VI	435,050	48	0	0	340,000	45,000	0	0	0	0	0	50,050
AS	3,580,700	24	480	0	1,792,600	211,300	0	0	399,100	55,500	5,600	1,116,600
TOTAL	138,500,639	1345	3807	0	51,216,712	2,846,286	0	548,318	21,564,478	27,223,250	1,693,914	33,407,681
% OF TOTAL	100.0				36.9	2.1		.4	15.6	19.7	1.2	24.1
1994-1995												
PA	1,200,000	0	0	0	1,200,000	0	0	0	0	0	0	0
PN	13,000,000	0	0	0	13,000,000	0	0	0	0	0	0	0
PC	2,045,000	72	0	0	1,287,600	72,500	0	0	25,500	543,600	0	115,800
PB	1,420,000	0	0	0	0	0	0	0	0	0	0	1,420,000
PD	897,000	0	0	0	7,000	20,000	0	0	0	750,000	0	120,000
PG	27,817,120	144	1776	0	9,563,300	426,600	0	0	1,052,115	6,890,000	380,000	9,505,105
PK	216,216	0	0	0	0	0	0	0	0	0	216,216	0
PU	15,000	0	0	0	10,000	3,000	0	0	0	2,000	0	0
PX	6,567,300	216	936	0	5,197,300	140,000	0	0	0	205,000	0	1,025,000
HP	191,600	0	48	0	191,600	0	0	0	0	0	0	0
HT	1,256,800	72	168	0	1,256,800	0	0	0	0	0	0	0
DP	100,000	0	0	0	72,000	0	0	0	0	22,000	0	6,000
FP	9,288,982	72	24	0	1,376,100	516,420	0	14,000	2,891,997	2,174,865	159,000	2,156,600
FX	165,000	0	0	0	0	0	0	0	0	165,000	0	0
VC	2,223,970	96	24	0	1,039,000	103,000	0	0	682,478	70,000	0	329,492
VD	874,000	0	0	0	220,796	50,000	0	0	312,655	100,000	0	190,549
VI	514,150	48	0	0	400,000	55,000	0	0	0	0	0	59,150
AS	3,990,800	24	480	0	1,997,200	234,900	0	0	443,800	61,700	6,200	1,247,000
TOTAL	71,782,938	744	3456	0	36,818,696	1,621,420	0	14,000	5,408,545	10,984,165	761,416	16,174,696
% OF TOTAL	100.0				51.3	2.3		.0	7.5	15.3	1.1	22.5

I. DIRECTION, COORDINATION AND MANAGEMENT

1. Governing Bodies		Includes the following program:
	GOB Governing Bodies	Activities related to the preparation and convening of meetings of the Organization's Governing Bodies (Pan American Sanitary Conference, Directing Council and Executive Committee); to such subcommittees as may be set up by the Governing Bodies; and to external audit.
2. General Program Development and Management		Activities of coordination and management at Headquarters, comprising the following programs:
	EXM Executive Management	Activities of the Offices of the Director/Deputy Director (D/DD); of the Chief of Administration (AM); and of two units under D/DD: Legal Affairs (DLA) and Internal Audit (IA).
	DGP Regional Director's Development Program	Budgetary provisions for innovative technical cooperation programs which cannot be specifically determined at the time of the program budget approval.
	GPD General Program Development	Activities of Analysis and Strategic Planning Coordination Unit (DAP); of two units for the supervision of Program Areas: Health Systems Infrastructure (HSI) and Health Programs Development (HPD); and the Program of Staff Development and Training (APL/SDT).
	COR External Coordination for Health and Social Development	Activities of a unit under D/DD: External Coordination (DEC), including collaboration with regional United Nations and inter-American systems, with other organizations and with multilateral and bilateral programs.
	ISS Informatics Management	Activities of information support services for PAHO's management.

II. HEALTH SYSTEM INFRASTRUCTURE

3. Managerial Process for National Health Development

Technical and administrative management of technical cooperation at country level, performed by the PAHO/WHO Representatives and their basic administrative staff, and comprehensive programmatic interventions aimed at the strengthening of national health development in the Member Countries, comprising the following subprograms:

MPN Managerial Support for National Health Development

Promotion, initiation and establishment of permanent functional mechanisms for the application of the process of broad national health program development and training of national personnel. Includes activities of the Office of Assistant Director (AD), Country Representative Offices, Caribbean Program Coordination, and the Filed Office on the US-Mexico Border.

AAN Administrative Analysis

Preparation of studies, directives, and procedures on the administrative management of technical cooperation programs at country level.

4. Technical Cooperation among Countries

Includes the following subprograms:

TCC Technical Cooperation among Countries

Promotion and support of activities of technical cooperation among countries, which would serve as a catalyst in supporting the governments' efforts in identifying, planning and implementing mechanisms of intercountry cooperation at bilateral, subregional, regional and global levels.

5. Health Situation and Trend Assessment

Includes the following subprogram:

HST Health Situation and Trend Assessment

Development of national health information systems including epidemiological surveillance, statistical support to national health programs, training of personnel and formulation of indicators in the context of requirements that the regional and global targets impose on the system of monitoring and evaluation.

6. Health Policy Development

Includes the following programs:

HDP Health Policy Analysis and Development

Analysis of the political dimensions of health; identification of relevant entities in defining health policies; promotion of health goals in national and regional development agendas; analysis of institutional aspects in health policies; articulation of state services, Social Security, and the private sector in national health systems; strengthening of intersectoral action in the formulation and implementation of health policies; analysis of the constitution, organization, resources, and operation of the sector in order to orient its strategic-situational conduct of health policies and sectoral development projects; and participation of the health system in integrated programs to combat extreme poverty.

HDE Health Economics and Financing

Analysis and search for alternatives for sectoral financing; economic-financial management of the sector for greater equity and efficiency in its benefits; and study of the impact of the crisis on health, on the adjustment policies, and on the relationships between health and economy.

HLE Health Legislation

Implementation of the Documentation System on Health Legislation of Latin America and the Caribbean; cooperation for the analysis, development, and evaluation of health legislation in the countries; and support for PAHO/WHO programs for development of the legal aspects involved in the respective health policies.

WHD Women, Health and Development

Activities of promotion and support aimed at introducing gender considerations in the epidemiological analysis of the population, at applying of this approach to the formulation of health policies and programs, and at disseminating information and developing training and research programs on women, health and development.

7. Organization of Health Services Based on Primary Health Care

General activities oriented towards achieving extension of coverage, increasing operating capacity and developing health services infrastructure through the following programs:

DHS Health Services Development

Activities in support of the provision of health services in accordance with the Primary Health Care Strategy, including establishment of adequate levels of care, identification of target population groups, assessment of health needs in different human groups, definition of norms and standards of care, including hospital services, utilization of appropriate technology, coordination of different institutions within the health delivery system, establishment of appropriate linkages with "informal" community health systems.

EDV Essential Drugs and Vaccines

Formulation and implementation of national drug policies to ensure quantification of needs, procurement, production, distribution and management of essential drugs and vaccines, including assurance of regular supply at the primary health care level. Includes activities geared to development of national programs for monitoring and maintaining the quality, safety and efficacy of drugs.

7. Organization of Health Services Based on Primary Health Care (Cont.)

ORH	Oral Health	Activities related to community prevention and control of oral diseases and to general promotion of oral health.
DPP	Disaster Preparedness	Activities related to disaster preparedness and emergency assistance, included in this program due to their obvious relationship with the organization of health services.
CLR	Clinical, Laboratory and Radiological Technology for Health Services	Activities concerned with the determination of standards for clinical, diagnostic and treatment methods (including surgical) appropriate for delivery through primary health care and the immediate supporting levels; and promotional activities in the field of health technology, including radiological and health laboratory techniques and dissemination of relevant information.
HED	Health Education and Community Participation	Activities related to the development and implementation of appropriate approaches aimed at promoting self-care, preventive measures and health practices in the population, as well as community participation in health and well-being. Includes development and utilization of simplified educational technology and materials.
RHB	Rehabilitation	Support for the countries in their development of national policies and programs for disability prevention and community-based rehabilitation which are integrated into the health services systems as part of primary care.

8. Human Resources Development — Activities related to human resources administration as well as health manpower education and training, comprising the following programs:

HMC	Coordination and Support of Human Resources Development	Coordination of human resources development activities at the regional level, emphasizing manpower administration and formation, including management of PAHO's fellowships and support activities for the production of teaching materials.
HMA	Human Resources Administration	Development of national means for planning and administration of health manpower, together with health care services institutions.
HME	Human Resources Education	Activities to support development of institutions and teaching programs, including formation of teaching manpower; promotion of educational research; and improvement of techniques and teaching methodology.

9. Health Information Support — One of the basic elements of PAHO's main policy on management of knowledge (fostering of knowledge, critical analysis and dissemination of information), including the following programs:

HBP	Official and Technical Publications	Production of publications and documents of the Organization.
HBF	Public Information	Activities related to the mobilization of public opinion in support of major health objectives, including utilization of mass communication techniques in the promulgation of basic tenets of health promotion.

9. Health Information Support (Cont.)

HBL	Language Services	Activities related to simultaneous interpretation during executive, technical, and administrative meetings; and to translation of books, documents and other publications of the Organization.
HBD	Scientific and Technical Information Dissemination	Development and promotion of health bibliographic and documentation services, including libraries and regional document centers.

10. Research Promotion and Technology Development — Includes the following programs:

RPD	Research Promotion and Development	An essential part of PAHO's main strategy of management of knowledge, comprising overall coordination of biomedical and health systems research, highlighting the functions of the regional Advisory Committee on Medical Research, its subcommittees and working groups; strengthening of national health research capabilities; promoting biomedical, socioepidemiological and health systems research methodology; managing health research, including ethical aspects; providing research information support; and promoting national and international health research development mechanisms.
HDT	Health Technology Policies and Development	Activities aimed at development of a conceptual framework and analytical, administrative and evaluating tools applied to technological development in health.
RDV	Research and Development in the Field of Vaccines	Activities aimed at stimulating and supporting research on new vaccines, the organization of vaccines trials with the Member Countries, and the evaluation of the results of introducing new vaccines.

III. HEALTH SCIENCE AND TECHNOLOGY

11. Food and Nutrition — Includes the following programs:

FOD	Food	Activities of analysis and surveillance of the food situation and its impact on health; cooperation in food assistance programs; education; availability and consumption of foods.
NUT	Nutrition	Activities related to prevention and control of malnutrition and development of nutrition and dietetic services in the community.

12. Environmental Health		Includes the following programs:
CWS	Community Water Supply and Sanitation	Activities aimed at the implementation of national programs geared to objectives of the International Drinking Water Supply and Sanitation Decade; promotion of policies, legislation and strategies to ensure that planning, assessment and implementation of development projects give full consideration to their impact on the ecology; development of methodologies for assessment of health and ecological impacts; and support mechanisms.
RUD	Solid Wastes and Housing Hygiene	Support of development of activities regarding solid wastes (collection, transportation and disposal); promotion of these activities in relation to rural and urban development; and sanitary control of housing.
CEH	Control of Environmental Health Hazards	Activities concerned with the formulation and implementation of national policies and programs for health protection of people against environmental hazards and assessment of possible adverse health effects from radiation hazards and chemicals in air, water, soil and food.
OCH	Workers' Health	Promotion of workers' health, early detection and prevention of workers' health problems, and the preparation of technical guidelines.
13. Maternal and Child Health		Includes the following programs:
MCH	Growth, Development and Human Reproduction	Program planning and general activities in support of integral protection of the processes of human reproduction; growth and development of the child, including promotion of multisectoral policies; and development of appropriate services for women and children, including family planning activities.
ADH	Adolescent Health	Activities geared to promote development of programs aimed at improving the physical and mental health of adolescents.
ARI	Acute Respiratory Infections	Prevention and control of acute respiratory infections.
EPI	Immunization	Activities related to the Expanded Program on Immunization.
CDD	Diarrheal Diseases	Activities related to diarrheal disease prevention and control.

14. Communicable Diseases		Includes the following programs:
OCD	General Communicable Disease Prevention and Control Activities	Communicable disease program planning and general activities, including administration of the International Health Regulations; activities related to prevention and control of other communicable diseases of major public health importance such as meningitis, plague, influenza, dengue and yellow fever.
TDR	Tropical Disease Research	Activities pertaining to and included in the special program only.
TUB	Tuberculosis	Prevention and control of tuberculosis.
HIV	Acquired Immunodeficiency Syndrome	Prevention and control of acquired immunodeficiency syndrome.
VBC	Vector-Borne Diseases	Control of vectors including the use of chemical pesticides and biological measures.
MAL	Malaria	Prevention and control of malaria.
PDP	Parasitic Diseases	Activities related to the prevention and control of schistosomiasis, helminthiasis, filariasis (including onchocerciasis), trypanosomiasis and leishmaniasis.
LEP	Leprosy	Control of leprosy.
VDT	Sexually Transmitted Diseases	Prevention and control of sexually transmitted diseases.
15. Health Promotion		Includes the following programs:
NCD	Health Promotion and Prevention and Control of Noncommunicable Diseases	Activities related to support the development of health promotion policies and programs, involving group and individual interventions directed toward the modification of common risk factors, especially smoking, alcohol and drug consumption, poor dietary habits, sedentary life-styles, aggressive behavior, and other psychosocial factors. General activities of prevention and control of noncommunicable diseases, and strengthening the organization of health services to provide care for this group of pathologies.
TOH	Tobacco or Health	Support to countries' actions aimed at reducing the incidence and prevalence of smoking, protecting the rights of nonsmokers, and decreasing diseases related to the use of tobacco. Promotion of societies and new generations that are tobacco-free.
MND	Prevention and Treatment of Mental and Neurological Disorders	Promotion and development of plans, programs and standards for mental health, and prevention of mental and neurological disorders, with psychosocial determinants being taken into account.

15. Health Promotion (Cont.)

CAN	Cancer	Promotion and support for activities in cancer prevention and control, with emphasis on programs for the detection of cancer in women and the prevention of lung cancer. Strengthening of cancer registries in the countries, and of epidemiological research as well. Dissemination of specialized information on cancer prevention and management.
APR	Accident Prevention	Expansion of knowledge about the epidemiology of accidents to help promote the establishment of intersectoral policies and programs for their prevention and control. Collection and dissemination of information on prevention techniques.
HEE	Health of the Elderly	Promotion of better understanding of the normal and pathological aging processes to provide a basis for the establishment of comprehensive plans, policies and programs for this emerging social group. Promotion of training in gerontology and dissemination of current knowledge.
ADA	Prevention and Control of Alcoholism and Drug Abuse	Promotional and technical advisory services on the formulation of national policies and programs for research on and prevention and treatment of the problems resulting from use of psychoactive substances.
PBD	Ocular Health	Support for the development of national programs on blindness prevention and ocular health that are integrated into the national health systems. Emphasis on the control of cataracts, ocular traumas, glaucoma, and parasitic and infectious diseases.
CVD	Cardiovascular Diseases	Support for the development of intervention programs at the individual and group level which cover the most important risk factors for cardiovascular diseases, with priority given to the detection and control of arterial hypertension.

16. Veterinary Public Health — Includes the following programs:

FOS	Food Safety	Promotional and other activities for development of national policies and programs for ensuring food safety, including effects on health of food additives and pesticide residues in food.
FMD	Foot-and-Mouth Disease	Prevention and control of foot-and-mouth disease.

16. Veterinary Public Health (cont.)

ZNS	Zoonoses	Prevention and control of the major zoonoses and related food-borne diseases.

IV. PROGRAM SUPPORT

17. Administration — Applies only to Headquarters and includes the following programs:

BFI	Budget and Finance	Budget, finance and accounting services.
PGS	General Services and Headquarters Operating Expenses	Conference, office and building services.
PER	Personnel	Personnel services.
SUP	Procurement	Procurement and related supply services.

I. DIRECTION, COORDINATION AND MANAGEMENT

1. GOVERNING BODIES

The Pan American Health Organization is governed by the Pan American Sanitary Conference, which meets every four years. The Directing Council acts on behalf of the Conference in the intervening years. In addition, the Executive Committee holds two regular meetings every year. By agreement with the World Health Organization, these Governing Bodies also serve as the Regional Committee of the World Health Organization. The category "Governing Bodies" covers the cost of scheduled meetings and supporting staff, as well as the cost of the external audit. The staff also serves other seminars and conferences as time allows.

1. GOVERNING BODIES (CONT.)

PROGRAM BUDGET DISTRIBUTION BY LOCATION

LOCATION	PAHO AND WHO REGULAR BUDGET 1990-1991	1992-1993	1994-1995	EXTRABUDGETARY FUNDS 1990-1991	1992-1993	1994-1995
GOVERNING BODIES	2,205,300	2,536,500	2,832,700	0	0	0
TOTAL	2,205,300	2,536,500	2,832,700	0	0	0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT $	PERSONNEL PROF. MONTHS	PERSONNEL LOCAL MONTHS	PERSONNEL CONS. DAYS	PERSONNEL AMOUNT $	DUTY TRAVEL AMOUNT $	FELLOWSHIPS MONTHS	FELLOWSHIPS AMOUNT $	SEMINARS AND COURSES $	SUPPLIES AND EQUIPMENT $	GRANTS $	OTHER $
1990-1991												
PAHO - PR	1,881,200	72	96	0	710,800	0	0	0	0	0	0	1,170,400
WHO - WR	324,100	0	0	0	0	0	0	0	0	0	0	324,100
TOTAL	2,205,300	72	96	0	710,800	0	0	0	0	0	0	1,494,500
% OF TOTAL	100.0				32.2	.0		.0	.0	.0	.0	67.8
1992-1993												
PAHO - PR	2,176,100	72	96	0	874,600	0	0	0	0	0	0	1,301,500
WHO - WR	360,400	0	0	0	0	0	0	0	0	0	0	360,400
TOTAL	2,536,500	72	96	0	874,600	0	0	0	0	0	0	1,661,900
% OF TOTAL	100.0				34.5	.0		.0	.0	.0	.0	65.5
1994-1995												
PAHO - PR	2,432,100	72	96	0	985,600	0	0	0	0	0	0	1,446,500
WHO - WR	400,600	0	0	0	0	0	0	0	0	0	0	400,600
TOTAL	2,832,700	72	96	0	985,600	0	0	0	0	0	0	1,847,100
% OF TOTAL	100.0				34.8	.0		.0	.0	.0	.0	65.2

2. GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT

ANALYSIS OF THE HEALTH SITUATION

1. In Resolution XIII of the XXIII Pan American Sanitary Conference the Member Governments adopted the document "Strategic Orientations and Program Priorities of PAHO during the Quadrennium 1991-1994," which consolidated previous developments and decisions into a line of action aimed at steering the technical cooperation of the Organization toward effective and efficient concentration of its resources in priority areas that will have the greatest possible impact on national health development.

2. Consequently, for the biennium 1992-1993 there is a basic doctrine which sets the criteria and priorities that will orient the General Policy of Technical Cooperation of PAHO/WHO, which is no longer solely the result of administrative continuity, projections received from the field, and policy lines drafted during the period 1987-1991. These basic principles embody, above all, the explicit collective mandate emanating from the Pan American Sanitary Conference--a mandate that establishes a frame of reference for responding to the needs of the countries of the Americas and that rationalizes technical cooperation so that available resources will be concentrated in priority areas.

3. The new orientation entrusted to the Organization by the Pan American Sanitary Conference calls for a series of qualitative transformations in the dialogue and coordination between the Bureau and the countries, in the patterns of joint formulation of technical cooperation activities through the program budgets, and in the technical and administrative operations of the Bureau. At the same time, significant changes will need to take place in order to enlist national efforts to work toward the goal of Health for All by the Year 2000.

4. This presupposes a process of effective application of the General Policy of Technical Cooperation of PAHO/WHO, the fundamental premise of which is the intention to maximize the effects produced by international technical cooperation in the countries and at the same time to achieve the greatest possible rationalization in the use of institutional resources. Thus, an increase in the Organization's efficiency and an active process of resource mobilization are sought in order to increase effective support to the Governments of the Member Countries in their efforts to resolve the growing needs of the health sector.

5. Implementation of the Organization's basic doctrine of action implies searching for and finding formulas that will bring about deep institutional changes, both in procedures and in the content of program action, as well as building solid creative ties with those who receive technical cooperation in the countries. This represents an enormous challenge for political, technical, and administrative management that will have to be faced gradually so that the advances made can be institutionalized.

6. During the last quadriennium, socioeconomic conditions and changing health patterns in the Americas limited the countries' ability to mobilize additional resources in behalf of progress toward Health for All. Recognizing this need, PAHO has developed a strategy for resource mobilization to provide complementary resources to its Member Countries.

7. In the next four years PAHO will continue to strengthen the capacity of the countries and the technical units to generate additional resources. It will continue to target potential external funding, expand ties already developed with multilateral and bilateral agencies, develop innovative approaches, and seek new avenues of collaboration with NGOs.

GLOBAL STRATEGY FOR COOPERATION

8. The basic principles and lines of action for a management strategy to optimize PAHO/WHO resources in direct support of the Member Countries will help to give direction to the priority program content of the General Policy of Technical Cooperation of PAHO/WHO for the present quadrennium. The operating mechanisms defined in that document constitute generic formulas for PAHO/WHO intervention to facilitate fulfillment of its basic task, for which they need to be activated and/or intensified so that progress in that direction will be in alignment with application of the General Policy of Technical Cooperation of PAHO/WHO.

9. Among the operating mechanisms used by the Organization that will be intensified during the biennium 1992-1993, since they have worked so well, are: promotion of joint action by groups of countries so that they can combine forces and make better use of available capacity, incorporated into the subregional initiatives being undertaken; effective mobilization of national resources and external financial support, fully coordinated with the Bureau's regular technical cooperation; support for coordination of the health sector's institutional and functional components and for intersectoral articulation for the achievement of health; special initiatives in specific subject areas; strengthening of organizational relationships--national and international, governmental and nongovernmental, technical and financial--for the purpose of coordinating international cooperation and mobilizing resources for health; and stimulation of Technical Cooperation among Countries (TCC).

10. The management strategy includes some other operational mechanisms for which development has so far not been as pronounced as might be desired, and which definitely need to be activated during the biennium in order to strengthen application of the General Policy of Technical Cooperation of PAHO/WHO. Among these are: the establishment of networks of national centers of technical excellence that will supplement and enrich the cooperation provided by the Organization; the promotion and effective implementation of a research policy

that will promote the production of knowledge in areas of health that lack sufficient information for action; the development of an information system that covers all the stages of management and supports the decision-making process at all levels of the Organization; simplification of the administrative processes that accompany the mechanisms of decentralization; action in the area of personnel development, and finally, interprogram coordination between the functional levels of the Bureau.

11. Some of the processes of institutional adjustment should receive particular attention during the biennium, especially to the extent that they reinforce the basic principle that the countries are the Organization's basic units of production and that the PWRs in the countries are the essential mechanism for the delivery of technical cooperation, which will require adaptation of the administrative systems in the Field Offices (PWRs and Centers) in order to increase their operating capacity and lay the foundation for progressive decentralization of responsibilities accompanied by the consequent delegation of authority. Also to be considered are the advances that are deemed necessary under the program for development of the PWRs during the biennium, which seeks to integrate the purposes of the management strategy with a view to establishing new working styles that will articulate all the functional levels of the Secretariat into an integrated process that will lend coherence and direction to the political, scientific and technical, and administrative functions of the PWRs.

12. The search for greater rationalization in allocation of the Organization's resources, with action concentrated on several strategic lines of intervention that will lead to truly significant results, becomes imperative in light of the restrictions on financial resources and the need to increase the efficiency and efficacy of the cooperation delivered.

13. In these circumstances, enhancement of the PAHO system of planning, programming, and evaluation takes on special importance, inasmuch as it contributes to a more precise definition of the priorities to which the Organization's actions are to be adjusted in the face of limited available resources; it strengthens application of the General Policy of Technical Cooperation of PAHO/WHO through the mechanisms of resource allocation; and it increases the absorptive capacity, relevance, and impact of the technical cooperation provided by the Bureau.

14. The biennium 1992-1993 will see a continuation of the comprehensive review of AMPES that has given rise to gradual modifications which have enhanced the system and succeeded in combining the programming and budgeting phases into single instruments that allocate resources and at the same time program activities in terms of both biennial targets and four-month and annual operating purposes. The development of automated systems for formulation and execution of the program budget, which will be part of the basis for an integrated information management system, will also be pursued.

15. Mechanisms for analysis of the regional and country-level situations in terms of the formulation of technical cooperation will continue to be strengthened and enhanced during the biennium and will be expressed both in the annual operating program cycles and in the biennial programming exercise. This process should be accompanied by supplementary efforts to develop the PAHO technical information system at both the regional and the country level, which will require joint action by the Bureau and the Member Countries.

16. The other aspect of the PAHO planning, programming, and evaluation system that will require increased attention during the biennium is the monitoring and evaluation of the Bureau's technical cooperation programs for the purpose of increasing the weight of this instrument in applying the General Policy of Technical Cooperation of PAHO/WHO. The fundamental intention will be to have a mechanism which, as an integral part of the planning and programming process, will provide bases for the reorientation of actions vis-à-vis the problems identified and for the formulation of recommendations in this regard. In addition, an effort will be made to generate information that will be useful for subsequent evaluation of PAHO/WHO technical cooperation programs.

17. From the preceding paragraphs it can be seen that the program area of General Program Development and Management encompasses the entire the executive management process, from the formulation of policies through the evaluation of technical cooperation programs. Thus it includes the activities of the Offices of the Director and Deputy Director, the Assistant Director, the Chief of Administration, the Area Program Directors (Health Program Development and Health Systems Infrastructure), the supporting and coordinating units that answer to the executive levels of the Organization, and the Regional Director's Development Program. It is in this area of the Bureau's organizational structure that promotion and supervision of the General Policy of Technical Cooperation of PAHO will take place during the biennium. As a result, during this period the basic functions to be carried out by these executive offices, in keeping with the quadrennial priorities, will be leadership, overall management of the program, external relations, institutional development, legal affairs, regional analysis, strategic planning and programming, program monitoring and evaluation, personnel development, and information management.

18. With regard to informatics management, the Organization expects to meet its changing needs for information processing. With the addition of personal computing and the local area network, dependence on a centralized mainframe computer has increased and will continue to do so. The principal applications for a mainframe computer will become very large databases and applications (for example, administrative), which need to be accessed simultaneously by a large number of users or extensive computational resources not available on even the largest personal computers.

19. In this environment, PAHO will be able to provide assistance in several areas. The training and skills in analysis and programming that the professional staff have developed over many years will be needed as the first generation of PC applications inevitably reaches the limit of its usefulness and

more sophisticated data processing techniques or linkages between independently developed applications are required.

20. Users will be assisted in defining projects, assessing both the hardware and software necessary to meet their requirements, gaining access to other users and systems, and selecting and managing complex projects which sometimes involve esoteric language and skills.

21. In addition, PAHO will continue to be involved in evaluation, advisory services, installation, and maintenence for several levels of information processing equipment. A small but important nucleus of specialized skills, such as data entry, hardware and software technicians, communications specialists, and technical procedures analysts will be available within DIC for the use and benefit of the entire Organization.

22. This category comprises five specific programs: Executive Management (EXM), Regional Director's Development Program (DGP), General Program Development (GPD), External Coordination for Health and Social Development (COR), and Informatics Management (ISS), all of which correspond to units and/or activities of coordination and management at Headquarters. Following are the biennial targets and general lines of action for these programs.

SPECIFIC PROGRAMS

EXECUTIVE MANAGEMENT (EXM)

BIENNIAL TARGETS

23. To provide efficient and effective administrative support for both headquarters and field offices, including budget, finance, personnel, general services, and procurement activities.

24. To improve institutional mechanisms in order to make the provision of legal services to the Director and the Secretariat more effective, and to extend these services as possible components of the technical cooperation activities carried out by the technical units, particularly in relation to local health systems, privatization of health services/industry, women and development, and the reform of health services provided by social security systems.

LINES OF ACTION

25. The AM Program will respond to the program priorities established by the Governing Bodies and the Director by providing required administrative support to the programs established by the Headquarters technical units and country offices and by supervising the administrative support activities of the Organization.

26. Provision of legal services to the Director, the Governing Bodies, and PAHO offices.

27. Coordination of legal services with WHO and other bi- and multilateral international agencies.

28. Provision of support for the analysis of legal and ethical issues relating to activities carried out by other programs in the Organization in such fields as AIDS, women and development, technology transfer, NGOs, mental health, etc.

REGIONAL DIRECTOR'S DEVELOPMENT PROGRAM (DGP)

BIENNIAL TARGETS

29. To promote the development, particularly at the country level, of programs that promise to be innovative and effective within the context of the collective mandates that orient the work of the Organization.

30. To provide budgetary flexibility for the Director in the allocation of resources for the support of new approaches, concepts, or innovative technological developments that have the potential to contribute to attainment of the goal of Health for All.

LINES OF ACTION

31. Strengthening of capabilities at the country level to develop new and innovative programs, with search for technical competence in specific areas.

32. Provision of financial and technical support for new approaches and incipient programs and projects that are geared toward attaining the goal of Health for All by the Year 2000.

GENERAL PROGRAM DEVELOPMENT (GPD)

BIENNIAL TARGETS

33. To develop and implement management strategies for PAHO in accordance with the Strategic Orientations and Program Priorities of PAHO during the Quadrennium 1990-1994.

34. To carry out regional and country-level technical cooperation activities coherently and effectively within the framework of the SOPP and the General Strategy of PHC, with a view toward attainment of the goal of HFA/2000.

35. To promote optimum utilization of the Organization's resources within the framework of short-, medium-, and long-term programs, taking into consideration the specific context of the Region and the changing international situation.

36. To implement the regional program and budget policy of PAHO/WHO.

37. To develop and carry out special initiatives and projects of the Bureau.

LINES OF ACTION

38. Development of studies and preparation of official PAHO documentation on PAHO general program development, policies, and priorities, as well as analyses and evaluations of technical cooperation and follow-up and implementation of the SOPP, in presentation thereof to the Governing Bodies and in the review and discussion of these matters in the Director's Advisory Committee.

39. Development, through ongoing internal and external consultation, of a process analysis of major regional and international trends in order to support actions being taken for the strategic planning of the institution. In addition, preparation of institutional development proposals on action policies for the Organization as well as management mechanisms for the Secretariat.

40. Continued development and enhancement of the AMPES system so that it will serve as a basic axis for management of the technical cooperation provided by the Bureau. For this purpose, an effort will be made to articulate the three subsystems related to the delivery of technical cooperation (analysis of the situation, planning and budgeting, and monitoring and evaluation). This line of action includes the development of automated systems for the formulation and implementation of short-term program and budget instruments.

41. Implementation of special projects aimed at strategically expanding PAHO participation in activities both within and outside the health sector as well as relations with other organizations.

42. Monitoring of qualitative and quantitative fulfillment of goals for the area as a whole and for the corresponding programs in terms of attainment of overall goal of HFA/2000 as well as goals related to regional strategies and priorities.

EXTERNAL COORDINATION FOR HEALTH AND SOCIAL DEVELOPMENT (COR)

BIENNIAL TARGETS

43. External Coordination for Health and Social Development is part of the Regional Director's Development Program. Through this project, efforts during 1992-1993 will continue to ensure and promote the presence and participatory role of PAHO within the international system in order to mobilize technical and financial external resources and promote and strengthen the Organization's external relations with other multilateral, bilateral, and nongovernmental organizations.

LINES OF ACTION

44. A series of activities will be undertaken leading to the promotion and support of TCC at the request of, and in close collaboration with, the countries involved, to be carried out jointly with the PWRs and in collaboration with SELA/UNDP and other subregional organizations.

45. Efforts will be directed toward the formulation of strategies for interagency collaboration and, when feasible, the establishment of interagency agreements. At the same time, actions will be taken to support the countries in strengthening their national capacity for external cooperation in health coordination, which should be based on sound national health planning and programming.

46. The responsibility of DEC in the process of channeling external financing toward the reorganization of the health sector, as established in the Strategic Orientations and Program Priorities, requires constant coordination with multilateral and bilateral agencies, which have approved and are implementing new sectoral strategies and approaches for their lending operations.

47. The activities under this project are intended to support the above-mentioned coordination.

48. The External Financial and Technical Resource Mobilization Component organizes and coordinates the PAHO strategy for resource mobilization during the quadriennium, with concentration on activities to strengthen the capacity of PAHO technical units and the countries to prepare, present, and successfully negotiate proposals for external technical and financial support, both bi- and multilateral. As part of this effort, activities will be initiated to support the quadriennial program priorities of PAHO. Also, guidelines will be prepared, country and subregional training seminars will be conducted, and direct technical assistance will be provided to countries on a one-to-one basis.

2. GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT (CONT.)

49. Since the main purpose of this component is to channel external financing to Member Countries for their priority programs, initiatives will be taken to strengthen PAHO-donor relations. For this purpose, donors will be visited systematically; donor conferences and annual consultations will be organized; joint PAHO-donor missions will be carried out in the countries; information and project documentation, progress reports, and evaluations will be transmitted to donors; and negotiations will be conducted with donors.

50. The activities carried out under the Project Review Process during the period 1992-1993 will assist the Organization in meeting the challenge of increasing health sector efficiency through collaborative activities with countries of the Region.

51. The major line of action will be the improvement of human resources capability to conceptualize and formulate extrabudgetary projects in order to facilitate comprehensive review and eventual implementation.

52. The activities will be supported by an information resource network to permit coordination and technical cooperation in similar areas.

53. Implementation of an extrabudgetary monitoring and evaluation system.

54. The activities of the NGO Liaison extend the Organization's technical and resource mobilization role to NGOs working in health and development. This will be done by assisting the Country Representative in catalyzing a process of Government-NGO partnerships through the promotion of opportunities to discuss joint health care strategies and activities.

55. Identification of creative financing mechanisms for the funding of NGO activities that are consistent with Member Government priorities in health, and the strengthening of NGO and government capability to work together on improving their capacity to identify local as well as international resources.

56. Activities will also include assistance to the Organization's technical staff in the identification of appropriate NGOs to collaborate on the design, execution, and evaluation of projects.

INFORMATICS MANAGEMENT (ISS)

BIENNIAL TARGETS

57. To maintain the high quality of information processing support for the Organization.

58. To convert all current mainframe programs to run in the outsource or downsized environment.

59. To gradually replace all Wang user equipment with LAN workstations.

60. To provide advisory services for all PAHO units in the implementation and use of all the computer platforms available.

LINES OF ACTION

61. General manangement and oversight of informatics, including maintaining currency in the developing field of information processing and dissemination.

62. Continued coordination with the ISS Geneva on similarities of problems and approaches, including the problem of system integration, security, and LAN developments.

63. Continued coordination with PAHO field offices to promote better and more efficient use of the computer resources available as well as communication between field and Headquarters.

64. Continued evaluation of hardware and software which may be of benefit, especially to the technical areas of the Organization, and assistance in the publication of selected technical papers and study conclusions.

65. Assistance to specific units in conducting statistical studies of a limited nature and analysis of the results.

66. Continuation of the work of making specific non-administrative databases available to a wider audience through the use of technologies such as CD-ROM.

67. Assistance in the development of statistical applications, techniques, and software that will be applicable in the LAN environment.

68. Continued exploration of non-mainframe-based platforms and alternatives for use by the Organization.

69. Provision of management and guidance in a wide range of areas dealing with user interface with the various platforms used; continued maintenance of the Technical Library for all hardware platforms and software used.

70. Expansion of the HELP DESK to include user assistance on all the equipment types used within the Organization, including PCs, LAN workstations, and terminals connected to various mainframe computers.

71. Continued administration and maintenance of the LAN system installed at PAHO Headquarters and continuous upgrading of the capabilities of the LAN.

72. Continued maintenance of Wang word processing capability as the number of users diminishes. The Wang users should be completely moved to the LAN environment prior to the move of PAHO headquarters, which would make it unnecessary to move the Wang.

73. Continued provision of a range of microcomputers on which other units can convert documents and evaluate software or use for overflow work.

74. Microcomputer hardware and software will continue to be evaluated for inclusion in the Approved Lists of the Organization and installed software will be updated with new releases as required.

75. Continued management of activities related to the Organization's mainframe computer resources.

76. Maintenance or administration of capacity sufficient for processing the work of the Organization. This will include a mainframe computer capacity, either within PAHO or as an outsourced resource, with sufficient operational capability to provide for PAHO needs.

77. Continue provision of system programming and database administration as necessary to meet the needs of both the currently installed systems and the anticipated needs of PAHO units.

78. Continued development, documentation, and improvement of the combined BPB, APB, and PTC, along with exploration of linkage to the Operating Budget and FMS systems, all under the PAHO LAN operating environment.

79. Other applications, such as the simplified on-line search, PAHEF subscription and mailing lists, machine translation, and the HPN field system will be converted to a LAN environment under the guidance of the CSA.

80. Administrative applications such as Personnel, Payroll, PAHO Reference Tables, and Fellowships will be maintained until such time as they can be reasonable replaced or downsized.

2. GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT (CONT.)

PROGRAM BUDGET DISTRIBUTION BY LOCATION

LOCATION	PAHO AND WHO REGULAR BUDGET 1990-1991	1992-1993	1994-1995	EXTRABUDGETARY FUNDS 1990-1991	1992-1993	1994-1995
DIRECT COOPERATION WITH COUNTRIES	4,796,700	5,226,800	5,883,700	379,693	245,000	245,000
REGIONAL PROGRAMS	5,582,900	5,861,600	6,509,300	210,065	260,000	288,000
TECHNICAL AND ADMINISTRATIVE DIRECTION	7,856,700	7,755,800	8,423,000	351,421	283,700	310,600
TOTAL	18,236,300	18,844,200	20,816,000	941,179	788,700	843,600

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL PROF. MONTHS	PERSONNEL LOCAL MONTHS	PERSONNEL CONS. DAYS	PERSONNEL AMOUNT	DUTY TRAVEL AMOUNT	FELLOWSHIPS MONTHS	FELLOWSHIPS AMOUNT	SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	15,451,500	864	960	1475	8,996,000	585,500	0	0	793,100	1,479,900	0	3,597,000
WHO - WR	2,784,800	168	96	0	1,613,700	121,700	0	0	470,200	295,900	0	283,300
TOTAL	18,236,300	1032	1056	1475	10,609,700	707,200	0	0	1,263,300	1,775,800	0	3,880,300
% OF TOTAL	100.0				58.2	3.9		.0	6.9	9.7	.0	21.3
1992-1993												
PAHO - PR	16,301,500	793	720	1440	9,188,100	535,200	0	0	991,500	1,768,200	0	3,818,500
WHO - WR	2,542,700	147	96	0	1,756,500	131,300	0	0	341,600	97,300	0	216,000
TOTAL	18,844,200	940	816	1440	10,944,600	666,500	0	0	1,333,100	1,865,500	0	4,034,500
% OF TOTAL	100.0				58.1	3.5		.0	7.1	9.9	.0	21.4
1994-1995												
PAHO - PR	17,985,200	768	720	1440	10,024,100	600,900	0	0	1,146,000	1,965,700	0	4,248,500
WHO - WR	2,830,800	144	96	0	1,938,500	146,400	0	0	396,300	108,200	0	241,400
TOTAL	20,816,000	912	816	1440	11,962,600	747,300	0	0	1,542,300	2,073,900	0	4,489,900
% OF TOTAL	100.0				57.4	3.6		.0	7.4	10.0	.0	21.6

II. HEALTH SYSTEM INFRASTRUCTURE

3. MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT

ANALYSIS OF THE HEALTH SITUATION

1. The health services systems in the majority of the countries in the Region could be improved by: clearer definition of policies, strategies and goals; planning that reaches the local levels; coordination among the different institutions within the health sector; coordination with other social and economic sectors; strengthening information and surveillance systems; and more rigorous evaluation procedures. Improvements in these areas would in turn lead to more efficient and equitable application of health resources and at the same time improve the coverage and quality of health services.

2. To assist the Member countries in improving their health service systems, PAHO/WHO is dedicated to providing technical cooperation which is focussed on priority problems as defined by national authorities and the Governing Bodies. Technical cooperation is provided to Member Countries upon their request and takes into account national, regional and global priorities and the policies, strategies and procedures established by the Governing Bodies and the Director of the Organization. This is done through five basic types of action: resource mobilization; information dissemination; training; development of norms, plans and policies; and research promotion.

3. The technical cooperation provided by PAHO/WHO requires: modern management techniques to support the activities of the Organization; a process of decentralization that makes it possible to reduce costs and increase effectiveness by linking the administration of resources to technical cooperation activities; the mobilization of national and external resources; improvement of the relationships between health and the other sectors; and greater participation by the governments in defining and delivering technical cooperation.

4. This program includes the Office of the Assistant Director, the Country Offices, the Country Caribbean Coordination, the Field Office in El Paso, and the Office of Administrative Analysis. It encompasses the activities of country program analysis and administrative development aimed at improving the management of the PAHO/WHO technical cooperation at the country level. It includes specifically the administrative support personnel and the other resources assigned to ensure the smooth functioning of these field offices.

5. The Offices of the PAHO/WHO Representatives are the key element in the decentralization of the functions and activities of PAHO/WHO and constitute the basic units for the delivery of technical cooperation.

ANALYSIS OF THE PROGRAMS

GLOBAL STRATEGY OF COOPERATION

6. All the parts of this program have together the aim of supporting the most effective delivery of the PAHO technical cooperation. The Office of the Assistant Director, assisted by the Country Program Analysts, is responsible for the overall coordination of the operational aspects related to the development, implementation, monitoring and evaluation of the technical cooperation programs at the country level: the offices of the PAHO/WHO Representatives, the Caribbean Coordination and the Field Office in El Paso have the direct responsibility for those political, administrative and technical functions which determine the effective delivery of the technical cooperation. The major strategy developed to further the aim described above is the appropriate and efficient application of the processes of planning, programming, implementation and evaluation of the technical cooperation as set out primarily in the AMPES and other collateral instruments. In the application of these instruments, particular attention is given to the constant and permanent dialogue with national authorities as the only method of ensuring the pertinence and relevance of the technical cooperation and the focusing of all resources towards that end. The promotion of the subregional initiatives is seen as a secondary strategy which facilitates the delivery of technical cooperation from PAHO to countries and among countries to address priority areas--many of which may be addressed by collaborative effort.

SPECIFIC PROGRAMS

MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT (MPN)

BIENNIAL TARGETS

7. That the technical cooperation of the Organization is of the quality necessary to support and strengthen the national health service systems in carrying out strategies, plans and national programs associated with the goal of health for all by the year 2000.

8. To have Country Offices so supervised, supported and developed that they can: carry out their political, technical and administrative functions; establish an adequate personnel profile and assure their technical excellence in light of the national priorities for technical cooperation; develop administrative systems and procedures; and provide the necessary physical installations and equipment.

3. MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT (CONT.)

9. To have the activities of technical cooperation oriented especially toward the Strategic Orientations and Program Priorities of the Organization and other mandates from the Governing Bodies.

10. To have all of the countries involved in the Subregional Initiatives to adopt the forms of work necessary to reach the established objectives of the Initiatives themselves.

LINES OF ACTION

11. Promote the formulation of country programs with full coordination, discussion and agreement with national authorities to identify the national priorities for PAHO/WHO technical cooperation.

12. Promote the Strategic Orientations and Program Priorities as a fundamental component in the development of the global strategy for technical cooperation in each country program.

13. Coordinate the organization and completion of the joint evaluation process in each country on a biennial basis.

14. Promote the development of clear and concise country programs which can be used as tools for managing and evaluating the delivery of technical cooperation.

15. Monitor and facilitate the execution of country programs as approved in the program review and approval process, including reprogramming actions where necessary.

16. Maintain documentation Centers which provide the publications of PAHO/WHO and other international agencies; journals, books and other reference materials; national publications; and access to computerized data basis.

ADMINISTRATIVE ANALYSIS (AAN)

BIENNIAL TARGETS

17. To provide administrative support to HQ and field offices in the design and development of administrative systems, organizational approaches to management functions and in the training of administrative staff.

LINES OF ACTION

18. Development of systems and methods of administrative organization, both at HQ and in the field for supporting the process of decentralization of program management to operational levels. This includes assistance in defining appropriate organizational approaches to management functions, and in formalizing policies and procedures to control administrative systems and subsystems.

PROGRAM BUDGET DISTRIBUTION BY LOCATION

LOCATION	PAHO AND WHO REGULAR BUDGET 1990-1991	1992-1993	1994-1995	EXTRABUDGETARY FUNDS 1990-1991	1992-1993	1994-1995
DIRECT COOPERATION WITH COUNTRIES	19,477,700	23,807,200	27,230,900	1,711,888	935,063	625,900
REGIONAL PROGRAMS	700,000	4,226,600	4,549,300	0	286,200	322,000
TECHNICAL AND ADMINISTRATIVE DIRECTION	935,100	2,225,200	2,489,700	91,800	0	0
TOTAL	21,112,800	30,259,000	34,269,900	1,803,688	1,221,263	947,900

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT $	PERSONNEL PROF. MONTHS	PERSONNEL LOCAL MONTHS	PERSONNEL CONS. DAYS	PERSONNEL AMOUNT $	DUTY TRAVEL AMOUNT $	FELLOWSHIPS MONTHS	FELLOWSHIPS AMOUNT $	SEMINARS AND COURSES $	SUPPLIES AND EQUIPMENT $	GRANTS $	OTHER $
1990-1991												
PAHO - PR	16,461,400	840	2544	115	10,857,800	533,300	0	0	167,200	256,400	190,100	4,456,600
WHO - WR	4,651,400	144	744	250	2,705,600	26,900	0	0	22,700	114,800	51,000	1,730,400
TOTAL	21,112,800	984	3288	365	13,563,400	560,200	0	0	189,900	371,200	241,100	6,187,000
% OF TOTAL	100.0				64.2	2.7		.0	.9	1.8	1.1	29.3
1992-1993												
PAHO - PR	24,726,200	1008	2616	300	17,332,100	879,900	0	0	269,500	555,900	127,600	5,561,200
WHO - WR	5,532,800	96	768	250	3,230,800	23,200	0	0	27,000	175,400	0	2,076,400
TOTAL	30,259,000	1104	3384	550	20,562,900	903,100	0	0	296,500	731,300	127,600	7,637,600
% OF TOTAL	100.0				68.0	3.0		.0	1.0	2.4	.4	25.2
1994-1995												
PAHO - PR	27,990,700	1008	2616	300	19,428,700	1,014,200	0	0	305,100	644,200	148,100	6,450,400
WHO - WR	6,279,200	96	768	250	3,608,100	26,900	0	0	31,300	203,600	0	2,409,300
TOTAL	34,269,900	1104	3384	550	23,036,800	1,041,100	0	0	336,400	847,800	148,100	8,859,700
% OF TOTAL	100.0				67.2	3.0		.0	1.0	2.5	.4	25.9

4. TECHNICAL COOPERATION AMONG COUNTRIES

ANALYSIS OF THE HEALTH SITUATION

1. The Strategic Orientation and Program Priorities for the Pan American Health Organization during the Quadrennium 1991-1994 emphasize the mobilization of resources for health.

2. During the last quadriennium, socioeconomic conditions and changing health patterns in the Americas limited the countries' ability to mobilize additional resources to move toward Health for All. Recognizing this need, PAHO has developed a strategy for resource mobilization to provide complementary resources for its Member Countries.

3. In the next four years the Organization will continue to strengthen the capacity of the countries themselves and the technical units to generate additional resources. It will continue to target potential external funding, expanding ties already developed with multilateral and bilateral agencies, developing innovative approaches, and seeking new avenues of collaboration with NGOs.

4. Technical Cooperation among Countries (TCC) is the exchange of experience, knowledge, and techniques between two or more countries. It includes the establishment of new ties and the strengthening of existing contacts and channels of communication for an ongoing process of mutual collaboration. It is a tool or mechanism for promoting cooperation among countries in almost all areas or sectors--principally those financed and administered by the cooperating countries themselves. Technical Cooperation among Countries is a systematic process for creating a support network among the countries. It is aimed at achieving self-reliance for promoting the national development process.

5. The forms of Technical Cooperation between Countries are multidimensional. They can be bilateral or multilateral, and they can be subregional, regional, or interregional. This cooperation should be organized by the governments--among those governments that are in a position promote the participation of public organizations for this purpose, and, within the framework of government policies, the participation of organizations and private individuals.

6. Within this context, and pursuant to the Plan of Action of Buenos Aires, the activities or projects under Technical Cooperation among Countries call for the joint participation in the deliberate and voluntary exchange of technical resources, knowledge, and capacities between two or more countries, to be organized and administered by the countries themselves. The elements that make up a TCC, including technical knowledge, advisory services, resources for research and training, and equipment and supplies, have to be provided as much as possible by the countries concerned.

7. Technical Cooperation among Countries may assume any of the following three forms:

7.1 Reciprocity: bilateral or multilateral cooperation by means of which two or more countries agree to provide assistance in their respective spheres of excellence.

7.2 Exchange and participation: cooperation between two or more countries in a common activity through the exchange of information and technology with a view to achieving a common objective as a part of a program or project.

7.3 Contribution: the transfer of resources or technology from one country to one or more countries with a view to developing collective self-reliance through the sharing of institutional excellence or the competence of individuals.

8. At the same time, without taking away from the responsibility of the countries, PAHO/WHO has a mandate to collaborate with them in the development of TCC. This collaboration is carried out through PAHO/WHO support aimed at: identifying, jointly with the governments, possible solutions or ways in which TCC could help to resolve concrete development problems in the area of health; incorporating TCC criteria and techniques into (PAHO/WHO) programs; facilitating the preparation and execution of TCC projects and activities; promoting new ideas and criteria for maximizing the potential of TCC in the countries and developing information systems on the capacity and need for TCC.

9. For many years the PAHO/WHO regional and subregional centers have functioned as TCC instruments. INCAP serves as vehicle for the exchange of information and experiences on nutrition among the countries of Central America and Panama; BIREME disseminates medical and health information; CEPIS and ECO collaborate in environmental sanitation; and CEPANZO and PANAFTOSA identify needs in the area of veterinary public health.

10. The following may be cited among the achievements of PAHO/WHO in promoting TCC: the building of regional networks of national centers in the areas of human resources, maternal, and child health and environmental health, which have facilitated the exchange of experiences and technical information. Advances at the subregional level, such as the Central American initiative, in which 200 health staff members jointly identified priority areas and formulated national and intercountry projects within the Plan for Priority Health Needs of Central America and Panama (PPS/CAP). Through this initiative it has been possible to channel financial resources to several of the PPS/CAP projects which have already entered on the execution phase within the TCC framework. PAHO/WHO has also provided technical support for formulating and planning the Caribbean Cooperation in Health (CCH) initiative, which has involved the planning and participation by 18 governments of the Caribbean, in cooperation with CARICOM. The CCH is being developed in the same spirit of cooperation among countries. Similarly, the Andean countries have already begun to undertake joint action for formulation and development of the Andean Cooperation in Health (ACH) initiative.

11. The Organization will embark on a vigorous process of strengthening the units in the Ministries of Health that are responsible for promoting TCC in the countries of the Region.

GLOBAL STRATEGY FOR COOPERATION

12. "Strategic Orientations and Program Priorities for the Pan American Health Organization" states that "it will be necessary to pay special attention to the process of preparing, managing and evaluating development projects in the health field so that during the next quadrennium, more external financial resources can be mobilized, both on a concessionary and non-concessionary basis, aimed at transforming the national health systems. This will require increased coordination between the setting of priorities, planning of activities in the sector, and mobilization of bilateral and multilateral technical and financial resources."

13. This coordination necessitates, on the one hand, an increased understanding of the policies and requirements of multilateral, bilateral and nongovernmental organizations, and, on the other, a strong liaison between PAHO and those organizations with a clear orientation toward supporting the efforts of the Member Countries.

14. "Strategic Orientation and Program Priorities" gives special emphasis to cooperation among countries as "an essential factor in the process of change in the Hemisphere's health sector." Based on the experience of the subregional health initiatives and other multicountry projects, "Strategic Orientation and Program Priorities" also states that "it is imperative that the Organization take this line of action further during the next quadrennium" and that "it must continue to promote with substance and vigor, the spirit of cooperation among countries, so as to resolve common health problems jointly."

15. The transformation of the health sector for the nineties presents many challenges, foremost among which will be the efficiency of the sector and an improved capacity to maximize available resources.

16. Over the years, the Organization has mobilized external resources to complement national funding. Through these efforts, projects have been developed to complement available health sector resources. This has been done by increasing the visibility of the health sector within the countries, strengthening their capacity to mobilize resources, and developing and implementing projects.

17. A project review and management process therefore becomes a critical element for the successful and effective utilization of extrabudgetary resources and technical cooperation.

18. PAHO has also recognized the fact that the ability to respond consistently and effectively to the health needs of the Member Countries requires that the Organization take a proactive role in promoting, coordinating, and accelerating the inclusion of NGOs in the planning, execution, and evaluation of health programs.

19. In October 1989, Agreement ATN/SF-3338-RE between PAHO and the IDB was signed. The strategic objective of this project is to mobilize financial resources from IDB to finance operations in the areas of health services, water and sanitation, nutrition, animal health, and the environment. This mobilization is accomplished through the preparation of preinvestment studies and institutional development of the health sector.

20. Technical cooperation between the Inter-American Development Bank and the Pan American Health Organization constitutes a strategy for supporting the countries of the Hemisphere in order to promote proposals for investment in health, in connection with which joint undertakings and agreements with IDB will be continued and actions with the World Bank will be promoted.

TECHNICAL COOPERATION AMONG COUNTRIES (TCC)

BIENNIAL TARGETS

21. To administer the IDB/PAHO Agreement and agreements with other multilateral institutions.

22. To coordinate and manage the IDB/PAHO Technical Cooperation Agreement, entering on its third year in 1992, which will be the first year of a new phase of the agreement. Focus will be toward the identification of investment projects in the three areas covered under the agreement: (a) environmental health, (b) health, (c) nutrition, and (d) animal health.

23. To continue to develop jointly with the IDB the ex-post evaluation to be carried out in 1992.

24. To initiate negotiations for the signature of a new IDB/PAHO Technical Cooperation Agreement.

25. The overall goal is to promote, in all the countries of the Region, a vigorous process of TCC in health that is consonant with the processes of development in the countries. The areas of special importance within the regional objectives for health are: operations research in health, with attention to the expansion of local health systems; research on technology and technological development; training institutions and programs; improvement of networks for the exchange of bibliography on health; food and nutrition, especially agreements between countries in the areas of research and training;

4. TECHNICAL COOPERATION AMONG COUNTRIES (CONT.)

essential drugs, in particular drug standardization; information exchange; improvement of quality control; establishment of reference centers; regulatory mechanisms; training; joint systems for the procurement and distribution of equipment and supplies; factors that help to give the population greater access to health services; support for the regional working groups so that they will explore cooperation among countries; control of vector-borne diseases; organization of seminars to give orientation and instruction to national and PAHO/WHO professionals on the concepts of TCC; support for getting financial resources allocated to TCC activities by the Member Governments and international agencies; and, finally, the relationship between health and development.

26. To develop, in international affairs and external relations units, a nucleus on TCC for health which will act as an interinstitutional and intersectoral coordinator to help promote TCC programs with the countries and with regional groups.

27. To disseminate, through periodical publications, up-to-date information about action being taken in the area of TCC for health throughout the world, especially in countries and subregional groups within the Hemisphere.

28. To identify and follow up on the processes of TCC for health (regional, subregional, border, etc.) with a view to deciding on methodologies and lines of action, and to disseminate these through publications.

29. To evaluate concrete TCC programs, especially in terms of quantifying the benefits and the impact of these processes and programs on health.

LINES OF ACTION

30. Coordination and administration of the IDB/PAHO Technical Cooperation Agreement, which will begin its third year in 1992, as well as the first year of a new phase of the agreement. Focus will be on the identification of investment projects in the four areas covered under the agreement: (a) environmental health, (b) Health, (c) nutrition, and (d) animal health. Development of technical proposals for reporting on investment projects through collaboration with individual governments and in close cooperation with the IDB. Monitoring and the provision of technical supervision in the countries, as well as field visits to other countries in order to identify and promote additional strategic projects for the health sector.

31. Evaluation of the Agreement, to be undertaken in 1992. Another phase of the project will be negotiated with the Bank, to begin in 1993.

32. The international affairs and external relations units of the Ministries of Health constitute a focal point for follow-up on TCC programs, the provision of training for the persons selected, and the development of follow-up systems.

33. Holding of at least one seminar-workshop a year to analyze the conceptual bases, processes, and programs for TCC in the Hemisphere; development of plans of work and TCC programs.

4. Evaluation, including benefits and technical and economic components of at least five TCC processes and programs in the Hemisphere. The evaluation will include two subregional and three border programs.

35. Publication of case studies in TCC for health, emphasizing especially their relationship to national development and their contribution to the incorporation of new technologies.

36. Analysis of the impact of TCC in a subregion or in a border program for the development of general economic and social development processes, including the procurement and absorption of technology.

4. TECHNICAL COOPERATION AMONG COUNTRIES (CONT.)

PROGRAM BUDGET DISTRIBUTION BY LOCATION

LOCATION	PAHO AND WHO REGULAR BUDGET			EXTRABUDGETARY FUNDS		
	1990-1991	1992-1993	1994-1995	1990-1991	1992-1993	1994-1995
DIRECT COOPERATION WITH COUNTRIES	2,279,500	2,645,700	3,069,700	2,901,969	1,215,530	0
REGIONAL PROGRAMS	0	0	0	188,580	87,420	0
TOTAL	2,279,500	2,645,700	3,069,700	3,090,549	1,302,950	0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	2,279,500	0	0	345	87,300	1,000	3	5,700	59,100	18,100	0	2,108,300
TOTAL	2,279,500	0	0	345	87,300	1,000	3	5,700	59,100	18,100	0	2,108,300
% OF TOTAL	100.0				3.8	.0		.3	2.6	.8	.0	92.5
1992-1993												
PAHO - PR	2,645,700	0	0	0	0	0	0	0	0	0	0	2,645,700
TOTAL	2,645,700	0	0	0	0	0	0	0	0	0	0	2,645,700
% OF TOTAL	100.0				.0	.0		.0	.0	.0	.0	100.0
1994-1995												
PAHO - PR	3,069,700	0	0	0	0	0	0	0	0	0	0	3,069,700
TOTAL	3,069,700	0	0	0	0	0	0	0	0	0	0	3,069,700
% OF TOTAL	100.0				.0	.0		.0	.0	.0	.0	100.0

5. HEALTH SITUATION AND TREND ASSESSMENT

ANALYSIS OF THE HEALTH SITUATION

1. Though infectious diseases continue to be a problem in all countries of the Region, chronic, degenerative and occupational diseases, injuries and environmental contamination are increasing in importance. As a result, complex epidemiological patterns are emerging, combining problems usually associated with developing and developed economies and societies. These problems are manifested in differing forms and intensities in the affected communities as a result of multiple factors acting unequally on individuals and population subgroups. The epidemiological patterns observed result not only from biological factors but, more importantly, from the conditions in which people live. Health is both a component and a result of these living conditions.

2. In addition to documenting existing epidemiological patterns and their trends, there is a need to better understand the factors contributing to different manifestations in individuals and populations and the effect of measures adopted to modify these patters. Little progress has been made in understanding the impact of interventions--actions, programs or services--on contributory factors or on the health situation. A further complication arises from the fact that the health situation is affected by determinants and actions which are often outside the control of the health sector. There is a need to consider the effect of multiple actions by diverse institutions on biological, ecological, sociological and behavioral determinants.

3. The proposal that public health institutions of Member Countries have the responsibility to diminish inequalities between groups implies the equitable provision of accesible services and the identification of interventions most likely to improve the health situation of the disadvantages. The role of events not controlled by the health sector necessitates an intersectoral and interinstitutional approach both for understanding the problems and to designing and implementing interventions.

4. Within the framework of extension of coverage and health for all by the year 2000, the Member Countries have committed themselves to programs that are most efficient, effective and equitable. While many countries have extended and restructured their services, most have limited capacity for strategic planning and programming, for assigning resources or for evaluating interventions. The application of appropriate epidemiological methods to understanding the health situation and its trends, to program planning and to evaluation will clearly be important for all countries.

GLOBAL STRATEGY OF COOPERATION

5. According to the Strategic Orientation and Program Priorities for the Pan American Health Organization for the Quadrennium 1991-1994, one of the challenges for health and for the transformation of the sector in the nineties is to improve the capacity for situational analysis and for identification of groups at high risk. Another is to concentrate resources in efficient interventions to diminish dangers and risks. Knowledge of the existing health situation, the understanding of trends and the ability to set priorities and evaluate programs is fundamental to PAHO's strategy. One of the priorities for development of the health service infrastructure is analysis of the sector and the assignment of resources. To accomplish these objectives, the Program on Health Trend Assessment will seek to increase the capacity of the countries and the secretariat to generate, disseminate and utilize information to assess the health situation and trends, both in general and in reference to specific problems and population subgroups. This strategy will contribute to (1) the identification of health priorities, (2) the definition of policies and (3) the evaluation of the impact on health of specific health interventions and programs, of the health services in general and of extrasectoral policies and actions.

6. The International Classification of Diseases and members of its family are basic instruments for the collection and analysis of information about morbidity and mortality. Promotion of the use of ICD is, therefore, basic to the strategic orientation of PAHO. The strategies for the Program are (1) implementation of ICD-10 in the Member Countries, (2) consolidation of the regional network of national centers, (3) elaboration of operating strategies for the improvement of basic data, (4) direct technical cooperation to improve health and vital statistics, done in conjunction with other programs in HST and PAHO and aimed primarily at enhancing the use of ICD, and (5) other technical cooperation, including dissemination of information, research, training and administration of knowledge.

SPECIFIC PROGRAMS

HEALTH SITUATION AND TREND ASSESSMENT (HST)

BIENNIAL TARGETS

7. All Member Countries and the Secretariat will increase their capability to assess the health situation, both in general and in reference to special population groups.

8. All Member Countries will strengthen the role of epidemiology in the health services.

9. Twelve countries will hold national epidemiological scientific meetings, with involvement of PAHO and other countries of the Region.

10. The Epidemiological Bulletin will continue to be published quarterly in both English and Spanish.

11. By the end of the biennium, an assessment of the health situation in the Region will be prepared that will serve as the basis for the Regional volumen of Health Conditions in the Americas-1994.

12. The preparation, printing and distribution of all 3 volumes of the 10th revision of the International Classification of Diseases (ICD-10) will be completed.

13. Two subregional courses for training of trainers regarding the introduction and use of ICD-10 will be completed.

14. Other members of the Family of the Classification will be developed and tested as requested by Member Countries.

15. A mechanism for updating ICD-10 between revisions will be tested in Member Countries and the method will be established in 4 countries.

16. An electronic network for ICD will be tested and the network will be functioning in 12 countries of the Region.

17. Guidelines for non-conventional methods for disease surveillance and reporting will be written for use by Member Countries where conventional methods are not sufficient.

18. Written guidelines for alternative methods for morbidity and mortality analysis will be available for Member Countries.

LINES OF ACTION

19. Study changes in health profiles to better understand the relationship between health and development and assess the impact on health of the health services systems.

20. Stimulate epidemiologic research and utilization of research results through support to biennial scientific meetings, by country and subregion.

21. Develop strategies to address training needs, especially in regard to training in and for the health services (with HSM).

22. Strengthen and expand the capture, utilization and dissemination of technical information, through the Epidemiological Bulletin and special periodic reports.

23. Strengthen the role of epidemiology in the health services in light of the ongoing revision of their organization and functions.

24. Strengthen the Regional Network of National Centers through information dissemination, sharing of knowledge and research collaboration.

25. Additional members of the family of ICD will be developed, such as the Classification of Surgical Procedures, using the model of the International Classification for Oncology.

26. A major activity will be the introduction and implementation of ICD-10 with preparation of not just coders but also analysts.

27. The method of multiple cause analysis, developed at the Regional level, will be disseminated for application, with simplifications where possible. Alternative or nonconventional methods, including simplified surveillance, will be promoted within Member Countries.

28. Together with other programs in HST and PAHO, this Program will promote the improvement of health and vital statistics, jointly with other national and international agencies and directed primarily at enhancing the use of ICD.

5. HEALTH SITUATION AND TREND ASSESSMENT (CONT.)

PROGRAM BUDGET DISTRIBUTION BY LOCATION

LOCATION	PAHO AND WHO REGULAR BUDGET 1990-1991	1992-1993	1994-1995	EXTRABUDGETARY FUNDS 1990-1991	1992-1993	1994-1995
DIRECT COOPERATION WITH COUNTRIES	5,652,500	6,473,200	7,321,600	188,989	0	0
REGIONAL PROGRAMS	2,497,200	2,889,500	3,250,800	0	0	0
CENTERS	983,800	1,219,200	1,381,400	4,489,462	3,067,624	2,045,000
TOTAL	9,133,500	10,581,900	11,953,800	4,678,451	3,067,624	2,045,000

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL PROF. MONTHS	PERSONNEL LOCAL MONTHS	PERSONNEL CONS. DAYS	PERSONNEL AMOUNT	DUTY TRAVEL AMOUNT	FELLOWSHIPS MONTHS	FELLOWSHIPS AMOUNT	SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	4,281,900	360	216	1605	3,233,100	246,300	101	191,900	218,800	159,500	19,500	212,800
WHO - WR	4,851,600	384	144	1475	3,263,800	245,100	173	328,700	402,300	222,700	38,900	350,100
TOTAL	9,133,500	744	360	3080	6,496,900	491,400	274	520,600	621,100	382,200	58,400	562,900
% OF TOTAL	100.0				71.1	5.4		5.7	6.8	4.2	.6	6.2
1992-1993												
PAHO - PR	4,381,700	288	216	915	3,182,900	246,400	48	96,000	290,800	228,800	15,800	321,000
WHO - WR	6,200,200	432	120	850	4,173,900	292,600	120	240,000	601,600	364,400	0	527,700
TOTAL	10,581,900	720	336	1765	7,356,800	539,000	168	336,000	892,400	593,200	15,800	848,700
% OF TOTAL	100.0				69.6	5.1		3.2	8.4	5.6	.1	8.0
1994-1995												
PAHO - PR	4,962,800	288	216	915	3,582,200	286,000	48	100,800	337,500	265,500	18,300	372,500
WHO - WR	6,991,000	432	120	755	4,666,300	339,600	120	252,000	698,000	423,000	0	612,100
TOTAL	11,953,800	720	336	1670	8,248,500	625,600	168	352,800	1,035,500	688,500	18,300	984,600
% OF TOTAL	100.0				68.9	5.2		3.0	8.7	5.8	.2	8.2

ANALYSIS OF THE HEALTH SITUATION

1. In recent years the Region of the Americas has been severely affected by an economic crisis that reveals the limitations of the development models the countries adopted in previous decades. However, the policies for adjusting to the crisis, which are being implemented in many countries, do not appear to be capable either of resolving the existing situational problems nor limitations of a more structural nature. Above and beyond the stagnation of the economies of these countries, inequities appear to be increasing between social groups within the countries as well as between the most industrialized nations and the rest of the Region. Fortunately, this picture is somewhat less negative when it is borne in mind that the Region is undergoing a period of extraordinary political development, marked by the expansion and enhancement of the democratic process and by citizen participation in national life. At the same time, there has been a resurgence of efforts toward integration within and between countries in a climate propitious for the elimination of barriers of all kinds to cooperation between peoples and nations. Partially related to this, a consensus is beginning to take shape in the Region on the need to reopen the development process in order to reconcile the objectives of growth with the demands for political and economic participation by the various social classes.

2. As part of this context, in recent years the health situation of the societies of the Americas has been characterized by a deacceleration of the usual trend toward improvement of its indicators and by an increase in the inequities between social groups as far as the risks of disease and death are concerned. The population, which is growing in size, life expectancy, knowledge of its needs, and awareness of its rights, is increasing and diversifying its demands on the health systems. In turn, the health systems are undergoing accelerated technological development that allows them, if only in theory, to face these new demands and even generate others, growing and becoming more sophisticated without necessarily guaranteeing that their benefits will be any more effective or equitable. At the same time, the crisis and the adjustment policies are reducing the capacity of the State and the society to fulfill the demands for health care and are making it difficult to adopt development strategies conducive to improving the health of the population.

3. The WHO Eighth General Program of Work covering the period 1990-1995, in reiterating the Global Strategy for Health for All, emphasizes that close and complex linkages exist between health and socioeconomic development. In this connection, it is recognized that the scope of health objectives is to a great extent determined by policies outside the responsibility of the health sector, particularly those involving universal access to the means for obtaining acceptable income. The Strategic Orientations and Program Priorities for the Pan American Health Organization during the Quadrennium 1991-1994, set forth in Resolution XIII of the XXIII Pan American Sanitary Conference, emphasize the need for the Organization to devote increasing attention to the reciprocal relations of health problems and actions to the socioeconomic and political development of the countries of the Americas. In accordance with these guidelines and the previous experience of the Organization in these fields, during the next quadrennium the Health Policy Development Program will concentrate its efforts on problems relating to the incorporation of health into development that affect the equity, effectiveness, and efficiency of the health policies of the countries.

4. Initially, mention is made of the difficulties in evaluating the impact on the health conditions of the population of the socioeconomic and political changes in the countries and their respective health policies. In the same manner, it is necessary to better understand--and demonstrate more convincingly--both the adverse effects on the development process devolving from the deterioration of health and the positive contributions that can be derived from improving it and from the actions of the health system. The lack of greater clarity with regard to these relations is a hindrance to more objective discussion of the questions involved, and consequently makes it difficult to consider health among the primary goals and factors of the development process. This problem assumes special importance in the present crisis situation, in which the ability to respond to multiple and growing demands are limited and the countries are forced to make a painful but unavoidable definition of priorities. This deficiency becomes evident when, as at the present time, favorable circumstances exist for reformulating orientations and styles of development, including the relative position of health in the equation. In both instances health goals must be formulated that can be understood and defended in the relevant forums, either at the national or international level.

5. The position occupied by health in national development priorities can express the extent to which a given society values equity as one of its basic objectives. In addition, the expansion of democratic privileges, which may be observed at the present time in the Americas, may be favorable to the satisfaction of social demands, including those relating to health. Furthermore, paying heed to such demands may make a positive contribution to strengthening the political process and, consequently, national development itself. In practical terms, however, the political dimensions of health have still not been sufficiently explored enough to induce positive changes in the health situation, in the consolidation of democracy, or in redefining development. With regard to health issues, the political process has traditionally been dominated by sectoral corporations and executive branches, a situation that prevents it from being assigned its proper importance by being accorded a more advantageous position on the agendas of our societies. In order to overcome this limitation and for the political process to receive the stature it deserves as far as health is concerned, health issues must be promoted among other agents, in legislatures, for example, at other levels of government, and in trade unions and community organizations so as to contribute elements that will enable them to participate in the process with at least a minimum level of political effectiveness.

6. Discussion and controversy regarding the new division of work between the State and society with reference to their respective roles in the development process is becoming increasingly intensified in the Region. The

trend toward privatization of economic activities with a concomitant concentration of the State in specific areas, the proposal for new forms of cooperation between the public and private sectors, the replacement of the State as entrepreneur by the State as regulator or catalyst, the decentralization and upgrading of subnational and local government organizations, and other polemic questions of this nature have far-reaching implications for health policies and services. The articulation of State prevention and treatment programs with the services provided by Social Security, and the care provided by commercial, mutual, and community systems continues to challenge the negotiation and organization capacity of public and private entities that seek to organize the mosaic of benefits provided by setting up national health systems. To the extent that acceptance of the multicausal nature of health problems becomes generalized, the limited capacity of the health authorities and institutions to define, negotiate, and monitor the actions of other sectors that can have a favorable impact on the health situation becomes increasingly evident.

7. The capacity of the governments to formulate and implement their health policies continues to be sharply challenged by the limitations imposed by the crisis, the adjustment measures taken to remedy the situation, the redefinition of the role of the State, the difficulties of intersectoral management, the institutional fragmentation of the health sector, the growing demands of the population, the pressures exercised by the producers of health goods and services, and the dynamics of the sectoral labor market. Activation of national political processes and the changes in macroeconomic policies brought about by structural adjustments impose frequent changes in ministerial cabinets within a single government administration. As a result, many countries have experienced a certain amount of instability in conducting and managing the health sector, in addition to some discontinuity in the policies desinged to govern the sector. This situation reveals the ineffectiveness of conventional planning and sectoral management schemes and of the recruitment and training of key personnel for the exercise of these functions. In addition, many countries need to create the capacity for ongoing reform of their sectoral management teams, including mastery of the techniques of sectoral analysis and policy planning that will enable them to face these challenges. A considerable portion of these efforts must be directed toward reform programs, sectoral development projects, and participation of the health system in integrated programs to combat extreme poverty.

8. The multisectoral character of many health policies demands of the State a decided capacity to standardize the actions of its agencies and to regulate participation of private institutions and citizens in implementing them. Inasmuch as conflicts between the interests at stake appear to be frequent, their resolution also depends on the capacity of the State to judge, arbitrate, nullify, and sanction. The search for growing levels of equity and safety with regard to health risks and health services also points to the need for constant updating of the regulations pertaining to the corresponding rights and duties. The atmosphere of democratic and institutional stability in the Region appears to create a favorable climate for reviewing, on different scales, the legislative bases governing the most varied aspects of development of the countries. In such circumstances, most of the countries of the Americas point to the insufficient development of their laws with respect to health problems, policies, institutions, professions, resources, and goods and services. This limitation is being strengthened, nevertheless, by the emergence of new forms of production and consumption of services, which is expanding by reason of the technological development of the sector. Improvement of this situation requires shared efforts between specialists in the various areas of health and the legal sciences and between the authorities of the executive, legislative, and judiciary branches.

9. The crisis and the concurrent policies of adjustment adopted by several countries in the Region constitute a continuous challenge to the various agencies funding health policies and services. As the experience of the industrialized countries indicates that the costs of health services grow faster than the respective price indexes, such restrictions will make it possible to maintain the levels of provision of services only with great difficulty. In this light, an increase in coverage to keep pace with population growth and aging of the population appears very unlikely. The search for alternative sources of sectoral financing and increased efficiency in managing the resources available are almost the only options that remain open to the countries. Reduction of the growing inequities in health expenditures, which would be problematic even if resources are expanded, has now become a true and more acute imperative, but also one that is much more difficult specify in the current restrictive situation. Perhaps it would be necessary to create a "basic basket" of services whose consumption can be ensured on a priority basis for the most vulnerable social groups until reactivation of development and an increase in income make it possible to equalize higher levels of consumption. It is also necessary to develop analytical and managerial capacity that will support the countries in defining, implementing, and monitoring emergency funds and social investment, which are gradually being transformed into the most common option for social policy in light of the crisis.

10. In respect to the situation of Women in Health and Development, advances in research during the last decade have emphasized the differential risks for becoming ill and dying to which the sexes are exposed and which particularly affect women. A significant portion of the origin of some differentials is associated with endogenous and biological factors associated with the reproductive function. Other, no less important origins, which on occasion are determinative, are linked to exogenous social factors associated with the social structure of gender.

11. Exogenous factors influence health through two mechanisms. At the micro level they exercise their effect during the socialization process through individual internalization of cultural paradigms of femininity and masculinity, which promote differential risk attitudes and behavior for the physical and mental integrity of men and women. At the macro level, gender determinants act through the division of labor by sex, practiced by the various economic, religious, family, sanitary, educational, and legal institutions and implemented

by the differential evaluations assigned to these activities in terms of prestige and remuneration.

12. Differential evaluation of activities is applied by extension to those who perform them and is eventually translated into differential assignments that are also in accordance with sex, the family, and the social resources necessary for the maintenance of individual health. Confluence of the various institutions in devaluating "feminine" activities and, thereby women themselves, has led to the inferior status of women appearing as a "natural" phenomenon, legalized, furthermore, by law and custom.

13. Examination of the most recent information available emphasized a series of conditions whose negative impact for the health of women is exacerbated by social factors associated with the social structure of gender and the division of labor by sex, as follows:

13.1 The greater social value assigned to the productive activities of men in comparison with those of women creates a situation in which from infancy males are given preference over females with regard to the distribution of food. Such differential treatment suggests an association with the higher female mortality characteristic of some countries in the Region. Anemia in adolescent girls and young women has been considered the most important health problem, a factor that affects physical and intellectual productive capacity by causing chronic fatigue and making the body vulnerable to infection.

13.2 Pregnancy, delivery, and puerperium complications continue among the five leading causes of mortality in women of reproductive age in the Region. This phenomenon is an extreme manifestation of sex-related inequities with regard to chances of survival, which not only derive simply from biological differences but are closely associated, on the one hand, with the value and priority that various societies assign to the reproductive function and on the other, by extension, with the legal and social inferiority of women.

13.3 The status of women is also expressed in terms of their options for exercising their right to full sexuality dissociated from the reproductive function. The reduction of fertility in most of the countries in the Region it thought to be associated with the changes taking place over the last decade, such as the massive incorporation of women into the work force and their greater access to contraceptive information and technologies. However, assumption of the responsibilities and risks associated with fertility regulation demonstrates the clear-cut inequities between men and women. Data indicate that in Latin America men bear direct responsibility for contraception in approximately 12% of all cases and that barely 5% use condoms or resort to vasectomy. In this connection, the most dramatic difference is observed in the recourse to sterilization on the part of men and women. In the Region of Latin America and the Caribbean, among all couples regulating their fertility, 36% of women and 0.9% of men are sterilized.

13.4 Gender determinants in assuming the risks implied in the free exercise of sexuality also become barriers to the prevention of sexually transmitted diseases, particularly in women. The increase in the prevalence of AIDS among heterosexuals, particularly in the less economically and socially developed countries, suggests the presence of cultural factors associated with male sexual behavior.

13.5 The phenomenon of the double work shift is a problem that is faced by a huge majority of working women, in particular those with limited resources and small children. Household work may lead to a variety of physical and psychological problems that range from chronic fatigue and an increase in the risks of accident up to depression resulting from low self-esteem and social devaluation. In addition, it has been suggested that the double shift produces psychological effects caused by the accumulation of "double blame;" that is, the discrimination experienced in work outside the home produces guilt feelings in women when they realize that they are not capable of maintaining their families at a satisfactory economic level and at the same timefeel guilty because their work outside the home takes time they would normally have to dedicate themselves to their families in order to perform their traditional roles in a satisfactory manner.

13.6 Various studies have indicated that women present more symptoms of severe depression than men and that men most frequently exhibit personality disorders manifested by antisocial, aggressive, violent, and irresponsible behavior. These differences appear to be associated with the male and female roles determined by the hierarchical system of gender relations, the expectations associated with dichotomous roles, and the differentiated socialization of boys and girls who are taught to reproduce the patterns of power and submission determined by society.

13.7 Physical abuse and the various manifestations of violence against women both in and outside the home have at the present time assumed endemic characteristics and have crossed the borders of countries, cultures, and social classes. To the underreporting of cases of abuse must be added the obstacles constituted by the lack of support of the judicial system and the blindness that rationalizes their occurrence as one more element in the "natural" subordination of women.

14. Although progress has been made in describing the differential risks and effects between the sexes with regard to living conditions, disease, and death, it is evident that there are gaps in knowledge and a lack of conceptual and methodological development that would make it possible to show the determining role or the determinant of the social structure of gender in the concrete manifestations of health and disease in different population groups. It may be seen that the interventions of health programs at the level of health promotion and disease prevention and control assign special importance to the traditional role of women with regard to their reproductive function both biologically and

socially, but neglect their development as individuals and citizens as a vital part of human development in conditions of greater equity.

15. In addition, and by extension of the division of labor by sex, women continue to be assigned an essential role in the health care not only of family members, but also at the community and social level. More than merely relieving this burden and promoting a more equitable distribution of responsibilities, the programs that promote social participation in health reinforce female roles that convert health into the "third voluntary job of women." Redimensioning the natural leadership of women in health in order to promote their identity, self-esteem, and control over their own bodies and the available resources could result in one of the most important contributions of women to human development and the development of the health of the people as a whole.

GLOBAL STRATEGY OF COOPERATION

16. This program chapter has a close relationship to three of the Strategic Orientations for the Quadrennium 1991-1994, Health in Development, Incorporating the Full Potential of Social Security, and Integrating Women into Health and Development. In the three cases high-level Advisory Committees will be mobilized, in addition to interprogram working groups, in order to ensure coordination of the activities of the entire Secretariat related to these strategies. It will also involve establishing support mechanisms for the countries in strengthening the role of the Country Representative Offices so as to dynamize the actions required for making the strategies operational.

17. Among the contents under the responsibility of the Regional Program are two of the Program Priorities for the Quadrennium, those related to Sectoral Analysis and Sectoral Financing. In addition to the increase in the resources assigned specifically to these priorities, they should act as nuclei for the other thematic contents of the Program in order to increase the impact of the respective actions. These priorities will also be expressed in the cooperation the Program will establish with other Regional Units and the PAHO Country Representative Offices . Special emphasis will be given to the contributions of the Program relating to these Strategic Orientations and Program Priorities, which are devoted to strengthening the Subregional Initiatives promoted by the Organization.

18. Owing to the nature of the subject fields under its responsibility, the Program will devote special attention to identifying and mobilizing institutions specialized in the socioeconomic and political dimensions of development in order to promote their participation in support of PAHO/WHO cooperation in various organizations at both the country and regional levels. At the same time, the Program will seek to support the other Regional Units and Country Representative Offices in disciplines in which its team functions as the focal point for the Secretariat.

19. Finally, the Program will seek to emphasize activities concerning training, research, and dissemination of information in order to achieve wider dissemination of the contents and disciplines under its responsibility in the countries and in the Secretariat.

20. Furthermore, the strategies related to Women in Health and Development will directed towards improving the status of women in the Region and overcoming the "discriminatory barriers" that affect their development as individuals and their living and health conditions means recognizing that differences based on sex are generating inequities that are detrimental to the health conditions of the population as a whole.

21. Recognition of this problem by the Member States of the Organization and the implementation of policies, programs, and health services to reduce the gap in the social and gender inequities suffered by women constitutes the principal goal of technical cooperation for Women, Health, and Development for the biennium 1992-1993.

22. In order to make the Strategic Orientation on the incorporation of Women in Health and Development (WHD) viable, the Regional WHD Program will direct its efforts toward the following specific objectives:

22.1 To upgrade the scientific and technical capacity of the Member States of the Organization in leading the mobilization of national and international resources for the promotion and development of women and their health.

22.2 To promote the formulation and evaluation of health policies, programs, and services using gender criteria, and review and amend the legal instruments that directly or indirectly affect the health of women and their accessibility to specific services.

22.3 To promote a multidisciplinary approach in the generation and dissemination of knowledge in order to incorporate analysis of the social structure of gender in health research activities.

22.4 To bring about the design and implementation of models of comprehensive health services for women, taking into account their particular needs and their specific gender problems throughout their lives (girls, adolescents, adults, and elderly women).

22.5 To promote and support the development of strategies for the mobilization, organization, and participation of women as dynamic, multiplier nuclei of innovative actions in the field of women's health.

23. The following will be adopted as strategic approaches for technical cooperation with regard to Women in Health and Development (WHD):

23.1 Mobilization of national and international institutional, financial, political, and human resources, in addition to the resources provided by civil society organizations to promote the formation of WHD exchange and cooperation networks at the national, subregional, and regional levels.

23.2 Dissemination of information on topics concerning women, gender, and health and development through scientific publications, bibliographies, and the preparation and dissemination of educational and informational materials on the subject.

23.3 Support for the review and formulation of policies, plans and regulations concerning health and legislation to promote exercise of the right to health in a framework of more equitable relations between the sexes.

23.4 Training and manpower development for the adoption of conceptual, methodological, and instrumental frameworks that incorporate the gender approach into health at the professional, technical, and community levels.

23.5 Promotion of research and production of knowledge on the subject of the social structure of gender, health, and development with emphasis on multicenter and action-oriented research using participatory methodologies.

23.6 Direct technical advisory services with the support of consultantships as a means of making progress in formulating programs or projects on Women in Health and Development in the countries in the Region.

SPECIFIC PROGRAMS

HEALTH POLICY ANALYSIS AND DEVELOPMENT (HDP)

BIENNIAL GOALS

24. The general goal of the Program in 1992-1993 will be to cooperate with the countries in order to develop policies geared to achieving HFA/2000 that take into account the mutually favorable interactions between health and socioeconomic, political, and technological development. In specific terms, this goal is expressed in the following biennial goals:

24.1 To achieve a greater degree of consensus with regard to health priorities and assign them higher priority among the goals of development in all the countries and in the Region.

24.2 To promote a unification of efforts between State health agencies, Social Security, other sectors, community organizations, and private producers of health goods and services in order to promote the attainment of HFA/2000.

24.3 To increase the capacity of the countries to analyze the health sector, its resources, and its operation, as well as to plan, implement, and evaluate health and social development policies, programs, and projects.

LINES OF ACTION

25. This classified Program constitutes the thematic and methodological nucleus that articulates the other Programs and Components of the program category in an attempt to devise an approach to incorporating health into development in order to ensure the equity, effectiveness, and efficiency of health policies. In order to fulfill this role, this Program is divided into the following three Components and their respective lines of work:

25.1 Political Development in Health: analysis of the political dimensions of health; identification of other relevant entities in defining health policies, such as legislatures, trade unions, and other social organizations; and promotion of health goals in national and regional development agendas.

25.2 Institutional Organization and Intersectoral Action in Health: analysis of institutional aspects in health policies; articulation of state services, Social Security, and the private sector in national health systems; and strengthening of intersectoral action in the formulation and implementation of health policies.

25.3 Sectoral Planning and Analysis: analysis of the constitution, organization, resources, and operation of the sector in order to orient its strategic-situational conduct and plannning of health policies and sectoral development projects; and participation of the health system in integrated programs to combat extreme poverty.

HEALTH ECONOMICS AND FINANCING (HDE)

BIENNIAL GOALS

26. To increase national capacity to monitor the impact on health of the crisis and the adjustment policies, and to achieve greater equity and efficiency in economic-financial management of the health sector.

LINES OF ACTION

27. Analysis and search for alternatives for sectoral financing; economic-financial management of the sector for greater equity and efficiency in its benefits; and study of the impact of the crisis on health, on the adjustment policies, and on the relationships between health and economy.

HEALTH LEGISLATION (HLE)

BIENNIAL GOALS

28. To develop legislation in each country with reference to the rights and responsibilities of the citizens, private institutions, and the State with regard to the promotion, protection, and recovery of health.

LINES OF ACTION

29. To continue implementation of the Documentation System on Health Legislation of Latin America and the Caribbean; cooperation for the analysis, development, and evaluation of health legislation in the countries; and support for PAHO/WHO programs for development of the legal aspects involved in the respective health policies.

WOMEN, HEALTH AND DEVELOPMENT (WHD)

BIENNIAL GOALS

30. To promote the design of strategies for awareness-creation and social mobilization in order to generate collective and informed awareness of the conditions of subordination and discrimination still endured by women in the Region that directly or indirectly affect their human development, their living conditions, and, by extension, the health conditions of the population as a whole.

31. To facilitate understanding of the gender factors that intervene in the living and health conditions of women and to favor policy decisions and juridical and legal provisions that will make it possible to plan a positive image of women and their economic and social revaluation as socializing agents for the promotion of individual, family, and collective health.

32. To bring about changes and reforms in the biological-reproductive approaches of programs for women, expanding their sphere of action in the psychosocial area, providing attention to their specific gender problems, and promoting the participation of men with a sense of shared responsibility based on the health of the individual, the couple, and the family.

33. To establish mechanisms for dialogue, exchange, and cooperation between governmental institutions and nongovernmental organizations working to promote women and their health, and in the areas of research, education, and services related to this subject.

34. To contribute toward upgrading and developing local health systems, supporting the formulation of strategies of participation and leadership of women and of alternative forms of self-management and self-care of health at the individual, family, and collective levels.

LINES OF ACTION

35. Promotion of women and their health by advocating their rights, their citizenship, and more equitable relations between the sexes as a contribution to health in the processes of development. To promote a positive image that will revalue the productive and reproductive functions of women in the various stages of their lives.

36. To improve the collection of information and the capacity to analyze the health situation and its trends, including the dimension of gender, ethnic group, and class in social and geographical areas. To promote and support epidemiological stratification and the use of the cultural and socioanthropological dimensions of gender in the criteria for the risk approach.

37. To support development of the institutional capacity of the sector to formulate and execute policies and programs for comprehensive care of women in the framework of local health systems. To incorporate institutional intervention modalities based on the process of participatory action-oriented research and mobilize to the greatest possible degree the real resources and potentials of civil society.

38. To strengthen the leadership capacity of women and promote shared participation and management between the sexes for the sake of individual, family, and collective health. To elevate the capacity to solve health problems at the household level and promote self-management and self-care for the promotion and protection of the health of women and family members. To retrieve and reevaluate the myths, beliefs, and values in which both women and men participate with regard to health care in the various cultures.

PROGRAM BUDGET DISTRIBUTION BY LOCATION

LOCATION	PAHO AND WHO REGULAR BUDGET 1990-1991	1992-1993	1994-1995	EXTRABUDGETARY FUNDS 1990-1991	1992-1993	1994-1995
DIRECT COOPERATION WITH COUNTRIES	3,366,000	3,726,800	4,249,900	386	1,100,000	0
REGIONAL PROGRAMS	1,588,300	2,591,300	2,915,300	0	0	0
TOTAL	4,954,300	6,318,100	7,165,200	386	1,100,000	0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL PROF. MONTHS	PERSONNEL LOCAL MONTHS	PERSONNEL CONS. DAYS	PERSONNEL AMOUNT	DUTY TRAVEL AMOUNT	FELLOWSHIPS MONTHS	FELLOWSHIPS AMOUNT	SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	3,600,200	216	144	1395	2,247,900	227,600	6	11,400	541,300	93,700	64,100	414,200
WHO - WR	1,354,100	48	0	450	644,100	46,200	28	53,200	142,700	64,800	34,400	368,700
TOTAL	4,954,300	264	144	1845	2,892,000	273,800	34	64,600	684,000	158,500	98,500	782,900
% OF TOTAL	100.0				58.4	5.5		1.3	13.8	3.2	2.0	15.8
1992-1993												
PAHO - PR	5,744,000	264	192	1685	3,292,500	520,300	6	12,000	744,300	91,300	47,800	1,035,800
WHO - WR	574,100	24	0	290	273,600	14,200	20	40,000	61,500	41,800	0	143,000
TOTAL	6,318,100	288	192	1975	3,566,100	534,500	26	52,000	805,800	133,100	47,800	1,178,800
% OF TOTAL	100.0				56.3	8.5		.8	12.8	2.1	.8	18.7
1994-1995												
PAHO - PR	6,517,400	264	192	1685	3,674,300	603,700	6	12,500	863,500	106,100	55,500	1,201,700
WHO - WR	647,800	24	0	290	303,600	16,400	20	42,000	71,300	48,600	0	165,900
TOTAL	7,165,200	288	192	1975	3,977,900	620,100	26	54,600	934,800	154,700	55,500	1,367,600
% OF TOTAL	100.0				55.4	8.7		.8	13.0	2.2	.8	19.1

7. ORGANIZATION OF HEALTH SERVICES BASED ON PRIMARY HEALTH CARE

ANALYSIS OF THE HEALTH SITUATION

1. As in the previous biennium, the health services systems continue to be affected by the severe economic crisis that has engulfed most of the countries in the Region.

2. This crisis is evidenced by the inadequate financing of the health systems (national, provincial, and municipal) resulting from the acute restrictions being applied to public sector budgets. The services provided by social security systems are also affected by the crisis, since these systems have been unable to increase their coverage because the contributions assessed have been reduced as a result of the high rates of unemployment and the need to contend with ever increasing costs in providing social security services. The population, meanwhile, finds it increasingly difficult to gain access to the services because the ability to afford direct payment has been diminished and because it is no longer even possible to afford the co-insurance payments required by the social security systems. This situation prompts the beneficiaries to increase their demand from the government sector for services that are supposedly free of charge. This, in turn, in response to the pressure for immediate financing, has institutionalized the payment of "contribution quotas" or payments in kind in the form of supplies as a means of providing health care. The panorama has thus been reduced to one of unfinanced state and social security services, on the one hand, accompanied by greater demand on the part of a population that is unable to use them to their full extent because of a real reduction in its payment capacity, and, on the other, to services that are underused because of a reduction in demand. This, in turn, translates into a lack of equity, a reduction in the coverage provided, and increasing inefficiency of the installed capacity. Such a situation, characterized by serious economic, financial, and organizational problems, is negatively affecting the implementation of health programs and is having repercussions on the accessibility, quality, continuity, and coverage of health care.

3. Faced with this crisis, the countries in the Region have continued their efforts to resolve these problems by reorienting and reorganizing the health services systems while seeking greater efficiency in the use of resources and at the same time attending to the need for improving the equity and quality of health care.

4. Consequently, the crisis has made it necessary to give more thought to finding solutions for these problems immediately and at the same time to establish the bases for far-reaching reforms that will provide an adequate response by the health sector to the challenges of democratization, participation, and equitable development. In this regard important progress has been achieved in both the conceptual and in the political decisions of the governments of the Region with regard to reorganization of the health sector and the health services as a means of achieving equity, quality, and efficiency in the provision of health services.

5. A study carried out recently by PAHO (Development and Strengthening of Local Health Systems in the Transformation of National Health Systems. Resolution XV of the XXXIII Directing Council. Progress Report. Sept. 1988 - Sept. 1990. PAHO, Nov. 1990.) showed the significant changes taking place in the Region with regard to examining the role of the State and its participation in the organization and administration of health services systems. Of the 34 countries analyzed, 94% are formulating and carrying out national or sectoral State decentralization policies, while 68% note that these reforms are being oriented toward decentralization and deconcentration, thereby affecting the health systems. Along these same lines, it was found that 27 countries--79% of the countries studied--have formulated explicit policies for the development of local health systems, while in 17 countries (68% of the 25 reporting) confirmed the existence of local operation systems. In addition, an analysis of nearly 100 concrete experiences in local health systems indicates the need for continuing to expand the concepts and methodologies of local programming, information systems, intersectorality, and social participation.

6. This brief information indicates that a clearly defined movement is taking place in the Region that is directed toward reformulating the provision of the health services and that at the same time an attempt is being made to implement decentralization and deconcentration processes.

7. This movement is taking place within the economic crisis that is affecting all the countries and within a framework of unprecedented democratization and social mobilization.

8. In this manner, the health services, as components of the social sector and as an integral part of society, receive and in turn influence the socioeconomic situations of the various countries. Reorganization of the sector using the strategy of decentralization is thus considered as an operational tactic for implementing the strategy of primary care within the context of the 1990s. It also constitutes the connecting thread that unites the priorities of the previous quadrennium with the new quadrennium 1991-1994 and emphasizes this process within the framework of health and development. Decentralization as an expression of democracy, social participation, and local intersectoral development are the basic elements for achieving the goal of HFA/2000.

9. The trend referred to in the previous quadrennium is consequently confirmed, and the countries have reaffirmed the basic strategies for development of the health services.

10. Problems of organization and administration in the operational aspects of the health services continue to be a concern of the countries and have given rise to the following priorities:

10.1 To continue to strengthen the role of the Ministries of Health as the regulatory institutions of the health sector and to assist in accommodating them to the processes of decentralization, privatization, and intersectoral coordination.

10.2 To achieve proper operation of the health services by incorporating mechanisms that will permit accessibility and coverage of all population groups without social, economic, cultural, and organizational restrictions.

10.3 To ensure that the financing schemes of social security systems facilitate rather than negatively influence the configuration of the care models by prioritizing quality, the appropriate use of technology, efficiency, and humanitarian treatment of patients.

10.4 To reconsider the financial systems of the State in granting direct assistance to special groups, their problems, and needs.

10.5 To adapt to changes in the epidemiological profiles of various population groups and to the principal risk factors involved through greater flexibility in the services in accepting new, differentiated demands such as the care of adolescents; dealing with chronic problems, emergencies, and health care in urban areas; and providing care for new pathologies such as AIDS and others deriving from development and urbanization.

10.6 To promote optimum implementation of an integrative care model using approaches to promote health, the prevention of disease, and early diagnosis, treatment, and rehabilitation within a framework of social participation. This should be supplemented by integration of the services networks at the local level through a process of local strategic administration.

10.7 To facilitate the organization of local services and to prioritize problems and population groups at greatest risk, either by reason of socioeconomic conditions or from risks deriving from special areas such as the workplace and urban fringe populations.

10.8 To develop the administration of hospitals and the network of services incorporated into local administration and programming through the use of a strategic approach.

10.9 To incorporate the concept of quality into the concept of equity in health care in order to ensure that the neediest population groups have access to the services and to adequate and effective health care.

10.10 To incorporate the community into the programming and management of the health services in the definition of priorities, the granting of resources, and their evaluation.

10.11 To improve efficiency in the utilization of limited resources by deriving greater production and productivity from the installed capacity.

10.12 To see to it that the search for efficiency of the health systems is also a concrete expression of the need for achieving greater coordination between the different institutions making up the health sector, particularly with regard to public institutions (national, provincial, municipal), social security institutions, NGOs, and private institutions.

10.13 To facilitate the development of strategic local administration for the integration of programs as a valid proposal for the definition of instruments designed to further intersectoral, interinstitutional, and interprogram coordination in the local area that will ensure social participation and equitable development.

11. In this way, development of the local health systems is a means of improving the equity, quality, and efficiency of the programs and is an end in itself as the democratic expression of the health sector and its contribution to the development and well-being of the population.

12. The regional situation should also be observed through the perspective of the specific areas that affect the development of health services, such as radiology, laboratories, drugs, and oral health.

13. While the situation in the United States and Canada has reached a steady state, the radiology services of the public health sector of Latin America and the Caribbean have continued to deteriorate. Because in these countries there are no governmental policies on the planning of radiological services, there is no stratification of services, and both equipment and personnel are concentrated in regional and university hospitals in the large urban areas. As a consequence, these hospitals perform many of the diagnostic examinations and radiotherapy treatments that could be done at the local level. Since radiological equipment has neither been fixed nor upgraded, coverage has diminished. Since no quality assurance programs have been established, the quality of the services has also worsened. Furthermore, the exodus of qualified professionals to better paying jobs has left the radiological services lacking the required knowledge of the beneficial uses as well as the potential deleterious effects of ionizing radiation. Several radiation accidents have occurred recently, and the lack of radiation protection legislation in many countries poses a potential risk of serious radiological emergencies.

14. In spite of the availability of highly useful and simple laboratory diagnostic procedures, many health programs still suffer from inadequate laboratory support, due in part to poor organization and management of the laboratory services, along with outdated technology, equipment, lack of quality reagents, and insufficiently trained personnel. There continues to exist an unbalanced development of clinical laboratory services favoring large urban hospitals and major centers, with inadequate support of local health system laboratories. Poor reliability of test results has eroded the implicit trust in the laboratory as a supporting instrument to quality health care. In contrast, in the more developed countries and large medical centers an unprecedented progression has taken place in the field of laboratory technology under the advances of biotechnology, molecular chemistry, and instrumentation, with the wide range of tests available in all the laboratory specialties, packed reagent kits, and computerized equipment. The introduction of new test procedures insufficiently evaluated with regard to their characteristics has contributed to inappropriate use of limited funds and led to erroneous interpretations; and the misuse of laboratory tests, aggravated by the gap that

7. ORGANIZATION OF HEALTH SERVICES BASED ON PRIMARY HEALTH CARE (CONT.)

so often separates clinicians from laboratory scientists in following a rational approach to test selection for patient management, continues to inflate costs.

15. The crisis concerning drugs worsened during the 1980s and was manifested in effects such as: frequent shortages of critical drugs, both in the private market and in the public sector, particularly in the peripheral units of the system at the primary level of care; insufficient purchasing power of the population in the face of marked price increases; low quality of pharmacotherapy; and uneven quality of marketed products due to the limited capacity for regulation, control, and surveillance by the health authorities.

16. The economic crisis sharpened the conflicts with reference to prices and the financing of this input, thereby distracting the attention of the leaders and the population and in the short term affecting the constant attention that should have been given to essential problems that had repercussions on the availability and use of drugs and vaccines.

17. The two major diseases associated with oral health problems, mainly caries and periodontal disease, continue to present extensive problems in the developing countries of the Americas, even though the incidence of dental caries has been reduced considerably in the more developed countries of the Region and the problems of periodontal diseases may not be as great as may have been originally estimated in the more developed countries of the Region. These trends have not yet been detected in the developing countries. The implementation of mass preventive measures for caries, combined with improved public education and participation in oral hygiene practices, have definitely had an impact on the incidence and severity of these diseases. On the other hand, whereas the number of dentists has been increasing considerably in the larger countries of the Region so that the dentist-population ratio now approximates those of several developed countries, the difficulties associated with implementing effective health care systems for the delivery of restorative care to the majority of the population would appear to have become more acute. The problem of HIV infection has had a considerable impact on the dental profession, demonstrating the need to improve infection control and protection of health workers.

18. The economic crisis has affected all sectors in the provision of dental services, especially the areas involved in the development and provision of equipment and the availability of medicaments and supplies. Nevertheless, considerable progress has been made recently with the introduction of fluoridated table salt as a mass preventive measure in which the Region of the Americas now has the greatest number of countries.

19. Although significant strides in disaster preparedness and health sector emergency management have been made throughout Latin America and the Caribbean in the last few years, the Region's vulnerability to both natural and potential man-made disasters remains unabated. Factors involved in the current economic crisis, coupled with continuing population pressure on urban centers from rural migration, continue taxing the overburdened health structure.

20. New or growing threats from potential technological disasters, especially chemical and radiological, have led to innovative courses being developed and taught at both regional and subregional levels. Promoting and keeping the pressure on the health sector to be prepared have sometimes acted as a catalyst to needed reforms and long-term improvements in the overall health system.

21. While most countries have now established Preparedness Departments in their Ministries of Health, with trained competent staff, many of these departments are still without permanent funding, especially in those countries undergoing the most serious economic problems. A number of countries have initiated their own in-service education programs using the "train-the-trainer" methodology, but have had difficulty sustaining the level of training commitment because of medium and long-term financing.

22. Positive strides have and continue to be made in intracountry technical cooperation and resource sharing (human and material), and PED continues to promote more and varied formal mutual assistance agreements and treaties.

23. New initiatives and inroads are being made in integrating preparedness issues with the curricula of health science faculties and schools of engineering in universities throughout the Region, and a series of regional and country training workshops for foreign affairs and diplomatic personnel has led to continued requests for more of this type of training.

24. A country's level of readiness in dealing effectively with disasters and other emergencies is reflected in the quality and efficiency of its normal health services. Using programs involving health preparedness and response to disasters as a way to promote health and other interrelated sectors at the top levels of government has resulted in positive contributions to the health services infrastructure.

25. Continued support will be required until such time as all countries have committed themselves to regular funding and staffing of the Health Ministry's Preparedness Departments.

26. Community-based rehabilitation, which has facilitated the promotion of health, prevention of risks, and integration of persons with disabilities, will continue to be the specific strategy of the intersectoral work of this program.

GLOBAL STRATEGY OF COOPERATION

27. The HSD program is composed of the DHS, CLR, EDV, HED, and ORH projects, whose strategies are:

27.1 Promotion and support of the development of local health systems as the fulcrum for reorientation of the sector in order to achieve equity, quality, efficiency, control of the environment, and social participation.

27.2 Integration of the health sector in regional and local development as a contribution to overall, equitable socioeconomic development and to the democratization process.

27.3 Promotion and support of the management of knowledge through research, analysis, and dissemination of national experiences.

27.4 Conceptual and methodological framework for the reorientation and reformulation of the health services systems, especially with regard to the strengthening of local strategic administration, which includes conduct, programming, and management; information systems; the development of intersectoral action and the consolidation of social participation; and reformulation of financing mechanisms.

27.5 The integration of specific DHS, CLR, EDV, HED, and ORH projects within the principal line of comprehensive development of the health services.

28. The PED strategy for 1992-1993 will continue to stress Total Resource Mobilization, Technical Cooperation, Intersectroal Training, and Information Dissemination, all compatible with the organization's orientation. The focus will be on strengthening the disaster preparedness infrastructures in Ministries of Health and Social Security, in Civil Defense organizations, and with the Red Cross and other NGOs.

29. Emphasis will be placed on country program self-sufficiency in the development of disaster plans, sponsoring or cosponsoring training activities, and having in-place mechanisms to deal effectively with large-scale natural and man-made disasters.

30. Recent initiatives in the area of training for technological disasters, training of diplomatic personnel, and preparedness curricula development in university health sciences and engineering departments will continue to be strengthened.

31. As the decade of the 1990s is the International Decade for Natural Disaster Reduction, special emphasis will be given to supporting close cooperation between national IDNDR Committees and the Health Sector.

ANALYSIS OF THE PROGRAMS

SPECIFIC PROGRAMS

HEALTH SERVICES DEVELOPMENT (DHS)

BIENNIAL TARGETS

32. To promote and develop transformation of the national health systems in the countries on the basis of development of local health systems as an operational tactic in order to apply the strategy of primary care, taking into account the goal of HFA/2000 with equity, quality, efficiency, social participation, and control of the environment.

33. To promote incorporation of the health sector into the processes of decentralization and socioeconomic development as appropriate instruments for achieving democratization, greater participation, and social justice.

34. To promote proper identification of the population groups with the greatest needs and to grant resources comprehensively to provide for priority health problems as far as promotion, prevention, treatment, and rehabilitation are concerned, and in this manner ensure that the local health systems become the agents of the health programs, of maternal and child care, and of the health of adults and the elderly, workers, and other special groups.

35. To cooperate in order to achieve the development of appropriate strategic management through the development of administration and local strategic programming processes.

36. To promote, based on the development of local health systems, interprogramming, interinstitutional, and interdisciplinary coordination to relate health with other contextual factors such as nutrition, housing, work, and education.

37. To promote leadership in the health sector through local development and support for the reorganization of the entire health system, the reorganization of the Ministries of Health, and the redesign of financing mechanisms and social security systems at both the national and provincial levels in order to achieve a proper balance between central institutional development and the regional and local levels.

38. To promote, based on the local health systems, the strengthening of hospital administration and its integration into local strategic administration and programming.

39. To promote the integrated development of subsystems and essential components of the health services, especially with regard to the following: laboratory services; public health nursing; radiology; drugs; blood banks and

biologicals; physical resources and equipment, their programming, maintenance, and recovery; information subsystems; oral health programs; and community education and social participation in the promotion of health.

40. To develop and apply appropriate methodologies for planning, programming, administration, organization, and evaluation of the health services aimed at achieving equity, effectiveness, efficiency, community participation, and intersectoral development, with special attention to mass, permanent, and in-service training of all health personnel in coordination with manpower development agencies, training and higher education institutions in the field of public health, universities, and other centers for the training of human resources.

41. To develop indicators that will permit the evaluation of coverage and the impact of the local health systems on the health of the population.

42. To introduce health services research as part of the permanent activities of the health services through the active participation of the health personnel and members of the community in defining the problems to be resolved in carrying out research and in applying the knowledge obtained.

43. To reorient investment in health and its relationship to national policies and strategies and to bring about coordination with financial institutions, banks, and bilateral support institutions.

LINES OF ACTION

44. Support for subregional initiatives and PWRs with regard to national reorganization of the sector with emphasis on the development of urban, suburban, and rural local health systems for the purpose of achieving greater equity, effectiveness, and efficiency.

45. Collection, analysis, and dissemination of national experiences in reorganizing the sector and developing local health systems, as well as the integration of health care into development and democracy through the local health systems.

46. Development of methodologies in order to aid in identifying the population groups at greatest risk and need; the incorporation of specific knowledge and technologies of health care, environment programs, laboratory support services, radiology, drugs, and oral health; and support for intersectoral health and development projects that will assist in coordinating the various sectors and institutions in the development of health, the private sector, the NGOs, and social security systems under the leadership of the national and provincial ministries and municipios and through the development of local health systems.

47. To emphasize and prioritize studies, research, and direct support to the countries in the priority subject, such as equity, social participation, effectiveness, quality, mechanisms for financing the development of health services; and in programming and management, relating this activity to other regional priority subjects such as health and women, the promotion of health, and workers' health.

48. Support for the mobilization of resources and for technical cooperation between countries in the areas included in the program.

ESSENTIAL DRUGS AND VACCINES (EDV)

BIENNIAL TARGETS

49. The Program on Essential Drugs and Vaccines supports the governments in formulating and implementing national policies and programs directed toward improving accessibility to these critical supplies and enabling the entire population to enjoy the benefits of a sound pharmacotherapy system. Among the goals proposed for the biennium are:

49.1 The formulation of policies relating to this subject in most of the countries of the Region and the enactment of pertinent legislation and regulations. In at least 10 countries intersectoral committees will be institutionalized to coordinate and monitor the execution of national essential drugs programs, particularly with regard to long-term processes aimed at organizing the sector.

49.2 The design and implementation of prototypes for pharmaceutical services in several countries in every subregion with the aim of developing effective pharmaceutical care.

49.3 The implementation of Good Laboratory Practices in most of the member institutions of the Latin American Network of Official Quality Control Laboratories, which will continue to serve as the core for technical cooperation in quality control and assurance.

49.4 The reorientation of training of pharmacists in order to achieve their full participation in transforming the health services. The rational use of drugs will be reflected in the curriculum changes in the pharmacy schools that will be promoted by the program.

LINES OF ACTION

50. Development of the pharmaceutical services with emphasis on local health systems. These actions at the national level will be carried out in programs and projects framed in a policy based on a concept of essential drugs commensurate with sectoral health policies and with general development policies.

51. Quality control and assurance of pharmaceutical products and biologicals. Development of systems to verify the quality of the products available in the health services in both the public and private sectors.

52. Training of the human pharmaceutical resources required for the implementation of cost-effective national drug programs aimed at improving the quality of pharmacotherapy.

53. Development of information services on drugs in order to ensure the availability of objective and updated information for sound prescription, dispensing, and use of drugs.

54. Support for national production and purchase of pharmaceutical products and biologicals. Promotion of policies to promote local production of national Formulary drugs when economically and technically justified and the provision of advisory services to the industries involved.

ORAL HEALTH (ORH)

BIENNIAL TARGETS

55. Development of oral health infrastructure which will enable oral health programs to be fully incorporated into general local health systems programs in countries of the Region.

56. Implementation of mass caries prevention measures in the Region.

57. Establishment of a network of communications for technical information between countries of the Region.

58. Provision of specific technical assistance to countries in the Region.

59. Organization of meetings to advance knowledge on appropriate technology, systems of prevention, integration of teaching with service in the development of human resources, evaluation of oral health programs within local health systems, development of research and research priorities, and development of hemispheric relationships with institutions in dental education and services.

60. Establishment of technical collaboration programs between countries in the Region.

61. Direct attention to human resources imbalance and assistance to dental training institutions to improve productivity and curriculum.

62. Expansion of coverage capacity in the countries.

63. Initiation of effective infection control procedures in selected countries and a program for immunization of dental personnel for hepatitis.

64. Implementation of a reporting system to provide region-wide dental health status data and reporting on HIV infections.

65. Conduct of major research studies on fluorides, nutrition and caries, and environmental factors influencing periodontal diseases.

66. Holding of courses on specific dental topics.

67. Establishment of one additional WHO intercountry collaborating center and two collaborating centers. Active promotion of dental epidemiology, research, and training program at the existing intercountry Collaborating Center in Ecuador (three courses per year).

68. Collaboration with major initiatives in the Caribbean by developed countries in the Region.

69. Production of relevant publications.

70. Participation in programs for the application of appropriate tecnology.

LINES OF ACTION

71. The main activities of the programs will be directed toward continued stimulation for the introduction of programs for the fluoridation of refined table salt where such measures will have an impact upon dental caries prevalence and, in particular, in regions which cannot be reached by other effective mass preventive dental measures.

72. Promote the concept of teaching with service and research as a mechanism to improve the knowledge of dental diseases and to develop human resources more appropriately trained to resolve the problem of coverage in the regions.

73. Develop the national and hemispheric bodies within the dental associations so that there is integration and collaboration in the implementation of activities to improve oral health and the more effective utilization of manpower as well as extension of coverage.

74. Introduce educational and other institutions to electronic communication networks and produce materials to improve the quality of education and information which can readily be made available to institutions throughout the Region.

ANALYSIS OF THE PROGRAMS

7. ORGANIZATION OF HEALTH SERVICES BASED ON PRIMARY HEALTH CARE (CONT.)

75. Promote epidemiological studies in those countries where limited information is still available in oral health.

76. Develop components for the incorporation of oral health into general health programs such as health of adults, health of workers, and maternal and child health.

77. Review and analyze factors associated with the provision of dental services, such as the availability of materials, equipment and supplies, and promote the appropriate local development of these items to resolve country problems.

78. Conduct courses to train investigators and initiate major research projects on needed areas of study within the Region.

79. Develop indicators for the evaluation of oral health status and the capability within oral health systems.

80. Stimulate the incorporation of oral health within general health systems through meetings, programs, and demonstration projects.

DISASTER PREPAREDNESS (DPP)

BIENNIAL TARGETS

81. PED will have targeted two of the four Subregional Initiatives and will have developed and included in them a specific preparedness project that will address a key Initiative priority such as the strengthening of the health infrastructure.

82. All disaster-prone countries of over one million inhabitants will have fully functioning Preparedness Departments within their Ministries of Health. PED will continue to work in establishing functioning offices with trained staff throughout the biennium.

83. When a disaster has occurred in a Member Country, PED will have provided a prompt and effective response to that disaster-affected Member Country and will have helped it assess its health needs and coordinated its international relief assistance.

LINES OF ACTION

84. Mobilize teachers and administrators at universities in the health sciences, public health, engineering, and schools of nursing by increasing training opportunities by 10% a year during the biennium and by making available more technical teacher-training material through the PED documentation center.

85. Insure active participation and cooperation of PWRs in all disaster-prone countries through established National Disaster Committees for the IDNDR.

86. Work with country Ministries of Health in their efforts to establish Preparedness Departments and Disaster Units within their Ministries.

87. At least one seminar per year as well as meetings will be held during the biennium to insure that the multilateral dialogue between the health sector and the NGO community (Red Cross and others), Civil Defense, Social Security and Foreign Affairs will continue and become institutionalized.

88. Increase technical training opportunities for professionals from many disciplines dealing with emergency management issues and allied with health to ensure a more integrated and intersectoral approach in Member Countries to deal with preparedness and relief.

CLINICAL, LABORATORY, AND RADIOLOGICAL TECHNOLOGY FOR HEALTH SERVICES (CLR)

BIENNIAL TARGETS

89. Increase the coverage of diagnostic imaging, radiation therapy, nuclear medicine and radiation safety services--especially in the local health systems--through the promotion of appropriate technology and qualified staff.

90. Improve the quality of existing services through comprehensive quality assurance programs that:

90.1 In diagnostic imaging services ensure optimum image quality at minimum radiation dose.

90.2 In radiotherapy services deliver accurate radiation doses to the volumes of interest.

91. Minimize risks from the use of ionizing radiations in the health services to the patients, the staff, and the general public through compliance with updated radiation protection laws, regulations, and norms.

92. To improve the laboratory and blood transfusion services in support of the health programs, particularly in the local health care systems through:

92.1 Improved management procedures, including personnel management, supervision, inventory control, workload and staff requirements, cost studies, etc.

92.2 Quality assurance programs to ensure reliable results through standarized procedures, proper quality reagents, and preventive maintenance equipment, and external and internal quality control schemes.

93. Information exchange in promoting new technologies as they become available and appropriate for the health care system. These new technologies exist in the area of biotechnology with improved detection systems, along with new mechanized equipment, computerized or otherwise automated noninvasive procedures.

94. Improve the biosafety measures and consideration for the public health laboratory and health care system, including prevention and control of nosocomial infections.

LINES OF ACTION

95. Develop inter- and intraprogrammatic activities to support radiology services.

96. Improve situation analysis in radiology at the country and regional level.

97. Support country offices in technical cooperation.

98. Improve research through support of research design and implementation of results.

99. Improve situation analysis of laboratory service to include amplitude of quality of service with emphasis on policies, organization, structure, and overall management of health laboratory systems and blood transfusion services, giving particular attention to primary health care--local health systems.

100. Regional, inter- and intraprogrammatic laboratory activities to support quality assessment, quality assurance, biosafety, biotechnology programs for health, and clinical and blood transfusion services.

ANALYSIS OF THE PROGRAMS

101. Consultation and training support for subregional and national laboratory program activities.

HEALTH EDUCATION AND COMMUNITY PARTICIPATION (HED)

BIENNIAL TARGETS

102. To promote social participation in reorganization of the sector and decentralization as an expression of the democratic process and of development with equity.

103. To promote the use of methodologies for analysis, definition of priorities, granting of resources, and evaluation of activities that will permit active participation by the people in the decisions that affect their health and their housing, work, study, etc.

104. To support the incorporation of health education methodologies into the processes of development and promotion of health.

105. To incorporate priority activities in the development of leadership in the field of health, especially with regard to women in development.

LINES OF ACTION

106. To support national, subregional, and regional initiatives that incorporate social participation experiences into the development of health.

107. To develop and incorporate methodologies for shared dialogue between the population and the health sectors, especially with regard to local strategic administration processes.

108. To promote studies to identify community organizations, NGOs, and other agencies related to the health development process.

REHABILITATION (RHB)

BIENNIAL TARGETS

109. To promote the early detection of risk and/or disability and timely and effective treatment.

110. To develop training modules for upgrading the management of rehabilitation services by levels, subsequently apply such models by subregions, and evaluate ongoing experiences.

7. ORGANIZATION OF HEALTH SERVICES BASED ON PRIMARY HEALTH CARE (CONT.)

111. To collaborate with the countries in order to diminish inequities in the acquisition of services and adapt the services for the development of rehabilitation activities.

112. To promote intra- and intersectoral coordination for community health care actions for persons with disabilities.

LINES OF ACTION

113. Dissemination of information and strengthening of activities concerning training and the dynamic concepts of damage, deficiency, disability, and disadvantage by employing promotion and prevention as the most appropriate element for breaking the cycle and promoting the functional state of health of disabled persons or those at potential risk.

114. Coordination with HSD and national groups in carrying out workshops in order to train personnel and communities in community participation and in the programming and execution of comprehensive plans through the integration of specific rehabilitation actions in the general health services.

115. Continuance of the application of community-based rehabilitation as an appropriate technology for achieving equity and expanding coverage.

7. ORGANIZATION OF HEALTH SERVICES BASED ON PRIMARY HEALTH CARE (CONT.)

PROGRAM BUDGET DISTRIBUTION BY LOCATION

LOCATION	PAHO AND WHO REGULAR BUDGET			EXTRABUDGETARY FUNDS		
	1990-1991	1992-1993	1994-1995	1990-1991	1992-1993	1994-1995
DIRECT COOPERATION WITH COUNTRIES	24,882,100	25,800,600	28,995,000	38,777,840	19,682,268	952,000
REGIONAL PROGRAMS	3,955,100	4,560,700	5,129,000	887,163	927,430	138,000
TOTAL	28,837,200	30,361,300	34,124,000	39,665,003	20,609,698	1,090,000

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	14,882,000	638	384	6050	6,622,600	590,700	581	1,103,900	2,374,000	1,152,700	662,700	2,375,400
WHO - WR	13,955,200	936	384	4790	8,306,600	533,900	924	1,755,600	1,362,300	874,700	66,700	1,055,400
TOTAL	28,837,200	1574	768	10840	14,929,200	1,124,600	1505	2,859,500	3,736,300	2,027,400	729,400	3,430,800
% OF TOTAL	100.0				51.8	3.9		9.9	13.0	7.0	2.5	11.9
1992-1993												
PAHO - PR	15,065,300	535	288	5175	6,709,400	813,400	530	1,060,000	2,819,700	1,252,600	91,400	2,318,800
WHO - WR	15,296,000	877	408	3990	9,511,900	538,800	653	1,306,000	1,344,100	825,900	0	1,769,300
TOTAL	30,361,300	1412	696	9165	16,221,300	1,352,200	1183	2,366,000	4,163,800	2,078,500	91,400	4,088,100
% OF TOTAL	100.0				53.4	4.5		7.8	13.7	6.8	.3	13.5
1994-1995												
PAHO - PR	16,995,700	528	288	5175	7,417,900	943,900	530	1,113,000	3,271,300	1,453,200	106,100	2,690,300
WHO - WR	17,128,300	864	408	3990	10,561,300	624,800	653	1,371,300	1,559,600	958,300	0	2,053,000
TOTAL	34,124,000	1392	696	9165	17,979,200	1,568,700	1183	2,484,300	4,830,900	2,411,500	106,100	4,743,300
% OF TOTAL	100.0				52.6	4.6		7.3	14.2	7.1	.3	13.9

8. HUMAN RESOURCES DEVELOPMENT

ANALYSIS OF THE HEALTH SITUATION

1. Any effort to analyze the situation of the development of human resources in health in the Region of the Americas encounters two elements that strongly influence the results of that analysis:

1.1 On the one hand, the effects and implications of the current crisis which, although part of an economic determinant, really has other factors that mold it, specifically of a social and political nature. The manifestations of that crisis extend from the decisions of the highest governmental level through the academic and service sectors to the individual lives of the health workers and the users of the services.

1.2 On the other hand, the influence of schemes, approaches, and forms of work for the development of human resources that originated in response to other times and to different needs and demands. Political proposals for planning, education, and utilization of health personnel attempted to respond (with successes and failures) to a conception of health different from the current one, within which there was always a lack of precision in the definition of the role of the human resource (professional, technical, and auxiliary) in the face of the strategies formulated by the governments in unstable, sociopolitical and economic contexts--changing and imprecise in most cases.

2. In the context of the crisis it should be noted that the work force of the sector is affected, with respect to policies for employment and wage adjustments, by the inability of the services to absorb the available professionals on one hand and, on the other, the migration of personnel related to offers of higher remuneration (from the public sector to the private sector and from underdeveloped to developed countries). Similarly, in the training sector the increases in gross expenditures on higher education have been reversed. The impact of the restrictions is translated into a serious crisis, characterized by the existence of poorly paid professors who are lacking in motivation to teach and devote less time to academic activity and by a marked reduction in the research work. To this is added the decay of the installations, with classrooms, laboratories, libraries, and equipment deteriorated and outdated, a picture that is completed with the utilization of inadequate hospital services with frequent questioning of the actual quality of the health care being provided. Of course, the unfavorable economic conditions do no more than exacerbate and reveal problems that had their beginnings in the past and present a warning, calling for more efficient, priority attention to the problem.

3. In addition, to replace the traditional approaches that are being used in this field, it becomes necessary to analyze the area of human resources in the context of the multiplicity of institutions and agencies involved, often with divergent interests and lines of action. The health services and the corresponding ministerial umbrella, the various union groupings, the university and its different levels of action, the professional schools, and the science and technology sector, among others, shape spaces of decision-making and action where various structures, modes of action, and strategies are interwoven and confront each other and through which every agent attempts to guarantee better ways of developing its own interests. The existing fragmentation in this field makes it a space where the capacity for decision-making and action is divided among the actors, resulting in a relatively ungovernable area and permanent conflict.

4. The complexity of the factors indicated leads to the disparity of situations found in the different countries, in which there are claims of overproduction and an excess of professionals concomitant with a trend toward a reduction in the rate of growth of essential categories, such as physicians, in which bad geographical distribution and an inappropriate balance of the composition of the health team in relation to the unability of the services to absorb new trained personnel are observed; in which growing numbers of unemployed physicians and a large number of communities without physicians are found; and in which, despite the deficiency of nurses, not more than one of every three newly graduated nurses is taken advantage of in the health service.

5. To this is added the apparent insensitivity of the training institutions which thus do not reorient their programs to relate to the real needs of the population and to the very policies adopted by the services in the context of the goal of health for all and the strategy of primary health care. What is called transition in health, evident in most of the countries of the Region, appears to have been considered neither at the teaching level nor by the investigators, with the result that conceptual, methodological, and operational gaps, especially in the field of public health, are perpetuated.

6. In particular, the failure of the curriculum changes developed from a pedagogical perspective call attention to the limitations of the educational process and its distance from the practice of health. There are distortions observed between medical practice and medical education when the latter does not take into account the dominant aspect of the former and there is a continuance of the influence of models of traditional practice already definitively replaced by others into which the majority of professional futures will have to be incorporated. It is also observed that part of the difficulty in the preparation of the human resources stems from conceptual gaps around the actual process of work in health and their implications for the production of learning in the services, from basing the possible integration of that learning with the care and achieving, in this way, the gradual and progressive transformation of the practice in health, an objective which in last analysis should be pursued with continuing education.

7. The entire scenario described is completed with the consideration that the public health community--those responsible for the conduct of the sector--do not perceive the work force as a priority in the operation of the services and do not recognize the need for greater technical and scientific knowledge in those charged with their management, who in many situations are deprived of the specific training and knowledge that they should have.

8. Finally, one notes the confusion and disorder generated by the same agencies of international cooperation that, upon defining lines of collaboration without a process of identification of real needs, without taking into account the changing facts and the existing situation, and without coherent planning, create duplications and discrepancies, thus contributing to further deterioration of the situation. The forms of delivery of international cooperation manifest, in addition, incoordination, little probing of the real problems, conflict between politicians and technicians, and the dubious suitability of the options proposed, to the point of requiring an urgent review and a more adequate orientation of the responsible personnel, in general, in the entire effort of development of health in the international context and, in specific terms, in what is relative to the actual development of the human resources.

GLOBAL STRATEGY OF COOPERATION

9. The global strategy for technical cooperation of the Manpower Development Program is directed toward collaboration with the governments in strengthening the coordination, planning, training, and utilization of the human resources, in the form of responding, in quantitative and qualitative terms, to the needs imposed by the transformation of the health services systems through decentralization and the strengthening of local health units.

10. In particular, in order to be able to put this global strategy into practice it is essential to promote a better understanding of the importance of the work force as a priority element in the operation of the services. It will be necessary to emphasize appropriate valuation and recognition of the coordination of the process of manpower development in health and, in addition, to promote implementation of the interventions in this field with increasing scientific and technical rigor by personnel trained to the high degree that the relevance of the subject merits.

11. With this orientation there is a need not only to deepen the knowledge of the entire process of manpower development and to introduce new approaches that take into account the determining structural factors in the problems of the area, but also to promote a more comprehensive approach to the elements relative to the training and utilization of personnel, in order to achieve a potential of action sufficient to explain and find the alternative solutions to these same problems.

12. Obviously, in this plan priority will be given to the intersectoral nature of the problem and to consideration of the subject in the context of the strategy of health in development.

13. In more specific terms, the following components, closely related to several of the other strategic orientations of PAHO for the 1991-1994 quadrennium, are distinguished from this general strategy:

13.1 Support for the development and strengthening of the information subsystems in the area of human resources, with emphasis on their application in the corresponding decision-making, either based on their direct utilization or through the realization of research that leads to a better comprehension of the situation.

13.2 Promotion of the review of the policies relative to the field of human resources with a strategic perspective, involving the social actors that intervene in this field and considering, in addition to the reality of the health services, the market dynamics that govern the exercise and practice of the profession, the influence of science and technology on training and work in health, and the characteristics of the actual basic training of that personnel.

13.3 Promotion of better utilization of all training opportunities in relation to the changes that are adopted at the service level and the need for continuous updating, including a reorientation of the utilization of the scholarship program, constant review and adjustment of the supply from the textbook program, and broad dissemination of the application of the methodology that is being proposed for the development of continuing education, centered on actual conditions in the services.

13.4 Promotion of the expansion of the participation of the academic institutions and of scientific and technical development in the orientation and implementation of the changes that are considered necessary in the area of health manpower, including in this amplification agencies that are not traditionally devoted to the field of health.

13.5 Support for basic training in priority areas and promotion, with the use of prospective analysis, of the institutional changes necessary for the coordination of the institutions for training personnel with the health institutions and their relationship to the practice and the social structure in the face of the health needs of the countries; in addition, emphasis on what is relative to the promotion of better articulation of basic biological and social knowledge.

13.6 Promotion of the development of leadership in health, supporting the advanced training of human resources in close relationship with the strategic orientation of management of knowledge and with emphasis on review of the theory and practice of public health, broader incorporation of the contributions of the social sciences, and deepening of the knowledge and practice of international health.

13.7 Application of all the mentioned strategies basically through subregional initiatives, strengthening cooperation among countries, and supporting joint activities in relation to the identity of the detected problems.

8. HUMAN RESOURCES DEVELOPMENT (CONT.)

SPECIFIC PROGRAMS

HUMAN RESOURCES ADMINISTRATION (HMA)

BIENNIAL TARGETS

14. To disseminate in the countries the application of the strategic approach in manpower development, promoting the articulation of the policies for education and health.

15. To implement in the countries an information system on human resources and to establish a flow of communication with the central data bank.

16. To promote the development of applied research in the area of human resources, with emphasis on the aspects relative to productivity, the sociology of the professions, and educational orientations in the service.

17. To train personnel in all the countries that have specialized in the area of human resources, with emphasis on the managerial aspects and educational development.

18. To support dissemination of the use of the methodology of continuing education centered on actual conditions in the services, and to meet the needs of personnel in local health systems, with emphasis on epidemiology and administration.

19. To support the other PAHO programs and the Country Representatives in the incorporation of this same methodology of continuing education into the other training activities that have been programmed.

LINES OF ACTION

20. Support will be provided to hold workshops on strategic planning of human resources at the local, institutional, and national levels.

21. Technical cooperation will be provided for the application of the strategic approach at the national level in the countries that decide to prepare plans for human resources.

22. National efforts for formulation and/or analysis of health manpower policies will be supported.

23. Promotion of nuclei of information on human resources at the national level will be continued.

24. An information system will be established at the central level for collection, analysis, and dissemination of information relevant to human resources.

25. An effort will be made to establish a new data bank for nonquantitative information on career systems, positions, and wages.

26. Support will be continued for national groups to prepare research protocols on productivity, the sociology of the professions, and education in the services.

27. The possibility of promoting new lines of research will be studied.

28. The realization of sectoral studies in the field of human resources will be promoted.

29. An effort will be made to maintain the subregional training courses in manpower development.

30. Based on the follow-up of these courses, it is expected that it will be possible to organize a regional course aimed at higher levels of scientific and technical development in order to train specialists in the matter.

31. A continuing education project will be prepared in order to capture extrabudgetary resources in this field.

32. Continued support will be provided for the application of the methodology of continuing education at the country level, with emphasis on training for development of local units.

33. An effort will be made to promote and support the adoption of the same methodology by the other technical cooperation programs.

COORDINATION AND SUPPORT OF HUMAN RESOURCES DEVELOPMENT (HMC)

BIENNIAL TARGETS

34. To achieve in all the countries full recognition of the need for coordination in the process of manpower development in health.

35. To strengthen, in this context, the development of the leadership that favors consideration of health in the process of development.

36. To expand the participation of the university as a whole in the reorientation of the development of personnel, in relation to the goal of health for all by the year 2000.

37. To support the initiatives for cooperation at the subregional level, strengthening the strategies of manpower development, directly in the countries involved and indirectly through the other program categories in the Organization.

38. To achieve more efficient use of the scholarships provided by the Organization, in the context of national manpower development policies.

39. To maintain the continuous adaptation of the materials offered by the Textbook Program with respect to the health priorities of the countries.

LINES OF ACTION

40. Coordination of efforts for manpower development will be promoted with international, bilateral, or nongovernmental agencies.

41. The search for extrabudgetary resources for new development projects will be expanded.

42. The initiatives will be supported through the Health Training Program for Central America and Panama (PASCAP), as a mechanism for mobilization of resources at this level.

43. Information on human resources in Medical Education and Health and in the Bibliographic Series on Human Resources will be disseminated in order to promote the recognition and understanding of the importance of the area.

44. Advice in the field of the manpower development will continue to be supplied directly to the countries, supplementing the action of PASCAP and the subregional advisers.

45. The development of manpower development units in the Ministries of Health and in the social security institutions will be supported.

46. The development of interdisciplinary nuclei in the universities will be developed as a way of maximizing participation in the investigative effort in support of the goal of health for all by the year 2000.

47. Continuous discussion that encourages the leadership that is needed for the consideration of health in the context of development.

48. A better orientation will be sought in the granting of scholarships for training based on national policies of manpower development.

49. An effort will be made to update the offerings from the Textbook Program.

ANALYSIS OF THE PROGRAMS

HUMAN RESOURCES EDUCATION (HME)

BIENNIAL TARGETS

50. To support development, in selected countries and institutions, of alternative schemes of professional training, on a priority basis in medicine and nursing and from the strategic perspective of attaining the goal of health for all by the year 2000.

51. To complete the analysis of the situation in the theory and practice of public health, to formulate an objective image of the desirable level, and to analyze the implications for the services, research, and education in the countries of the Region.

52. To support the reorientation of graduate-level education and eventual creation of new programs in public health, taking into account the analysis of the critical areas of the infrastructure and the delivery of health services.

53. To continue to develop the approach of promotion of leadership through a residency in international health and to disseminate in the Region the conceptual and operational aspects of this approach, with emphasis on the enhancement of international technical cooperation.

54. To establish networks of academic communication and of service, with electronic resources and possibly meetings, with emphasis on the flow of information in the field on the development of human resources and international health and on the possibility of access to large bibliographic data banks.

LINES OF ACTION

55. Advisory services will be provided to the professional schools in general, with emphasis on medicine and nursing for their incorporation into schemes of strategic development closely related to reaching the goal of health for all by the year 2000.

56. Promotion of the integration of the schools of the area in the BITNET electronic communication network will be continued in close collaboration with the Pan American Federation of Associations of Faculties and Schools of Medicine (PAFAMS).

57. Analysis of the theory and practice of public health in groups oriented to the development of the services, research, and education will be promoted at the country level.

8. HUMAN RESOURCES DEVELOPMENT (CONT.)

58. It is expected that it will be possible to hold integrated subregional meetings for consolidation of the knowledge produced in this respect.

59. In parallel with the line of analysis of the theory and practice of public health, the corresponding schools for the application of the concepts developed will be supported.

60. Support will be continued for international health as a field of practice and basic theoretical development for a greater exchange among the countries.

61. Development of the residency in international health will be continued at the regional level.

62. The establishment of training programs in international health will be promoted at the level of the developing countries.

PROGRAM BUDGET DISTRIBUTION BY LOCATION

LOCATION	PAHO AND WHO REGULAR BUDGET 1990-1991	1992-1993	1994-1995	EXTRABUDGETARY FUNDS 1990-1991	1992-1993	1994-1995
DIRECT COOPERATION WITH COUNTRIES	8,036,200	9,360,800	10,590,000	3,222,184	2,271,956	491,516
REGIONAL PROGRAMS	3,386,500	3,947,600	4,290,700	867,400	1,046,000	1,173,100
TOTAL	11,422,700	13,308,400	14,880,700	4,089,584	3,317,956	1,664,616

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL PROF. MONTHS	PERSONNEL LOCAL MONTHS	PERSONNEL CONS. DAYS	PERSONNEL AMOUNT	DUTY TRAVEL AMOUNT	FELLOWSHIPS MONTHS	FELLOWSHIPS AMOUNT	SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	7,304,300	384	528	1315	4,248,400	285,700	216	410,400	893,700	188,500	22,900	1,254,700
WHO - WR	4,118,400	96	216	2200	1,709,400	143,400	382	725,800	924,000	289,100	52,300	274,400
TOTAL	11,422,700	480	744	3515	5,957,800	429,100	598	1,136,200	1,817,700	477,600	75,200	1,529,100
% OF TOTAL	100.0				52.1	3.8		9.9	15.9	4.2	.7	13.4
1992-1993												
PAHO - PR	8,997,200	350	552	1240	5,027,200	388,500	218	436,000	1,328,200	349,900	0	1,467,400
WHO - WR	4,311,200	96	192	1350	1,729,700	183,700	315	630,000	855,800	357,700	0	554,300
TOTAL	13,308,400	446	744	2590	6,756,900	572,200	533	1,066,000	2,184,000	707,600	0	2,021,700
% OF TOTAL	100.0				50.8	4.3		8.0	16.4	5.3	.0	15.2
1994-1995												
PAHO - PR	10,034,900	336	552	1240	5,511,400	450,900	218	457,800	1,541,100	406,000	0	1,667,700
WHO - WR	4,845,800	96	192	1350	1,920,700	213,000	315	661,500	992,700	414,800	0	643,100
TOTAL	14,880,700	432	744	2590	7,432,100	663,900	533	1,119,300	2,533,800	820,800	0	2,310,800
% OF TOTAL	100.0				50.0	4.5		7.5	17.0	5.5	.0	15.5

9. HEALTH INFORMATION SUPPORT

ANALYSIS OF THE HEALTH SITUATION

1. The continuous exchange of scientific and technical health and biomedical information among governments, health practitioners, and the general public is essential for the development of health resources and the achievement of health for all by the year 2000.

2. The efficient exchange of this information is complicated by two major factors: (1) an excess of information, much of which may not be validated, which, in turn, poses problems for health professionals who may not have the time or the means of selecting that information which is important, and--ostensibly a contradiction--(2) few available sources of information, as so much information is irrelevant to actual needs or prohibitively expensive to acquire.

3. The availability and the use of scientific and technical health information in most countries of Latin America and the Caribbean has been hindered in recent years by the growing deterioration of libraries and national centers for health and biomedical information and documentation. Among the causes of this deterioration are limited resources--brought about by a prolonged economic crisis and, in particular, the problem of debt servicing that places a premium on foreign currency reserves--which constrain the ability to renew or expand subscriptions to periodical publications, to procure other publications, and to obtain the means required to access electronic databases through the currently available technologies.

4. Scientific and technical health information plays a critical role in solving specific health problems and developing national and local health systems in the countries of the Americas. This issue was considered by the PAHO Subcommittee on Planning and Programming in April 1990, by the 105th Meeting of the PAHO Executive Committee in June, and by the XXIII Pan American Sanitary Conference in September 1990.

5. The Conference also approved the "Strategic Orientations and Program Priorities for the Pan American Health Organization during the Quadrennium 1991-1994," which included the management of knowledge as an essential component in the process of transformating of the national and local health systems. PAHO has sought to redress that problem by making information dissemination a key strategy of its technical cooperation programs, channeling information not only to academia but to health service systems, assuring at the same time the dissemination of information dissemination to the community at large.

6. At the present time, data processing technologies, electronic communications, and the use of satellites make it possible to provide vital health and medical information on a regular basis. These systems are in a continuous process of development and are ever-expanding in their capacity to disseminate information. There could be expected to be an explosion in the near future of possibilities to increase health workers' access to scientific and technical information. Nevertheless, in the countries of Latin America and the Caribbean, the scarcity of this kind of information has always been an important problem that has hindered development of the biomedical disciplines.

7. The situation with regard to biomedical journals published in Latin America and the Caribbean reflects a fourfold crisis: a) journals tend to be short-lived (lasting an average of 22 months); b) content, especially original articles, is in short supply, which often makes regular publication difficult; c) the validity of the content is questionable, owing to the lack of editorial boards and peer-review systems; and d) costs are rising and financing is uncertain. Whereas the Latin American Index Medicus--IMLA--comprises information published in 426 journals, only 47 of those journals have met the standards of quality that permit their inclusion in the Index Medicus of the United States National Library of Medicine.

8. Publishing is merely a latter stage of a continuum. It is the quality of research ongoing in the countries, regardless of whether the results are published by PAHO or not, that will dictate the quality of information disseminated in the Region.

9. PAHO works in four official languages: Spanish, English, Portuguese, and French. As a consequence, there is a need for: a) scientific-technical health publications in those languages, especially Spanish and English; b) simultaneous interpretation services in the four languages at the Executive Committee, the Directing Council and the Pan American Sanitary Conference. Moreover, simultaneous interpretation services in English and Spanish at Headquarters and in the field are needed for numerous scientific and technical meetings held at Headquarters and in the field.

10. The 1992-93 BPB marks the beginning of a new stage in recognition of the important role that Public Information plays in carrying out the mandates of the Governing Bodies, as expressed in the Strategic Orientations and Priorities for 1991-94. Two of the key strategies, Health Promotion and Social Communication, fall in part within the area of expertise of Public Information, and the BPB reflects, within the limited resources available, this recognition of the importance of communications in improving health.

11. Analysis of the situation with respect to communications in the Hemisphere reveals that the needs in the countries are high and continue to increase. There is a constant demand from health sector organizations, groups, PAHO Centers, and individuals for the types of materials and assistance that the program provides, including media campaigns, videotapes, press materials, publications, travel information, research assistance, photographs, graphic

designs, and other materials; along with requests for help both from the countries and from technical units for DPI expertise in media relations, teleconference development,and organization and production, publications, training, and other areas.

12. Creation of the Communicating for Health program by the Director of PAHO in 1989 also signifies increasing responsibility and activity for DPI, especially in designing and implementing an integrated approach to communication, using a wide variety of distribution methods at the national, sub-regional, regional and even global levels.

GLOBAL STRATEGY OF COOPERATION

13. PAHO technical cooperation in the area of publishing has as its objective the provision of good, useful, and important information to public health practitioners throughout the Americas. Its specific aims include serving the Organization's unique mission and reflecting its various priorities; covering the many areas of interest and need of health workers throughout the Region; and filling the gaps in knowledge that exist by publishing information which--if PAHO did not publish it--would simply not be available, either because the expertise needed to gather, compile, analyze, and synthesize it could not or would not be marshalled by any other agency or because, to other publishing enterprises, it would not be commercially attractive or remunerative to undertake. This program also collaborates with national entities and talents to improve country health publications.

14. The PAHO publications program seeks to achieve its aims by using quality controls to assure the selection of appropriate texts for publication, by producing those texts in various publication series, by identifying target audiences and their information needs, by seeking effective means of distributing PAHO publications, and by strengthening national publishing capacities to do research, to write, and to publish opportunely and adequately.

15. Thus, the program strives to facilitate access to and select information that in turn results in better trained health workers and improved health services.

16. PAHO cooperates in the development of an integrated regional system of national scientific and technical networks that aim to meet the information needs of health professionals throughout the Americas, regardless of their level or place of work. The system stimulates, coordinates, and organizes national systems, to which that of PAHO, with its Pan American Centers, field offices, the Headquarter's Library and various technical programs at Headquarters, are joined. By sharing information and documentation resources at the local, national, and regional level--as the most rational means of minimizing the growing cost of the enormous volume of information currently generated throughout the world--each unit in the system can acquire the bibliographic material it needs to satisfy a reasonable percentage of its demand and can share the bibliographic and human resources at the disposal of the entire system.

17. The principal activities of the regional system are related to bibliographic exchange services, access to national and international data bases, and the Latin American Literature in Health Sciences (LILACS)--a data base designed to hold selected published material that records the intellectual production of health professionals in the countries of the Region as well as publications and documents produced by PAHO.

18. Several problems remain to be resolved both in the countries and in the Organization. It is necessary to put greater emphasis on the identification of needs to ensure that the publications are responsive to health managers and administrators and other workers concerned with primary care, particularly at the level of local health systems.

19. Measures need to be taken to distribute the information processed by the Organization more rapidly to assure its usefulness. In addition, information should be disseminated more effectively, so that the right information gets to the right reader opportunely. Difficulties in reaching target groups outside officialdom should be overcome. Further efforts to develop national focal points should be made. The policy regarding free, discounted, and sales publications should be reviewed.

20. Translation should proceed of scientific-technical documents from English into Spanish and from Spanish into English through in-house machine translation with post editing, as should translation of scientific-technical manusripts of articles, monographs or books from Spanish to English and from English to Spanish through contractual services with professional translators from various countries of the Western Hemisphere and Spain.

21. Simultaneous interpretation should continue to be provided through in-house staff and ad-hoc contractual services.

22. To carry out the communications and promotion activities for 1992-1993, PAHO will continue to stress technical cooperation based on the expressed needs of Member Countries and technical programs, concentrating on the use of the mass media for general health promotion, creation of an awareness of the importance of health in development, technical collaboration in health promotion and social communications, and use of modern telecommunications and traditional methods of information transfer in these efforts.

23. Emphasis will be placed on support to regional, country and PAHO Center level communications efforts; continued development of telecommunications activities; continued use of entertainers and celebrities to help bring health messages to the general public; continued and improved channeling of health information to the mass media to keep the public informed and involved; taking advantage of PAHO-sponsored meetings of experts and scientists to achieve a multiplier effect by assigning media relations stafff to help disseminate information resulting from such meetings.

24. Another important aspect of the global strategy is additional training for key PAHO and country staff in media relations, to be carried out in collaboration with APL, to help these staff members better fulfill their responsibilities of improving health conditions through better information.

SPECIFIC PROGRAMS

OFFICIAL AND TECHNICAL PUBLICATIONS (HBP)

BIENNIAL TARGETS

25. The publications program will become an integral part of a new "Communicating for Health" program. The main thrusts of that program will be information processing, request processing, products and services development, dissemination, and outreach. That is, the focus will be on what information there is; what areas of information are needed or in demand; what information should be developed, how, and in what form; how to get that information to target audiences/readerships; and how to strengthen publishing activities.

26. The promotion of PAHO publications seeks out organizational opportunities consistent with PAHO/WHO's management-of-knowledge mission; identifies the specific target audience(s) for new and existing publications, and ensures that a publication reaches each identified target audience, either through free distribution or through effective promotion.

27. The distribution and sales unit has as its purpose to assure that the right publications get to the right people in time for them to be of use to them.

28. The collaborative development of scientific and technical research will, in turn, feed both, national and international publications.

LINES OF ACTION

29. The national biomedical journals need to be improved in both content and penetration.

30. PAHO publications are important tools for informing, educating, and training health professionals in the Region and for sharing among them the latest developments in knowledge resulting from research. They have the potential of transcending the more passive function of informing, by becoming the catalysts of change in attitude and behavior. They are a reflection of the cause, the standards, and the prestige of the Organization. For those reasons, the selection of manuscripts for publication is a critical function of the program.

31. The publications produced in recent years through the Program for Scientific and Technical Health Information range from scientific and technical titles to periodicals and official documents. The subject matters covered by these publications represent priority areas of concern for the Organization.

32. Over the decades, PAHO has developed a unique storehouse of biomedical and health information. Notwithstanding the existence of this wealth of knowledge, the intended users of it are not always reached. It is important to ensure that health workers in the Member Countries are aware of the PAHO storehouse; that they know what literature and other information relevant to their needs is available to them; that they make full use of it. The Organization must identify target audiences and assure that its publications reach the audiences for which they are intended.

33. The publications program has tried in recent years to decentralize its distribution function to the country level and to make it possible for public health workers, trainers, students, and researchers to acquire its books and journals nearby in local currencies.

34. The WHO Distribution and Sales Office now serves as the agent for PAHO English-language publications in Europe and other WHO regions.

35. To help authors throughout the Region to plan, write, and present their studies for publication in an internationally standardized manner tht will enhance their chances of success and foster a greater exchange of information among health researchers in the Americas.

36. To seek the collaboration of more nationals with PAHO as authors and peer reviewers for PAHO publications.

53. Focal points at headquarters and in the field will be established to work with the program by helping maintain contact with the media, respond to media needs, obtain press clippings, and help coordinate, plan and develop social communications activities.

54. With the collaboration of focal points, a region-wide database of media representatives will be created and constantly updated, with concomitant information fields. More efficient methods of maintaining communication will be explored, to utilize the database for PAHO announcements, special events, and other types of material of interest to the Organization.

55. Create open lines of communication with key individuals, publications, and other programs interested in health related matters.

56. Seek additional resources to carry out health education and social communications programs through the PAHO development Committee and in collaboration with the External Coordination Program.

57. Maintain close liaison with PED in order to responds aequately in times of natural disaster.

LANGUAGE SERVICES (HBL)

BIENNIAL TARGETS

58. PAHO will continue cooperating in the exchange of validated scientific-technical health information among institutions in their languages. This will include both printed information in various forms, and oral exchange in different types of meetings dealing with policy and program matters, as well as scientific-technical subjects.

LINES OF ACTION

59. Activities in Language Services include translation and interpretation in the four official languages of the Organization, especially English and Spanish through the operation and development of ENGSPAN and SPANAM. Machine translation with postediting is now being used as the principal method of translation in PAHO.

SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION (HBD)

BIENNIAL TARGETS

60. PAHO will continue to support the free interchange of health and biomedical information that is validated and of use to the countries in building their health system infrastructures and adapting existing and new health technologies to national conditions. Efforts will be made to increase substantially the penetration of this information at all levels of the health systems in every country--not only within the academic community but among professionals and technical personnel in local health services. At the same time, PAHO will cooperate with national counterparts in strengthening their systems for disseminating health information.

61. This program direction is consistent with WHO's Eighth General Program of Work, covering the period 1990-1995, a) all countries will have national policies and programs designed to meet their particular needs for health information support; b) all countries will have mechanisms to screen WHO's publications and selectively disseminate throughout the health system those that are of relevance to them, supported by modern documentation centers in the WHO Representatives' offices.

62. The Organization will continue to cooperate with the countries in enhancing and modernizing their networks of information centers, so that health information becomes readily available and easily accessible. This will include the strengthening of documentation centers in PAHO country offices and in the Pan American Centers as well as of the Headquarters library. At the regional level, the Organization will promote efforts to build the Latin American and Caribbean Health Information Network, including the sharing of library experience and skills, techniques in information management, lists and catalogues, and training opportunities. PAHO will continue to support the countries in their development of high-quality and relevant health library services.

LINES OF ACTION

63. Activation of the various structures created to fulfill the functions of these networks, at both the national and the local level.

64. Expansion of the services of the networks (bibliographic searches, articles photocopies, etc.) from the current academic settings to the local health services scenarios.

9. HEALTH INFORMATION SUPPORT (CONT.)

53. Focal points at headquarters and in the field will be established to work with the program by helping maintain contact with the media, respond to media needs, obtain press clippings, and help coordinate, plan and develop social communications activities.

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57. Maintain close liaison with PED in order to responds aequately in times of natural disaster.

LANGUAGE SERVICES (HBL)

BIENNIAL TARGETS

58. PAHO will continue cooperating in the exchange of validated scientific-technical health information among institutions in their languages. This will include both printed information in various forms, and oral exchange in different types of meetings dealing with policy and program matters, as well as scientific-technical subjects.

LINES OF ACTION

59. Activities in Language Services include translation and interpretation in the four official languages of the Organization, especially English and Spanish through the operation and development of ENGSPAN and SPANAM. Machine translation with postediting is now being used as the principal method of translation in PAHO.

SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION (HBD)

BIENNIAL TARGETS

60. PAHO will continue to support the free interchange of health and biomedical information that is validated and of use to the countries in building their health system infrastructures and adapting existing and new health technologies to national conditions. Efforts will be made to increase substantially the penetration of this information at all levels of the health systems in every country--not only within the academic community but among professionals and technical personnel in local health services. At the same time, PAHO will cooperate with national counterparts in strengthening their systems for disseminating health information.

61. This program direction is consistent with WHO's Eighth General Program of Work, covering the period 1990-1995, a) all countries will have national policies and programs designed to meet their particular needs for health information support; b) all countries will have mechanisms to screen WHO's publications and selectively disseminate throughout the health system those that are of relevance to them, supported by modern documentation centers in the WHO Representatives' offices.

62. The Organization will continue to cooperate with the countries in enhancing and modernizing their networks of information centers, so that health information becomes readily available and easily accessible. This will include the strengthening of documentation centers in PAHO country offices and in the Pan American Centers as well as of the Headquarters library. At the regional level, the Organization will promote efforts to build the Latin American and Caribbean Health Information Network, including the sharing of library experience and skills, techniques in information management, lists and catalogues, and training opportunities. PAHO will continue to support the countries in their development of high-quality and relevant health library services.

LINES OF ACTION

63. Activation of the various structures created to fulfill the functions of these networks, at both the national and the local level.

64. Expansion of the services of the networks (bibliographic searches, articles photocopies, etc.) from the current academic settings to the local health services scenarios.

65. The Organization is promoting the creation of additional national networks in all countries in which these structures do not as yet officially exist; establishment of these networks results both from the adoption of legal provisions, at the behest of national health authorities, and from the initiative of individual institutions; the inclusion of those networks in PAHO/country joint programming as an integral part of support for national and local health services; the collaboration of financing agencies in developing these structures.

66. National biomedical publications are processed using a common methodology developed by BIREME and transferred to the countries through in-service trained librarians. National networks are supposed to contribute to this collective effort by compiling and processing the literature generated in the country and transmitting the results to BIREME, which then generates the data base on a compact disc (CD-ROM) and distributes copies of it, free of charge. To make this network exchange work, PAHO has provided CD-ROM readers to all the institutions in the network--some 160 institutions in 19 countries--which has thereby also accorded them access to other data bases that are currently marketed in optical form.

67. The institutions within the national networks share bibliographic resources through the bibliographic exchange service. This consists of providing photocopies of articles and documents that are not available in institutions at the local level.

68. Publication of a Regional Union Catalogue of the collections held by all libraries in the system. The catalogue will be recorded on CD-ROM and distributed to all participating biomedical libraries. It will make it possible to establish a policy for rationalizing collections that will avoid unnecessary duplication and ensure effective cooperation.

69. Incorporation of all countries into BITNET (Because It's Time NETwork) as a fast and low-cost option for transmitting biomedical information to developing countries. The creation of BITNIS (BITNET-National Library of Medicine Intercommunication System) will permit linking information sources with users in various countries by means of an academic, low-cost, and nonprofit computerized network.

70. Strengthening the PAHO/WHO Information Data Base, which includes both conventional literature and selected technical documents.

71. Incorporation of biomedical and public health literature from Spain and Portugal into the LILACS data base.

72. Strengthening of PAHO/WHO Bibliographic Information Service, including the processes of bibliographic gathering, selection, description, and content analysis. Provision of information to and dissemination from centers participating in the regional network.

73. Developing the LILACS-MEDLARS union catalog to be used as a search tool and the basis for rationalizing journal acquisitions in libraries throughout the Region.

74. Expanding the United States National Library of Medicine's BITNET system to all the national information networks. In addition, expanding the project by producing and distributing CD-ROM will provide hundred of institutions a less expensive access to the main data bases.

75. Establishing a PAHO scientific and technical central memory to preserve and transfer institutional knowledge.

76. Expanding the PAHO/WHO thesaurus to include new terminology and increase the categories of health sciences descriptors.

9. HEALTH INFORMATION SUPPORT (CONT.)

PROGRAM BUDGET DISTRIBUTION BY LOCATION

LOCATION	PAHO AND WHO REGULAR BUDGET 1990-1991	1992-1993	1994-1995	EXTRABUDGETARY FUNDS 1990-1991	1992-1993	1994-1995
DIRECT COOPERATION WITH COUNTRIES	307,500	396,400	455,900	7,600	0	0
REGIONAL PROGRAMS	8,777,700	9,016,000	10,022,600	1,127,642	1,084,500	1,184,400
CENTERS	729,100	1,029,100	1,160,800	2,069,176	2,183,063	2,300,000
TOTAL	9,814,300	10,441,500	11,639,300	3,204,418	3,267,563	3,484,400

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL PROF. MONTHS	PERSONNEL LOCAL MONTHS	PERSONNEL CONS. DAYS	PERSONNEL AMOUNT	DUTY TRAVEL AMOUNT	FELLOWSHIPS MONTHS	FELLOWSHIPS AMOUNT	SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	6,455,100	600	648	95	5,402,700	218,000	15	28,500	91,800	260,400	0	453,700
WHO - WR	3,359,200	264	144	30	1,939,400	7,900	0	0	19,200	214,900	0	1,177,800
TOTAL	9,814,300	864	792	125	7,342,100	225,900	15	28,500	111,000	475,300	0	1,631,500
% OF TOTAL	100.0				74.9	2.3		.3	1.1	4.8	.0	16.6
1992-1993												
PAHO - PR	7,088,000	447	576	95	5,330,700	201,000	12	24,000	144,600	311,500	0	1,076,200
WHO - WR	3,353,500	264	144	30	2,424,900	2,200	0	0	16,000	170,400	0	740,000
TOTAL	10,441,500	711	720	125	7,755,600	203,200	12	24,000	160,600	481,900	0	1,816,200
% OF TOTAL	100.0				74.4	1.9		.2	1.5	4.6	.0	17.4
1994-1995												
PAHO - PR	7,872,600	432	576	95	5,895,800	226,400	12	25,200	167,900	354,000	0	1,203,300
WHO - WR	3,766,700	264	144	30	2,734,200	2,500	0	0	17,800	189,500	0	822,700
TOTAL	11,639,300	696	720	125	8,630,000	228,900	12	25,200	185,700	543,500	0	2,026,000
% OF TOTAL	100.0				74.1	2.0		.2	1.6	4.7	.0	17.4

ANALYSIS OF THE HEALTH SITUATION

1. During the 1980s, Latin America and the Caribbean suffered a convergence of several crises: one that derived from the imbalances taking place in the world economy in the 1970s, whose effects became more acute in the less developed countries during the following decade; another that was the result of the exhaustion of the development models promoted by the countries of the Region during the postwar period; and, at the end of the decade, still another deriving from the world-wide readjustments that will surely have far-reaching effects on the Region. The confluence of these processes intensified their consequences, which, in many cases, were exacerbated by the adoption of regressive "adjustment" measures.

2. It has become increasingly evident that the adjustment measures taken have not revised the structural determinants of the crisis and that a resurgence of growth must necessarily depend on improving obsolete forms of production, organization, and trade, which will demand new investment, the restructuring of processes, the expansion of markets, and the massive and generalized adoption of the technological revolution.

3. During the 1980s, as well as in the preceding decade, some countries in the Region carried out sectoral scientific and technological development policies, which, although successful in creating limited niches of development, could never be transformed into a target for public policies associated with a comprehensive concept of development. This is evidenced in the weakness of the scientific-technological infrastructure and in the insufficient expenditures made on research and development.

4. Scientific production in the Region, in addition to being relatively limited, is also extremely concentrated. Between 1973 and 1984 barely five countries (Argentina, Brazil, Chile, Mexico, and Venezuela) accounted for nearly 90% of all publications. Productivity in the countries is also quite low and, in addition, extremely heterogeneous. For example, Peru and Ecuador have nearly one scientific author for every 54 researchers, while Chile has one author for every 4.2 researchers. Similarly, whereas in Chile and Costa Rica an expenditure of $US90,000 is required per scientific author published in an international journal, in Ecuador this figure rises to $US830,000. The same diversity is observed with regard to technological productivity.

5. These indicators clearly reflect the precariousness of the scientific and technological base, an indispensable requirement for the selection, adaptation, incorporation, and generation of new knowledge and technologies capable of promoting the productive transformation of the countries of the Region. This precariousness is also observed, as will be seen below, in the field of health science and technology.

6. Health research in the Region plays a relatively important role, particularly since the social problems relating to industrialization/urbanization and the need to control urban epidemics began to demand knowledge in the interests of carrying out more effective action. It is important to note, however, that during the period from 1973 to 1984 there was a significant change in the relative importance of this field in the overall scientific production of the Region. These changes tend to bring the profile of the Region's scientific production closer to that observed at the world level.

7. The development of health science and technology can play a major role in renewing the Region's economic development, not only by virtue of its impact on improving the productive potential of the countries' human resources, but also because the sum total of health services and inputs offers many opportunities for the creation and upgrading of a technological base that will permit the development, adoption, and incorporation of new technologies in areas such as drugs, immunobiologicals, and medical equipment.

8. Notwithstanding the weaknesses noted above, science in the Region, in certain areas of knowledge, displays notable quality and originality. This is the case of biomedical research, in which a level has been attained that permits, for example, the development of a promising vaccine for malaria or the development of diagnostic kits for several diseases through the use of modern recombinant DNA techniques. The same is true of public health research, which is increasingly expanding its knowledge of the relations between the objective living conditions of the various social groups and their health situation, as well as knowledge of the dynamics of the health services as a tool for setting down the bases for new organizational models.

9. With regard to the problems deriving from health technology development in the current situation of the countries of the Region, it may be pointed out that favorable motivations exist in the direction of technological innovation and incorporation that should be promoted, since such changes can lead to an increase in coverage and to an improvement in the quality of the services provided to the population. This dynamism also provides the countries with new opportunities for undertaking economic activities as part of cooperation between countries and regional integration. Promotion of this economic dimension of the health system has not been common practice on the part of the public or private sectors, although it appears to offer a valid additional argument for taking part in providing health services. However, this same trend toward technological development may result in a concentration of coverage for the benefit of the privileged classes in a given population and in inefficient use of the limited resources available to the sector. Conflict of the objectives of social policy with economic interests related to health technology poses a difficult dilemma for the authorities charged with the management of such technology. A great capacity for negotiation and conciliation is required of the various parties representing the interests in dispute, together with technical and instrumental habilitation of the government agencies responsible for evaluating and regulating health technology. At the same time, mechanisms

should be established to coordinate policies for health, scientific and technological development, industrial promotion, the promotion of trade, TCDC, and regional integration.

10. Few countries in the Region have the scientific and technological capacity required for the production and control of the biologicals their populations demand owing to the complexity of modern technology and other factors such as the difficulty of securing economic equilibrium in this activity.

11. The efforts carried out by some countries in the direction of self-sufficiency in biologicals have been hobbled by the high cost of the investments required for the operation and modernization of infrastructure. In addition, production must be coupled with the system of scientific and technological development, which will otherwise rapidly become obsolete, thereby compromising not only competitiveness, but also quality and performance.

12. EPI is improving administration of the Revolving Fund, which permits the acquisition of biologicals at low cost based on advance planning of demand, thereby making it possible to obtain better prices for producers.

13. In another connection, it has been ascertained that as a consequence of the great scientific and technological advances that have been attained in the areas of molecular biology, immunochemistry, genetic engineering, microbiology, and production processes, the development of new products that would not be possible by means of conventional technology is progressing with great speed and may lead to entirely new standards in this area in the near future.

GLOBAL COOPERATION STRATEGY

14. The strategies formulated below basically provide for the creation of areas in which the quality and originality of the public health and biomedical research being carried out in the Region will be better oriented and developed. Toward this end, the strategies are aimed at:

14.1 Reversing the vertical and fragmentary nature of scientific policies and transforming them into the object of public policies and, consequently, into subjects for public debate, the only means of achieving consensus and social evaluation.

14.2 Strengthening the mechanisms to articulate scientific and technological research in the field of health with the production of health goods and services. This should, of course, take into account the fact that both Latin American industry and Latin American universities have limited research capacity, that the universities lack the regulatory and administrative framework for managing such articulation, and that neither a sufficient number of trained human resources nor accumulated experience exists in the area of technological management.

14.3 Strengthening the links of technical cooperation between the countries in the Region. If the assertion is valid that the development of knowledge and technologies for the solution of global problems such as AIDS, environmental preservation, and new energy sources is an undertaking that exceeds the resources of any country alone, whatever its degree of development, the same may be said with regard to the search for solutions for the serious common problems of the countries of Latin America. In addition to the ethical consideration that technical cooperation contributes to strengthening the ties of solidarity and peace among the peoples of the Region, it is also an imposition of reality, for without a pooling of efforts and resources it will not be possible to meet the challenge of creating a scientific and technical infrastructure capable of responding to the specific problems of Latin America.

SPECIFIC PROGRAMS

RESEARCH PROMOTION AND DEVELOPMENT (RPD)

BIENNIAL GOALS

15. To strengthen the organizational processes of health science and technology by:

15.1 To study in greater depth the health research situation in the Region.

15.2 To train human resources in the planning and administration of health science and technology.

15.3 To strengthen policy-making bodies and coordinate health research.

16. To upgrade the scientific and technical infrastructure in the fields of biomedicine and public health:

16.1 To train researchers in priority areas.

16.2 To upgrade research institutions physically, materially, and administratively.

16.3 To disseminate scientific and technical health information.

16.4 To support the development of research proposals in line with PAHO/WHO priorities.

17. To strengthen, develop, and coordinate PAHO/WHO's cooperation capacity in health science and technology:

17.1 To mobilize the institutional resources of the countries of the Region in order to collaborate with PAHO/WHO.

LINES OF ACTION

18. Development of cooperation activities that will support national organizations responsible for the formulation of scientific and technical, industrial, and health development policies in order to ensure that such organizations coordinate their objectives, achieve organic articulation, and maintain a constant flow of information with one another.

19. Support for the development of national knowledge-producing institutions in areas of strategic interest, both for the development of science and technology and for the solution of health problems.

20. Coordination of the research-related activities that are being carried out at the various technical levels of the Organization and organization of the activities of PAHO's advisory bodies in this field, such as the Advisory Committee on Health Research (ACHR) and its subcommittees for the development of biotechnology applied to health and for research on health systems and services; and the Internal Advisory Committees on Research (IACR), on Biotechnology (IACB), and Ethical Review (CER).

ANALYSIS OF THE PROGRAMS

HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT (HDT)

BIENNIAL GOALS

21. To promote and support the implementation of national health technology development policies in order to increase their equity, effectiveness, and efficiency, and to promote and support cooperation between countries and regional integration in this field.

LINES OF ACTION

22. Promotion of technological development policies in order to ensure increasing levels of equity, effectiveness, and efficiency in the health services; promotion of cooperation between countries for the exchange of health technologies; strengthening of management processes; and regulation and evaluation of health technologies.

RESEARCH AND DEVELOPMENT IN THE FIELD OF VACCINES (RDV)

BIENNIAL GOALS

23. To upgrade scientific and technological training in the Region, using as a basis the Regional System for Vaccines (SIREVA), with the following action strategy:

23.1 Structuring of the system of technological and epidemiological laboratories, supported by already existing laboratories and researchers in the Region.

23.2 Searching for and developing scientific cooperation mechanisms and transfer of technology within and outside SIREVA.

23.3 Providing intensive training of human resources specialized in epidemiology and in the development, production, and quality control of biologicals.

23.4 Specifying the products that will be developed on the basis of epidemiological, scientific-technological, and social impact criteria.

23.5 In addition to furthering the implementation of SIREVA, the biologicals program will seek to provide increased support to EPI through the strategy of strengthening and expanding quality control capacity in existing laboratories and designating new Collaborating Centers in order to monitor vaccines subsequent to their distribution and prior to their use on children.

23.6 In conjunction with state or private production laboratories, technological exchange will be sought with the purpose of ensuring the application of good manufacturing practices (GMP) and establishing systems of quality control and guarantee.

LINES OF ACTION

24. Support for EPI activities in the selection of production laboratories.

25. Identification, selection, and designation of Collaborating Centers.

26. Organization of courses in GMP in biological-producing laboratories.

27. Organization of courses in quality control and guarantee.

28. Promotion of scientific and technological development projects and activities with regard to biologicals needed by the Region, especially through the use of modern technologies such as genetic engineering.

29. Promotion of scientific and technical cooperation between the countries of the Region.

30. Participation in the development of the biotechnology program in the Region.

31. Participation in the establishment of SIREVA.

10. RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT (CONT.)

PROGRAM BUDGET DISTRIBUTION BY LOCATION

LOCATION	PAHO AND WHO REGULAR BUDGET			EXTRABUDGETARY FUNDS		
	1990-1991	1992-1993	1994-1995	1990-1991	1992-1993	1994-1995
DIRECT COOPERATION WITH COUNTRIES	2,870,900	2,990,000	3,431,600	30,610	0	0
REGIONAL PROGRAMS	1,377,800	1,467,400	1,649,400	21,000	60,000	68,000
TOTAL	4,248,700	4,457,400	5,081,000	51,610	60,000	68,000

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	3,532,800	120	96	1005	1,293,600	73,400	15	28,500	261,500	43,600	1,738,400	93,800
WHO - WR	715,900	48	24	140	391,300	34,400	40	76,000	85,000	69,200	0	60,000
TOTAL	4,248,700	168	120	1145	1,684,900	107,800	55	104,500	346,500	112,800	1,738,400	153,800
% OF TOTAL	100.0				39.7	2.5		2.5	8.2	2.7	40.8	3.6
1992-1993												
PAHO - PR	3,916,300	120	72	1115	1,537,700	166,200	5	10,000	242,900	73,600	1,693,600	192,300
WHO - WR	541,100	24	24	95	273,200	5,800	15	30,000	87,000	74,300	0	70,800
TOTAL	4,457,400	144	96	1210	1,810,900	172,000	20	40,000	329,900	147,900	1,693,600	263,100
% OF TOTAL	100.0				40.6	3.9		.9	7.4	3.3	38.0	5.9
1994-1995												
PAHO - PR	4,466,800	120	72	1115	1,708,700	192,800	5	10,500	281,800	85,500	1,964,500	223,000
WHO - WR	614,200	24	24	95	306,700	6,700	15	31,500	101,000	86,200	0	82,100
TOTAL	5,081,000	144	96	1210	2,015,400	199,500	20	42,000	382,800	171,700	1,964,500	305,100
% OF TOTAL	100.0				39.7	3.9		.8	7.5	3.4	38.7	6.0

III. HEALTH SCIENCE AND TECHNOLOGY

11. FOOD AND NUTRITION

ANALYSIS OF THE HEALTH SITUATION

1. All the countries of Latin America and the Caribbean have been going through a major economic depression since the beginning of the 1980s. In addition, some of the countries in the Region have had severe natural disasters and political upheavals. In general, rising food prices have outstripped increases in salaries, which have declined in terms of real purchasing power.

2. Since food consumption tends to be dictated by real income, these figures point to deteriorating levels of dietary consumption, especially among the poor.

3. At the same time, the information available on output indicates a decrease in the volume of food produced between 1976 and 1987.

4. The foregoing situation is having an impact on the nutritional status of vulnerable groups in the Region. Although the information available indicates a decline in the prevalence of overall undernutrition, for the most part it is only moderate and the process has taken place over a long period, so that in reality the level has not changed significantly, and in some vulnerable population groups it has actually increased, as can be seen when the information is examined in detail.

5. While acute undernutrition (low weight for height) is relatively infrequent, the prevalence of overall undernutrition (low weight for age) continues to affect approximately 15% of the children under 5, which means that approximately 9.5 million children suffer from moderate or severe undernutrition. The prevalence of chronic undernutrition (small stature for age) is even greater, amounting in some countries to half the preschool population.

6. Data from the English-speaking Caribbean and some of the Latin American countries indicate that the prevalence of iron-deficiency anemia is high, particularly among pregnant women, ranging from 20.0% to 82.3%. In preschool children the proportion ranges from 12.9% to 69.1%, and in schoolchildren, from 0.8% to 57.0%.

7. Iodine deficiency continues to be particularly serious in Bolivia, Ecuador, and Peru. In some of the Andean areas there is also a high incidence of mental retardation and cretinism associated with endemic goiter. From Mexico to Chile this condition is a public health problem, and it constitutes a serious threat to the genetic potential of millions of people.

8. Vitamin A deficiency, which occurs in populations with diets that are low in calories and carotene-rich foods, is considered a public health problem in Haiti and arid areas of the Brazilian northeast. In the former, it is estimated that in at least some parts of the country 2% to 3% of the preschool population have corneal lesions.

9. In other countries of the Region, such as Bolivia, El Salvador, Guatemala, and Honduras, it is estimated that the problem may be fairly widespread, but it has not been quantified recently.

10. Overnutrition and its consequences--obesity, hypertension, cardiovascular diseases, and diabetes--is taking on greater importance. In Costa Rica, 5.1% of the children paprticipating in growth and development monitoring in 1987, plus 6.9% of those being followed in the primary health care program, were overweight. In Antigua and Barbuda, 15.5% of the children aged 15 to 19 weighed at least 20% over the maximum expected for their height.

11. In the English-speaking Caribbean, the prevalence of obesity in women has ranged from 24% to 39%, and two comparable surveys in Barbados demonstrated that obesity in men went from 7% to 28% between 1969 and 1982. In a recent study in Chile it was observed that 10% of the women in the upper economic bracket, 22% of those in the intermediate bracket, and 40% of those with low incomes were overweight for their height. At the same time, information from various sources indicates that a high proportion of obese individuals suffer from iron, vitamin C, and other specific deficiencies, indicating a serious nutritional imbalance.

12. The food production index (FPI) shows increases in only 11 of 29 countries, with declines in the remaining 18.

13. In order to have an adequate food supply, the countries have to import food and to obtain donations for international cooperation agencies. According to the World Bank's World Development Report 1989, grain imports rose 49.5% on average between 1974 and 1987.

14. In order to alleviate the nutritional situation of the most vulnerable groups, the countries have for a long time resorted to food aid.

GLOBAL STRATEGY OF COOPERATION

15. The Food and Nutrition Program's global technical cooperation strategy is geared to collaborating with the Governments in the identification, adaptation, development, application, and evaluation of appropriate methods for promoting, achieving, and maintaining optimum nutritional status for the entire population of the Region.

16. Within this broad global strategy, there are a number of components that are closely related to PAHO's strategic orientations for 1991-1994.

17. Support for the development and strengthening of food and nutrition surveillance systems (FNSS), with emphasis on use of the information for decision-making in the area of food and nutrition, including policy relating to the impact of national development programs and economic adjustments on the nutritional status of the most vulnerable groups of the community.

18. Support for the strengthening of national technical capability for formulating, carrying out, and evaluating policies, plans and programs for improving the availability, adequate consumption, and biological utilization of food. This technical capability should be at two levels: the central level, where socioeconomic and dietary macropolicies are set, and also the local level, where experience in some of the countries has demonstrated the importance of grass-roots planning for community development and the improvement of nutritional status.

19. Review of the food and nutrition curricula in health science schools, based on a review of the profiles developed by nutritionists and dietitians. HPN will help to strengthen the teaching of nutrition and dietetics in these schools, with emphasis on a multisectoral food and nutrition approach and the development of these professionals within local health systems.

20. Promotion of appropriate dietary practices for the prevention of chronic noncommunicable diseases associated with excess or imbalance of nutrients as well as the prevention or adequate management of energy-protein undernutrition. While undernutrition continues to be a problem in disadvantaged population groups, concomitant obesity with iron and other specific deficiencies has also been found in these population groups.

21. In addition to the promotion of adequate dietary habits, it is necessary to promote and to give technical support for programs to reduce energy-protein undernutrition, such as in-hospital management of severe undernutrition and community-level management of moderate undernutrition, as well as programs aimed at controlling iron, iodine, and vitamin A deficiencies, through multisectoral strategies involving the entire community as agents of change--strategies such as food fortification, supplementation with specific nutrients, and the provision of increased supplies of appropriate foods.

22. Strengthening of institutional food and nutrition services, as well as promotion of the management of obesity, diabetes, and cardiovascular diseases through diet.

23. Support for institutional and operational strengthening for the formulation of policies and strategies that will make it possible to focus on nutrition and food security interventions for high-risk groups and the poorer sectors of society.

SPECIFIC PROGRAMS

FOOD (FOD)

BIENNIAL TARGETS

24. Formulate broad guidelines for national food aid policies.

25. Promote grass-roots food and nutrition planning at the level of the local health systems based on local information.

26. Assess the situation and formulate guidelines for the control of vitamin A deficiency in Central America, Brazil, Bolivia, Ecuador, and Haiti.

27. Strengthen and rationalize cooperation with the World Food Program (WFP) through the WHO Food Aid Program (FAP/HQ).

28. Implement food and nutrition activities under the Project for the Improvement of Nutritional Status (Haiti) and Comprehensive Support for Implementation of the National Food and Nutrition Plan (Bolivia).

29. Identify the socioeconomic development trends that are affecting food consumption.

30. Formulate strategies for improving food distribution systems within the context of food security.

LINES OF ACTION

31. Promotion of the formulation and implementation of food and nutrition policies, plans, and programs, ensuring the participation of various sectors from the conception of the programs up to their execution and evaluation.

32. Support for the formulation of policies, plans, and programs for food aid.

33. Promotion of the formulation and implementation of strategies for controlling iodine deficiency disorders (IDD), hypovitaminosis A, and iron-deficiency anemia.

34. Support for the development of educational programs for the promotion of breast-feeding, weaning, and the management of obesity and related chronic diseases through diet.

35. Review and updating of curricula in the areas of nutrition and dietetics in the health science schools.

NUTRITION (NUT)

BIENNIAL TARGETS

36. Strengthen food and nutrition surveillance in the countries where an advanced system already exists (Caribbean area, Costa Rica, Venezuela, Colombia, Peru, Bolivia) and initiate cooperation activities in this area in Haiti, the Dominican Republic, Paraguay, Argentina, Uruguay, and Brazil.

37. Collect and disseminate information on food and nutrition and promote its use for planning and programming in this area.

38. Train national personnel in food and nutrition surveillance.

39. Standardize practices for the feeding of infants under the age of 3.

40. Strengthen the teaching of dietetic nutrition in the health science schools.

41. Promote monitoring of the nutritional status of pregnant women.

42. Initiate or to expand activities for controlling obesity and nutrition-related chronic diseases.

LINES OF ACTION

43. Coordination of actions undertaken with international, bilateral, and nongovernmental agencies; intensified search for extrabudgetary funds; and drafting of proposals for external financing.

44. Expansion and ongoing updating of the HPN data base and periodic dissemination of the information to the entire Region.

45. Manpower training in food and nutrition surveillance, with emphasis on the management of information for planning, programming, and evaluation.

46. Technical cooperation with the countries for the strengthening of food and nutrition surveillance systems.

47. Formulation and dissemination of nutritional guidelines for infants under the age of 3.

48. Standardization of the assessment of nutritional status in pregnant women.

49. Promotion of breast-feeding and the International Code of Marketing of Breast-Milk Substitutes.

50. Promotion of adequate food management in order to prevent the transmission of diseases, including parasitic diseases, that affect nutritional status.

51. Development of collaborative studies on the relationship between infection and vitamin A deficiency.

52. Assessment of the current prevalence of nutrition-related chronic diseases.

53. Support for programs to control obesity and related processes.

PROGRAM BUDGET DISTRIBUTION BY LOCATION

LOCATION	PAHO AND WHO REGULAR BUDGET 1990-1991	1992-1993	1994-1995	EXTRABUDGETARY FUNDS 1990-1991	1992-1993	1994-1995
DIRECT COOPERATION WITH COUNTRIES	1,312,500	1,409,100	1,601,000	1,991,106	0	0
REGIONAL PROGRAMS	688,300	808,200	909,400	56,400	56,500	62,800
CENTERS	4,536,300	5,148,300	5,576,400	14,564,401	14,891,700	14,954,600
TOTAL	6,537,100	7,365,600	8,086,800	16,611,907	14,948,200	15,017,400

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT $	PERSONNEL PROF. MONTHS	PERSONNEL LOCAL MONTHS	PERSONNEL CONS. DAYS	PERSONNEL AMOUNT $	DUTY TRAVEL AMOUNT $	FELLOWSHIPS MONTHS	FELLOWSHIPS AMOUNT $	SEMINARS AND COURSES $	SUPPLIES AND EQUIPMENT $	GRANTS $	OTHER $
1990-1991												
PAHO - PR	4,779,800	264	72	450	3,762,700	336,300	31	58,900	134,400	64,300	10,900	412,300
WHO - WR	1,757,300	144	72	225	1,359,200	34,300	23	43,700	48,900	55,100	0	216,100
TOTAL	6,537,100	408	144	675	5,121,900	370,600	54	102,600	183,300	119,400	10,900	628,400
% OF TOTAL	100.0				78.3	5.7		1.6	2.8	1.8	.2	9.6
1992-1993												
PAHO - PR	5,462,200	257	72	585	4,171,800	382,200	27	54,000	225,900	226,000	12,700	389,600
WHO - WR	1,903,400	120	72	320	1,417,400	45,800	2	4,000	100,700	37,800	0	297,700
TOTAL	7,365,600	377	144	905	5,589,200	428,000	29	58,000	326,600	263,800	12,700	687,300
% OF TOTAL	100.0				75.9	5.8		.8	4.4	3.6	.2	9.3
1994-1995												
PAHO - PR	5,914,300	216	72	585	4,423,100	443,300	27	56,700	262,100	262,300	14,700	452,100
WHO - WR	2,172,500	120	72	320	1,609,200	53,200	2	4,200	116,800	43,800	0	345,300
TOTAL	8,086,800	336	144	905	6,032,300	496,500	29	60,900	378,900	306,100	14,700	797,400
% OF TOTAL	100.0				74.5	6.1		.8	4.7	3.8	.2	9.9

12. ENVIRONMENTAL HEALTH

ANALYSIS OF THE HEALTH SITUATION

1. The quality of the environment for human life in the countries of the Region is deteriorating at an increasingly rapid rate as a result of industrial development, the expansion of agriculture and mining, and other economic activities. This situation is having a severely negative impact on environmental quality in both rural and urban areas, and its potential effect on the health of individuals has become a fundamental issue that must be dealt with by the governments and the community. This situation needs to be addressed in order to ensure sustained development.

2. In general, the Region has echoed the worldwide concern in recent years about the quality and conservation of natural resources--water, air, and soil--with primary reflections in the flora and fauna. Unfortunately, this movement has not given sufficient importance to human health as a primary consideration.

3. Most of the countries of the Region continue to have a health profile in which diarrheal and parasitic diseases stemming from poor sanitation play a major role in high mortality and morbidity among certain segments of the population, especially children. At the same time, the processes of industrial and urban development in the countries increasingly jeopardize the population's health as a result of exposure to chemical and toxic substances that contaminate the air, water, soil, and food. There are also precarious conditions in the workplace that demand special attention, particularly in view of the fact that most of the working population does not have access to preventive occupational health services.

4. Population growth continues to be another important factor in deterioration of the environment. The Region's population stands at 440 million and is increasing at an annual rate of 2.1%, mainly in urban areas. By the year 2000, nearly 80% of the population in the developing countries will be located in cities, and it is estimated that 40% of this population will life in unplanned shantytowns on the urban outskirts or inner city slums. This trend will continue to aggravate the deficits in water supply, sanitation, and waste management services as well as housing, and it will add to the current problems of pollution, especially biological contamination resulting largely from the poor hygienic habits of a population that tends to receive little or no health education.

5. Another important factor associated with the situation just described is the economic deterioration of the Region, which is reflected in the high cost of living, inflation, unemployment, and steadily worsening poverty. As result, there is a shortage of capital resources for investments in water and sanitation services, housing, urban infrastructure, and pollution control.

6. According to 1988 information supplied by the countries for the Evaluation of the International Drinking Water Supply and Sanitation Decade held in 1990, the Region's coverage with urban water supply (household connections or easy access) and wastewater and excreta disposal (connections to sewerage or individual systems) was 88% and 80%, respectively, and in rural areas the levels were 47% and 32%, this latter being very low. The coverage was not the same in all the countries. It should also be noted that urban services, with few exceptions, did not meet the necessary requirements in terms of quality and efficiency. There are frequent deficiencies in operation and maintenance; in many cases, service is intermittent. Water losses in the urban systems are estimated at between 40% and 60% of the water produced, which is considered excessive.

7. Not more than 10% of the wastewater collected receives treatment, and as a result, surface and underground water gets contaminated. In addition, orchards are frequently irrigated with untreated wastewater, which gives rise to serious health problems.

8. The volume of urban refuse that is generated in Latin America and the Caribbean doubles every 12 years and now amounts to 250,000 tons a day. The Region currently has 40 cities with more than a million inhabitants in which the problem of collection and disposal is becoming urgent. Estimates for this group indicate that collection coverage is 80%, but only 35% of the cities have sanitary landfills, and even these are deficient. Few institutions handle refuse properly. Municipal offices usually lack the resources and know-how to adequately deal with this problem. The situation is further aggravated by poor management practices and limited financial resources for maintaining the installations and equipment.

9. Air quality is getting worse because of unregulated emissions from factories and vehicles. More than 50 million people living in the urban areas of Latin America and the Caribbean are affected by unhealthful levels of air pollution from contaminant concentrations that frequently exceed the standards in developed countries, thus causing health problems.

10. Electric power generation, petroleum refining, mining, agroindustry, and other economic activities produce large volumes of waste, including chemical compounds, heavy metals, and other substances, many of which are toxic. In Latin America and the Caribbean the management of hazardous waste is only in its incipient stages and many industries do not treat their wastewater. There is widespread and indiscriminate use of pesticides, and compounds are employed that have been prohibited in developing countries. Unfortunately, exposure to chemical substances has led to the appearance of adverse effects on human health. These products are responsible for acute poisoning and for delayed and chronic effects in the population, which is exposed either from work-related causes or involuntarily. In one Central American country there was an annual

average of 1,000 work-related poisonings from pesticides, which suggests the impact that these chemical substances can have on health when their use is unregulated.

11. One important aspect is the international transportation of hazardous wastes from developed to developing countries. The health authorities should be alerted to this condition in order to adopt the necessary measures.

12. The economically active population in Latin America and the Caribbean represents 35% of the total population. The participation of women in the labor force has been tripled in the last 30 years and currently constitutes 30% of the working population. Child labor in several of the countries amounts to as much as one-fourth of the economically active population. Labor activities in the informal sector are on the increase. It is estimated that some 70% to 80% of the economically active low-income urban population works in the informal sector. Occupational health programs are scattered in different units of the national administration (health, labor, social security, private sector, and others). In all cases the countries have significant shortfalls in coverage in both qualitative and quantitative terms.

13. The proportion of workers who receive comprehensive care, including preventive care, is less than 10% of the total working population. This deficiency in preventive care has a major effect on the working population and those in the informal sector.

14. While there is a serious dearth of information on occupational diseases, existing studies suggest that they are widespread and that they are a public health problem because of the high associated mortality and the high incidence of serious cases. The pathologies most frequently diagnosed are respiratory diseases and poisoning from metals, pesticides, solvents, etc. Undoubtedly the prevalence of common diseases, poverty, poor nutrition, etc. serve to aggravate the problem. Occupational accidents are underreported by some 50%. It is estimated that every worker will suffer two to four accidents during his working life.

15. From a rough assessment of the environmental problems that the developing countries are experiencing in the Region, it can be said that in terms of solutions they all need to: address institutional weaknesses and develop coordination mechanisms among the responsible agencies, mobilize manpower in all categories, improve the transfer of information, extend the use of technologies that are adapted to socioeconomic conditions, and mobilize internal and external resources in support of action programs.

GLOBAL STRATEGY OF COOPERATION

16. The technical cooperation to be developed by the Program during the biennium will be within the framework of the "Strategic Orientations and Program Priorities for PAHO during the Quadrennium 1991-1994," with particular emphasis on the priority theme "Health and Environment." In addition, there are regional mandates that the Program should address.

17. With regard to water supply and sanitation, efforts will be made to promote the recommendations contained in the "Declaration of Puerto Rico" which emanated from the Regional Evaluation of the International Water Supply and Sanitation Decade (1981-1990) and to collaborate with the countries in their fulfillment. Accordingly, actions will be centered on: (a) promoting the extension of service coverage with a view to HFA/2000; (b) improving water quality from the standpoint both of supply and the sources that serve the population in light of the increasingly limited availability of superficial and underground water resources, the demand for multiple uses, and the effects of contamination; and (c) improving the efficiency of water and sanitation services including loss control, the rationalization of consumption, and the promotion of an effective approach to conservation.

18. The XXIII Pan American Sanitary Conference adopted Resolution XI on "Environmental Protection," which mandates the Governments to strengthen their administrative capacity; formulate strategies, policies, and programs; and improve intersectoral cooperation. According to this resolution, the Program will provide technical cooperation to facilitate the Governments' action, it will promote cooperation between countries, and it will facilitate the mobilization of extrabudgetary resources for the execution of programs and projects that will help to improve the countries' response capacity. Also, external financing will continue to be mobilized for the execution of both regional projects and subregional initiatives.

19. The same Conference also adopted Resolution XIV on "Workers' Health," which calls for priority to be given to occupational health, with special attention to the planning, organization, and adaptation of occupational health programs and services. For this purpose, activities will focus on the promotion of institutional coordination, the formulation and execution of plans and programs in occupational health, the formation of specialists, and assistance in the mobilization of financial resources for the upgrading of national programs.

20. In all environmental health interventions, including urban sanitation and the sanitary improvement of housing, technical cooperation will focus on the strengthening of local health systems, a task that will be facilitated by the nature itself of environmental problems, which basically involve local action

and close contact with the community. The participation of women will be important in this effort, since they have the main responsibility for environmental health protection as facilitators of the services and as promoters of household and community hygiene. A major component of the programs will be community participation in the planning and management of programs and services. Social communication will be enlisted to make this participation a reality while at the same time incorporating the people in activities for prevention and the reduction of pollution. Also, the Program makes use of networks of cooperating institutions, which in turn will encourage cooperation between countries.

21. The work of the Program will be carried out mainly through support for subregional initiatives. The second phase of the Central American initiative will include execution the MASICA Project, and in the Andean Area intercountry actions will have been initiated in the fields of health and the environment.

22. In summary, it can be said that environmental health actions will have as their constant the strengthening of national capacity at all levels. The focus will be on assisting the Ministries of Health so that they will be able to carry out their executive and advisory functions. Preferential attention will be given to the development of needed human resources, ranging from specialized academic formation all the way to the training of health personnel to act at the local level.

SPECIFIC PROGRAMS

CONTROL OF ENVIRONMENTAL HEALTH HAZARDS (CEH)

BIENNIAL TARGETS

23. Implementation of Resolution XI of the XXIII Pan American Sanitary Conference on Environmental Protection including the development of a regional framework project addressed to institutional capacity building and coordination in support to national environmental health programs.

24. In the area of risk assessment have advanced the regional program on environmental epidemiology and toxicology as well as research on pollution problems, as they relate to health, to respond to the needs of information in the countries.

25. In the area of risk management have established operational networks through which effective technical assistance in the form of training, information and consultancies can be extended on priority environmental hazards to country programs.

LINES OF ACTION

26. Foster environmental health considerations and awareness at the policy and community levels.

27. Emphasize self reliance by developing and/or strengthening the long-term capabilities of the countries at all levels for identifying and dealing with environmental health issues including institutional building and human resource development at all levels, through mobilization of external resources.

28. Support environmental health planning and program development in the countries in priority areas through an incremental and integrated approach using where possible Technical Cooperation among Countries (TCC).

COMMUNITY WATER SUPPLY AND SANITATION (CWS)

BIENNIAL TARGETS

29. Support the development of the necessary basic capacities of the countries for the best approach to the environmental health problems.

30. Contribute to the reduction of those risk factors associated with water-borne diseases and ailments through the extension of coverage of safe services of water supply, sanitary wastewater and excreta collection and disposal, aiming at universal coverage as a basic requirement for the health and well-being of the population.

31. Foster and support the institutional building and strengthening for the efficient use of drinking water supplies aimed at optimizing the use of resources, equitable service among users, control of water losses, diminish wastage and foster conservation practices.

32. Protect the water resources against biological, physcal and chemical pollution with special emphasis in the control and recovering of those sources used for water supply and irrigation of agricultural products used for human consumption.

LINES OF ACTION

33. strengthen the programs for education and training in order to improve the human resources that require the countries for the attention of the environmental health programs.

34. Preparation and distribution of technical-scientific information on environmental health as environment for the dissemination of new concepts and technologies.

35. Development of the institutional and managerial capacities in order to increase the efficiency and effectiveness of the environmental health sector and of its institutions.

36. Expansion of water supply and sanitation services to urban and to rural communities with special emphasis on urban poor with a view to achieve universal coverage in line with HFA/2000.

37. Strengthening of sector performance through reorganization; institution building and human resource development to improve efficiency.

38. Improvement of operational capability for providing potable water and establishment of a quality monitoring capacity.

39. Improvement of water resources management program for effective control of water sources used for drinking water supplies and for irrigation of agricultural crops used for human consumption.

WORKERS' HEALTH (OCH)

BIENNIAL TARGETS

40. Promote and support the countries in applying the lines of program action indicated by the XXIII Pan American Sanitary Conference in Resolution XIV on Workers' Health through the planning, organization, and adaptation of occupational health programs and services.

41. Fulfillment of the program for celebrating the "Year of Workers' Health, 1992," which is aimed at stimulating collective interest and political will in order to vitalize and extend the coverage of occupational health programs and services, especially those targeted to worker groups that are underserved.

42. Cooperation with the countries in the review and updating of their workers health policies, for both the formal and informal sectors, priority being given to those worker groups that receive less protection or none at all and those that are more vulnerable and at greater risk.

LINES OF ACTION

43. Development and strengthening of national capacity for planning and management in the area of workers' health, including the assignment of responsibilities, the articulation of actions, the formulation of intersectoral national and participatory plans, the inclusion of occupational health in local health systems as part of primary health care, and the encouragement of forms of cooperation that favor the incorporation of existing potential into health and social security programs as well as the programs of other sectors, economic guilds, and labor and community organizations.

44. Mobilization and optimization of internal and external resources with a view to extending occupational health coverage to high-risk workers and underserved groups, with emphasis on manpower development at all levels and institutional strengthening.

45. Dissemination of technical and scientific knowledge for facilitating comprehension and broad participation in the development of workers health programs, including a systematic survey of risk profiles and profiles of different types of workers in order to identify groups at greatest risk, the assessment of exposures as well as programs and services, and the application of needed interventions.

SOLID WASTES AND HOUSING HYGIENE (RUD)

BIENNIAL TARGETS

46. Promotion and support for capital cities and those with populations of over a million in Latin America and the Caribbean for improving their coverage of solid waste collection and sanitary disposal.

47. Promotion and support for the countries in the formulation and execution of national urban sanitation plans aimed at improving the coverage of solid waste collection and sanitary disposal in medium-sized and small cities.

48. Support for the Ministries of Health in the promotion and execution of measures for the hygienic improvement of housing, to be carried out through the institutions responsible for housing and community programs.

ANALYSIS OF THE PROGRAMS

12. ENVIRONMENTAL HEALTH (CONT.)

LINES OF ACTION

49. Assistance in the strengthening of enterprises (development of institutions and human resources), sanitation services in the capitals and cities with more than a million inhabitants, and development of the countries' sectoral capacity with a view to improving services in medium-sized and small cities. Special attention will be given to the problem of marginal urban areas, community participation, the adoption of low-cost technologies, conservation of natural resources through recycling, and the mobilization of national and external resources in order to upgrade facilities and installations.

50. Support for the development of capacity in the Ministries of Health to ensure that the question of housing hygiene is included in the housing programs developed by the pertinent national institutions and the community itself.

PROGRAM BUDGET DISTRIBUTION BY LOCATION

LOCATION	PAHO AND WHO REGULAR BUDGET 1990-1991	1992-1993	1994-1995	EXTRABUDGETARY FUNDS 1990-1991	1992-1993	1994-1995
DIRECT COOPERATION WITH COUNTRIES	8,809,500	9,696,300	10,937,500	6,671,231	3,701,505	40,400
REGIONAL PROGRAMS	2,274,500	2,501,800	2,814,200	149,955	170,000	185,000
CENTERS	3,638,400	4,433,800	5,019,400	1,975,470	1,310,127	1,166,800
TOTAL	14,722,400	16,631,900	18,771,100	8,796,656	5,181,632	1,392,200

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL PROF. MONTHS	PERSONNEL LOCAL MONTHS	PERSONNEL CONS. DAYS	PERSONNEL AMOUNT	DUTY TRAVEL AMOUNT	FELLOWSHIPS MONTHS	FELLOWSHIPS AMOUNT	SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	9,134,100	624	504	4065	6,081,300	400,700	354	672,600	983,900	410,300	47,600	537,700
WHO - WR	5,588,300	528	264	1330	4,222,400	219,700	111	210,900	248,600	195,300	5,700	485,700
TOTAL	14,722,400	1152	768	5395	10,303,700	620,400	465	883,500	1,232,500	605,600	53,300	1,023,400
% OF TOTAL	100.0				69.9	4.2		6.0	8.4	4.1	.4	7.0
1992-1993												
PAHO - PR	9,922,500	552	456	2875	6,599,600	488,700	278	556,000	1,032,600	551,900	13,300	680,400
WHO - WR	6,709,400	456	264	1190	4,864,000	267,900	68	136,000	435,000	306,900	0	699,600
TOTAL	16,631,900	1008	720	4065	11,463,600	756,600	346	692,000	1,467,600	858,800	13,300	1,380,000
% OF TOTAL	100.0				68.9	4.5		4.2	8.8	5.2	.1	8.3
1994-1995												
PAHO - PR	11,188,600	552	456	2875	7,394,100	567,000	278	583,800	1,198,400	640,400	15,500	789,400
WHO - WR	7,582,500	456	264	1190	5,456,000	311,200	68	142,800	504,600	356,200	0	811,700
TOTAL	18,771,100	1008	720	4065	12,850,100	878,200	346	726,600	1,703,000	996,600	15,500	1,601,100
% OF TOTAL	100.0				68.4	4.7		3.9	9.1	5.3	.1	8.5

ANALYSIS OF THE HEALTH SITUATION

1. The epidemiological analysis of the state of health of the population of the Americas finds that the most vulnerable groups are women--especially those of reproductive age, children, and adolescents who are considered to be at greatest risk of becoming ill and dying.

2. Latin America and the Caribbean have, in 1990, a population estimated at 449 million inhabitants. The population growth rate in Latin America is 2.8% per year and in the Caribbean it is 2%, which determines that the times for doubling the populations are 25 and 35 years, respectively. There is an accelerated process of urbanization, which reaches 72%.

3. Women of reproductive age--from 15 to 49 years old, children, and adolescents constitute 70.6% of the population, more than 316.4 million inhabitants who form the target population of this program.

4. Maternal and child health problems are accentuated by rapid urban growth, particularly of the marginal sectors. It is estimated that 93 million Latin Americans in these areas are in poverty. Of the rural population of approximately 200 million, 70% live in conditions of poverty and 40% are destitute. At least 130 million people in Latin America and the Caribbean do not have access to health services and of them, 90 million are children and women of reproductive age.

5. Infant mortality is different in the three subregions of the Americas. For around 1990, Latin America has a rate of 55 per 1,000 live births; North America, 10 per 1,000 live births; and the English Caribbean, 21. Only three countries in Latin America have levels lower than the English Caribbean: Cuba, Costa Rica, and Chile. On the other hand, there are 10 Latin American countries with rates equal to or higher than 60 per 1,000; they register 55% of the births of the subregion. The decline in infant mortality observed occurred mainly in the postneonatal component. As a result, the neonatal component became greater; this has implications for the strategies to reduce mortality in the coming years.

6. In 21 countries, the leading cause of infant mortality lay in the conditions originating in the perinatal period; diarrheal diseases, although they appeared among the five leading causes of death in 22 countries, are third in 14 of them. Only in two countries did whooping cough appear as a cause of death, occupying the fourth and fifth positions.

7. As a cause of death of children from one to four years of age, diarrheal diseases occupied first place in 11 countries. Influenza and pneumonia were among the five leading causes of death in 19 countries, nutritional deficiencies in 13 countries, and accidents in 16. Measles appeared in the age group from one to four years in six countries and whooping cough in two countries.

8. Mortality due specifically to diarrhea in children under one year of age and from one to four years was 26 and 118 times greater, respectively, in Nicaragua and Guatemala than in the Bahamas and Cuba. Mortality due to pneumonia in the same age groups was 25 and 43 times greater in Peru than in the western Caribbean.

9. In addition to reducing mortality, implementation of the oral rehydration therapy (ORT) reduced hospitalization due to diarrhea, serious cases of dehydration, and the hospital case-fatality rate in children under five.

10. The rate of access to oral rehydration salts reached 65% of the total population under five years of age in the Region with a rate of use of 41% in this same population. There is data that make it possible to relate part of the decline observed in infant mortality to the appearance and utilization of oral hydration salts and their use in the programs for prevention. However, it has not been possible to reduce morbidity from diarrhea substantially, a fact that is explained by the hygienic and environmental conditions under which the people live.

11. The interagency coordinating committee to support the development of the activities for the control of diarrheal diseases (ICC/CDD) is functioning with EPI and also USAID and UNICEF. The ICC formulated a plan of action for the years 1990-1995 which includes objectives, goals, and strategies. The aim is to expand the acute respiratory infections program in the biennium.

12. Acute respiratory infections (ARI), pneumonia in particular, cause approximately 250,000 deaths annually among children under five. Those infections are the cause of 25% to 30% of all deaths in this age group in the developing countries, in comparison with 10% to 15% in the industrialized countries; mortality due to pneumonia is particularly high in children under one year of age. ARI are responsible, in addition, for 30% to 50% of the visits of children to medical care centers and 30% to 40% of the hospitalizations.

13. A considerable proportion of episodes of ARI are viral infections of limited duration, such as common colds and coughs. However, approximately one in every 50 episodes of ARI results in pneumonia and, without treatment, 10% to 20% of those cases will die. Most of the cases of children hospitalized with pneumonia acquired in the community are caused by two bacteria, Streptococcus pneumoniae and Haemophilus influenzae. It has been demonstrated that the timely recognition of the signs of pneumonia--by the families as well as by the health workers, antibiotic treatment, support measures, and shipment of the serious cases to a higher level of care can result in a considerable reduction of the mortality due to ARI. At present 20 countries carry out activities for control of ARI following the standards proposed by PAHO/WHO.

14. Morbidity and mortality due to the diseases preventable by vaccination follow a downward trend but continue to be a problem despite the availability of highly effective, easily administered vaccines.

15. The achievements in the Program for Eradication of Wild Poliovirus can be observed in the number of confirmed cases of the disease in 1989 and 1990, 24 and 10, respectively.

16. Measles and neonatal tetanus continue to be a serious problem in numerous countries but the areas of greatest risk of neonatal tetanus have been identified and now control measures can be developed. The behavior of measles in the Region is better understood and measures for its control can be developed with greater efficiency and effectiveness.

17. Between 1988 and 1990 coverage by vaccination of children under one year of age reached levels never before achieved, approximately 60% for all vaccines, but there still are a great number of unvaccinated children. The problem of the high degree of abandonment between the first and subsequent doses in multiple vaccines and the lost opportunities for vaccination in the health establishments continue to be basic concerns of the program. All the countries have improved their systems of surveillance for the detection of the wild virus of poliomyelitis and the system can now be expanded to include other diseases preventable by vaccination.

18. For adolescents from 15 to 19 years of age among the five leading causes of death, accidents appear in first place in 17 countries, suicides between second and fifth place in 13 countries, and homicides between second and fourth place in 14 countries. It should be pointed out that in two countries the complications of pregnancy, delivery, and the puerperium appeared among the 10 leading causes of death in women of this age group.

19. Analysis of maternal mortality makes it possible to place the countries of the Region at four different levels: the first group, with the lowest rates, includes the United States of America and Canada; the second, with moderate rates between 21 and 49 per 100,000 live births, includes the Bahamas, Chile, Costa Rica, Cuba, Panama, and Uruguay; the third, with high rates, from 60 to 140, includes 10 countries; and the fourth, with very high rates, from 160 to 480 per 100,000 live births, comprises another 10 countries in Central America, the Andean area, and the Latin Caribbean.

20. For women of reproductive age (15 to 49 years) in 22 countries on which information is available, the complications of pregnancy, delivery, and the puerperium were among the ten leading causes of death, appearing in 11 countries as one of the first five. Accidents occupied a place within this group of causes of death in 21 countries, suicide in 15, and homicide in 16.

21. The coverage of prenatal care is inadequate in Latin America and the Caribbean as a whole, for in only 60% of the 13 million estimated births did the mother receive some type of prenatal care; there were large variations by country.

22. The coverage of deliveries with institutional care or by professional personnel is 72%. In the Region 3.8 million births (28%) still do not have this type of care.

23. Contraception, according to the best available figures, is estimated to be used by 60% of sexually active women from 15 to 49 years in the countries where information is to be had and which represent 70% of the population of Latin America and the Caribbean.

24. This level and the structure of infant, maternal, and adolescent mortality reflect the stages of demographic and epidemiological transition that coexist among countries and in their interiors with substantial variations.

25. In addition, the quality of the services can be related to the availability of the resources necessary for prevention and for access to a level of care with adequate capacity to resolve the problem.

26. The overall level of the conditions of effectiveness of the maternal and child health services was recorded at 67%, which indicates that the majority is still found in conditions considered to be less than satisfactory (80%). Principal deficiencies persist in the managerial aspects of administration and programming and community participation. One effect of the crises and the adjustments made that has been observed is a relative deterioration of the human resources in the services.

GLOBAL STRATEGY OF COOPERATION

27. The programming for maternal and child and adolescent health for the 1992-1993 biennium is set in a well defined framework: the PAHO/WHO global strategy of health for all by the year 2,000 and primary health care in the eighth WHO work program for 1990 to 1995, the strategic orientations and programming priorities of PAHO for 1991 to 1994, the recent mandates of the Governing Bodies, and their corresponding regional goals.

28. In treating highly vulnerable population groups the program contributes substantively to the national development effort inasmuch as it protects and increases the investment in human capital that would be necessary in the future to reach sustained development. At the same time, it favors the integration of women into health and development. In addition, it facilitates and permits decentralization and solidification of the strengthening of local health systems and the incorporation not only of social security but also of other sectoral institutions and other sectors as well as official and nongovernmental institutions, thus strengthening the health sector in its capacity to negotiate, coordinate, and manage action.

29. The regional maternal and child health program is oriented toward well-defined lines of action and strategies as a response to the challenges in maternal and child health and to the transformation of the health sector. It establishes a connection with the programming priorities and strategic orientations of the Organization for the quadrennium, among which the following are noted:

30. Concentration on high-risk groups and priority interventions:

30.1 All the actions of the program flow together in three large lines: a) health of women, with emphasis on sexual and reproductive health and prevention of maternal mortality; b) child health with emphasis on surveillance, conservation and/or restoration in the case of the processes of growth and development including breast-feeding, nutrition, and the categorical interventions required by the epidemiological profile of childhood in the countries of the region; c) adolescent health with emphasis on the promotion of comprehensive health and prevention, with multisectoral participation, including that of adolescents. Lines of work will be initiated in maternal and child AIDS, abused children, and school health.

30.2 The program gives priority to action in those countries in which the problems are more serious and affect a greater number of people, either at the national level or in the interior of the countries, and will place special emphasis on cooperation with those Member States that express their political will with the allocation, reassignment, or increase of their national resources, that favor international, interinstitutional, official, and nongovernmental coordination, and that, upon preparing their programs of technical cooperation with PAHO, assign resources to PAHO in their countries.

31. Lifestyles, promotion of health, and social communication:

31.1 The actions of the program will evolve with specific emphasis on prevention and the promotion of health of women, children, and adolescents. Intensive use will be made of social communication which, together with school education and health education, makes it possible to achieve a change of behavior and lifestyle and more positive attitudes toward health. Special care will be given to the work oriented toward integrating health care and reducing lost opportunities to provide appropriate additional services, when they are pertinent, to individuals who come for care of specific health problems, all in order to achieve a better quality of overall care; the intent is to add activities such as the detection of cervical and uterine cancer, sexually transmitted diseases and maternal and child AIDS, diabetes, hypertension, and nutritional deficiencies.

31.2 The program responds as a comprehensive technical whole. The division of the work that arises at the central level for reasons of specialization should not necessarily be applied at the local level where the consultants will have to prepare to act in a comprehensive fashion and develop complementary actions among the programs of the Organization that are especially focused on achieving the strengthening and development of local health systems, including among them social security and other agencies and institutions that work in health.

32. Mobilization of resources:

32.1 There will be a constant search for opportunities to strengthen the activities of the program in collaboration with other areas of the Organization.

Activities will be continued and increased that are aimed at strengthening interagency coordination with the United Nations system, bilateral cooperation agencies, development banks, governmental and nongovernmental agencies, universities, scientific societies, and especially the civilian society. This aggressive strategy of search for and mobilization of regular and extrabudgetary resources is of supreme importance for the program and the countries, since if these are not increased, the viability of the different components will continue be under continuous threat and it will not be possible to implement many of the actions programmed.

33. Management of knowledge, research, dissemination, and information:

33.1 The promotion of the generation of scientific and technical knowledge and its dissemination will continue to be a priority through the strategies of research and dissemination of the information. In this respect, use will be made of the potential of the national groups and the universities so that they better utilize research subsidies, the Program on Human Reproduction, and regional, extrabudgetary, and country project funds. The possible range of research includes biomedical, epidemiological, operational, and behaviorial areas, but the common denominator for the program will be research as a vitalizing element of the programs and for the development of the services. The collection of technologies, publications, and research produced by CLAP will be widely disseminated through normal activities of cooperation and scientific events. There will be continued development of the data bases at the regional level in the countries to allow better understanding of the state of health and its determinants, monitoring, and the evaluation of proposed interventions.

33.2 Technical discussions with the Ministries of Health and social security should result in updating and progress in the policies of promotion and protection of maternal and child health at the country level. The subject should be addressed by the Governing Bodies and in subregional meetings and initiatives and emphasized to donors and should be expressed in operating plans, programs, and standards developed by the maternal and child health and adolescent services so that, in addition to coverage, there is quality and warmth in the care provided to the population. The technical normative aspects will be promoted so that they have national application.

34. Adaptation of educational profiles, manpower development, and educational technology:

34.1 Manpower development at all the levels in the country and in the health infrastructures will continue to be important and actions will be carried out that are aimed at intensifying the participation of the universities, federations, and scientific societies, not only in national and international courses but in the training of the human resource and in the preparation of teaching material, which should be evaluated with respect to its quantity,

penetration, quality, and adaptation to the needs of the countries. It involves keeping regional and subregional events to the indispensable minimum in order to favor country events and those that strengthen local health systems.

34.2 The maternal and child health programs centering on reproduction, growth, and development offer a biological basis for the integration of the services at the different levels of care for the population served and for the health conditions, as well as for the interventions that result. Substantive aspects of responsibility are shared with other programmatic priorities of the Organization such as: nutrition, lifestyles and risk factors, control of avoidable diseases, workers' health, dependence, and maternal and child and adolescent AIDS.

SPECIFIC PROGRAMS

GROWTH, DEVELOPMENT, AND HUMAN REPRODUCTION (MCH)

BIENNIAL TARGETS

35. To contribute with all the countries to the development of the national capacities to increase the coverage and quality of the services for fertility regulation, control of pregnancy, care at delivery and of the newborn, surveillance of the growth and development of children, and care of adolescents, with a risk approach and emphasis on the neglected groups and integration of the activities into the health systems.

36. All the countries of the Region will have designed and implemented national plans and local family planning programs that are integrated into maternal and child care and that facilitate decentralization. The prevalence of use is expected to be at least 60% and there will be an increase in the use of more modern methods with fewer secondary effects.

37. All the countries of the Region will have designed and implemented national plans and local programs for prevention and reduction of maternal mortality among the target groups established in the regional plan. At least three strategies are contemplated: establishment of committees on maternal mortality, strengthening hospital referral, improvement of perinatal consultation, and training of traditional midwives as appropriate.

38. All the countries of the Region will, in order to facilitate action, have designed and implemented systems of epidemiological surveillance of maternal deaths, of monitoring and evaluation of the state of health of the population and analysis of its determinants, and of periodic evaluation of the conditions for the efficiency of services; models to estimate costs will be designed. The foregoing should improve the optimization of the utilization of the resources and of the process of decision-making.

ANALYSIS OF THE PROGRAMS

39. Of the countries of the Region 60% will have prepared and be applying plans and standards of surveillance of the growth and development of children.

40. Of the services 50% will be utilizing growth and development criteria and charts according to PAHO/WHO recommendations.

41. At least 30% of the countries of the Region will be utilizing validated instruments for evaluation of the psychosocial development of children.

42. Of the countries of the Region 80% will have done at least one evaluation of the efficiency of their maternal and child services.

LINES OF ACTION

43. National plans, policies, and programs should be developed in local health systems in order to guarantee the possibility of providing information, education, and integrated family planning services to the entire population, to the individuals that demand them, and to those for whom they are medically indicated; all this should be provided with adequate consideration of quality and with an appropriate mixture of modern contraceptive methods. In addition, better use should be made of demographic information in health planning and in the programming of the local health systems.

44. Prenatal control will be implemented through the updating of standards in accordance with the criteria recommended by CLAP, so that prenatal consultations are timely and thorough in order to guarantee a good level of quality and to detect perinatal risks and so that they include tetanus vaccination.

45. To promote adequate institutional care at delivery and clean delivery through improving the care at delivery and during the puerperium, either by trained lay midwives or by professional medical or nursing personnel, trained in obstetrics. There should be improvement of intermediate sites of care for risk-free delivery and of the referral hospitals.

46. Control during the puerperium will be effected through observation during the 24 hours after delivery and examination 42 days afterwards in order to prevent the complications of the puerperium. Preventive actions for the period between pregnancies and family life should be carried out.

47. Development of information systems and committees of maternal mortality that allow epidemiological surveillance of maternal deaths and monitoring of the maternal and child health situation and its determinants and the efficiency of the services.

48. Preparation and provision to services and communities of tables and criteria for evaluation of growth in children and the appropriate interventions.

49. Application of validity criteria for evaluation of the development and use of schemes appropriate to the sociocultural reality in each every country.

50. Systematic evaluation of conditions of efficiency and implementation of their results.

ADOLESCENT HEALTH (ADH)

BIENNIAL TARGETS

51. At the end of the biennium all the countries of the Region will have established policies and plans and initiated the process of development of programs for comprehensive health care for adolescents and young people with an eminently preventive and promotional approach and with effective social participation of the group and of the sectors involved in the health, well-being, and development of adolescents.

52. The countries will have the critical mass of multidisciplinary human resources from many professions necessary for the development of service and educational programs, nourished by effective and continuous mechanisms for dissemination of up-to-date information.

53. There should be regional and national networks of active groups that are developing service, educational, and research activities with a community approach and that serve to support the national initiatives for comprehensive health care of adolescents and young people.

LINES OF ACTION

54. Preparation of a plan for the development of the human resources--for implementation of health, educational, and training programs on adolescence and youth.

55. Strengthening of the health services to adapt them to the need for promotion and care of the health of adolescents and young people. This strengthening will include sensitization and mobilization of political will in order to incorporate adolescents and young people in the agenda of priority groups.

56. Strengthening of local, national, and regional networks of groups and institutions involved in caring for and promoting the general health of adolescents and young people.

ACUTE RESPIRATORY INFECTIONS (ARI)

BIENNIAL TARGETS

57. Establishment of a program for control of ARI at the national level in at least six countries of the Region that have infant mortality higher than 40 per 1,000.

58. In these countries 50% of the population will have regular access to drugs and 40% of the cases of pneumonia will be treated correctly.

59. All the health workers that serve children will have received training in the management of cases of ARI.

LINES OF ACTION

60. To consolidate the updated PAHO/WHO guidelines for the diagnosis and treatment of ARI in all the countries of the Region.

61. To continue cooperation with the regional UNICEF office and to encourage the central UNICEF organization and USAID to incorporate ARI in their programs for cooperation, including the creation of committees on interagency cooperation.

62. To promote epidemiological and clinical research and research on the health services, in the field of the acute infections.

63. To advise on the preparation of national operating plans for the control of ARI, including all the components, such as training, monitoring, supervision, and provision of supplies and drugs, in the context of comprehensive care for children.

64. To evaluate the progress in the country programs, using as indicators the number of health services with ARI activities programmed and standardized, the quality of the service, and the trend in mortality by cause in children under five years of age.

65. To promote, at the level of the local health services, the measurement and evaluation of the impact of the control measures.

66. To establish training units for the treatment of acute respiratory infections in hospitals and to train the technical team, medical and nursing students, and auxiliary personnel. To the extent possible these units will be established jointly with the CDD program.

67. To support the realization, at the national and departmental (state or provincial) levels, of courses on organization of the ARI program and on supervisory skills in ARI.

68. To promote training activities with the professors in the departments of pediatrics of the schools of medicine and schools of nursing, to be developed jointly with CDD.

69. To establish training units for the treatment of acute respiratory infections in the referral hospitals, in order to train the technical team, medical and nursing students, and auxiliary personnel. Insofar as possible these units will be implemented jointly with the CDD program.

IMMUNIZATION (EPI)

BIENNIAL TARGETS

70. All the countries of the Region will provide immunization services for all the diseases included in the Expanded Program on Immunization (EPI) to all children under one year of age.

71. All the countries will have covered no fewer than 80% of the children under one year of age with polio, measles, and DPT vaccination and all women of child-bearing age in the areas with a high risk of neonatal tetanus in all the municipalities or equivalent geopolitical units with vaccination with tetanus toxoid.

72. All the countries will have systems of epidemiological surveillance that are capable of investigating all cases of flaccid paralysis and initiating control activities within the 48 hours after the report of possible cases, determining the actual magnitude of neonatal tetanus, and anticipating the outbreaks of measles so that control activities can be initiated.

73. All the countries of the Region will have initiated the process of certification of the interruption of the transmission of the wild virus of poliomyelitis.

74. All the countries of the English Caribbean will have initiated actions for eradication of measles by 1995.

75. All the countries of Latin America will have initiated actions to eliminate neonatal tetanus in the areas of risk and to control measles.

LINES OF ACTION

76. The principal line of action in this area will be the strengthening of vaccination through the regular health services, particularly those that are directed toward mothers and children. Special importance will be placed on the elimination of lost opportunities to vaccinate in these services. This approach will be implemented with the national vaccination days, or similar types of campaigns, that will be developed at least twice per year in those countries in which the health infrastructure does not reach the target population. In the presence of outbreaks of diseases for which there is immunization, sweeping operations will be developed in order to immunize all those in the areas at risk who are susceptible. The identification of the areas of low coverage will be carried out routinely, particularly coverage at the municipal or district level, so that when they are identified vaccination will begin immediately.

77. Epidemiological surveillance will be expanded and based on notification by all the health units of the absence of cases of diseases preventable by vaccination. Initially emphasis will be placed on the system currently in operation for epidemiological surveillance of poliomyelitis in order to include measles and neonatal tetanus. The criteria for a "case" will be defined specifically for every disease and guidelines will be prepared for reporting, investigating outbreaks, implementing control measures, and evaluating their impact. This line of action will be supported by a laboratory network for specific diagnoses.

DIARRHEAL DISEASES (CDD)

BIENNIAL TARGETS

78. Toward the end of the biennium, all the countries of the Region will have in operation national programs for prevention and control of morbidity and mortality due to diarrhea. These programs should include the following elements: access to a supplier of ORS and effective management of oral rehydration in the health services and in the community oral rehydration units.

79. At the end of the biennium instruments and support will have been provided for the training of the responsible personnel at the central, regional, supervisory, and service levels so that standards are met.

80. Guidelines for training in CDD will have been provided to 70% of the institutions training physicians, nurses, and auxiliary health personnel.

81. Training in interventions for CDD will have been initiated for the personnel of 20% of the NGOs that work in health.

82. Efforts to provide training in the effective management of diarrhea will be supported for 20% of the dispensers of drugs.

LINES OF ACTION

83. Establishment of effective management of diarrhea in children in the homes and in the community oral rehydration units through education, social communication, and provision of ORS.

84. Establishment of effective management of diarrhea in the health establishments.

85. Guarantee of self-reliance in the production, quality control, and distribution of ORS.

86. Social mobilization through communication, education, and training.

87. Development of information systems that permit the monitoring and evaluation of the program and its activities.

88. Promotion of measures to prevent diarrhea: exclusive breast-feeding during the first four to six months of life and continued breast-feeding during the two first years of life; better weaning practices; use of clean water; hand-washing; use of latrines; proper disposal of the feces of young children; and immunization against measles.

13. MATERNAL AND CHILD HEALTH (CONT.)

PROGRAM BUDGET DISTRIBUTION BY LOCATION

LOCATION	PAHO AND WHO REGULAR BUDGET 1990-1991	1992-1993	1994-1995	EXTRABUDGETARY FUNDS 1990-1991	1992-1993	1994-1995
DIRECT COOPERATION WITH COUNTRIES	4,507,000	5,499,100	6,140,900	43,721,411	29,880,185	23,658,542
REGIONAL PROGRAMS	2,016,900	2,415,900	2,593,300	1,845,850	2,106,240	2,326,980
CENTERS	1,262,500	1,526,000	1,741,200	2,236,755	1,534,830	0
TOTAL	7,786,400	9,441,000	10,475,400	47,804,016	33,521,255	25,985,522

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL PROF. MONTHS	PERSONNEL LOCAL MONTHS	PERSONNEL CONS. DAYS	PERSONNEL AMOUNT	DUTY TRAVEL AMOUNT	FELLOWSHIPS MONTHS	FELLOWSHIPS AMOUNT	SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	4,265,000	192	96	915	1,850,100	238,800	128	243,200	638,400	398,100	13,800	882,600
WHO - WR	3,521,400	336	72	620	2,577,400	163,900	75	142,500	304,600	163,100	0	169,900
TOTAL	7,786,400	528	168	1535	4,427,500	402,700	203	385,700	943,000	561,200	13,800	1,052,500
% OF TOTAL	100.0				56.8	5.2		5.0	12.1	7.2	.2	13.5
1992-1993												
PAHO - PR	5,045,400	168	96	732	2,040,900	260,400	90	180,000	921,900	504,400	6,600	1,131,200
WHO - WR	4,395,600	336	72	935	3,306,200	182,000	52	104,000	422,800	179,400	0	201,200
TOTAL	9,441,000	504	168	1667	5,347,100	442,400	142	284,000	1,344,700	683,800	6,600	1,332,400
% OF TOTAL	100.0				56.7	4.7		3.0	14.2	7.2	.1	14.1
1994-1995												
PAHO - PR	5,509,100	144	96	732	2,041,900	302,400	90	189,000	1,069,800	585,500	7,700	1,312,800
WHO - WR	4,966,300	336	72	935	3,714,000	211,200	52	109,200	490,700	207,900	0	233,300
TOTAL	10,475,400	480	168	1667	5,755,900	513,600	142	298,200	1,560,500	793,400	7,700	1,546,100
% OF TOTAL	100.0				54.9	4.9		2.8	14.9	7.6	.1	14.8

ANALYSIS OF THE HEALTH SITUATION

1. The 1980s saw a substantial deterioration in the status of a number of communicable diseases in the Region, particularly vector-borne diseases such as malaria and dengue. The situation with regard to schistosomiasis, leprosy, filariases, leishmaniasis, and Chagas' disease has also deteriorated or remained unchanged. The opening of new lands to agriculture, lumbering, and mining has caused epidemic outbreaks in several areas where some of these diseases were already prevalent. This phenomenon has not only added to the burden facing an already overloaded health care system but has also impeded the full utilization of potentially rich areas that have recently started to be exploited. At the same time, the emigration of infected individuals from rural to urban areas has placed a new burden on the metropolitan institutions that offer health care services and has produced cases of human infection through non-vector transmission. Most of the Aedes aegypti-free countries in the Region have been reinfested, which accounts for both the notable increase of classic dengue in endemic areas and also dissemination of the virus to countries previously free of the disease, where there have been explosive epidemics. Still more serious was the occurrence, for the first time in the Americas, of major epidemics of hemorrhagic dengue in two countries of the Region. There has also been a significant increase in jungle yellow fever in two countries of South America. The presence of Aedes albopictus in several states of Brazil and of the the United States of America has serious implications because of the difficulties inherent in controlling this exotic species whose habitat is partially different from that of Aedes aegypti and which is also considered to be a vector of dengue and potentially of yellow fever and other viral diseases.

2. In the 21 countries of the Americas that maintain active programs for the control of malaria, the year 1989 had the largest number of cases in the entire decade. Approximately 1,101,646 cases were diagnosed. Of these, 65.19% were Plasmodium vivax, 32.34% Plasmodium falciparum, and 0.4% other Plasmodia species. For 2.0% of them, no information on species was available.

3. Nevertheless, the incidence by the end of that year was 383 cases per 100,000 population in the malarious area of the Hemisphere. There is no clear explanation for this apparent improvement except possibly the considerable reduction in case-detection activities in Ecuador, Panama, and Suriname due to labor, social, and political problems. Every country's malaria situation is different in terms of the intervention strategies being used: they can be aimed at preventing the reintroduction of malaria in the areas where transmission has already been interrupted, interrupting transmission where this is feasible, or merely reducing mortality and morbidity due to the disease.

4. Although the prevalence and incidence of schistosomiasis has declined in some geographical areas of the Region, in others the rates have gone up, especially with the creation of artificial reservoirs for irrigation, the generation of electric power, and population increases resulting from mass migrations in connection with development projects. Currently it is estimated that there are more than 12 million infected individuals in the Region and that around 30 million are at risk.

5. Trypanosoma cruzi infection, according to different estimates, affects between 12 and 16 million people in Central and South America. Transmission takes place in the urban and rural environment through the triatome vector. Particularly important in cities is transmission via blood transfusions. It is estimated that in a single country of the Region this route produced more than 20,000 cases of T. cruzi infection in one year. In addition, infected mothers account for an incidence of between 1% to 3% in newborns. Because of the extensive migratory movements, the potential of transfusing infected blood exists in countries where the possibility of vector transmission is remote, such as Canada and the United States of America.

6. The number of cases of visceral leishmaniasis, associated with severe undernutrition, has increased in children under 3, especially in Honduras and Brazil. Although the real magnitude of the problem in the Region is unknown, it is estimated that there are more than 10,000 new cases of cutaneous, mucocutaneous, and disseminated leishmaniasis each year.

7. Onchocerciasis currently affects more than 100,000 persons in six countries of the Region and it is estimated that the population at risk is on the order of 5.5 million.

8. The existence of numerous areas in which hepatitis B is hyperendemic, as well as several that have hepatitis delta, constitutes a serious challenge. It is estimated that the number of hepatitis B carriers exceeds 6 million. Influenza is endemic in the Region, with seasonal epidemic peaks. The viruses in circulation are types A and B, and, although mortality is low, the epidemics produce high morbidity that can have a considerable impact on community activities.

9. It is important to channel control efforts and to prevent the viral diseases mentioned above, while at the same time not overlooking such others as the Argentine hemorrhagic fevers and the respiratory viral diseases caused by adenoviruses and respiratory syncytial virus, as well as the rotavirus intestinal diseases that cause high mortality in the Region's children.

14. COMMUNICABLE DISEASES (CONT.)

10. In the last decade there was growing recognition of the importance of intestinal parasitic diseases, which in the poorer countries affect more than half the school-age population. In some areas, one in every 10 individuals in this age group develops a severe case. It is recognized that this disease impacts on both nutrition and child development. Uncinariasis causes iron-deficiency anemia, reduces productivity, and severely affects the development and intellectual capacity of children.

11. Leprosy continues to be endemic in almost all the countries of the Region. It is estimated that there are more than 350,000 cases. Most of them are in Brazil, where the number exceeds 250,000, representing more than 85% of the incidence and 70% of the prevalence in the Region. In five countries the prevalence is around one case per 10,000 population, but the problem is limited to specific regions. There are seven countries in which the incidence and prevalence are high throughout almost the entire national territory. Although in most of the countries the cases are detected early and multiple drug treatment has begun to be implemented, the lack of participation in the program by the general health services has meant that coverage with these measures has been insufficient to effectively control the disease. In addition, the existence of primary and secondary resistance to dapsone has also complicated program execution.

12. Tuberculosis continues to be one of the severest health problems in the countries of the Region. The current epidemiological situation is characterized by a high incidence (bacteriologically confirmed cases), a high accumulated prevalence of chronic cases, persistence of cases of meningitis, and mortality in children, all of which have nullified or slowed the downward trend of this disease, and in some countries it is even on the increase. The control problems have still not achieved full coverage and efficiency. Advances have been made in immunization of the newborn with BCG, in the use of bacteriology as a means of case-finding and diagnosis, and in the use of short-term drug regimens, adjunct therapy, and treatments capable of sterilizing the lesions. In many countries, budgetary restrictions have led to a deterioration in health sector services and, in some of them, prolonged shortages of tuberculosis drugs with serious epidemiological and operational consequences.

13. Bacterial diseases are a major public health problem in the Region. Typhoid fever is endemic in Chile, Mexico, and Peru, among others countries, and there are frequent epidemics caused by S. typhi strains that are resistant to antibiotics. Pneumonia and meningitis from St. pneumoniae and H. influenzae are a significant cause of mortality and morbidity in children under 4, and pneumococcus pneumonia is a problem in the elderly. In addition, there are thousands of cases each year of meningitis from N. meningitidis A, B, or C, largely in children under 2, sometimes with case fatality rates of more than 20%.

14. Despite the fact that it is known how to reduce the transmission of most of these diseases, practical methodologies for implementing prevention and control programs at a realistic cost are still insufficient. Even the diagnostic tools and effective treatment schemes are only used to a limited extent because of the economic or operational obstacles. In addition, there is a time lag between the availability of new knowledge and its application to the improvement of program activities.

15. At the end of 1990, 157 countries of the world had reported more than 300,000 cases of acquired immunodeficiency syndrome (AIDS) to WHO, of which more than 60% have been reported from 46 countries and territories of the Americas. Because of underreporting, it is estimated that the cumulative number of cases in adults and children is actually over 1,200,000. The largest number of reported cases in the Americas has occurred in the United States, but the highest case rates have occurred in some of the Caribbean countries. In most, if not all, countries of the Region, transmission of HIV was seen initially in homosexual and bisexual males. However, heterosexual transmission has increased in frequency in many countries and is now the most important mode of infection in the Caribbean and parts of Central America. Transmission among intravenous drug users and their sexual partners is also of increasing importance in a number of large cities of North and South America and some islands of the Caribbean. As a result of these changes, more cases of AIDS are being seen in women and children.

16. Rates of HIV infection are slowing in industrialized countries but are increasing in most developing countries, which will bear the major burden of AIDS in the future. It is estimated that 1.0-1.5 million persons are infected in North America, with a similar number in the Caribbean and Latin America. These estimates are based on surveys of varying size and quality, and better data are needed in almost all countries of the Region in order to anticipate the burden of AIDS during the next decade and to permit the dedication of suitable resources. There is also a need for further study of the study of the legal, economic and social impact of AIDS and HIV infection, so that the effects can be reduced or controlled wherever possible.

17. Sexually transmitted diseases are among the most common diseases worldwide. WHO extimates that more than 250 million cases occur annually. The economic and medical costs of STDs are very high, and they are frequently the cause of sterility, abortion, blindness, cervical cancer and other complications. In Latin America and the Caribbean there are only limited data on the occurrence and sequelae of STDs. In most countries, reporting of these diseases is incomplete, and the ability to confirm diagnoses with laboratory tests is largely absent. Furthermore, STDs, expecially those producing genital ulcers, such as syphilis and herpes, may facilitate the transmission of HIV. Therefore, it is imperative that STD control programs be strengthened and integrated with efforts to prevent and control HIV infection.

GLOBAL STRATEGY OF COOPERATION

18. Improvement in the communicable disease situation should be viewed in the context of the primary health care strategy and in accordance with the Strategic Orientations and Program Priorities of PAHO during the quadrennium.

19. It is within this framework that the Program's promotion, coordination, and support initiatives will be effective. These actions, basically oriented toward strengthening national capacity for prevention and control, will be carried out in accordance with the following strategic orientations.

20. In terms of reorganization of the health sector, it is important to bear in mind that one of the goals should be the effective decentralization of prevention and control activities. The vertical programs, although efficient in some cases, are impossible to maintain in the socioeconomic circumstances that the countries are currently facing in the Region. In order for decentralization to be possible, the infrastructure of the local health services will need to be strengthened through efforts to improve efficiency in terms of cost-benefit and the environmental impact of interventions. Greater decision-making capacity at the periphery will be reflected in improved local programming, the execution of activities, and the evaluation of prevention and control methods in local situations.

21. With regard to focus on risk groups, these actions, based on the concept of epidemiological stratification, will be an essential element in orienting specific intervention measures. This will mean organizing and strengthening epidemiological surveillance systems and analyzing the different risk factors that intervene in and/or influence transmission.

22. Social communication will be enlisted by beaming relevant messages on the prevention of communicable diseases to different audiences via the mass media and using available health education tools so that individuals and communities will have the information with which to make informed decisions on different aspects of health maintenance.

23. Within the broad framework of health promotion, emphasis will be placed on the improvement of dwellings and surrounding areas, as well as on environmental sanitation. The target population for the promotion efforts will be women and school-age children, both because they are the main victims of inadequate housing, since they spend more time at home, and because of the potential that these two groups have as agents of change.

24. The management of knowledge will be reflected in the collection, production, analysis, and dissemination thereof, which will be the axis that will make it possible to select technically adequate, economically feasible, and socially acceptable alternatives for intervention. Research and the testing of technologies will be promoted to generate knowledge about the local factors that determine the distribution, prevalence, and incidence of communicable diseases. The testing of innovative strategies for intervention will also be promoted, as well as assessment of the operational capacity of services; development and evaluation of simple and practical diagnostic methods; treatments based on simple, standardized, and effective schemes; and initiatives carried out in conjunction with other development sectors (mining, agriculture, tourism, irrigation, water supply and sewerage systems, food safety, sanitation, and management and protection of the environment).

25. AIDS is one of the program priorities for PAHO during the quadriennium 1991-1994. During the biennium, the Program will provide technical cooperation to Member Countries in order to achieve the following objectives. (1) All countries of the Region will have in full operation medium term plans for the control and prevention of AIDS, and many countries will begin the development of long term plans. (2) Administrative and managerial capacity in the national programs will be strengthened. (3) Policies will be in place to integrate AIDS control programs into national health services and will foster coordination with other programs for women, children and the family, including family planning, maternal and child health and reproductive health. (4) Involvement of NGO's into national AIDS programs will be promoted. (5) All national programs will have fully developed educational and intervention activities targeted at high risk groups, school-age persons, health workers and the general population. (6) National programs will continue to promote the use of condoms and virucides and other practices to decrease the risk of sexual transmission, especially to women. (7) All programs will have activities for the care of persons with AIDS and those infected with HIV. (8) By the end of 1992, national reference laboratories will have more rapid, sensitive, specific and cheaper tests for HIV and will achieve a better coverage nationally. This will permit more complete and accurate serosurveillance and better knowledge of the prevalence of HIV infection in each country. (9) By mid 1993, essentially all blood banks, both private and public, will be providing secure blood products through donor screening, self-deferral, testing, autotransfusion and other techniques of transfusion medicine. (10) By 1993, there will be 4 subregional laboratories providing technical support and training to national laboratories. Finally, PAHO will develop a regional research program in HIV and other retroviruses, to be carried out in various Member Countries.

26. The STD Program strategy during the biennium consists of strengthening national programs through direct technical cooperation and through participating NGOs, especially ULACETS. Improved surveillance will produce a clearer understanding of the extent of STDs nationally and regionally. The establishment, by the end of 1993, of a Regional network of laboratories to

carry out training in diagnostic techniques will improve laboratory capacity at the national, subregional and regional levels. The use of standard treatment protocols using established guidelines will permit a more rational approach to patient management and STD control. By the end of 1993, at least 6 countries should have developed specific projects for the prevention of congenital syphilis. Finally, activities will have been initiated to eradicate endemic trepanematoses from recurrent foci in the Americas.

SPECIFIC PROGRAMS

LEPROSY (LEP)

BIENNIAL TARGETS

27. To incorporate prevention and control actions into the health services, in keeping with the primary health care strategy.

28. To train personnel from the peripheral health services in the early detection of suspicious cases, ensuring multiple drug treatment for confirmed cases and for professional personnel at the intermediate level for the prevention and treatment of disabilities and the provision of care in the event of complications.

LINES OF ACTION

29. To promote the incorporation of prevention and control actions in the general care services, in keeping with the primary health care strategy.

30. To improve epidemiological and operational information.

31. To support the implementation of multiple drug treatment.

32. To promote the training of personnel at every level in the early detection and treatment of cases and in the prevention and treatment of disabilities.

MALARIA (MAL)

BIENNIAL TARGETS

33. To adjust the structure of control programs and, in keeping with the primary health care strategy, incorporate diagnosis, treatment, and intervention activities as part of the local health services, bearing in mind the risk factors for transmission, with a view to reducing morbidity and preventing mortality.

34. To develop technical, managerial, operational, and epidemiological surveillance capability for maintaining and expanding the malaria-free area area, and to reduce the endemic disease or at least to prevent its recurrence by applying appropriate technology to control the risk factors.

LINES OF ACTION

35. To promote and support epidemiological stratification with a view to improving the orientation and efficiency of intervention measures, and to support the enhancement of systems for recording activities and maintaining the flow of information.

36. To promote the utilization of bilateral and subregional agreements for technical cooperation between countries.

37. To promote the dissemination of epidemiological and technical information and information about the ecological and economic factors that should be considered in evaluating intervention measures and preparing plans and projects as well as the work of the services.

38. To promote and collaborate in the execution, follow-up, and dissemination of research aimed at the solution of prevention and control services.

39. To promote the follow-up and dissemination of experiences and research aimed at defining minimum infrastructure needs, as well as a process that will permit greater operational capacity at the local level of the general health services, with a view to reducing mortality and morbidity.

40. To promote the search for, and systematization of, social promotion mechanisms at the level local designed to enlist community and intersectoral participation in the solution of the problems related to the prevention, treatment, and control of malaria.

41. Promotion of the utilization of the mass media and health education methodologies in control programs.

GENERAL COMMUNICABLE DISEASE PREVENTION AND CONTROL ACTIVITIES (OCD)

BIENNIAL TARGETS

42. To reduce the transmission of infectious diseases of importance in the Region through well-structured programs that utilize integrated measures for prevention and control, including social participation.

43. To carry out special studies for the development of interventions that take into account the epidemiological facts, especially those based on the stratification of groups or areas at risk.

44. To strengthen the capacity of national laboratory networks to support epidemiological surveillance and the diagnosis of infectious viral and bacterial diseases.

LINES OF ACTION

45. To promote and support the development of integrated strategies for the control of epidemics.

46. To support the development and/or evaluation of vaccines against viral diseases, bacterioses, rickettsioses, and parasitic diseases of regional importance.

47. To promote the development of epidemiological studies on priority infectious diseases.

48. To promote the establishment of a regional laboratory network for the diagnosis of viral disease and build up timely and effective diagnostic capacity.

PARASITIC DISEASES (PDP)

BIENNIAL TARGETS

49. To develop and strengthen the multipurpose laboratory network for the diagnosis and epidemiological surveillance of priority parasitic diseases in the Region.

50. To ensure that the countries in the Region most affected by parasitic zoonoses establish the legal bases for compulsory reporting and registration of cases, with a view to supporting the information and epidemiological surveillance systems.

51. To rationalize theoretical/methodological viewpoints for the implementation of actions aimed at the elimination of onchocerciasis in at least three countries.

52. To produce guidelines on health education and the utilization of social communication in a multisectoral approach in order to strengthen health promotion activities in support of the control measures.

LINES OF ACTION

Soil-borne helminthiasis

53. To promote the development and execution of methods for the epidemiological stratification of helminthiasis, including teniasis/cysticercosis.

54. To promote the creation and development of multipurpose parasitological and immunological laboratory networks in the health services.

55. To promote the development of national education and disparasitization programs in school-age children.

56. To promote the mobilization of resources for carrying out prevention and control actions through veterinary public health activities.

57. To promote the development of national and regional plans for the training of human resources capable of participating in control, research, and training on parasitic diseases.

Onchocerciasis

58. To promote the design, operationalization, and evaluation of a Plan of Action aimed at the elimination of onchocerciasis in selected countries.

59. To support the initiation of actions for determining levels of endemicity in select foci in order to promote development of a plan for the elimination of onchocerciasis.

60. To participate in follow-up relating to the donation of ivermectin.

Leishmaniasis

61. To promote compulsory notification in the countries of the Region that are most affected, as well as the standardization of procedures for diagnosis, treatment management, and control.

62. To support the execution of control measures within the PHC strategy, with optimum utilization of local health systems.

TROPICAL DISEASE RESEARCH (TDR)

BIENNIAL TARGETS

63. To develop new methods and/or improve existing ones for the prevention, diagnosis, and treatment of tropical diseases.

64. To strengthen national capacity so that the institutions of the Region are capable of carrying out research and research training on the biomedical, epidemiological and social aspects of tropical diseases.

LINES OF ACTION

65. To promote epidemiological studies directed toward improving knowledge about the factors that affect the transmission and control of tropical diseases.

66. To promote research on diagnostic techniques, therapeutic schemes, and immunizing agents.

67. To support the evaluation of different intervention strategies for prevention and control.

68. To promote training in the biomedical and social sciences for research on tropical diseases.

69. To promote the strengthening of institutions that carry out research and training in malaria, leishmaniasis, and W. bancrofti.

TUBERCULOSIS (TUB)

BIENNIAL TARGETS

70. To create conditions for increasing the number of countries in which the efficient application of control measures has led to a sustained and progressive reduction in tuberculosis morbidity and annual risk of infection which in turn has resulted in control of the disease within a brief period of time.

LINES OF ACTION

71. To promote and support the incorporation of prevention and control activities into the local health systems, achieving total integration of the Program into all the health units.

72. To support the strengthening of laboratory networks with a view to improving quality control, information, and full articulation of the laboratory with the care delivery units.

73. To promote improvement of the system for registering and reporting on the Program's activities.

74. To promote training for personnel at the different levels of the health services who perform prevention and control activities and who have potential for the epidemiological and operational analysis of TB.

75. To promote resource mobilization.

VECTOR-BORNE DISEASES (VBC)

BIENNIAL TARGETS

76. To develop national plans of action in the most affected countries for the detection, epidemiological surveillance, and control of the vectors and viruses of dengue and yellow fever.

77. To reduce the populations of Aedes spp. to levels compatible with the absence of dengue transmission through a program for intersectoral action, using social communication media and effective community participation.

78. To incorporate guidelines for prevention and vector control within national development plans that call for investments in dam-building, irrigation works, mining development, and colonization programs in the Region.

79. To help ensure the continuity of conditions that will make it possible to implement measures for the control of vector-borne parasitic diseases in the context of the PHC strategy through community participation.

LINES OF ACTION

80. To promote the implementation of integrated vector control measures (reduction and/or treatment of foci, biological control, viable social participation, management of the environment, and agriculture and livestock activities).

81. To support organizational, environmental, and social protection aspects in the preparation of proposals for development projects.

82. To promote the inclusion of training plans in national, bilateral, and multilateral development projects with a view to improving the efficiency of vector control programs.

83. To promote community participation in prevention and control measures.

84. To promote the decentralization of control measures.

85. To support the use of mass media and health education methodologies through prevention and control programs.

86. To encourage health promotion, with emphasis on the improvement of housing and surrounding areas and on environmental sanitation.

ACQUIRED IMMUNODEFICIENCY SYNDROME (HIV)

BIENNIAL TARGETS

87. By the end of each year of the biennium, the regional program, the subregional initiatives and all National AIDS Programs will have carried out successfully at least 85% of all planned activities for AIDS prevention described in their Annual Program Budget.

88. By the end of 1992, all Member Countries will have in place a functioning system for planning and budgeting and for reporting activities and budget execution based on the APB and the four-month planning document.

89. At the regional and subregional levels, at least six successful collaborative efforts between AIDS programs and other health programs will be fully operational. These efforts will involve the participation of various countries and relevant external agencies and will include areas such as blood safety, STD control, and health manpower development.

90. By the end of 1993, all Member Countries will have established systems for eliminating the risk of blood-borne transmission of the human immunodeficiency virus (HIV), including identification of reliable, uninfected, voluntary donor pools, testing of donated blood, and avoidance of unnecessary transfusions.

91. By the end of 1993, there will be four active and functional subregional reference laboratories to meet the needs of Member Countries. By the end of the same period, all countries with population larger than 1 million will have a functioning national reference laboratory.

92. By the end of 1992, at least one-third of all national AIDS programs will have active involvement and participation of non-governmental organizations (NGO's). This proportion will increase to one-half by the end of 1993.

93. By the end of the biennium, all National AIDS Programs will have developed the capacity for planning, mobilization and procurement of resources, and program evaluation.

94. By the end of 1993, at least 15 Member Countries will be reporting HIV seroprevalence results in sentinel groups and all Member Countries will report AIDS cases and deaths on a quarterly basis.

95. By the end of 1993, at least six countries with a large incidence of AIDS cases will have established mechanisms for providing comprehensive health and social services for HIV infected individuals. These services will include community care and community hospices for terminally-ill patients and for children orphaned because of AIDS.

96. By the end of the biennium, all intervention programs in Member Countries will be targeting women, disadvantaged children and sexually active youth, and will direct their activities to reducing the sexual transmission of disease, including HIV. Specific behavioral interventions directed at the prevention of both STD and AIDS will be integrated in 50% of Member Countries.

97. By the end of 1993, 50% of Member Countries will have established systems for the purchase, storage, distribution and quality testing of condoms, with assistance from regional and global level.

98. By the end of the biennium, all countries will have developed a national capacity to conduct evaluation, behavioral or ethnographic research, and at least ten countries will have developed the capacity to evaluate specific behavioral interventions.

99. By the end of 1993, guidelines for AIDS/STD education in school curricula will have been adapted and put into effect by one-half of Member Countries.

100. By the end of 1993, specific training programs will have been established at the regional/subregional levels in the areas of program management and patient management. Nationals from at least 20 countries will have undergone this training.

101. By the end of the biennium, all Member Countries will be participating in regional and subregional networks providing technical and scientific information on AIDS, HIV and STDs.

102. By the end of 1992, a regional HIV/AIDS research program with continuous regular and extrabudgetary support will be established at PAHO.

103. By the end of the biennium, studies will have been finalized or will be underway in at least six countries to estimate the prevalence of retroviral infection.

104. By the end of biennium, the main risk factors for perinatal transmission will be determined in at least two areas or countries in the Region (English-speaking Caribbean and Latin America).

105. By the end of 1993, investigations on the association between STD, mycobacterial and retroviral infections will be underway in at least two countries of the Region.

106. By the end of 1993, research on the appropriate use of affordable drugs and their cost-effectiveness will be initiated in four countries. Besides, two or more sites for vaccine trials will have been established in the Americas.

107. By the end of 1993, the capacity to conduct essential national research on HIV, AIDS, other STD and opportunistic infections will be defined and strengthened in all National AIDS Programs.

108. By the end of the biennium, a system to update the regional research inventory will be fully operational.

14. COMMUNICABLE DISEASES (CONT.)

LINES OF ACTION

Coordination and special initiatives

109. Consolidate regional, subregional and national AIDS prevention efforts.

110. Promote interprogrammatic and interagency collaboration.

111. Develop special initiatives to strengthen national programs.

112. Strengthen national reference laboratories and support the establishment of subregional laboratories.

113. Promote the involvement of NGO's in AIDS prevention and control activities.

National program support

114. Assist in the preparation, implementation and revision of medium term plans for AIDS control.

115. Support the mobilization of resources and the follow-up, evaluation and reporting to donor agencies.
Identify training needs in strategic areas such as surveillance and program management.

116. Promote operational research relevant to the execution of national programs.

Intervention development and support

117. Improve targeted behavioral intervention activities.

118. Procure, store and distribute condoms and promote the use of condoms and virucides.

119. Conduct appropriate and adequate knowledge and behavior surveys and ethnographic studies.

120. Develop educational approaches to AIDS and sexuality for schools.

121. Train health workers in aspects of AIDS and HIV, including counselling.

122. Disseminate technical and scientific information.

Research

123. Improve knowledge of the prevalence of HIV and other retroviruses.

124. Define the level of and factors involved in perinatal transmission.

125. Determine the interaction of HIV with other infectious agents, such as STDs and mycobacteria.

126. Document the genetic, phenotypic and biological variability of HIV.

127. Identify affordable drugs for the prevention and treatment of opportunistic infections.

128. Facilitate access to training programs and obtain funding for research projects in various countries.

SEXUALLY TRANSMITTED DISEASES (DST)

BIENNIAL TARGETS

129. By the end of 1993, STD prevention and control efforts will be fully integrated with National AIDS Programs in 50% of Member Countries. Progress will be underway in the remaining countries to achieve integration.

130. By the end of 1993, technical cooperation for STD control emphasizing surveillance, improved diagnostic capability, development and application of technical guidelines, essential research and mobilization of resources will have been provided to at least 20 countries.

131. By the end of the biennium, training, demonstration projects and scientific activities will be promoted through the Latin American Union Against Sexually Transmitted Diseases (ULACETS). Specifically, the 3rd STD World Congress and VII International Conference on AIDS (1992) and the IX Latin American Congress on STD (1993) will have been successfully implemented.

LINES OF ACTION

132. Cooperation with Member Countries to strengthen their activities for the control of STDs by mobilizing resources, promoting investigations, developing technical guidelines, disseminating information and improving surveillance.

133. Cooperation with the Latin American Union Against Sexually Transmitted Diseases (ULACETS) for the execution of certain regional and national activities.

134. Promotion of the integration of STD control with other programs, including AIDS prevention, family planning and maternal and child health.

14. COMMUNICABLE DISEASES (CONT.)

PROGRAM BUDGET DISTRIBUTION BY LOCATION

LOCATION	PAHO AND WHO REGULAR BUDGET 1990-1991	1992-1993	1994-1995	EXTRABUDGETARY FUNDS 1990-1991	1992-1993	1994-1995
DIRECT COOPERATION WITH COUNTRIES	9,687,700	10,526,400	11,980,900	33,851,742	26,447,103	340,000
REGIONAL PROGRAMS	1,942,900	2,011,600	2,261,500	2,414,293	1,946,886	69,300
CENTERS	0	0	0	3,095,222	2,125,823	0
TOTAL	11,630,600	12,538,000	14,242,400	39,361,257	30,519,812	409,300

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT $	PERSONNEL PROF. MONTHS	PERSONNEL LOCAL MONTHS	PERSONNEL CONS. DAYS	PERSONNEL AMOUNT $	DUTY TRAVEL AMOUNT $	FELLOWSHIPS MONTHS	FELLOWSHIPS AMOUNT $	SEMINARS AND COURSES $	SUPPLIES AND EQUIPMENT $	GRANTS $	OTHER $
1990-1991												
PAHO - PR	4,254,000	216	72	1725	1,875,500	222,400	170	323,000	862,000	678,500	10,300	282,300
WHO - WR	7,376,600	618	264	1695	5,124,200	436,400	105	199,500	629,700	626,200	197,500	163,100
TOTAL	11,630,600	834	336	3420	6,999,700	658,800	275	522,500	1,491,700	1,304,700	207,800	445,400
% OF TOTAL	100.0				60.2	5.7		4.5	12.8	11.2	1.8	3.8
1992-1993												
PAHO - PR	4,975,000	144	96	1655	2,011,600	265,300	99	198,000	839,200	762,500	153,000	745,400
WHO - WR	7,563,000	528	240	1320	5,282,800	406,500	79	158,000	687,300	410,700	61,100	556,600
TOTAL	12,538,000	672	336	2975	7,294,400	671,800	178	356,000	1,526,500	1,173,200	214,100	1,302,000
% OF TOTAL	100.0				58.1	5.4		2.8	12.2	9.4	1.7	10.4
1994-1995												
PAHO - PR	5,666,900	144	96	1655	2,242,400	307,700	99	207,900	973,800	885,000	177,500	872,600
WHO - WR	8,575,500	528	240	1320	5,947,100	471,800	79	165,900	797,600	476,500	71,000	645,600
TOTAL	14,242,400	672	336	2975	8,189,500	779,500	178	373,800	1,771,400	1,361,500	248,500	1,518,200
% OF TOTAL	100.0				57.5	5.5		2.6	12.4	9.6	1.7	10.7

15. HEALTH PROMOTION

ANALYSIS OF THE HEALTH SITUATION

1. The demographics of the developing countries of Latin America and the Caribbean are characterized by intense growth of the adult population, a reduction in child mortality, sharply declining fertility, an increase in life expectancy at birth, and rapid urbanization.

2. By the year 2000 the total population of the Region will be more than 550 million, which is double that of 1970. The urban population has grown at even greater speed, increasing during the same 30 years from 160 to 420 million. This means that the American Hemisphere is becoming increasingly urban and is characterized by large conglomerations of cities, thereby presenting a challenge for the conservation and protection of the environment and for the planning of social services. The health problems associated with haphazard urbanization are derived mainly from social behavior and lifestyles.

3. With respect to the age structure of the population foreseen for the year 2000 in Latin America, most of the population--340 million, or 62% of the total--will be between 15 and 64 years of age. Aging of the population is already notable in North America and in several countries in the Caribbean and Latin America. In most of the countries an increase is expected of more than 3% in those 65 years of age and over, and in the more elderly the percentage will reach 13% or 14%. In addition, if the age group of those over 45 years of age is taken into account, the increase will be even greater, since this is the age group in which chronic diseases, disabilities, and occupational diseases begin to appear.

4. The most important specific problems to be considered in analyzing the epidemiological situation of the Region by virtue of both their magnitude and their complexity are the following:

4.1 Cardiovascular diseases are the leading cause of death in 31 countries in the Region. Malignant tumors rank second as the cause of death in North America, the English-speaking Caribbean, southern Brazil, the countries of the Southern Cone, Cuba, Colombia, and Costa Rica. Accidents figure among the first five causes of death in all the countries, and diabetes mellitus also appears among the leading causes in several countries in the various subregions. Chronic respiratory diseases and their complications in the circulatory system also contribute substantially to pathologies of adults and elderly persons.

4.2 Cancer in women is responsible for most of the mortality due to malignant tumors in most of the countries; the pattern of distribution differs, however, between the most developed and the less developed countries. In the latter, mortality and the incidence of invasive cancer of the cervix are most frequent; in the most affluent societies it is breast cancer that reaches epidemic dimensions. These differences are attributed to risk, and in the case of cancer of the uterine cervix, mainly to the lack of access of the most socially marginalized women to effective preventive programs.

4.3 Lung cancer, directly associated with the use of tobacco, ranks first as the cause of death from malignant tumors in males in North America and in some countries of Latin America where smoking is highly prevalent, such as Cuba and Uruguay. Although the death rates from this kind of cancer in women are significantly lower than in men in all the countries, a trend has recently been observed toward an increase in many of the countries, possibly due to an increase in the use of tobacco by women in contemporary society.

4.4 These problems, which together make up the chronic noncommunicable diseases, are unmistakably predominant in the Region's epidemiological profile, and there is evidence that they are continuing to increase. Of these diseases, those affecting the heart and the arteries, including the cerebrovascular diseases, are the most common and are apparently increasingly, affecting the poorest populations as much as the most prosperous because of the importance of the risk factors associated in their causes with very generalized consumption of tobacco and alcohol, in addition to the influence of eating habits, the stress of modern life, and sedentary lifestyles.

4.5 Hypertension is one of the most prevalent diseases in the populations of Latin America and the Caribbean, affecting between 10% and 18% of those above the age of 15, according to data provided by surveys carried out among the general population in several of the countries. Mortality from cerebrovascular diseases is higher in populations where epidemiological evidence shows a high prevalence of hypertension that is poorly controlled by the health services.

4.6 Ischemic heart disease also accounts for a substantial portion of deaths from heart disease in all the countries. Data are not available on their incidence, or in any case are very limited, but mortality studies reveal in some countries that the rates among adult men are tending to increase, especially in the English-speaking Caribbean and Cuba.

4.7 Diabetes mellitus, in addition to constituting a major risk for eventual death from cardiovascular disease, is in itself a public health problem in most of the countries. The prevalence in the adult population ranges from 4% to 6%, according to various studies carried out internationally that coincide in this respect.

4.8 At the same time, the diseases that affect the arteries, such as hypertension and diabetes, may lead to ophthalmological complications, such as cataracts and eventual blindness. Cataracts are the most frequent cause of major loss of vision in adults in most of the countries. This problem tends to become worse with age.

4.9 Other social pathological conditions affect large population groups, especially in the urban and suburban areas of Latin America and the Caribbean, causing many disabilities and a great deal of suffering to families and individuals. This complex group includes drug addiction and alcoholism, as well as acts of violence and accidents, by virtue of their great impact on health. Mental diseases, suicide, and chronic neurological disorders should also be included among these conditions.

4.10 Suicides, for example, already account for more than 1% of deaths in Canada, Cuba, El Salvador, the United States of America, Puerto Rico, Suriname, Trinidad and Tobago, and Uruguay.

4.11 Accidents in all forms are the cause of the greatest loss of potential years of life, especially childhood accidents and traffic accidents among the young population. Prevention, although beyond the realm of the health sector, should be promoted from the perspective of promoting health and bringing about changes in lifestyles.

4.12 The risk factors that affect the health situation of middle-aged and elderly adults are found in behaviors, habits, and consumption that generically make up what are considered to be improper lifestyles. Smoking, excess consumption of alcohol, obesity, sedentary lifestyles, and stress are highly prevalent. Although few studies have been carried out on the prevalence of these risk factors in the countries of Latin America and the Caribbean, data are available with regard to certain selected populations in several of these countries.

4.13 For example, a study sponsored by PAHO in six urban communities of Brazil, Chile, Cuba, Mexico, and Venezuela confirmed the hypothesis that the prevalence of smoking in men amounts to than 30% in the populations surveyed. A survey carried out by the Ministry of Health of Barbados in 1981 showed a prevalence of between 28% and 39% in obesity in adult women.

5. The measurement and surveillance of the magnitude of several of these psychosocial factors escape the practices routinely exercised by the health sector. In order to determine their real impact, other approximations are required--many of them indirect--that are not provided by routine information. Such is the case of the absenteeism and disability rates caused by chronic conditions and the consequences of actions and violent acts; the sale and consumption of alcohol and cigarettes; the school dropout rates related to personality disorders and drug addiction; the social and cultural indicators that identify critical stress situations; and the average consumption of calories, fats, and animal protein among various population groups.

6. The situation described poses major problems for the health sectors of the countries engaged in the development process. All the countries in the Region have pointed out as vulnerable populations those that live in extreme poverty; that is, those for whom access to preventive services and the use of the complex and high-cost technologies required for the care of chronic illnesses is becoming increasingly difficult in light of the economic crisis that is affecting the countries.

7. As a result, the complex factors associated with the increase in the proportion of adult persons in crisis situations makes it necessary to identify, investigate, and carry out innovative actions in order to prevent the risks that affect this population segment, which is responsible for the processes of production and social reproduction, and consequently of development as a whole.

8. In summary, with the information currently available on the changes taking place in the Region, two important trends appear to be taking shape: a) a transition from the predominance of mortality from infectious and parasitic diseases to one of chronic noncommunicable diseases, especially chronic cardiovascular diseases, malignant tumors, and accidents and violent acts; and b) a gradual increase in morbidity from modern-day pathologies and disordered urbanization associated with high-risk factors for health deriving from lifestyles interrelated in complex causal networks.

9. The response of the health services in resolving the problems of adults is increasingly inefficient and ineffectual. Institutional development is insufficient to carry out preventive programs for the promotion of health. Thus, for example, early detection and timely treatment of diseases such as hypertension, diabetes, cancer, and rheumatic diseases are very deficient, thereby leading to eventual overcrowding of the health services and higher costs for providing treatment for complications and advanced states of disease.

10. The capacity of the laboratories has not been expanded to cope adequately with programs of broad coverage, and the laboratories that do exist perform very inefficiently. Still more deficient is the institutional capacity of the sector to provide information and to educate the population regarding risks and healthy behavior.

11. The costs of providing medical care for the increasingly frequent chronic problems brought about by the increase in life expectancy and of risk factors related to lifestyles, forces the expenditure on health to be focused primarily on dealing with critical episodes and much less on promoting health and preventing risks.

GLOBAL STRATEGY OF COOPERATION

12. The Health Promotion Program, owing to the diversity and complexity of its components, which refer both to specific problems or diseases and to

population subgroups with special characteristics, has very clearly defined the strategic focal points or axes for articulating comprehensive public health actions.

13. These central axes, which serve as guidelines for technical cooperation for the Member Countries, are defined in the following three approaches:

13.1 The promotion of health and changes in lifestyles.

13.2 The organization and transformation of the health services in order to administer to the prevalent health problems of adults and elderly persons.

13.3 Organization of the production and use of complex, high-cost technologies.

14. At the same time these axes systematically facilitate the delivery of technical cooperation, they provide orientation for health actions in accordance with the strategic orientations and program priorities approved by the countries at the XXIII Pan American Sanitary Conference for the next quadrennium.

15. In view of the situation described above, the challenges being faced by the countries to coping with the magnitude of the problems deriving from the demographic and epidemiological changes taking place necessarily demand the formulation of policies and plans that emphasize the promotion of health and the prevention of risk through the participation of other social sectors.

16. The action of the Organization should be geared toward promoting such a process of policy formulation by providing the Member Countries with clear-cut guidelines for the study and analysis of the health situation and for actions that will assist in providing healthy options for the population.

17. At the same time, the provision of, and access to, adequate services in order to carry out preventive activities and provide treatment for disease efficiently and effectively constitutes another challenge.

18. The Organization proposes the following actions with regard to health promotion and health of adults: health promotion by means of actions that will assist the community in taking appropriate decisions for protecting its health on the one hand, and on the other, institutional development in order to ensure availability of the services and technologies required for resolving the problems of adults.

19. The principles of supporting individual and collective health, included in the Charter of Ottawa in 1986, reiterate the political responsibility of the various sectors for conserving and promoting health. The Health Promotion Program, in welcoming these concepts, promotes activities concerned with the dissemination of information, mass communication, and education regarding the risks associated with unhealthy lifestyles; the mobilization of resources to promote awareness and action on the part of individuals and public and private organizations; the training of the health workers and workers in other social sectors so that they may employ preventive participatory methodologies; and epidemiological research as a means of obtaining knowledge of problems and of the results of interventions.

20. The implementation of programs directed toward the principal risks approached from the perspective of health promotion, requires the indispensable support of mass communication. Consequently, an attempt will be made in the next biennium to develop the program's capacity to support the countries in this field with the aim of reaching all segments of society.

21. Institutional development of the health services for the adult and elderly population requires changes aimed at achieving earlier treatment of chronic problems in order to prevent deaths and disabilities. For this purpose it will be essential to employ the risk approach in programming and to bring about organizational change in the health services so as to make them more active in the early detection and treatment of problems.

22. Obviously, the strategies for the care of the elderly differ notably from traditional strategies of medical care employed for the rest of the population by reason of the particular needs of the elderly for psychosocial support.

23. The strengthening of local health systems as a primary strategy for bringing about changes in the health services will provide the principal framework for the activities of the Health Promotion Program. Manpower training in new working tools to promote community participation and the use of epidemiology will continue to be advanced in the countries.

24. The strategic axis defined with regard to the production and use of technologies makes it possible to cooperate with the countries in formulating policies to organize the production, transfer, financing, and utilization of the most complex and expensive technologies, in view of the need for technological development and taking into account the ethical principles of equity in health.

SPECIFIC PROGRAMS

HEALTH PROMOTION AND PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES (NCD)

BIENNIAL GOALS

25. To further the implementation of actions to promote health in the countries, supported by management of information and mass communication.

26. To make headway in incorporating and developing health promotion components within the health services, emphasizing local health systems and taking into account the changes required for providing adequate attention to the current healthg problems.

27. To disseminate widely the pronouncements of consensus on the rational use of complex technologies for the diagnosis and treatment of diseases of adults and to continue to promote the formulation of the respective policies in the countries of Latin America and the Caribbean.

28. To develop institutional capacity in the countries of Latin America and the Caribbean to disseminate information, educate the population, provide and mass communication directed toward changing unhealthy lifestyles associated with noncommunicable diseases.

29. To promote the development of "operational interventions" for the promotion of health and the prevention of noncommunicable diseases in the context of local health systems.

30. To promote study of the situation of noncommunicable diseases in the Region in order to be availed of the information required for presentation to public opinion and the political decision-making levels.

31. To collaborate in training in epidemiology and in the formulation of programs for the promotion of health and the prevention of noncommunicable diseases.

32. To promote research on the need to transform the health services for the management of noncommunicable diseases of adults and the elderly.

33. To promote the development of policies for the rational use of complex technologies for the diagnosis and treatment of chronic noncommunicable diseases.

ANALYSIS OF THE PROGRAMS

LINES OF ACTION

34. Mobilization of political, technical, and financial resources in order to increase the level of awareness of the whole community with regard to the promotion of health and changes in lifestyles.

35. Development of the capacity of the program with regard to the use of mass communication and management of information in order to promote the strategies and priorities.

36. Support for the countries in the diagnosis and analysis of the health situations.

37. Promotion of the transformation of the adult health services within the strategy of local health systems.

38. Promotion of manpower training in technical fields and methodologies that facilitate working with the strategies of the program and program priorities.

39. Promotion of policies for the organization of complex adult health technologies based on pronouncements of consensus.

40. Identification and mobilization of resources for carrying out activities in health promotion and mass communication aimed at changing unhealthy lifestyles associated with noncommunicable diseases.

41. Development and support of operational activities for the promotion of health and the prevention of chronic noncommunicable diseases in local health systems.

42. Promotion of the production, analysis, and interpretation of information regarding the situation of noncommunicable diseases and their determining factors.

43. Support for training in epidemiological methods and the formulation of programs for prevention and control of noncommunicable diseases and in-service training for the management of risk factors.

44. Support of research in order to determine the need for transforming the health services in order to cope with noncommunicable diseases.

45. Support for the countries in developing policies for the rational utilization and improvement of access to advanced technologies for the management of noncommunicable diseases.

15. HEALTH PROMOTION (CONT.)

TOBACCO OR HEALTH (TOH)

BIENNIAL GOALS

46. To identify and mobilize resources for development of the Regional Plan of Action for the Prevention and Control of the Use of Tobacco.

47. To identify and mobilize resources for the utilization of educational/informational material for the control of smoking in support of national programs.

48. To support epidemiological research on the determining factors and consequences of smoking in the Region.

49. To develop strategies and mechanisms for the political mobilization of public opinion and the decision-making levels for antismoking action.

50. To promote the enactment of antismoking legislation and/or adaptation of the existing legislation in the developing countries.

LINES OF ACTION

51. Development and implementation of the Regional Plan of Action for the Prevention and Control of the Use of Tobacco through the establishment of national programs.

52. Preparation and promotion of the use of educational/informational material against smoking at the regional level .

53. Promotion and cooperation in analysis of the situation and determining smoking factors in the Region.

54. Support for the development and adaptation of antismoking legislation.

PREVENTION AND TREATMENT OF MENTAL AND NEUROLOGICAL DISORDERS (MND)

BIENNIAL GOALS

55. To continue comprehensive promotion of national mental health plans in the countries of Latin America and the Caribbean, emphasizing the promotion of health with community participation.

56. To continue support for the process of restructuring psychiatric care in the Region of the Americas within the strategy of local health systems, taking into account ethical principles of respect for the human rights of mental patients.

57. To promote epidemiological and health services research in the field of mental and neurological disorders, including the impact of violence on health.

58. To continue to identify and coordinate international and regional resources in order to support the implementation of mental health programs in the countries.

LINES OF ACTION

59. Promotion of the preparation and execution of national mental health plans closely linked to national health and social development plans, whose objectives, inter alia, are the upgrading of community support systems and the channeling of mental health activities through primary care within the framework of local health systems.

60. Promotion of the restructuring of psychiatric care with the objective of establishing a network of community-based, preventive services geared to the various needs of patients and their families.

61. Promotion of epidemiological research with the objective of identifying the subpopulations at greatest risk and focusing attention on priority problems.

62. Promotion of intra- and intersectoral collaboration, the mobilization of regional and international resources, and the establishment of subregional action groups in the area of mental health in order to support national programs.

CANCER (CAN)

BIENNIAL GOALS

63. To contribute to the analysis of the increasing problem of cancer frequency.

64. To develop strategies of intervention in health promotion to reduce the incidence and mortality by cancer.

LINES OF ACTION

65. Promotion of health as a strategy to prevent cancer risk factors.

66. Development of information on cancer with emphasis in the recording of incidence to promote the knowledge of epidemiological behavior of cancer in the Region.

67. Promote epidemiological research in cancer.

68. Support national programs for cancer prevention with emphasis on cancer in women.

ACCIDENT PREVENTION (APR)

BIENNIAL GOALS

69. To promote, in most of the countries, intervention of the State, coordinated with other public sectors and nongovernmental agencies, in order to attain the highest possible levels of accident prevention and control.

70. To promote the design and execution of projects and programs in which the community itself is involved in order to attain optimum levels of safety and the prevention of lesions and unintentional deaths.

71. To collaborate with the countries in analyzing the situation through the collection and processing of information on accidents and violent acts.

LINES OF ACTION

72. Promotion of initiatives in order for governmental and nongovernmental agencies that deal with accident prevention and control to attain tangible achievements in the field.

73. Promotion of community-level interventions in search of optimum safety levels in the community environment.

HEALTH OF THE ELDERLY (HEE)

BIENNIAL GOALS

74. To contribute to analysis of the demographic changes that are taking place in the countries of Latin America and the Caribbean with the aim of obtaining valid information for planning actions to respond to the increasing aging of the population.

75. To promote the development of intersectoral social plans and programs for improving the quality of life of the elderly in all the countries of the Region.

76. To promote and support understanding of the processes of aging of the population through the development of epidemiological research.

77. To develop intervention methodologies that will make it possible to attain optimum levels of health of the older adult population and the elderly within the context of local health systems.

LINES OF ACTION

78. Promotion and support of actions linked to national health and social development plans to promote the health of the elderly.

79. Promotion and support of epidemiological studies of a clinical and social nature that will advance knowledge of the normal aging process and the identification of groups at greatest risk.

80. Promotion of intra- and intersectoral collaboration in order to upgrade currently existing structures and programs.

PREVENTION AND CONTROL OF ALCOHOLISM AND DRUG ABUSE (ADA)

BIENNIAL GOALS

81. To develop health promotion plans and programs in order to encourage behavior and lifestyles that will counteract the consumption of psychoactive substances and alcoholic beverages, emphasizing the methodologies of mass communication and participatory education.

82. To strengthen leadership in the health sector in implementing multidisciplinary national programs and policies and adequate intersectoral articulation for the prevention and control of drug abuse.

83. To strengthen the technical and administrative capability of the services with regard to drug abuse through technical advisory services, training, research, and dissemination of information.

84. To continue and increase the implementation of methodologies with regard to research and epidemiological surveillance for diagnosis of the situation and trends in the abuse of psychoactive substances in the Region.

15. HEALTH PROMOTION (CONT.)

LINES OF ACTION

85. Promotion of health as a strategy for the prevention of drug abuse.

86. Strengthening of leadership in the health sector in national programs to combat drug abuse.

87. Improvement of the technical and administrative response capacity of the health services.

88. Epidemiological surveillance in order to determine the magnitude, nature, and trends of the abuse of psychoactive substances and alcohol.

OCULAR HEALTH (PBD)

BIENNIAL GOALS

89. To promote in the countries the development of programs for health promotion and prevention of risks that lead to loss or reduction of visual function.

90. To collaborate with the countries in implementing specific programs for eye care in the health services with emphasis on local health systems.

91. To promote epidemiological research on the risk factors and diseases that affect vision in the various population groups.

LINES OF ACTION

92. Dissemination of information on risks and prevention of ocular health problems related to nutrition, exposure to infectious agents, accidental lesions, and the like.

93. Development of guidelines for local programming of ocular health activities in local health systems.

94. Promotion of training for health workers in eye care and prevention of blindness.

95. Promotion of research and collection of information on the frequency and distribution of the principal ocular health problems in the countries.

PROGRAM BUDGET DISTRIBUTION BY LOCATION

LOCATION	PAHO AND WHO REGULAR BUDGET 1990-1991	1992-1993	1994-1995	EXTRABUDGETARY FUNDS 1990-1991	1992-1993	1994-1995
DIRECT COOPERATION WITH COUNTRIES	2,829,000	4,312,900	4,889,900	1,987,687	0	0
REGIONAL PROGRAMS	1,590,000	2,136,200	2,404,500	224,435	222,140	0
TOTAL	4,419,000	6,449,100	7,294,400	2,212,122	222,140	0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT $	PERSONNEL PROF. MONTHS	PERSONNEL LOCAL MONTHS	PERSONNEL CONS. DAYS	PERSONNEL AMOUNT $	DUTY TRAVEL AMOUNT $	FELLOWSHIPS MONTHS	FELLOWSHIPS AMOUNT $	SEMINARS AND COURSES $	SUPPLIES AND EQUIPMENT $	GRANTS $	OTHER $
1990-1991												
PAHO - PR	2,618,700	120	96	1265	1,390,600	160,000	46	87,400	500,100	199,100	22,900	258,600
WHO - WR	1,800,300	96	72	865	1,136,400	84,700	40	76,000	285,500	123,000	0	94,700
TOTAL	4,419,000	216	168	2130	2,527,000	244,700	86	163,400	785,600	322,100	22,900	353,300
% OF TOTAL	100.0				57.2	5.5		3.7	17.8	7.3	.5	8.0
1992-1993												
PAHO - PR	3,944,300	192	96	1360	2,243,100	241,700	59	118,000	625,800	256,100	0	459,600
WHO - WR	2,504,800	120	72	955	1,583,900	120,200	51	102,000	355,600	142,900	0	200,200
TOTAL	6,449,100	312	168	2315	3,827,000	361,900	110	220,000	981,400	399,000	0	659,800
% OF TOTAL	100.0				59.4	5.6		3.4	15.2	6.2	.0	10.2
1994-1995												
PAHO - PR	4,468,700	192	96	1360	2,507,700	280,200	59	123,900	726,100	297,300	0	533,500
WHO - WR	2,825,700	120	72	955	1,768,200	139,400	51	107,100	412,700	165,800	0	232,500
TOTAL	7,294,400	312	168	2315	4,275,900	419,600	110	231,000	1,138,800	463,100	0	766,000
% OF TOTAL	100.0				58.6	5.8		3.2	15.6	6.3	.0	10.5

16. VETERINARY PUBLIC HEALTH

ANALYSIS OF THE HEALTH SITUATION

1. Veterinary public health, according to the WHO definition, is the component of public health activities concerned with the application of the professional knowledge, ability, and resources in veterinary matters for the purpose of protecting and improving human health. Its principal function is to serve as a catalyst for intersectoral collaboration between agriculture and health. It is one of the principal foundations of the declaration of Alma Ata on primary health care, which recognizes that health is inextricably interrelated with socioeconomic development and that health is not a goal that can be achieved by the public sector alone. The task will require the participation and coordinated effort of all the related sectors, organizations, and individuals in national and community development, in particular zootechny and the food industry, among others.

2. Resolution XV of the XXXIII Meeting of the PAHO Directing Council gave instructions for the strengthening of the activities of technical cooperation with a view to transforming the national health systems on the basis of the development of local health systems. Among the 10 fundamentals that support the development of the local health systems, eight are related directly to the health activities of public veterinary medicine; they include decentralization and deconcentration, social participation, multisectoral involvement, the development of new health care models, strengthening administrative capacity, integration of programs for prevention and control, training the work force in the subject of health, and research.

3. In the Strategic Orientation and Programming Priorities for the Pan American Health Organization during the Quadrennium 1991-1994, approved by the XXIII Pan American Sanitary Conference, the contributions of veterinary public health are essential in five of the eight priorities identified, that is to say, concerning health and the environment, food and nutrition, control and/or elimination of preventable diseases, maternal and child health, and occupational health.

4. During the VI Inter-American Meeting, at the Ministerial Level, on Animal Health, the close relationship between the agricultural sectors and health was noted, with reiteration of the political decision of the Member Governments of PAHO to maintain their commitments to the elimination of urban rabies in Latin America by 1992, the Regional Plan of Action for PAHO Technical Cooperation on Food Safety, 1986-1990, and hemispheric eradication of foot-and-mouth disease by the year 2000.

5. There are more than 200 known zoonoses which continue to cause notable morbidity and mortality among the vulnerable demographic groups--among them children, adolescents, mothers, and workers. New zoonoses continue to be recognized as a result of the changing pattern of diseases produced by the unending struggle between the biological agents, their hosts, and the environment.

6. Rabies transmitted by canines continues to be a public health problem in Latin America, where 95% of the human cases in the Region occur. In the 1980s resources were actively mobilized to reach the goal of the elimination of urban rabies in the large cities of Latin America. Thanks to this, human rabies transmitted by canines has been controlled in the principal urban areas. However, the risk persists because canine rabies continues to be endemic in the rural and periurban areas. On the average, the number of human deaths from rabies per year between 1986 and 1989 was 200, which represents a reduction of 38% with respect to the previous quadrennium. Most of the human deaths occurred in small rural communities with fewer than 50,000 inhabitants.

7. Rabies among wild animals increased; the proportion of registered cases in all animals went from 12% to 21% in the past decade, with the vampire bat causing the greatest number of human deaths.

8. Equine encephalitis, which is active in several countries, causes epidemics among equine livestock and it also can cause disease in human beings. Some of these epidemics tend to extend over broad areas, as in the case of the outbreak of Venezuelan equine encephalomyelitis in 1971 in Central America, Mexico, and the United States of America. Reports have also been received in recent years of viral activity of eastern equine encephalomyelitis in several countries. There is an urgent need for reactivating the epidemiological surveillance system, diagnostic capacity, and the program for prevention of this zoonosis.

9. Leptospirosis is a serious occupational disease among those who work in rice and sugarcane fields, sewerage systems, and slaughterhouses. The recent outbreaks have been linked to floods--for example, those in Rio de Janeiro (1,676 cases with 147 deaths), Costa Rica (264 cases), Buenos Aires (150 cases), and Venezuela.

10. Bovine tuberculosis has serious implications for public health and the national economy. It is one of the limiting factors in the development of the livestock industry, reducing the availability of meat and milk from 10% to 20% and causing the destruction of 60% of the cattle infected. The Mycobacterium bovis causes 6% of pulmonary and 8% of extrapulmonary tuberculosis, affecting principally workers in rural areas and slaughterhouses. Canada, Cuba, Panama, and the United States of America, as well as areas of Paraguay and Uruguay, have completed the international requirements to be declared free of bovine tuberculosis. In 15 other countries the incidence of the disease is 1% or less.

11. Brucellosis continues to affect a considerable number of workers in rural areas and in the animal industry. The number of infected persons is estimated at 30,000 per year. Most of the cases caused by Brucella melitensis occur in Mexico, Peru, and Argentina. The direct economic losses due to brucellosis exceed US$200 million per year. It has been eradicated in Canada and in the greater part of the United States. Jamaica and Cuba have achieved notable progress in their national programs for eradication. The low incidence registered in Uruguay and Panama is the product of the eradication policy. Chile continues to implement a program of free zones successfully, while Paraguay has achieved eradication in a small area.

12. Hydatidosis continues to be an important public health problem, especially in the sheep-raising areas of South America. Most of the cases occur in Argentina, Chile, Uruguay, southern Brazil, and in the high regions of Peru and Bolivia. More than 2,500 persons receive surgical treatment every year as a result of this disease. Most of the cases are registered in rural areas, but the process of urbanization has introduced procedures that promote the transmission in urban areas, with alarming consequences.

13. The prevalence of taeniasis and cysticercosis, due to Taenia solium in 18 countries of Latin America, has attracted considerable interest as a model for the program for integrated control as applied in the local health systems. Currently, there are five countries with active programs that encompass 15 endemic foci and a population at risk of some 260,000 inhabitants. Serological studies in local rural communities in Mexico, Colombia, Peru, and Ecuador show a rate of seropositivity of from 3% to 12%, in association with a incidence of taeniasis of from 1% to 3%. Neurocysticercosis is the most serious form presented in humans; it is more notable in Mexico, Central America, and Brazil.

14. Human deaths due to infection with Pneumocystis carinii, a common zoonosis, have increased in recent years as a result of the AIDS epidemic.

15. Foot-and-mouth disease is an important animal disease; it causes serious socioeconomic losses through livestock underproductivity and restrictions on agricultural trade. It reduces significantly the availability of animal protein essential for human nutrition.

16. It is estimated that the rate of infection is 1 per 1,000 head, while morbidity is 5.9 per 10,000 head among the cattle population. The program effectively covers 68% of South America and 90% of the bovine population. The foot-and-mouth disease situation has not changed in the last four years, although it is favorable. This has encouraged the Member Governments to undertake, during RIMSA V, a policy of eradication in 1985. The program for the hemispheric eradication of foot-and-mouth disease has been approved; a plan of action has been prepared and a hemispheric committee has been established, composed of ministers of agriculture and livestock representatives from the different subregions.

17. Food safety has direct implications for public health and the economy. For example, the highest rates of morbidity and mortality among the children of Latin America have their origin in the transmission of diseases by food. There has been a notable increase in outbreaks of food-borne diseases, especially salmonellosis. The extensive utilization of chemical products in food production, as well as in its processing, is reason for alarm, because of harmful chemical residues.

18. In most of the countries of Latin America and the Caribbean, 75% of the handling and distribution of food in the urban areas is carried out through itinerant vendors. The infrastructure and the systems for proper sanitary control of food systems at critical points in the distribution chain are deficient or ineffective. The legislative basis and organization of the national programs for food safety are not adequate to treat effectively the complex problems related to insufficiently defined and articulated food policies. There is a lack of coordination among the various agencies and the governmental levels lack support and analytic and inspection services. These problems at the national level are magnified at the local level.

19. Laboratory animals, particularly nonhuman primates, perform an important function in the national health services, especially in diagnosis, in quality control of vaccines, and in the understanding of various diseases, such as AIDS, malaria, hepatitis, and poliomyelitis. The rapid expansion of the human population and agroindustrial development have resulted in the destruction of the natural habitat of the neotropical primates and have seriously reduced their numbers. A Regional Primatological Commission has been created to promote cooperation among the countries for the conservation, reproduction, and biomedical use of primates.

20. The principal lines of action that will be put into effect during the biennium respond to the strategic needs of the Veterinary Public Health Program, in accordance with the instructions of the regulatory organs of PAHO, among them the "Elimination of Urban Rabies in Latin America", the "Medium-term Program for PAHO Technical Cooperation in Food Safety, 1991-1995", and the "Hemispheric Eradication of Foot-and-Mouth Disease."

GLOBAL STRATEGY OF COOPERATION

21. The global strategy for technical cooperation in veterinary public health will be continued within the framework of the strategic orientations and programming priorities of PAHO in the 1991-1994 quadrennium, in support of the national strategies and health plans. In order to achieve significant effects and to be able to generate a more equitable, efficient, and effective response to the health needs of the population of the Americas, the resources of the program and the instruments for carrying out technical cooperation will be concentrated on three strategic approaches: (i) elimination of urban rabies in Latin America; (ii) a medium-term technical cooperation program for food safety, for 1991-1995; and (iii) continental eradication of foot-and-mouth disease.

22. The eradication of foot-and-mouth disease will have direct benefits for health and development by improving the availability of meat and milk, essential products for human nutrition, and for the generation of very necessary foreign exchange through the elimination of the barriers to the exchange of agricultural and livestock products imposed because of foot-and-mouth disease.

23. The veterinary public health and animal health programs are generally concentrated at the community level in order to provide services for significant profitable activities in agriculture and livestock production. This infrastructure of the program will be utilized in the development and consolidation of the local health services. Sectoral projects in agriculture

will be developed; they will include components for the reorganization of the health sector, directed toward ensuring the availability of critical supplies, and of the services in order to consolidate the final attack phase in the elimination of urban rabies, and for the organization of integrated food safety programs.

24. The application of the method of map quadrants in epidemiological surveillance of foot-and-mouth disease and of other vesicular diseases will be expanded in order to cover other diseases and, in a like manner, to generate information on social, economic, and environmental indicators for the characterization and analyses of the ecosystems for the purpose of orienting the actions toward high-risk groups. In this context, there should be particular surveillance of the rapid migration of the rural populations toward the urban areas where they will exert new pressures on the already overloaded social and health services and will create new environmental problems, in addition to those caused by domestic and synanthropic animals.

25. Activities related to the eradication of foot-and-mouth disease, food safety, and elimination of urban rabies are carried out within the context of promotion of health. For example, community participation in the vaccination campaigns for rabies and foot-and-mouth disease have generated civic awareness and participation in health programs, in individuals as well as in the population in general. Activities for the protection of consumers, as an integral part of the programs for food safety, will increase the awareness of individuals and of the community that they should demand and consume food that is not only nourishing but also safe.

26. The paradigms of social communication used in the animal health programs should be adapted to transmit messages related to human health. The health sector should use the training methodology already developed for animal health for the purpose of transmitting educational messages for improving human health and the quality of life. The veterinary public health program will continue the institutionalization of the programs in social communication that were developed as a part of the Regional Program for Training in Animal Health in Latin America (PROASA), financed jointly with the IDB.

27. Because of the traditional function performed by women in the home and in the life of the community, the veterinary public health program will mobilize women in both the urban and rural areas so that they participate in the animal health and production programs with a view to ensuring the availability of food and increasing the family income. Through activities in social communication, education, community organization, and training an effort will be made to integrate women into the programs for prevention of the food-borne diseases and for vaccination against foot-and-mouth disease and rabies and for control of important zoonoses (in particular those that affect women and children in high-risk groups, such as toxoplasmosis, brucellosis, tuberculosis, leptospirosis, and hydatidosis).

28. The specialized centers of the Veterinary Public Health Program (CEPANZO and PANAFTOSA) will direct research efforts toward the generation of results and information necessary for decision-making in epidemiological surveillance, diagnosis, and disease control.

29. The control and the eradication of the zoonoses, including foot-and-mouth disease, offer enormous potentials for investment. Cost/benefit analysis has indicated favorable economic results. Because of these potentials for investment, the banks, the multilateral and bilateral agencies, and the foundations are interested in financing such projects. During the last five years, 80% of the budget of the program has been obtained systematically from extrabudgetary resources through the effective mobilization of resources; this is one of the principal activities of the program. This strategic orientation will be continued with vigor in the next biennium in order to guarantee the financial resources for the final attack phase in the elimination of urban rabies, the implementation of the PAHO medium-term technical cooperation program in food safety for 1991-1995, and the successful execution of the subregional plans for the eradication of foot-and-mouth disease.

30. The development of technical cooperation among the countries (TCC) is one of the most effective methods that the Veterinary Public Health Program has used to ensure the availability of the vaccine necessary for the final attack phase of the program for the elimination of urban rabies. Through TCC, the countries with surplus production of rabies vaccine have provided it to those countries with technical and economic limitations on its production. TCC has been an instrument in the strengthening of the program for the elimination of rabies and the eradication of foot-and-mouth disease in the border areas. The program will continue this strategy in the next biennium in order to reach the final attack phase to eliminate urban rabies and consolidate the eradication of foot-and-mouth disease.

31. The program will continue to promote the orderly, systematic adaptation of new knowledge and technology to strengthen the existing national programs within the framework of the appropriate technology. For example, the technology for the production of oil-adjuvant vaccine against foot-and-mouth disease will be transferred gradually to the countries and will thus supplement the existing production. PANAFTOSA will continue research on the biotechnology for the development of new vaccines created genetically with the aim of guaranteeing their suitability for integration at the level of the technology existing in each country. In the next biennium the program will continue to orient an integrated process for administering the knowledge and thus guarantee its incorporation and rational use in the programs for food safety and control of zoonoses.

SPECIFIC PROGRAMS

FOOT-AND-MOUTH DISEASE (FMD)

BIENNIAL TARGETS

32. Consolidation of the project for eradication of foot-and-mouth disease in the La Plata Basin, with the inclusion of Paraguay and border regions of Brazil.

33. Consolidation of the program for eradication of foot-and-mouth disease in the Andean subregion and extention of the free area in northern Colombia.

34. Progress in control in the east-central, eastern, and northeastern regions of Brazil in the Amazon subregion.

35. Maintenance of the status of foot-and-mouth-free countries.

36. Strengthening the systems of epidemiological surveillance in ports, airports, and land borders.

37. Achieving the functioning of subcommissions in foot-and-mouth-free countries.

38. Strengthening the programs for prevention of foot-and-mouth disease at the following borders: Argentina-Chile, Brazil-Guyana, and Colombia-Panama.

39. To have 80% of the countries of the affected and foot-and-mouth-free areas maintain in operation and improve the information system and epidemiological surveillance.

40. To have 50% of the countries expand the system for surveillance of other animal diseases and zoonoses.

41. Integration of sanitary, production, and economic activities in the information system by quadrant.

LINES OF ACTION

42. Intra- and interinstitutional, intersectoral and intercountry coordination to strengthen programs for eradication of foot-and-mouth disease.

43. Strengthening of the laboratories for production and control of vaccine against foot-and-mouth disease.

44. Structuring plans for prevention of foot-and-mouth disease and other exotic diseases.

45. Organization of emergency plans for unexpected cases of the introduction of exotic diseases.

46. Strengthening of the quarantine services.

47. Expansion and strengthening of the systems of epidemiological surveillance by quadrant for other diseases.

FOOD SAFETY (FOS)

BIENNIAL TARGETS

48. Inventory of institutions with activities in food safety in 80% of the countries.

49. Organization of intersectoral food safety committees in 30% of the countries.

50. Diagnosis of the situation and plan of action in 50% of the countries of Latin America and the Caribbean.

51. Review of legislation on food safety in 20% of the countries.

52. Organization of national networks of food analysis laboratories in 10% of the countries.

53. Organization of subregional networks of analytical laboratories.

54. Dissemination of information on the ARPCC method of inspection in 30% of the countries.

55. Standardization of analytical methods and techniques.

56. Development and operation of a Latin American and Caribbean network for epidemiological surveillance of food-borne diseases.

57. Development of the systems of epidemiological surveillance of food-borne diseases in all the countries.

58. Integration of the networks for surveillance of food-borne diseases and existing analytical laboratories for food control.

16. VETERINARY PUBLIC HEALTH (CONT.)

59. Organization of the private sector and NGOs for the protection of the consumer.

60. Preparation of guidelines and manuals on hygiene and food handling for schoolchildren, housewives, street vendors, and restaurant kitchens.

61. Incorporation of food safety activities in local health systems and in health and tourism programs.

LINES OF ACTION

62. Creation of intersectoral committees.

63. Preparation of national analyses of situations and plans of action.

64. Review and adaptation of legislation on food safety.

65. Organization of laboratory networks for microbiological analysis and analysis of chemical residues in food, to supplement sanitary control of food.

66. Application of risk analysis and critical control points (ARPCC) in food inspection.

67. Development and strengthening of national networks and the regional network of epidemiological surveillance of foodborne-diseases.

68. Preparation of guidelines for the development of the systems of epidemiological surveillance of food-borne diseases in the countries.

69. Mobilization and organization of community groups for participation in food safety activities.

70. Development of model educational programs in food safety for different groups.

71. Development of food safety activities in local health systems, particularly in tourist areas.

72. Development of models for food hygiene for street vendors.

ZOONOSES (ZNS)

BIENNIAL TARGETS

73. Coverage of canine vaccination greater than 80% in urban areas of Brazil, Mexico, Bolivia, Peru, Ecuador, and Guatemala.

74. Distribution of information on the procedures for treatment of individuals exposed to rabies.

75. Maintenance of programs for continuous vaccination in order to prevent the introduction of canine rabies in free urban areas.

76. Arranging for the strategic availability of canine rabies vaccine for high-risk areas.

77. Development of controls for the reliability of the laboratory diagnosis of rabies in high-risk countries.

78. Integration of surveillance of urban and wild rabies in the system by quadrant.

79. Preparation of strategies and a regional plan of action for the control of rabies transmitted by vampire bats.

80. All the countries will have policies for eradication of bovine tuberculosis and 50% will have national plans of action.

81. Updating of the brucellosis situation in the countries.

82. Preparation of strategies and a regional plan of action for the eradication of brucellosis.

83. Establishment of areas free of hydatidosis in the affected countries.

84. Development of programs for elimination of taeniasis and cysticercosis at a minimum of 100 foci in the affected countries.

85. Characterization of the situation with respect to the zoonoses prevalent in larger cities.

86. Development of techniques for diagnosis of the emerging zoonoses in urban areas.

87. Development of activities for control of harmful fauna in the health and tourism programs.

88. Development of guidelines and policies for the protection of the environment with regard to the possession of productive animals and pets.

89. Diagnosis of the situation with respect to the impact of animal possession and production on the environment.

90. Inventory of the use of pesticides in animal production.

91. Promotion of research on potentially zoonotic diseases and distribution of information.

92. Development of national primatology programs in six countries of the Americas.

93. Adaptation of in vitro models in at least five techniques for analysis, production, or control of biologicals.

94. Adequate supply of laboratory animals for the diagnosis of diseases and control of biologicals.

95. Application of programs for control of zoonoses or for food safety in local health systems, in six countries of the Region.

96. Improvement of the laboratory services for animal health and/or veterinary public health in four countries of the Region.

97. Realization of a prospective study of veterinary public health education in all the faculties of the Region.

98. Preparation of institutional and personnel development plans in at least 40 schools of veterinary medicine in the Region.

99. Execution of institutional and personnel development plans in 10 faculties of veterinary medicine.

LINES OF ACTION

100. Consolidation of national plans for mass canine vaccination in high-risk areas.

101. Strengthening of the epidemiological surveillance system for rabies.

102. Updating of the procedures for treatment of exposed individuals.

103. Production and availability of vaccine for canine use.

104. Improvement of diagnostic techniques.

105. Development of programs for eradication of tuberculosis and brucellosis.

106. Development of programs for elimination of hydatidosis and taeniasis and cysticercosis.

107. Characterization of risks of zoonoses in urban areas.

108. Control of harmful fauna.

109. Surveillance of potentially zoonotic diseases.

110. Protection of the environment with regard to the possession of productive animals and pets.

111. Control of the rational use of pesticides in animal production.

112. Conservation, reproduction, and biomedical use of nonhuman primates.

113. Improvement of the animal quarters.

114. Development of in vitro models for the gradual replacement of in vivo models.

115. Development of programs for control of zoonoses and for food safety, applied in local health systems.

116. Strengthening of organizational, administrative, and technical aspects of the animal health and veterinary public health laboratories.

117. Strengthening of veterinary public health education in the schools of veterinary medicine.

16. VETERINARY PUBLIC HEALTH (CONT.)

PROGRAM BUDGET DISTRIBUTION BY LOCATION

LOCATION	PAHO AND WHO REGULAR BUDGET 1990-1991	1992-1993	1994-1995	EXTRABUDGETARY FUNDS 1990-1991	1992-1993	1994-1995
DIRECT COOPERATION WITH COUNTRIES	3,874,200	4,178,700	4,734,100	4,437,399	1,714,955	625,000
REGIONAL PROGRAMS	906,700	1,079,100	1,214,600	107,978	60,741	65,500
CENTERS	10,939,000	11,724,300	13,301,000	11,172,122	11,129,750	12,462,100
TOTAL	15,719,900	16,982,100	19,249,700	15,717,499	12,905,446	13,152,600

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT $	PERSONNEL PROF. MONTHS	PERSONNEL LOCAL MONTHS	PERSONNEL CONS. DAYS	PERSONNEL AMOUNT $	DUTY TRAVEL AMOUNT $	FELLOWSHIPS MONTHS	FELLOWSHIPS AMOUNT $	SEMINARS AND COURSES $	SUPPLIES AND EQUIPMENT $	GRANTS $	OTHER $
1990-1991												
PAHO - PR	12,769,000	884	4848	865	9,356,500	527,800	125	237,500	376,200	603,600	0	1,667,400
WHO - WR	2,950,900	240	96	985	2,122,200	164,900	111	210,900	200,000	149,600	16,000	87,300
TOTAL	15,719,900	1124	4944	1850	11,478,700	692,700	236	448,400	576,200	753,200	16,000	1,754,700
% OF TOTAL	100.0				72.9	4.4		2.9	3.7	4.8	.1	11.2
1992-1993												
PAHO - PR	14,176,900	720	4344	670	10,115,900	589,800	150	300,000	433,600	716,700	0	2,020,900
WHO - WR	2,805,200	168	96	820	1,927,900	240,100	43	86,000	206,800	176,700	0	167,700
TOTAL	16,982,100	888	4440	1490	12,043,800	829,900	193	386,000	640,400	893,400	0	2,188,600
% OF TOTAL	100.0				70.8	4.9		2.3	3.8	5.3	.0	12.9
1994-1995												
PAHO - PR	16,079,400	720	4344	670	11,400,100	684,400	150	315,000	503,200	831,900	0	2,344,800
WHO - WR	3,170,300	168	96	820	2,162,100	278,400	43	90,300	240,000	204,900	0	194,600
TOTAL	19,249,700	888	4440	1490	13,562,200	962,800	193	405,300	743,200	1,036,800	0	2,539,400
% OF TOTAL	100.0				70.4	5.0		2.1	3.9	5.4	.0	13.2

ANALYSIS OF THE HEALTH SITUATION

1. Administration provides the full administrative support activities for both the Headquarters and Field Offices. It includes the formulation of policy for and the functions and operations of Budget, Finance, Personnel, General Services and Headquarters Operating Expenses, and Procurement.

2. Budgetary policies and procedures as well as budget development and execution activities provide the basic financial infrastructure for the Organization's programs. These activities include the operation, control and analysis of the monetary portion of the program budget (including extrabudgetary funding) in order to ensure an efficient and effective utilization of the available funds for the program.

3. Financial management of the Organization includes execution of financial rules and regulations with supporting procedures, sound accounting policies and systems, banking and investment of the Organization, field office financial administration, health insurance, payroll, pension and income tax administration, and financial management of extrabudgetary grants.

4. Personnel management programs will have as their primary objective the enhancement of the quality of technical cooperation which the staff of the Region renders to the Member Countries. The programs will be adapted to the continuing goals of administrative reforms designed to achieve decentralization and simplification of administrative procedures and decision-making processes. Within this context, major emphasis will be placed on providing support to augment the administrative skills and capabilities of the Region at the country level. The various approaches selected will further reflect policies and priorities concerning the geographical representation of the Member Countries on the staff and the recruitment of women to professional and higher-graded posts. The use of special agreements will be expanded for the hiring of national project personnel on PAHO/WHO projects in order to mobilize the diversity and scope of the cooperation available from national sources. For staff at all levels, their development, training, utilization and evaluation will likewise receive priority attention. In the process, more emphasis will be put on participatory, rather than individualistic, management, and the staff will be encouraged to participate effectively by providing inputs into personnel advisory boards and working groups.

5. General Services and Headquarters Operating Expenses activities include responsibility for providing administrative services support, building and other services for the Organization. Specific responsibilities include the development of administrative norms and guidelines on telecommunications, mail, management of reproduction services, building maintenance and insurance coverage for real estate, installations and equipment throughout the Organization. The estimates for the various general operating expenses for the Washington Office are shown by major expense items in the schedules. Costs are apportioned on a pro rata basis between funds budgeted under PAHO and WHO.

6. The procurement and related supply services for the operating programs of the Organization and procurement and shipment of supplies and equipment on behalf of Member Countries and of WHO are essential activities of administrative support for the Organization's Program.

GLOBAL STRATEGY OF COOPERATION

7. The basic strategy is to provide efficient and effective administrative support for both Headquarters and Field Offices, to include budgetary, financial, personnel, general services and procurement activities.

8. The specific programs under Administration will respond to the Program Priorities established by the Governing Bodies and the Director by providing required administrative support to the programs established by the Headquarters technical units and country offices and by supervising the administrative support activities of the Organization.

SPECIFIC PROGRAMS

BUDGET AND FINANCE (BFI)

BIENNIAL TARGETS

9. Maintain policies and procedures for the functions and operations of a sound budgetary system for the Organization.

10. Maintain policies and procedures for the functions and operations of a sound financial management system for the Organization.

LINES OF ACTION

11. Establish, formulate and maintain budgetary policies and procedures to provide basic budgetary infrastructure for the implementation of program activities of the Organization and to continue to maintain a sound budgetary management system for the Organization.

IV. PROGRAM SUPPORT

17. ADMINISTRATION (CONT.)

12. To continue and maintain the integration of the computerized program budget planning system with the overall financial management system.

13. Supervision of the analysis and forecasting of delivery rates and make recommendations to top management as to whether the program budget should be increased due to projected savings or cut due to projected deficits in order to insure maximum deployment and utilization of funds.

14. Operation, control and analysis of the monetary portion of the annual operating program budget, including extrabudgetary funding, in order to insure efficient and effective utilization of the available funds to the programs. Determination of the status of the APB delivery in order to prepare supporting documentation and recommendations for periodic budget reviews and potential adjustments. Rephasing and closure of extrabudgetary projects. Constant analysis of the funding situation and delivery in order to advise the Director on the efficient and effective utilization of funds.

15. Establish and maintain sound financial management policies and procedures for the effective implementation of program activities of the Organization and continue to comply with the financial rules and regulations of the Organization. To continue to cooperate and participate in the development and implementation of an effective computerized accounting and payments system within the overall financial management system. Maintenance of books and records which accurately reflect the financial transactions of the Organization and provision of financial reports thereon which meet generally accepted accounting principles and standards. Establish and maintain a sound financial payment services system in support of the Organization's programs and projects.

GENERAL SERVICES AND HEADQUARTERS OPERATING EXPENSES (PGS)

BIENNIAL TARGETS

16. To assure effective management of PAHO's properties, communication services and other general operations.

LINES OF ACTION

17. Activities related to the overall management and operation of the headquarters building, provision of office supplies, equipment and furniture, insurance, inventory, transportation, parking, receiving and dispatching, warehousing, communications, word processing, printing and reproduction. Maintenance and repair of the headquarters building and leased office space. Management of the funds for general operating expenses and other special funds that may be allocated to ACG.

PERSONNEL (PER)

BIENNIAL TARGETS

18. To execute effective, coordinated personnel services and programs throughout the Organization, fulfilling the commitments of the Secretariat to the Governing Bodies, as well as the essential needs of the management and the staff in areas of broad personnel administration.

LINES OF ACTION

19. To determine the classification level of the professional and general services positions throughout the Organization.

20. To coordinate compensation and salary matters including GS salary scales, post adjustment, allowances, benefits, and other related issues.

21. To develop and recommend revised or new post classification criteria.

22. To coordinate with other international and UN organizations on matters related to post classification and salaries.

23. To define and administer the recruitment and promotion functions of the Organization, including the provision of information to applicants and the maintenance of the candidate register.

24. To issue and provide advice on the use of Contractual Service Agreements.

25. To administer the recruitment programs related to Short-Term Consultants (STC), Temporary Advisers (TA), Conference Staff and National Professionals, in accordance with the Organization's policies and practices.

26. To maintain pertinent data and files for analysis and reporting of these programs.

27. To maintain the personnel files of staff members from their date of appointment to their date of termination and to ensure, in the process, the provision of the benefits due to the staff under the Staff Regulations and Rules.

28. To be responsible for the issuance of the Staff Information Roster and other computer-generated reports on the staff.

29. To coordinate personnel program activities within the Department and to establish effective consultative relation with the staff representatives by way of correspondence, meetings, and discussions.

30. To prepare appeals at the level of the Board of Appeal.

31. To develop and administer the Staff Regulations and Rules and other personnel administrative procedures.

32. To review the documentation/actions emanating from CCAQ/ACC and ICSC and to maintain an appropriate system of records on personnel policy matters.

33. To collect and study statistical information and to prepare reports in the field of PAHO personnel management.

PROCUREMENT (SUP)

BIENNIAL TARGETS

34. To assure timely an efficient procurement of supplies, equipments and services for the Organization and for the Member Countries.

LINES OF ACTION

35. Purchase equipment, supplies and services in a worldwide market in response to requests from PAHO headquarters, PAHO/WHO projects, Member Governments and other agencies. Arrange shipment of equipment and supplies to ultimate consignees.

17. ADMINISTRATION (CONT.)

PROGRAM BUDGET DISTRIBUTION BY LOCATION

LOCATION	PAHO AND WHO REGULAR BUDGET 1990-1991	1992-1993	1994-1995	EXTRABUDGETARY FUNDS 1990-1991	1992-1993	1994-1995
TECHNICAL AND ADMINISTRATIVE DIRECTION	21,990,000	24,905,300	27,872,900	5,893,007	6,466,400	5,682,400
TOTAL	21,990,000	24,905,300	27,872,900	5,893,007	6,466,400	5,682,400

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL PROF. MONTHS	PERSONNEL LOCAL MONTHS	PERSONNEL CONS. DAYS	PERSONNEL AMOUNT	DUTY TRAVEL AMOUNT	FELLOWSHIPS MONTHS	FELLOWSHIPS AMOUNT	SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	16,072,500	830	2002	40	10,841,700	110,300	0	0	0	12,900	0	5,107,600
WHO - WR	5,917,500	168	576	0	2,909,900	31,100	0	0	0	0	0	2,976,500
TOTAL	21,990,000	998	2578	40	13,751,600	141,400	0	0	0	12,900	0	8,084,100
% OF TOTAL	100.0				62.5	.6		.0	.0	.1	.0	36.8
1992-1993												
PAHO - PR	18,007,700	744	1944	0	12,134,500	115,000	0	0	0	14,300	0	5,743,900
WHO - WR	6,897,600	216	528	0	3,563,500	52,300	0	0	0	0	0	3,281,800
TOTAL	24,905,300	960	2472	0	15,698,000	167,300	0	0	0	14,300	0	9,025,700
% OF TOTAL	100.0				63.0	.7		.0	.0	.1	.0	36.2
1994-1995												
PAHO - PR	20,161,100	744	1944	0	13,632,400	127,800	0	0	0	15,900	0	6,385,000
WHO - WR	7,711,800	216	528	0	4,004,900	58,000	0	0	0	0	0	3,648,900
TOTAL	27,872,900	960	2472	0	17,637,300	185,800	0	0	0	15,900	0	10,033,900
% OF TOTAL	100.0				63.2	.7		.0	.0	.1	.0	36.0

III. SUMMARY BY LOCATION

1. The country programs continue to be the central focus of the proposed program and budget for 1991-1992 and this philosophy represents a further strengthening of the key principle underlying the managerial strategy of PAHO/WHO which emphasizes the country as the basic unit of production. All the resources of the Organization, whether or not they are applied primarily at the country level serve to strengthen the technical cooperation at that level.

2. The process for formulating the country program is rooted in discussions and agreement with national authorities. These discussions take account of the national economic and social situation, the prevailing priorities in the health sector, the priority needs for technical cooperation, and ultimately the identification of those needs for which technical cooperation is required from PAHO/WHO.

3. The development of the country programs also takes account, where pertinent, of the recommendations of the Joint Evaluations of the PAHO/WHO technical cooperation at the country level. This process involves an examination by the national authorities and PAHO/WHO of the effectiveness of technical cooperation given and determination of the adjustments needed in terms of strategy or resource allocation.

4. The country programs reflect not only the peculiarly local situation, but also the collective Regional mandates and recommendations agreed upon by the Governing Bodies of the Organization. The programs have also been cast in such a manner that the technical cooperation from PAHO/WHO faithfully reflects the Strategic Orientations and Program Priorities for the Quadrennium 1991-1994 which were adopted by the XXIII Pan American Sanitary Conference in September 1990. These Strategic Orientations and Program Priorities give emphases and directions appropriate to new realities and provide continuity with similar directions accepted by the previous Sanitary Conference in which particular stress was laid on technical cooperation to strengthen and transform the health system infrastructure, particularly through the development and/or improvements of the local health systems. This focus on local health systems will permeate all the country programs. Particular attention will be given to that strategic orientation which deals with Health Development, in particular to the national expressions of the activities which PAHO/WHO will carry out to promote the acceptance of health as an indicator of and an instrument of human development.

5. In addition to indicating the key results areas to which the PAHO/WHO technical cooperation can best be applied, the country programs, also reflect the strategic approaches to be used in delivering such cooperation. Among the most important of these is the mobilization of resources to address the identified problems. In this context the technical cooperation among countries will assume greater importance and the country programs will also indicate the participation in the various subregional health initiatives. Considerable attention has been given to identifying results to be expected, thus enhancing the capacity of the Organization to monitor and evaluate the technical cooperation.

6. The process of preparing the country programs involves discussion with national authorities, as mentioned above, formulation of a program and budget within the framework of a series of projects, examination of these by the appropriate technical units and final review by the Director and his Advisory Committee. The results of this iterative and participatory process are found in the following section.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		50,742,900	70.4	58,279,800	70.0	66,030,400	70.1
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		16,739,900	23.2	20,852,300	25.1	23,857,700	25.2
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	16,739,900	23.2	20,852,300	25.1	23,857,700	25.2
TECHNICAL COOPERATION AMONG COUNTRIES		1,853,800	2.6	2,371,800	2.8	2,751,900	2.9
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	1,853,800	2.6	2,371,800	2.8	2,751,900	2.9
HEALTH SITUATION AND TREND ASSESSMENT		4,313,400	6.0	5,119,600	6.2	5,786,300	6.1
HEALTH SITUATION AND TREND ASSESSMENT	HST	4,313,400	6.0	5,119,600	6.2	5,786,300	6.1
HEALTH POLICY DEVELOPMENT		1,345,700	1.9	1,445,600	1.8	1,643,300	1.8
HEALTH POLICY ANALYSIS AND DEVELOPMENT	HDP	1,071,700	1.5	1,301,000	1.6	1,479,700	1.6
HEALTH ECONOMICS AND FINANCING	HDE	274,000	.4	98,200	.1	109,800	.1
WOMEN, HEALTH AND DEVELOPMENT	WHD	0	-	46,400	.1	53,800	.1
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		20,850,300	28.9	21,991,100	26.3	24,647,900	26.3
HEALTH SERVICES DEVELOPMENT	DHS	19,318,200	26.8	20,919,200	24.9	23,434,500	24.9
ESSENTIAL DRUGS AND VACCINES	EDV	803,100	1.1	633,900	.8	714,900	.8
ORAL HEALTH	ORH	71,300	.1	143,300	.2	164,400	.2
DISASTER PREPAREDNESS	DPP	22,900	.*	62,900	.1	72,100	.1
CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY	CLR	145,900	.2	0	-	0	-
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	269,200	.4	126,000	.2	143,500	.2
REHABILITATION	RHB	219,700	.3	105,800	.1	118,500	.1
HUMAN RESOURCES DEVELOPMENT		4,746,500	6.6	5,683,100	6.8	6,407,600	6.8
COORDINATION & SUPPORT OF HUMAN RESOURCES DEVELOP.	HMC	734,000	1.0	950,100	1.1	1,076,500	1.1
HUMAN RESOURCES EDUCATION	HME	4,012,500	5.6	4,733,000	5.7	5,331,100	5.7
HEALTH INFORMATION SUPPORT		307,500	.4	396,400	.5	455,900	.5
SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION	HBD	307,500	.4	396,400	.5	455,900	.5
RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT		585,800	.8	419,900	.5	479,800	.5
RESEARCH PROMOTION AND DEVELOPMENT	RPD	441,200	.6	321,800	.4	370,200	.4
HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT	HDT	144,600	.2	98,100	.1	109,600	.1

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
III. HEALTH SCIENCE AND TECHNOLOGY		21,546,500	29.6	24,957,300	30.0	28,171,700	29.9
FOOD AND NUTRITION		608,900	.8	705,400	.8	800,900	.9
NUTRITION	NUT	608,900	.8	705,400	.8	800,900	.9
ENVIRONMENTAL HEALTH		8,091,000	11.2	8,819,200	10.6	9,936,800	10.5
COMMUNITY WATER SUPPLY AND SANITATION	CWS	7,452,200	10.3	7,234,400	8.7	8,148,100	8.6
SOLID WASTES AND HOUSING HYGIENE	RUD	73,800	.1	0	-	0	-
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	478,900	.7	1,521,400	1.8	1,715,600	1.8
WORKERS' HEALTH	OCH	86,100	.1	63,400	.1	73,100	.1
MATERNAL AND CHILD HEALTH		3,004,200	4.1	3,901,000	4.7	4,323,600	4.6
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	2,742,000	3.8	3,744,200	4.5	4,143,600	4.4
ADOLESCENT HEALTH	ADH	68,700	.1	0	-	0	-
IMMUNIZATION	EPI	170,500	.2	156,800	.2	180,000	.2
DIARRHEAL DISEASES	CDD	23,000	.*	0	-	0	-
COMMUNICABLE DISEASES		5,724,900	7.9	6,168,200	7.5	7,038,100	7.5
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	4,351,600	6.0	5,394,400	6.5	6,158,600	6.5
TUBERCULOSIS	TUB	269,000	.4	0	-	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	14,600	.*	15,700	.*	17,300	.*
VECTOR-BORNE DISEASES	VBC	457,700	.6	458,400	.6	520,700	.6
MALARIA	MAL	632,000	.9	299,700	.4	341,500	.4
HEALTH PROMOTION		1,885,800	2.5	3,145,500	3.8	3,566,800	3.8
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	1,818,600	2.5	3,088,500	3.7	3,501,700	3.7
TOBACCO OR HEALTH	TOH	17,200	.*	0	-	0	-
CANCER	CAN	0	-	57,000	.1	65,100	.1
ACCIDENT PREVENTION	APR	15,600	.*	0	-	0	-
PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE	ADA	34,400	.*	0	-	0	-
VETERINARY PUBLIC HEALTH		2,231,700	3.1	2,218,000	2.6	2,505,500	2.6
FOOD SAFETY	FOS	704,500	1.0	957,000	1.1	1,077,400	1.1
ZOONOSES	ZNS	1,527,200	2.1	1,261,000	1.5	1,428,100	1.5
GRAND TOTAL		72,289,400	100.0	83,237,100	100.0	94,202,100	100.0

* LESS THAN .05 PER CENT

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		26,083,529	34.7	10,029,127	25.4	625,900	6.7
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		1,412,462	1.9	935,063	2.4	625,900	6.7
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	1,412,462	1.9	935,063	2.4	625,900	6.7
HEALTH SITUATION AND TREND ASSESSMENT		188,989	.2	0	-	0	-
HEALTH SITUATION AND TREND ASSESSMENT	HST	188,989	.2	0	-	0	-
HEALTH POLICY DEVELOPMENT		386	.*	0	-	0	-
HEALTH POLICY ANALYSIS AND DEVELOPMENT	HDP	386	.*	0	-	0	-
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		23,682,215	31.6	9,094,064	23.0	0	-
HEALTH SERVICES DEVELOPMENT	DHS	17,626,866	23.7	5,952,020	15.0	0	-
ESSENTIAL DRUGS AND VACCINES	EDV	2,829,791	3.7	1,141,044	2.9	0	-
ORAL HEALTH	ORH	536,239	.7	71,000	.2	0	-
DISASTER PREPAREDNESS	DPP	1,000,128	1.3	0	-	0	-
CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY	CLR	3,892	.*	0	-	0	-
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	134,695	.2	0	-	0	-
REHABILITATION	RHB	1,550,604	2.0	1,930,000	4.9	0	-
HUMAN RESOURCES DEVELOPMENT		761,267	1.0	0	-	0	-
HUMAN RESOURCES EDUCATION	HME	761,267	1.0	0	-	0	-
HEALTH INFORMATION SUPPORT		7,600	.*	0	-	0	-
SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION	HBD	7,600	.*	0	-	0	-
RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT		30,610	.*	0	-	0	-
RESEARCH PROMOTION AND DEVELOPMENT	RPD	30,610	.*	0	-	0	-

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
III. HEALTH SCIENCE AND TECHNOLOGY		49,703,598	65.3	29,585,358	74.6	8,776,782	93.3
FOOD AND NUTRITION		1,742,880	2.3	0	-	0	-
NUTRITION	NUT	1,742,880	2.3	0	-	0	-
ENVIRONMENTAL HEALTH		4,643,006	6.1	1,101,505	2.7	40,400	.4
COMMUNITY WATER SUPPLY AND SANITATION	CWS	4,027,504	5.3	84,537	.2	40,400	.4
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	530,997	.7	1,000,000	2.5	0	-
WORKERS' HEALTH	OCH	84,505	.1	16,968	.*	0	-
MATERNAL AND CHILD HEALTH		18,754,436	24.8	13,915,820	35.1	8,396,382	89.2
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	16,276,856	21.5	13,483,029	33.9	8,331,800	88.5
ADOLESCENT HEALTH	ADH	435,561	.6	145,945	.4	64,582	.7
ACUTE RESPIRATORY INFECTIONS	ARI	417,579	.6	147,000	.4	0	-
IMMUNIZATION	EPI	1,150,805	1.5	139,120	.4	0	-
DIARRHEAL DISEASES	CDD	473,635	.6	726	.*	0	-
COMMUNICABLE DISEASES		22,811,923	29.9	14,568,033	36.8	340,000	3.7
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	2,152,330	2.8	0	-	0	-
TUBERCULOSIS	TUB	5,352	.*	0	-	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	15,635,625	20.6	11,698,777	29.5	165,000	1.8
VECTOR-BORNE DISEASES	VBC	400,000	.5	940,000	2.4	0	-
MALARIA	MAL	4,266,664	5.6	1,850,000	4.7	100,000	1.1
PARASITIC DISEASES	PDP	262,908	.3	75,000	.2	75,000	.8
SEXUALLY TRANSMITTED DISEASES	VDT	89,044	.1	4,256	.*	0	-
HEALTH PROMOTION		1,033,983	1.3	0	-	0	-
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	25,560	.*	0	-	0	-
CANCER	CAN	537,500	.7	0	-	0	-
PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE	ADA	377,616	.5	0	-	0	-
OCULAR HEALTH	PBD	93,307	.1	0	-	0	-
VETERINARY PUBLIC HEALTH		717,370	.9	0	-	0	-
FOOT-AND-MOUTH DISEASE	FMD	552,070	.7	0	-	0	-
ZOONOSES	ZNS	165,300	.2	0	-	0	-
GRAND TOTAL		75,787,127	100.0	39,614,485	100.0	9,402,682	100.0

* LESS THAN .05 PER CENT

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	41,723,700	1616	2680	12835	18,949,400	989,600	1709	3,247,100	5,348,400	3,221,000	916,700	9,051,500
WHO - WR	30,565,700	1722	1056	11530	15,905,600	871,500	2012	3,822,800	3,742,300	2,363,300	291,300	3,568,900
TOTAL	72,289,400	3338	3936	24365	34,855,000	1,861,100	3721	7,069,900	9,090,700	5,584,300	1,208,000	12,620,400
% OF TOTAL	100.0				48.1	2.6		9.8	12.6	7.7	1.7	17.5
1992-1993												
PAHO - PR	49,111,100	1603	2832	9542	22,296,400	1,370,600	1410	2,820,000	6,305,500	3,879,100	107,200	12,332,300
WHO - WR	34,126,000	1597	1080	9545	17,444,800	1,184,300	1418	2,836,000	4,369,900	2,672,900	15,400	5,602,700
TOTAL	83,237,100	3200	3912	19087	39,741,200	2,554,900	2828	5,656,000	10,675,400	6,552,000	122,600	17,935,000
% OF TOTAL	100.0				47.8	3.1		6.8	12.8	7.9	.1	21.5
1994-1995												
PAHO - PR	55,692,100	1584	2832	9542	24,889,000	1,591,400	1410	2,961,000	7,309,500	4,501,800	124,400	14,315,000
WHO - WR	38,510,000	1584	1080	9450	19,467,900	1,374,100	1418	2,977,800	5,070,400	3,101,200	17,900	6,500,700
TOTAL	94,202,100	3168	3912	18992	44,356,900	2,965,500	2828	5,938,800	12,379,900	7,603,000	142,300	20,815,700
% OF TOTAL	100.0				47.1	3.1		6.3	13.1	8.1	.2	22.1

ANALYSIS OF THE HEALTH SITUATION

Demography

1. Antigua and Barbuda had a mid-year population estimated at 86000 in 1990, and based on the current projections of an annual growth rate of 0.5%, the population during the 1991-1992 biennium should reach close to 87000. The population under 15 years of age represents 28% of the total and those over 65 years 7%.

Indicators of health status

2. The life expectancy at birth was 68.6 years for males and 71.9 for females in 1983. This represents an increase over 1970 of 6.6 and 6.9 years respectively.

3. The leading causes for mortality in 1987 in order of rank were heart diseases, malignant neoplasms, cerebrovascular diseases, hypertensive disease, senility without mention of psychosis, diabetes mellitus, pneumonia, atherosclerosis, alcoholism and liver disease.

4. Among children under one year of age the main causes of mortality were conditions originating in the perinatal period, intestinal infectious disease and acute respiratory disease.

5. In the age group 1-4 the principal causes for mortality have been conditions originating in the perinatal period, acute respiratory diseases and protein calorie malnutrition.

6. Maternal deaths not exceeding two (2) years have been recorded for the years 1980 to 1983 and again in 1988 two deaths were registered.

7. Accidents, although ranked at ten, includes road fatalities, which have been doubled between 1981 and 1988.

Factors affecting health status

8. The economic climate of Antigua and Barbuda is relatively favorable. There has been a steady growth in the GNP in the period 1983 to 1987. Per capita GNP was $US2,060 in 1983 and rose to US$3,400 in 1987. Tourism is a significant contributor to the economy. The unemployment rate has decreased from 20.8% of the work force in 1983 to 5% in 1987.

9. A review of the functioning of the health services indicate that despite the policy statements on primary health care, there is no clearly defined strategy for the implementation of the primary health care approach. Resource allocation is still heavily in favor of secondary care development. Attempts at introducing the model district health team approach have been unsuccessful. However, the nursing service is totally committed to the primary health care approach and the regional strategy on maternal and child health is being implemented. Secondary care is provided by the Holberton Hospital, the only referral institution on the twin island.

10. There is a need to enhance community participation and intersectoral coordination, and also to expand the capacity of the newly developed Community Health Services information system to permit utilization for managerial decisions at all levels of the health care system.

11. Thus although health service coverage has remained relatively high, there is still need for improvement. The government has recognized that reorganization and improved management are critical issues that should be addressed as soon as possible.

12. The environmental situation is of continuous concern. The inadequate coverage of the water supply system and the poor supply of water, exacerbated by the 1984/85 drought, appear to have been solved through a USAID water project which ended in March 1988. Growing tourism has increased the volume of solid waste while at the same time intensifying the need for a higher quality of environment. This has placed a burden on the outdated solid waste collection systems. The sewerage disposal system requires improved operation and maintenance. There is a serious problem of a lack of basic sanitation in Barbuda.

13. There is no definitive data on nutritional problems of the adults, but it is speculated that obesity is a growing concern, especially among the female population. Substance abuse, especially marijuana, is now a common phenomenon and is no longer associated solely with the rastafarian population. Fifty-six percent (56%) of the patients with mental health problems, seen at health centers, are registered drug users.

National health strategies, policies and plans

14. The central authority responsible for health is the Ministry of health. The Government has formulated a policy statement reaffirming its commitment to the primary health care approach and the development of the local health systems.

15. It is proposed to utilize the following strategies:

15.1 Reorganization and restructuring of the health sector to ensure effective support for primary care.

15.2 Development of annual plans at all levels of the sector.

15.3 Reviewing of legislation as it affects the sector.

15.4 Development and establishment of guidelines for norms, standards and procedures for each level of care.

15.5 Establishment of a technical/managerial group including a representative of Barbuda with responsibility for monitoring and advising on relevant program development or strengthening.

15.6 Determining the financial and human resources required and the feasibility of program expansion.

15.7 Improvement of the accessibility of health delivery at the local level through a program of facility development and/or improved human and material resource allocation.

16. The Government has declared that: "it will continue to conduct basic training programs for selected categories of health personnel and organize continuing education programs for all levels of health care workers in relation to identified needs."

17. A policy on nursing is clearly stated and a detailed plan (1989-1993) and a proposal for strengthening the nursing service was developed.

18. The Ministry of Health has begun the process of defining more clearly the levels of care to be given at the various points in the network of services.

19. In order to improve the environmental program the functions of the central board of health and the Environmental Health Department will be assessed and reorganized to ensure the effective management of the environment.

20. Consideration is being given to alternative methods of financing the health care system and the medical benefits scheme of the national insurance scheme is being evaluated.

GLOBAL STRATEGY OF COOPERATION

21. PAHO technical cooperation will provide support to the Government of Antigua and Barbuda to facilitate the development of health services based upon primary health care, the protection of the environment, the strengthening of the maternal and child health program and the control of chronic diseases including AIDS.

22. The cooperation will emphasis support for the implementation of studies on the management systems and organization of the health services which are now in progress. In particular it will emphasis the development of systems for the monitoring of health manpower needs, and for effective management. Resource mobilization will be required for the implementation of systems. Antigua will benefit from the sharing of information and expenses at the meetings of coordination of CCH priority areas. Updating of health legislation will be undertaken. Human resource development will be accorded priority and PAHO will collaborate with local and subregional institutions in assisting to meet the health manpower needs of Antigua and Barbuda. The PAHO Fellowship program will continue to assist in meeting the needs of Antigua for training when such is not available locally. PAHO will cooperate to strengthen the national programs in mental health/drug abuse, chronic disease control and a plan will be developed to manage disasters in the health sector.

23. Cooperation in environmental health will be focused on: assistance in the development of waste disposal systems; assistance in the design of information systems that will permit the continuous monitoring of environmental hazard; and collaborate with the Barbuda Council to improve basic sanitation. PAHO will assist in the development of an Occupational Health program. Where possible, PAHO will sensitize the decision makers to the interrelationships between Tourism and Health.

24. The maternal and child health program will continue the work now in progress in the development of adolescent health care programs and will continue to provide support to the Government in maintaining its EPI program, keeping Antigua and Barbuda free of poliomyelitis and eliminating measles.

25. Health promotion activities will be promoted, particularly with respect to non communicable disease and drug abuse. The potential of NGOs, PVOs will be highlighted.

26. PAHO will collaborate in the development of the following specific programs:

DHS: Health Services Development
CWS: Community Water Supply and Sanitation
MCH: Growth, Development and Human Reproduction

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		114,800	71.3	121,300	70.5	132,400	70.4
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		114,800	71.3	121,300	70.5	132,400	70.4
HEALTH SERVICES DEVELOPMENT	DHS	114,800	71.3	121,300	70.5	132,400	70.4
III. HEALTH SCIENCE AND TECHNOLOGY		46,200	28.7	50,800	29.5	55,700	29.6
ENVIRONMENTAL HEALTH		30,700	19.1	33,800	19.6	37,200	19.8
COMMUNITY WATER SUPPLY AND SANITATION	CWS	30,700	19.1	33,800	19.6	37,200	19.8
MATERNAL AND CHILD HEALTH		15,500	9.6	17,000	9.9	18,500	9.8
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	15,500	9.6	17,000	9.9	18,500	9.8
GRAND TOTAL		161,000	100.0	172,100	100.0	188,100	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		24,684	9.9	0	-	0	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		24,684	9.9	0	-	0	100.0
ESSENTIAL DRUGS AND VACCINES	EDV	23,328	9.4	0	-	0	100.0
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	1,356	.5	0	-	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		223,214	90.1	190,528	100.0	0	-
MATERNAL AND CHILD HEALTH		51,960	21.0	19,274	10.1	0	-
ADOLESCENT HEALTH	ADH	51,960	21.0	19,274	10.1	0	-
COMMUNICABLE DISEASES		171,254	69.1	171,254	89.9	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	171,254	69.1	171,254	89.9	0	-
GRAND TOTAL		247,898	100.0	190,528	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	145,500	0	0	60	20,900	0	37	70,300	18,900	5,800	0	29,600
WHO - WR	15,500	0	0	0	0	0	6	11,400	4,100	0	0	0
TOTAL	161,000	0	0	60	20,900	0	43	81,700	23,000	5,800	0	29,600
% OF TOTAL	100.0				13.0	.0		50.7	14.3	3.6	.0	18.4
1992-1993												
PAHO - PR	155,100	0	0	105	29,300	9,300	33	66,000	17,400	10,400	0	22,700
WHO - WR	17,000	0	0	40	10,700	0	0	0	5,100	1,200	0	0
TOTAL	172,100	0	0	145	40,000	9,300	33	66,000	22,500	11,600	0	22,700
% OF TOTAL	100.0				23.2	5.4		38.4	13.1	6.7	.0	13.2
1994-1995												
PAHO - PR	169,600	0	0	105	31,000	10,800	33	69,300	20,200	12,100	0	26,200
WHO - WR	18,500	0	0	40	11,300	0	0	0	5,900	1,300	0	0
TOTAL	188,100	0	0	145	42,300	10,800	33	69,300	26,100	13,400	0	26,200
% OF TOTAL	100.0				22.5	5.7		36.9	13.9	7.1	.0	13.9

ARGENTINA

ANALYSIS OF THE HEALTH SITUATION

1. The information available in organized form is restricted mainly to morbidity and mortality and to characteristics of the medical care system. It thus becomes necessary to deepen the analysis of the health situation and of its trends, a priority subject for our future technical cooperation.

Child mortality

2. During the last decade, infant mortality continued to decrease, although at a lower rate than in the previous ten years, since the low level which it had reached made for a slower reduction process. While in 1970 the value was 116 (147 in Jujuy and 31 in the Federal Capital), in 1981 it had decreased to 34 (51 in Salta and 18 in the Capital), and to 20 in 1987 (35 in Formosa and 15 in the Federal Capital). Neonatal mortality represented 41% of child deaths in 1970, 56% in 1980, and 58% in 1985.

3. Mortality in the group from one to four years old was reduced from 3.3 per 1,000 in 1970 to 1.0 in 1985. This is due mainly to the reduction in mortality caused by infectious and parasitic diseases, especially diarrhea. In the group from five to 14 years of age, the death rates in 1985 decreased to almost half of what they were in 1969 and 1970.

Mortality in adolescents and adults

4. Between 1969 and 1985, all the rates by age and sex in the group from 15 to 64 years old decreased appreciably. In the group from 15 to 29 years of age, accidents and mental diseases account for over 50% of the mortality. In those 30 to 44 years of age, cerebrocardiac vascular disorders took over first place. Beginning at age 45, cerebrocardiac vascular diseases and tumors contribute to more than 50% of the deaths. Both maternal mortality and tumors peculiar to females are of such importance that they appear in the profile of general mortality by age.

Mortality in the elderly

5. Coronary diseases are the leading cause of death in the group 65 years of age and older, and account for twice the mortality from the second cause. Malignant tumors, cerebrovascular diseases, arteriosclerosis, and influenza and pneumonia complete the leading causes of death in the elderly. No significant differences by sex are observed.

General problems

6. The Ministry of Health and Social Action estimates that 30% of children under five suffer from undernutrition. Although somewhat high, this estimate would apply to the rural areas of the northern provinces. The high sustained level of agricultural and livestock production and the decline in real income in recent years appear to indicate that undernutrition in Argentina is due mainly to poverty rates, rather than to a scarcity of food.

7. The infectious diseases reported most frequently are diarrhea, respiratory infections, viral hepatitis, blennorrhagia, syphilis, and measles. Of the major endemic diseases, Chagas' disease is reported most often. Serological surveys carried out in segments of the population indicate that its rate of transmission is decreasing. There are registered cases of malaria along the borders with Bolivia, Brazil, and Paraguay. Aedes aegypti has invaded localities in Buenos Aires, Formosa, and Misiones but no cases of dengue have been recorded. Hydatidosis in humans has been found in all but one province. The last case of human rabies registered in the country occurred in 1985. Oral pathologies are very prevalent; eight of every 10 children 12 years of age have or have had dental caries; at 50 years of age, one of every five inhabitants has no teeth in the upper jaw.

Characteristics of the health services

8. Within the structure of the health sector three subsectors are identified: public, social welfare, and private. The provinces and municipalities have great autonomy to organize and carry out health actions. The official figures for coverage indicate that 74% of the population is covered by social security, while the remaining 26% depends on public services or private services requiring direct payment. However, the figure of 74% for affiliation with social security includes duplications. The real coverage probably approximates 65% for social security and 35% for public services and the private subsector; it is estimated that 25% of the population receives all its medical care from the public subsector. In addition to the social security system, approximately 1,000 nonprofit mutual funds offer medical care plans financed by individual contributions. In the urban centers, supplementary insurance (coinsurance and plans for emergencies and intensive care, among others) plays an increasingly larger role.

9. One needs to recognize the loss of the leading role of the public hospital in recent years, due to the decreased importance of the public subsector in total expenditure in health. This situation is expressed through a series of critical factors, namely: limitations in the schedules for the operation of the services, unsatisfactory quality of the benefits, lack of provision of drugs to outpatients, scarcity of medical and surgical materials, low ratio of staff to beds in the provincial hospitals, lack of personnel training, poor installation maintenance, and organizations structured exclusively around the hospitalization of the patient.

GLOBAL STRATEGY OF COOPERATION

10. The year 1990 has been a period of great political instability and of difficulties for the Ministry of Health and Social Action, not only in orienting technical cooperation activities, but basically in managing the medical care system. In the year and a half that the current government has been in office, five Ministers have held the Health and Social Action portfolio. In this context, it has been difficult to develop continued activities.

11. The economic administration has defined criteria that serve as a guideline for an approximation to a "health policy." There is consolidation of the trend toward the privatization of the complex levels of medical care and toward the development of basic services for the population without coverage, with the action thus focused on the high-risk groups. This proposal would be carried out in the provinces that show seriousness in fiscal responsibility. In addition, the reorganization of the sector is being promoted through the strengthening and development of local health systems, the incorporation of the potential of the National Health Insurance Administration, and the orientation of the externally financed projects toward the reorganization of the sector. The modernization of the management processes encompasses the promotion of health, the utilization of social communication, the integration of women in health and development, information management, and the mobilization of resources.

12. Consequently, with respect to the table of definitions of technical cooperation, a set of questions is posed concerning the articulations between the health processes and the political and social structures. Hence possibilities open up for joint work with the provinces in areas such as: health in development; analyses of the health situation and trends; political analyses, decisions, and evaluations; redefinition of the models of medical care including the proposals for establishing local systems; the role of health in social development; the impact of the economic crisis and the adjustment on the health situation; and new forms of organizing programs and services.

13. In addition, cooperation among countries has accelerated due to the Argentine-Brazilian trade integration, including in the medical and health areas.

14. In this way, the situation has opened new areas of technical cooperation, while it demands an effort to inhibit the erosion of previous achievements in the improvement of health conditions and health care. This technical cooperation is aimed at integrating the following programming priorities into a small number of projects: analyses of the allocation of resources, sectoral financing, management of local health systems, technological development, human resources, environmental health, food and nutrition, lifestyles and risk factors, disease control, maternal and child health, occupational health, drug dependence, acquired immunodeficiency syndrome, and cholera.

15. The Organization will collaborate in the development of the following specific programs:

MPN:	Managerial Support for National Health Development
TCC:	Technical Cooperation among Countries
HST:	Health Situation and Trend Assessment
DHS:	Health Services Development
HME:	Health Manpower Education
CWS:	Community Water Supply and Sanitation

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		3,631,800	92.5	3,983,400	91.5	4,555,900	91.6
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		1,138,400	29.0	1,575,500	36.1	1,810,000	36.4
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	1,138,400	29.0	1,575,500	36.1	1,810,000	36.4
TECHNICAL COOPERATION AMONG COUNTRIES		114,500	2.9	132,800	3.1	154,100	3.1
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	114,500	2.9	132,800	3.1	154,100	3.1
HEALTH SITUATION AND TREND ASSESSMENT		109,900	2.8	396,500	9.1	458,500	9.2
HEALTH SITUATION AND TREND ASSESSMENT	HST	109,900	2.8	396,500	9.1	458,500	9.2
HEALTH POLICY DEVELOPMENT		543,200	13.8	0	-	0	-
HEALTH POLICY ANALYSIS AND DEVELOPMENT	HDP	362,600	9.2	0	-	0	-
HEALTH ECONOMICS AND FINANCING	HDE	180,600	4.6	0	-	0	-
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		1,098,200	28.0	982,200	22.6	1,117,200	22.5
HEALTH SERVICES DEVELOPMENT	DHS	1,098,200	28.0	982,200	22.6	1,117,200	22.5
HUMAN RESOURCES DEVELOPMENT		627,600	16.0	896,400	20.6	1,016,100	20.4
HUMAN RESOURCES EDUCATION	HME	627,600	16.0	896,400	20.6	1,016,100	20.4
III. HEALTH SCIENCE AND TECHNOLOGY		292,800	7.5	370,300	8.5	420,000	8.4
ENVIRONMENTAL HEALTH		292,800	7.5	370,300	8.5	420,000	8.4
COMMUNITY WATER SUPPLY AND SANITATION	CWS	292,800	7.5	370,300	8.5	420,000	8.4
GRAND TOTAL		3,924,600	100.0	4,353,700	100.0	4,975,900	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		789,411	24.3	0	-	0	100.0
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		58,129	1.8	0	-	0	100.0
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	58,129	1.8	0	-	0	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		731,282	22.5	0	-	0	-
HEALTH SERVICES DEVELOPMENT	OHS	731,282	22.5	0	-	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		2,455,412	75.7	220,350	100.0	0	-
FOOD AND NUTRITION		2,311	.1	0	-	0	-
NUTRITION	NUT	2,311	.1	0	-	0	-
ENVIRONMENTAL HEALTH		26,931	.8	0	-	0	-
COMMUNITY WATER SUPPLY AND SANITATION	CWS	26,931	.8	0	-	0	-
COMMUNICABLE DISEASES		2,426,170	74.8	220,350	100.0	0	-
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	1,948,169	60.1	0	-	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	478,001	14.7	220,350	100.0	0	-
GRAND TOTAL		3,244,823	100.0	220,350	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	2,930,300	96	264	430	1,315,200	49,700	30	57,000	289,700	92,700	0	1,126,000
WHO - WR	994,300	48	0	275	401,400	15,500	18	34,200	126,500	43,500	34,400	338,800
TOTAL	3,924,600	144	264	705	1,716,600	65,200	48	91,200	416,200	136,200	34,400	1,464,800
% OF TOTAL	100.0				43.7	1.7		2.3	10.6	3.5	.9	37.3
1992-1993												
PAHO - PR	3,480,300	96	312	195	1,665,200	71,900	102	204,000	354,300	209,000	0	975,900
WHO - WR	873,400	48	0	60	435,600	80,500	0	0	183,600	78,300	0	95,400
TOTAL	4,353,700	144	312	255	2,100,800	152,400	102	204,000	537,900	287,300	0	1,071,300
% OF TOTAL	100.0				48.2	3.5		4.7	12.4	6.6	.0	24.6
1994-1995												
PAHO - PR	3,978,300	96	312	195	1,894,300	83,500	102	214,200	411,200	242,600	0	1,132,500
WHO - WR	997,600	48	0	60	489,600	93,400	0	0	213,000	90,900	0	110,700
TOTAL	4,975,900	144	312	255	2,383,900	176,900	102	214,200	624,200	333,500	0	1,243,200
% OF TOTAL	100.0				47.9	3.6		4.3	12.5	6.7	.0	25.0

ANALYSIS OF THE HEALTH SITUATION

Demography

1. The Bahamas is an archipelago of over 700 islands and cays of which about twenty-four are inhabited. The islands stretch over an ocean area of 100,000 square miles. Nassau, the capital city is located on New Providence island on which some 65% of the population lives.

2. The 1990 population estimate for the Bahamas is 253,000, with 38.3% under 15 years of age and 84.5% under 45 years of age.

3. The favorable per capita GNP, in addition to its limitations as an accurate indicator of development in that it does not speak to the diffusion of wealth in any society, requires even closer examination in the case of an archipelago of scattered islands with fairly remote community settlements.

Health indicators and contributing factors

4. Preliminary figures for 1988 place infant mortality at 21.4 per 1000 live births. This estimate, as in previous years, is based on registered events. It is noted that over the last two years, an increased problem of under registration and/or under counting of live births points to the need for early attention to be given to restructuring the births and deaths components of the vital statistics generation system.

5. The leading causes of death in 1988 include: diseases of the heart, malignant neoplasms, accidents and acts of violence, cerebrovascular disease and diabetes.

6. Principal causes of death among children under one year include: perinatal conditions, abnormalities, pneumonia and accidents. Child morbidity due to diseases preventable by immunization have decreased, but diarrhoeal diseases and acute respiratory infection remain areas of concern. Accordingly, the PHC services are being strengthened to increase and improve services in these areas.

7. The priority health problems include: hypertension, diabetes, obesity, accidents and violence, maternal and childhood conditions, communicable diseases including AIDS, alcohol and drug abuse and problems associated with environmental health.

8. Accidents and acts of violence are on the increase and are now the leading cause of hospital admissions except for maternity cases.

9. The coverage achieved by the Expanded Program on Immunization (EPI) showed a steady increase in 1989 and 1990. It is considered that coverage is in excess of 80% of those eligible.

10. Community dental public health services, especially for children of school age, require further development. Chronic non-communicable diseases have gained significance as a health priority and this trend is likely to continue as the population ages and infectious diseases are increasingly controlled. Care of the elderly is expected to become an increasing health service problem.

11. Sexually transmitted diseases remain a significant health problem. The Bahamas has one of the highest reported incidence of AIDS in the Region. As of 30th September, 1990 a total of 554 cases were reported. AIDS has, therefore, become the most important infectious disease.

12. Alcohol and drug abuse, the latter mainly of cocaine variety, are a significant health problem locally and are expected to remain of significant concern in the short and medium terms. These in turn have caused increased attention to be paid to mental health services.

13. Solid waste management as a problem has proven somewhat intractable and increasing policy initiatives for further industrialization have brought up for consideration issues of pollution, industrial hygiene and occupational health.

Strategies and national health plans

14. The delivery of health care in the Bahamas is based on a tiered approach comprising a network of health facilities, both public and private, with referral linkages between different levels of care. Increasing attention is being given to the strengthening of primary health care (PHC), not merely in response to international mandates but as the most feasible strategy to provide effective and efficient services to scattered population settlements throughout the archipelago. To this end, a number of new primary care facilities are currently being completed in both New Providence and in the Family Islands, while existing ones are being up-graded to provide increased services.

15. The present health policy which guides the Ministry of Health's activities, lists the areas of priority as: extension of PHC coverage; development of a comprehensive mental health program; strengthening of the special services to mothers and children; strengthening of the dental health program; development of a program for the prevention and control of acute communicable diseases; strengthening of the environmental health services; development of a disaster preparedness plan; promotion of nutrition; development of a manpower program; strengthening of the Ministry of Health's Information Systems; the establishment of a population policy; development of a program for the health of the adult; development of a health education and health promotion program; and the further development of a management organization to reflect a cohesive system. The Ministry's priority areas clearly incorporate the CCH priorities.

16. Achieving comprehensive coverage of services to a population scattered among several islands is the challenge addressed by the public health system. PHC coverage is given through the outpatient department of the Princess Margaret Hospital in New Providence and the Rand Memorial Hospital in Grand Bahamas, public health centers and clinics in New Providence as well as through private physicians general practice clinics. In the Family Islands there are 20 health districts; comprising 12 health centers, 34 main clinics and delivered by physicians, dentists, community nurses, midwives and health aides. Further development of PHC services include the increase in and the rationalization of clinics and health centers, the continued training of health care workers and the promotion of community participation through improved health education.

17. Devolution is seen as a strategy for delivery of PHC and the geophysical nature of the country points to the need to develop and strengthen local health systems.

18. Preliminary arrangements are well advanced to mobilize funding for the possible replacements of the Princess Margaret and Rand Memorial Hospitals, to manage them within a public corporation and to strengthen their capability as referral centers.

19. Activities for the improvement of infrastructure, including health services management and alternative methods of health financing have actively been undertaken with assistance of a grant from the IDB.

20. The manpower program is proceeding apace and will receive a further fillip from the mobilization of IDB funds for infrastructural improvement.

21. The Health Information and Coordinating Services (HICS) Unit has now seen the completion of its first development phase; headed by a biostatistician and includes staff with EDP capability. During the biennium, HICS will need to increase its middle level support staff to cope with increased demands being made on the unit which has now become the focal point for all of the Ministry's information needs.

22. To meet the additional demands for care brought about by a significant increase in alcohol and drug abuse, additional facilities have been provided at the Sandilands Rehabilitation Center and further facilities have been planned. International and national resources have been mobilized to improve public health education and effect research.

23. Maternal and Child Health Services remain a top priority and in the public sector the guidelines established in MCH strategy developed for the Caribbean provides direction for the program. Increasing emphasis has been placed on antenatal care in the community. Breastfeeding, too, is being emphasized with intensified health education. Respiratory diseases, followed by gastroenteritis continue to be the two most prevalent conditions affecting young children.

24. The introduction of ORT has brought significant improvement in the management of acute gastroenteritis.

25. The program for primary and secondary prevention and control of acute communicable diseases, in particular diarrhoeal diseases and diseases preventable by immunization, has been further developed. The Bahamas hopes to eliminate measles by 1992.

26. The ratio of dentists to the population is very low, resulting in inadequate coverage of the population. Consequently, emphasis is being placed on coverage for children of compulsory school age and includes a fluoride mouth rinse program.

27. The program of sexually transmitted diseases including AIDS, has been significantly strengthened and has benefitted from the mobilization of international funding; in the case of AIDS, from GPA funding.

28. Solid Waste Management and Environmental Pollution continue to require improvement. With assistance from PAHO/WHO, improvements are being effected in solid waste management and air pollution, and environmental monitoring and impact assessment have benefitted from additional equipment and trained manpower. Water quality monitoring and vector control surveillance are in place and staff continue to be trained and skills upgraded in food sanitation and food handling. An interim solid waste task force has been established to assist in the transfer of the Solid Waste division of the Department of Environmental Health Services into a public corporation. Significant PAHO input is envisaged in the biennium.

29. An Emergency Preparedness Committee has been established to further develop and monitor a sectoral emergency plan. A National Health Coordinator has been appointed.

30. A National Nutrition Survey has been carried out, the results of which will form the basis for a National Food and Nutrition Policy.

31. A Population Policy is still at "drawing board" stage and is expected to be advanced appreciably during the biennium with possible input from UNFPA.

32. Chronic non-communicable disorders are expected to assume increased importance. Accidents and violence is a priority health problem, necessitating the formation of a National Trauma Committee with support at the highest levels of government.

GLOBAL STRATEGY OF COOPERATION

33. PAHO/WHO's principal overall strategy for the biennium is to cooperate with the Government of the Bahamas to support its national health priorities within the context and framework of the Strategic Orientation and Program Priorities for PAHO during the quadrennium 1991-1994 and Caribbean Cooperation

in Health (CCH). PAHO will continue to collaborate with the Ministry and IDB-funded consultants in the development of infrastructure, including the further strengthening of the information systems to provide for improved planning, management and evaluation of the services.

34. The project for Managerial Support for National Health Development is expected to expand as a direct reflection of the increased scope of the management and administration of the entire country program.

35. PAHO/WHO resident staff, together with its regional and subregional staff/consultants will provide technical cooperation to the Ministry of Health in the continued move to decentralize the services and in the further development of local health systems (LHS).

36. The need to plan for and provide adequate personnel to match the new challenges has been recognized. Efforts in human resources development will continue particularly, given the increased emphasis in Maternal and Child Health, AIDS and Drug Abuse, Care of the Elderly and Environmental Health Services.

37. Support will be provided for the increased coordination and development of the chronic disease program and opportunities will be identified to promote integrated involvement of NGOs in this program. Other priority areas in which NGO involvement will be encouraged includes drug abuse and elimination of measles.

38. A program will be developed to assist the Ministry of Health to take a leadership role in the area of Women, Health and Development. The above strategy is expected to mobilize significant national resources for the health development process.

39. The management of knowledge will become vital as PAHO seeks to sensitize the health sector of its role in health and development, while at the same time assisting the Ministry of Health with the integration of the health promotion components of its programs.

40. AIDS prevention and control will remain a high priority within PAHO's program. Direct support will be provided for the coordination of activities, funded through GPA, and technical guidance will be facilitated by CAREC and the regional office.

41. Increased activity is envisaged in PAHO/WHO's assistance in the Environmental Health. PAHO/WHO's efforts will be intensified, with increasing emphasis being placed on the strengthening of the operating capacity of the DEHS. Direct support and technical assistance will be provided for improving the level of solid waste management, development of additional legislative and technical instruments to permit monitoring and control of pollution from existing and planned industrial, commercial, residential and recreational development. The Family Islands will benefit from personnel training and an extensive environmental survey. The Environmental Health and Tourism interaction is of special concern and will merit increasing attention with emphasis on water quality, food safety and environmental sanitation.

42. In view of the Government's success in mobilizing external funding for infrastructural strengthening and improvement to environmental health services, it is envisaged that PAHO/WHO's role will be constructively centered around project proposal writing and project management. In addition, PAHO will collaborate with the Government to facilitate the achievement of technical excellence within the priority programs and will promote the global and regional mandates while assisting with the restructuring of the health system.

43. PAHO will collaborate in the development of the following specific programs:

MPN:	Managerial Support for National Health Development
TCC:	Technical Cooperation among Countries
HST:	Health Situation and Trend Assessment
DHS:	Health Services Development
CWS:	Community Water Supply and Sanitation
OCD:	General Communicable Disease Prevention and Control Activities
HIV:	Acquired Immunodeficiency Syndrome
NCD:	Health Promotion and Prevention and Control of Noncommunicable Diseases

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		587,800	64.9	705,500	67.9	778,600	68.0
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		356,000	39.3	516,800	49.8	566,300	49.5
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	356,000	39.3	516,800	49.8	566,300	49.5
TECHNICAL COOPERATION AMONG COUNTRIES		17,300	1.9	20,100	1.9	23,300	2.0
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	17,300	1.9	20,100	1.9	23,300	2.0
HEALTH SITUATION AND TREND ASSESSMENT		37,600	4.2	16,700	1.6	19,000	1.7
HEALTH SITUATION AND TREND ASSESSMENT	HST	37,600	4.2	16,700	1.6	19,000	1.7
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		176,900	19.5	151,900	14.6	170,000	14.8
HEALTH SERVICES DEVELOPMENT	DHS	176,900	19.5	151,900	14.6	170,000	14.8
III. HEALTH SCIENCE AND TECHNOLOGY		317,600	35.1	334,200	32.1	367,800	32.0
ENVIRONMENTAL HEALTH		241,800	26.7	252,400	24.3	274,300	23.9
COMMUNITY WATER SUPPLY AND SANITATION	CWS	241,800	26.7	252,400	24.3	274,300	23.9
COMMUNICABLE DISEASES		43,600	4.8	45,200	4.3	51,900	4.5
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	43,600	4.8	45,200	4.3	51,900	4.5
HEALTH PROMOTION		32,200	3.6	36,600	3.5	41,600	3.6
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	32,200	3.6	36,600	3.5	41,600	3.6
GRAND TOTAL		905,400	100.0	1,039,700	100.0	1,146,400	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		3,000	.4	0	-	0	100.0
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		3,000	.4	0	-	0	100.0
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	3,000	.4	0	-	0	100.0
III. HEALTH SCIENCE AND TECHNOLOGY		698,875	99.6	317,639	100.0	0	-
COMMUNICABLE DISEASES		420,491	59.9	317,639	100.0	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	420,491	59.9	317,639	100.0	0	-
HEALTH PROMOTION		278,384	39.7	0	-	0	-
PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE	ADA	278,384	39.7	0	-	0	-
GRAND TOTAL		701,875	100.0	317,639	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL PROF. MONTHS	PERSONNEL LOCAL MONTHS	PERSONNEL CONS. DAYS	PERSONNEL AMOUNT	DUTY TRAVEL AMOUNT	FELLOWSHIPS MONTHS	FELLOWSHIPS AMOUNT	SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	383,900	24	0	145	215,800	13,700	25	47,500	36,000	26,800	0	44,100
WHO - WR	521,500	24	24	110	293,600	11,500	39	74,100	18,900	12,600	0	110,800
TOTAL	905,400	48	24	255	509,400	25,200	64	121,600	54,900	39,400	0	154,900
% OF TOTAL	100.0				56.2	2.8		13.4	6.1	4.4	.0	17.1
1992-1993												
PAHO - PR	467,100	24	0	105	331,300	22,900	0	0	40,600	30,700	0	41,600
WHO - WR	572,600	24	24	90	343,400	13,900	18	36,000	22,800	26,300	0	130,200
TOTAL	1,039,700	48	24	195	674,700	36,800	18	36,000	63,400	57,000	0	171,800
% OF TOTAL	100.0				64.9	3.5		3.5	6.1	5.5	.0	16.5
1994-1995												
PAHO - PR	508,900	24	0	105	351,400	26,400	0	0	47,200	35,700	0	48,200
WHO - WR	637,500	24	24	90	375,400	16,200	18	37,800	26,400	30,600	0	151,100
TOTAL	1,146,400	48	24	195	726,800	42,600	18	37,800	73,600	66,300	0	199,300
% OF TOTAL	100.0				63.4	3.7		3.3	6.4	5.8	.0	17.4

ANALYSIS OF THE HEALTH SITUATION

Demography

1. Barbados is the most easterly of the Caribbean Islands. It has a total land area of approximately 430 sq km (166 sq miles). The most recent figures available (1986) indicate a population of 253,838. The population of 590 per sq km makes it the most densely populated state in the Caribbean. Between 1980 and 1986, the population grew by 4,855, an annual rate of increase of 0.4%. The population aged 65 and over was 22,408 for 1980 and increased to 28,938 in 1986. The population under 15 decreased from 72,205 in 1980 to 64,729 in 1986. The birth rates fell from 16.9 per thousand livebirths in 1980 to 16.2 in 1986.

2. During the decade, the age-specific fertility rates declined for all age groups. The demographic changes can be attributed to successful family planning, family life education programs, and to migration. The projections are that the population will continue to age and that by 2010 the elderly (65 and over) will constitute 35% of the population.

Indicators of health status

3. Health status indicators have improved over the last decade. Life expectancy at birth increased to 75.2 years for females and 70.2 years for males in 1986. This increase was more marked in females than in males. Infant mortality rates continued to decline, reducing from 21.6 per thousand livebirths in 1980 to 18.7 in 1986. The majority of infant deaths were in the early neonatal period.

4. Chronic noncommunicable diseases continued to be the main causes of mortality and morbidity. The five leading causes of death in the decade 1980 to 1990 were: heart disease, malignant neoplasms, cerebrovascular disease, diabetes mellitus, and hypertension. Chronic noncommunicable disease accounted for 55% of deaths from all causes, and has been recognized by the Government as the leading causes of disability and loss of productivity. The number of lower limb amputations resulting from complications of diabetes and circulatory disorders is unacceptably high, averaging approximately 120 per year during the decade.

5. The main causes of infant mortality are perinatal causes. Accidents are a significant cause of deaths in the age group 1 to 4, and in the school-age and adolescent population.

6. Barbados has been affected by the global AIDS pandemic. The cumulative total of AIDS cases up to December 1990 was 172. Between January 1984 and December 1990, there have been 116 deaths. The pattern of transmission is still chiefly homosexual but heterosexual transmission is increasing. Cases are also now being reported in children. Of concern is the observation that cases are increasingly occurring in the age group 15 to 24, indicating that transmission may be occurring in the school-age population. The most recent projection indicates that by 1995, if present trends continue, as many as 1 in 50 of the adult population of Barbados will be HIV+.

Factors affecting health status

7. A general election was held on January 22, 1991. The Democratic Labor Party was returned to office with a reduced majority. The manifesto under which the party conducted and won the general election stressed a continuation of the present health policies. The Barbados economy expanded between 1986 and 1989 and the per capita GDP in 1989 was more than US$5000. As a result of this economic growth, consideration is being given to the graduation of Barbados from the IBRD and from UNDP developmental activities.

8. However during 1990 there were some indications that the continued expansion of the economy was threatened, and there was increased pressure on the foreign exchange reserves. This led to the Government taking steps to reduce liquidity. It seems unlikely that additional resources will be made available to the health sector in the near future and it is possible that Barbados will have difficulty in accessing external resources at concessional rates. As a result of this, it is anticipated that the quality of management of the health sector will impact upon the ability of the Government to meet its stated objective of ensuring that all Barbadians have access to good quality health care.

9. Barbados suffers from managerial weaknesses at all levels in the health care system. In some areas, there is sufficient commitment and support for change. The changing and the acceptance of new values still meet with major obstacles. In some instances, there appears to be inertia. This inertia has impeded decentralization of the health services and efforts to introduce a greater degree of accountability by managers at different levels.

10. The existing network of polyclinics and hospitals ensures that all Barbadians have access to health care. Access will be further facilitated when the polyclinics now under construction are completed. The focus will then shift to ensuring that the services are efficiently managed and that equity is achieved by improving the quality of care.

11. The patterns of disease and mortality have shifted in Barbados and lifestyle issues now predominate. The most recent nutrition survey has shown a significant prevalence of obesity. The past decade also shows increasing prevalence of drug abuse so that by 1989 a significant number of cocaine abusers were seen at the Psychiatric Hospital, whereas none were seen prior to 1985.

12. Alcohol-related admissions to the Psychiatric Hospital and the QEH increased over the decade. It is likely that some of the increase in mortality from road traffic accidents was related to alcohol, but no data is available to

demonstrate this. The prevalence of smoking appears to have declined in the last ten years.

13. KABP Studies done in relationship to the continuing epidemic of AIDS have shown that a high percentage of the school-age population (11-14) is sexually active. This has implications not only for STDs but for adolescent pregnancy.

14. The vast majority of Barbadians now have access to potable water derived from extensive groundwater sources. The quality of the water is threatened by urbanization, increasing use of pesticides in agriculture, and by indiscriminate disposal of solid and hazardous waste. A major problem facing the country is the availability of land for the siting of sanitary landfills so that alternate means of waste disposal must be considered. The marine and coastal environment, which is essential to the survival of the Barbados economy, is also threatened by inappropriate liquid waste disposal. This has been recognized and it is expected that the efforts made to install and extend sewerage systems will need to continue.

15. The management of the health services is severely hampered by inadequate and antiquated information systems. There is a need to design and install modern management information systems and to bring about the attitudinal change which will lead to greater use of information in decision-making.

16. Disease surveillance systems are also inadequate and do not permit continuous monitoring of the totality of the health situation of the country.

17. Human resource development is now recognized to be a limiting factor in the continued improvement of the health services of Barbados. There has been little formal manpower planning, in particular succession planning, and it is anticipated that there will be an increased demand for well-trained manpower in order to improve the quality of care and to better utilize changing technologies. There is a need to determine and to recruit the right type and mix of manpower and to ensure that promotion to leadership positions results from the demonstration of effective leadership capabilities and not merely by longevity.

18. National policies on the selection and utilization of technology also need to be developed and operational research strengthened.

National health strategies, policies and plans

19. The Government of Barbados recognizes that 'the right to health care is a fundamental human right. The Government has prepared a five-year development plan covering the period 1988-1993 and will continue to execute this plan during the biennium.

20. The document sets out the Government strategy in the health sector and states that it will emphasize community approaches, wide participation and consultation, with involvement of the private sector.

21. The strategy recognizes the achievement of improved health for the country is dependent upon community involvement, especially in the environmental health services, such as solid and liquid waste disposal, rodent and vector control.

22. As a result, the Government will seek to involve the community and private organizations in the development of health care and health-related activities.

23. Greater emphasis will be placed on environmental impact issues. The Ministry of Health, through the Environmental Health Care programs, will pay special attention to such problems as solid and liquid waste disposal, monitoring of coastal waters and drinking water, soil contamination, drainage, occupational health, and the development of positive lifestyles.

24. Emphasis will be placed on the restoration of health, the prevention of disease, activities for rehabilitation and an improved ecological environment for healthy living.

25. The Government will continue to bring Primary Health Care to all areas of the nation through the polyclinics and, where possible, through general practitioners, especially in the care of the elderly and disadvantaged. Special attention will be given to those suffering from diabetes mellitus, hypertension and cancer.

26. In addition, programs in community mental health and the care of the elderly and chronically ill will be developed through community nursing and other service programs.

27. Government recognizes that as the productive sectors change to provide new programs and services to meet the aspirations and needs of Barbadians, needs in Primary Health Care will also change in keeping with the changed lifestyles of the people. Taking into consideration the financial limitations and the increasing demands for primary health care, the Government will undertake the following activities:

27.1 Extension of the expanded program of immunization.

27.2 The full integration of family life development and family planning in the Maternal and Child Health program.

27.3 In cooperation with the Ministry of Agriculture, continued and improved control and prevention of diseases spread by animals to man.

27.4 The prevention and control of diseases--communicable and noncommunicable--with special emphasis on chronic diseases such as hypertension, diabetes and cancer.

27.5 Improved care of the aged and the disabled.

27.6 The promotion of maximum community/individual self-reliance and participation in the planning, organization, operation and control of health care.

27.7 Through appropriate health marketing and health education, preparation of the community to make full use of local, national and other available resources and to participate fully in the delivery of its own health care.

27.8 Improvement of environmental health, with special reference to provision of piped water in every home, food safety and control, the sanitary disposal of human waste, and improvement in the disposal of garbage.

27.9 Continuation of the food and nutrition strategy which makes provision for the needs of vulnerable groups and which, in the long run, ensures that no citizen is prevented by malnutrition from achieving his or her true potential.

27.10 The continuous improvement in Maternal and Child Health services, and the inclusion of postnatal care by counselling and other social intervention.

27.11 The provision of an improved dental health program with emphasis on preventive dental care for adults, especially high risk groups.

27.12 The provision of an improved community mental health program which will be integrated into the total primary health care service.

27.13 Continued improvement of the Barbados Drug Service.

27.14 Development of a more dynamic and creative management system to ensure an integrated, innovative and updated health care system.

27.15 Foster the development of the team approach at all levels within the Ministry.

27.16 Development of an effective and efficient health information system.

27.17 Promotion and development of effective intra- and inter-sectoral linkage and coordination to facilitate the delivery of health care.

27.18 The training and retraining of staff to facilitate the Primary Health Care team approach and to ensure maximum utilization of manpower and other available resources.

27.19 The adoption of a more cooperative participatory management style in the delivery of health care.

GLOBAL STRATEGY OF COOPERATION

28. The priorities of PAHO technical cooperation which have been identified in consultation with the Government are the following priority areas of the Caribbean Cooperation in Health: 1) Environmental protection, including vector control; 2) Human resources development; 3) Chronic non communicable diseases and accidents; 4) Strengthening health systems; 5) Food and nutrition; 6) Maternal and child health and population activities; 7) Mental health, and 8) AIDS.

29. The main focus of the technical cooperation however, will be in the areas of development of the health services, human resource development and chronic disease.

30. PAHO/WHO strategies for providing technical cooperation in these priority areas will be based upon the strategies approved by the Caribbean Governments under the Caribbean Cooperation in Health Initiative. As such, they will therefore stress resource mobilization in all areas, closer collaboration with other Caribbean countries in the spirit of TCDC, collaboration with the other agencies working in the health field in Barbados, in particular, the developmental banks and greater collaboration with non governmental organizations (NGOs) and private voluntary organizations.

31. It is expected that during the biennium, major loans now under discussion with the IDB will become available to permit the Government to rationalize its health services and to continue the process of bringing about improvement in the quality of care through improving the efficiency of the hospitals and introducing new technologies. PAHO/WHO programs will be complementary to these activities and will be geared to ensuring that the changes within the system result in health services which incorporate the principles of PHC and Local Health Systems Development.

32. PAHO will continue to collaborate with the Government in the process of developing its health services. Collaboration will be extended to assist in improving the efficiency of the main hospital, the Queen Elizabeth Hospital, so that it can be further developed to provide an extended range of secondary and tertiary care services and enhance its capacity to serve as a major teaching hospital for undergraduate and postgraduate students of the University of the West Indies.

33. The technical cooperation strategy will stress the closer integration with the primary levels of care. Assistance will be provided to bring the second hospital, St. Joseph's, fully on stream and to integrate it with the rest of the health systems in order to assure greater access to quality care.

34. The strategy will stress effective management of the health services so that the resources made available to the health sector can be effectively utilized.

35. The development of management information systems will continue and there will be increased emphasis on management training at all levels of the

health care system. Alternative methods of financing the systems will be explored.

36. A greater degree of social participation will be promoted as well as an increased role for non governmental and private voluntary organizations. Emphasis will continue to be placed on the development of geriatric and psychiatric services integrated with the rest of the systems.

37. Efforts will be made to induce the intersectoral articulation required to fully address the needs of the priority groups, especially children, adolescents and youth, women and the elderly.

Human resource development

38. Emphasis will be placed on continued monitoring of the manpower needs of the services and the development of appropriate local training programs in conjunction with the Ministry of Education and the University of the West Indies. The PAHO Fellowship program will be utilized to supplement local training.

Chronic non communicable disease

39. The technical cooperation strategy will emphasize the formulation of clearly defined programs for the control of the chronic non communicable diseases and accidents. There will be major emphasis on health promotion and on increased utilization of nongovernmental and private voluntary organizations in this effort. It will emphasize the need for the formulation and development of appropriate policies by the Government and the enactment where necessary of appropriate legislation.

40. Within the chronic noncommunicable diseases, continuing emphasis will be placed on diabetes, hypertension and cervical cancer. Collaboration with CAREC and CFNI will be strengthened so that all available resources can be mobilized to assist the Government in ensuring the necessary information systems, including disease registers, are in place and that the relevant epidemiological, sociocultural, operational and biomedical research is pursued.

Environmental health

41. PAHO technical cooperation with the Government will seek to develop the necessary information systems to permit continuous monitoring of the quality of the water supply. PAHO will collaborate with CEHI, CEPIS and ECO in providing assistance in monitoring the environmental impact of development on health. In particular, focus will be placed on all aspects of health and tourism.

42. Food protection, especially as it impacts upon the hospitality industry, will continue to be emphasized as will the development of disease surveillance systems. This latter will be conducted in collaboration with CAREC.

43. With respect to vector control, the strategy will stress the development of community-based vector control programs. It will emphasize public education, social participation, biological control where appropriate and a decreased reliance upon insecticides. Concomitantly, the strategy will emphasize improvement in surveillance systems. It is expected that extrabudgetary funds will be available to support the programmatic activities undertaken.

Food and nutrition

44. CFNI will be expected to continue to promote the development of comprehensive food and nutrition policies by the Government and to ensure that the information systems developed will permit continuous surveillance of the nutritional status and food availability. Appropriate food and nutrition interventions will be incorporated into the strategies developed with respect to chronic noncommunicable disease, maternal and child health, care of the elderly and environmental protection.

Maternal and child health

45. The PAHO strategy will emphasize the formulation and execution of well-defined maternal and child health programs geared towards achieving further reductions in infant mortality and closer integration of the primary level of care with secondary and tertiary care services. The development of information support will be emphasized. Specifically, collaboration with CAREC will be developed to ensure that Barbados remains free of poliomyelitis and that measles is eliminated.

AIDS

46. The emphases of the existing strategy will be maintained, but the emphasis will be placed on promoting more efficient management of the AIDS programs. Continued assistance will be provided to the Government in the mobilization of the resources required to combat the AIDS epidemic.

47. PAHO will collaborate in the development of the following specific programs:

MPN:	Managerial Support for National Health Development
DHS:	Health Services Development
CWS:	Community Water Supply and Sanitation
MCH:	Growth, Development and Human Reproduction
OCD:	General Communicable Disease Prevention and Control Activities
NCD:	Health Promotion and Prevention and Control of Noncommunicable Diseases

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		509,100	74.9	502,700	67.9	561,100	68.0
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		190,600	28.1	176,100	23.8	204,400	24.8
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	190,600	28.1	176,100	23.8	204,400	24.8
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		318,500	46.8	326,600	44.1	356,700	43.2
HEALTH SERVICES DEVELOPMENT	DHS	318,500	46.8	326,600	44.1	356,700	43.2
III. HEALTH SCIENCE AND TECHNOLOGY		169,600	25.1	236,800	32.1	264,200	32.0
ENVIRONMENTAL HEALTH		96,900	14.3	104,900	14.2	113,700	13.8
COMMUNITY WATER SUPPLY AND SANITATION	CWS	96,900	14.3	104,900	14.2	113,700	13.8
MATERNAL AND CHILD HEALTH		0	-	27,200	3.7	30,700	3.7
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	0	-	27,200	3.7	30,700	3.7
COMMUNICABLE DISEASES		24,100	3.6	50,000	6.8	58,000	7.0
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	24,100	3.6	50,000	6.8	58,000	7.0
HEALTH PROMOTION		48,600	7.2	54,700	7.4	61,800	7.5
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	48,600	7.2	54,700	7.4	61,800	7.5
GRAND TOTAL		678,700	100.0	739,500	100.0	825,300	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		238,572	34.2	0	-	0	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		238,572	34.2	0	-	0	100.0
HEALTH SERVICES DEVELOPMENT	DHS	227,272	32.6	0	-	0	100.0
ESSENTIAL DRUGS AND VACCINES	EDV	11,300	1.6	0	-	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		458,712	65.8	464,939	100.0	0	-
MATERNAL AND CHILD HEALTH		41,125	5.9	126,275	27.2	0	-
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	41,125	5.9	126,275	27.2	0	-
COMMUNICABLE DISEASES		417,587	59.9	338,664	72.8	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	417,587	59.9	338,664	72.8	0	-
GRAND TOTAL		697,284	100.0	464,939	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	678,700	0	0	395	105,600	0	104	197,600	68,800	42,600	11,500	252,600
TOTAL	678,700	0	0	395	105,600	0	104	197,600	68,800	42,600	11,500	252,600
% OF TOTAL	100.0				15.6	.0		29.1	10.1	6.3	1.7	37.2
1992-1993												
PAHO - PR	712,300	0	0	415	110,900	0	94	188,000	77,600	41,700	13,300	280,800
WHO - WR	27,200	0	0	30	8,000	0	0	0	10,000	9,200	0	0
TOTAL	739,500	0	0	445	118,900	0	94	188,000	87,600	50,900	13,300	280,800
% OF TOTAL	100.0				16.1	.0		25.4	11.8	6.9	1.8	38.0
1994-1995												
PAHO - PR	794,600	0	0	415	117,400	0	94	197,400	90,000	48,400	15,500	325,900
WHO - WR	30,700	0	0	30	8,500	0	0	0	11,600	10,600	0	0
TOTAL	825,300	0	0	445	125,900	0	94	197,400	101,600	59,000	15,500	325,900
% OF TOTAL	100.0				15.3	.0		23.9	12.3	7.1	1.9	39.5

ANALYSIS OF THE HEALTH SITUATION

1. Belize is an independent Nation since 1981 with an estimated population by 1990 of 200,000 inhabitants. It is a sovereign and democratic state ruled by a parliamentary system with a Prime Minister as Head of Government elected in free, direct and universal elections.

2. Administratively Belize is divided in six districts: Corozal and Orange Walk at the North, Belize at the East, where the city of the same name with one third of the total population is located, Cayo at the West, Stann Creek and Toledo at the South. The new capital Belmopan, with 5,000 inhabitants, is located in the Cayo District.

3. The agricultural production of the country is mainly sugar cane, citrus, bananas, and sea products. The tourist industry is another important source of income. There are good communications by road with Mexico and Guatemala and with the United States and other Central American Countries by air.

4. The level of illiteracy was under 10% in accord with last census of 1980 and the Infant Mortality Rate was 19.4 per thousand live births in 1989. In general, the educational and health indicators are one of the best for the subregion.

5. The demographic profile is one of a young population and, therefore, priority health problems are those related to a very high population of children and mothers with a high fertility rate. A high number of temporary immigrants from neighbor countries (more than 10% by several estimations) has been an important concern in the last years.

6. Communicable diseases such as Malaria, Tuberculosis and Sexually Transmitted Diseases continue to be priority health problems for adults. Correspondent vulnerable groups are workers, unoccupied adults, mothers and children of low income families.

7. Communicable diseases constitute an important cause of morbidity in the country. The five most frequently reported communicable diseases in 1986 were: malaria, gastroenteritis, gonorrhea, chickenpox and syphilis. The incidence of tuberculosis continues to decline, from 3.9 per 10,000 population in 1985 to 2.4 in 1987.

8. Tropical diseases of concern in Belize are: leptospirosis, which is endemic in the country; Chagas' disease; and schistosomiasis.

9. Malaria is endemic. The extensive eradication program carried out in the 1950s and 1960s virtually eradicated malaria. However, fiscal constraints that led to insufficient follow-up after the campaign and new agricultural production patters have resulted in a dramatic increase in incidence of cases from 876 in 1977 to 4,595 in 1983. From 1984 to 1986, the number of cases decreased, but they remain at around 3,000 cases per year.

10. In 1989 around two thirds of all births were attended in hospitals. This number added to discharges related to complications of pregnancy, childbirth and puerperium, and abortion constitute more than 50% of total discharges of 394 beds for acute patients in seven state hospitals all around the country. A national network of 31 health clinics and 5 primary level hospitals form the basic infrastructure for primary health care.

11. The secondary level of health services is the main concern of the Ministry of Health due to the fact that only at the Belize City Hospital (186 beds) it is possible to make General Surgery and some for specialties. Other district hospitals (one in each of the six districts, with a total of 208 beds) serve mainly for Primary Health Care, deliveries and small surgical needs.

12. There are 422 hospital beds in the country (one bed per 473 inhabitants) and each health center covers on average 6,451 inhabitants. However, the distribution of beds and centers per population varies among the districts. There are two health care clinics operated by private denominational groups and three private clinics run for profit.

13. Approximately 88.6% of the population is covered by services provided by health centers; 56.1% have close direct access and 32.5% are served through periodic visits by mobile clinics on a prearranged schedule. Of those with direct access, 92.1% are urban dwellers living in the district capitals or major towns. According to the Ministry's figures, 8.9% of the rural dwellers have direct access to the health centers, 3% have intermittent access, and 24% have no access.

14. Another concern recognized by the Government is the one related to the lack of health specialists, although a special program has been set up. Physicians are trained abroad (mainly at San Carlos University in Guatemala at present) and arrive periodically in a reasonable number for the country needs. Nurses are trained at the Belizean School of Nurses to supply the national needs and compensate the emigration to the USA. Recently, the Belize University College started a program to train health technicians. There were 92 physicians, 12 dentists and 245 nurses in 1990, with a ratio per 10,000 of 4.6, 0.6 and 12.2, respectively.

15. The lack of availability of health professionals is a major obstacle for the development of health programs. Around 43% of the physicians and 30% of the dentists were working for the Ministry in 1990, which is less than the 58% and the 40%, respectively, in 1984. All nurses are employed by the Government, but the number did not increase in the last years despite the annual production by the nursing school, this is due to their migration to other countries.

National health strategies and plans

16. A National Health Plan was established for the period 1990-1994. This plan set up priorities for primary and secondary levels of health services.

17. The Government recognizes health as a basic human right and a fundamental aspect of the development process, and is committed to provide health services to every Belizean using community participation and intersectoral coordination as key elements. The national health policy is guided by the principles of democracy, comprehensiveness, education, participation, and accessibility.

18. The health plan identifies mothers and children from birth to 5 years old, low income groups, the disabled, the elderly, and those living in underserved areas as priority groups. In addition, the prevention and treatment of high-prevalence diseases and conditions also is considered a priority. The plan emphasizes manpower training with appropriate technical and managerial skills geared to local needs and resources, with an integrated approach to preventive and curative health care, and with the capability to function as part of health team. The need to decentralize program execution and management to the peripheral level through a local health systems approach also is considered.

19. The primary health care approach will be complemented with a basic secondary level as district hospitals of Dangriga, Belmopan and Orange Walk will be implemented. The only national reference hospital, the Belize City Hospital, will start its construction soon.

20. A special technical cooperation among countries program has been implemented mainly with Mexico, Guatemala and Cuba, which will provide possibilities of interchange and training for Belizean health professionals. In the case of public health specialist a post graduate training is in process and is providing a reasonable answer to the growing structure of the Ministry of Health at the highest level of decision making.

21. The main epidemiological characteristics identified for Belize as priority health problems are: communicable sexual and vector transmitted diseases.

22. At health services infrastructure the main concern is the lack of self sufficient secondary level of reference at district and at national level.

23. The lack of sufficient trained human resources at all levels, from technical and professional to specialized, in both Public Health, Clinical and Surgical fields, is the other main identified problem.

GLOBAL STRATEGY OF COOPERATION

24. The PAHO global strategy for Belize is based on the mentioned epidemiological profile and has two components: to assist in the health service infrastructure and in the provision of professional and specialized human resources for health.

25. These components are included in the main priority areas set up in the "Strategic Orientations and Program Priorities of PAHO for the Quadrennium 1991-1994":

25.1 Development of the health services infrastructure with emphasis on primary health care.

25.2 Provision of responses to priority health problems present in vulnerable groups, with specific programs implemented through the health service system.

25.3 The management of knowledge required to make head-way in the first two areas.

26. PAHO global strategy is then focussed on some of the strategic orientations: health in development, reorganizing the health sector, processing action on high risk groups, and management of knowledge.

27. PAHO global strategy in Belize is also focussed in some priority program: management of local health systems and local programming development of human resources.

28. In order to strengthen local health planning (SILOS) and develop infrastructure for health services, two interrelated systems are in process of being implemented: one for epidemiological surveillance and one for health planning.

29. Human resources will be developed through national institutions, as it is the case of the University College of Belize for Technical level, and School of Nursing for nurses and midwives, as well as through continuous education with emphasis in research for other professionals. Training abroad through fellowships, meetings and visits is also included.

30. Therefore, for an optimal use of PAHO/WHO resources some modes of operation will be adopted as those of: mobilization of national resources to meet national needs, selective concentration of resources, promotion of coordination among all levels of the Organization.

31. PAHO will collaborate in the development of the following specific programs:

MPN:	Managerial Suppport for National Health Development
TCC:	Technical Cooperation among Countries
HST:	Health Situtation and Trend Assessment
DHS:	Health Services Development
HME:	Health Manpower Education
NUT:	Nutrition
CWS:	Community Water Supply and Sanitation
MCH:	Growth, Development and Human Reproduction
OCD:	General Communicable Disease Prevention and Control Activities
NCD:	Health Promotion and Prevention and Control of Noncommunicable Diseases

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		703,900	86.0	729,800	79.7	824,300	80.0
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		285,400	34.9	367,000	40.0	419,700	40.7
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	285,400	34.9	367,000	40.0	419,700	40.7
TECHNICAL COOPERATION AMONG COUNTRIES		61,200	7.5	71,000	7.8	82,400	8.0
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	61,200	7.5	71,000	7.8	82,400	8.0
HEALTH SITUATION AND TREND ASSESSMENT		0	-	17,300	1.9	19,300	1.9
HEALTH SITUATION AND TREND ASSESSMENT	HST	0	-	17,300	1.9	19,300	1.9
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		249,100	30.4	165,800	18.1	183,100	17.8
HEALTH SERVICES DEVELOPMENT	DHS	249,100	30.4	165,800	18.1	183,100	17.8
HUMAN RESOURCES DEVELOPMENT		108,200	13.2	108,700	11.9	119,800	11.6
HUMAN RESOURCES EDUCATION	HME	108,200	13.2	108,700	11.9	119,800	11.6
III. HEALTH SCIENCE AND TECHNOLOGY		115,300	14.0	184,400	20.3	205,900	20.0
FOOD AND NUTRITION		0	-	25,400	2.8	28,700	2.8
NUTRITION	NUT	0	-	25,400	2.8	28,700	2.8
ENVIRONMENTAL HEALTH		76,500	9.3	46,600	5.1	51,200	5.0
COMMUNITY WATER SUPPLY AND SANITATION	CWS	76,500	9.3	46,600	5.1	51,200	5.0
MATERNAL AND CHILD HEALTH		0	-	38,000	4.2	42,500	4.1
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	0	-	38,000	4.2	42,500	4.1

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
COMMUNICABLE DISEASES		38,800	4.7	36,400	4.0	41,000	4.0
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	38,800	4.7	36,400	4.0	41,000	4.0
HEALTH PROMOTION		0	-	38,000	4.2	42,500	4.1
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	0	-	38,000	4.2	42,500	4.1
GRAND TOTAL		819,200	100.0	914,200	100.0	1,030,200	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		429,846	78.2	537,541	85.3	0	100.0
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		23,800	4.3	0	-	0	100.0
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	23,800	4.3	0	-	0	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		406,046	73.9	537,541	85.3	0	-
HEALTH SERVICES DEVELOPMENT	DHS	406,046	73.9	537,541	85.3	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		120,009	21.8	92,481	14.7	0	-
MATERNAL AND CHILD HEALTH		4,650	.8	0	-	0	-
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	4,650	.8	0	-	0	-
COMMUNICABLE DISEASES		109,883	20.0	92,481	14.7	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	109,883	20.0	92,481	14.7	0	-
HEALTH PROMOTION		5,476	1.0	0	-	0	-
OCULAR HEALTH	PBD	5,476	1.0	0	-	0	-
GRAND TOTAL		549,855	100.0	630,022	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	362,400	24	24	40	192,100	10,400	21	39,900	34,400	7,700	0	77,900
WHO - WR	456,800	0	0	305	89,100	0	63	119,700	63,000	66,200	5,800	113,000
TOTAL	819,200	24	24	345	281,200	10,400	84	159,600	97,400	73,900	5,800	190,900
% OF TOTAL	100.0				34.3	1.3		19.5	11.9	9.0	.7	23.3
1992-1993												
PAHO - PR	442,600	24	24	45	257,400	28,400	24	48,000	11,600	11,600	0	85,600
WHO - WR	471,600	0	0	435	116,100	5,800	30	60,000	90,500	63,800	0	135,400
TOTAL	914,200	24	24	480	373,500	34,200	54	108,000	102,100	75,400	0	221,000
% OF TOTAL	100.0				40.9	3.7		11.8	11.2	8.2	.0	24.2
1994-1995												
PAHO - PR	501,100	24	24	45	291,300	33,000	24	50,400	13,500	13,500	0	99,400
WHO - WR	529,100	0	0	435	123,200	6,700	30	63,000	105,000	74,000	0	157,200
TOTAL	1,030,200	24	24	480	414,500	39,700	54	113,400	118,500	87,500	0	256,600
% OF TOTAL	100.0				40.2	3.9		11.0	11.5	8.5	.0	24.9

BOLIVIA

ANALYSIS OF THE HEALTH SITUATION

Demography

1. The total population estimated for 1989 was 6,405,100, of which 48.7% was rural compared to 58.1% in 1976; this shows the importance of the migration from the country to the city during that period. For the 1992-1993 biennium, it is estimated that the population will reach 7,000,000, with an annual average growth rate of 2.2%. The population pyramid by age has a wide base and a narrow vertex, expressing the youth of the population. Those under 15 years of age make up 41% of the total population. The average age of the population is 18.4 years. Life expectancy at birth is 48.55 years for men, and 53.03 for women.

2. Between 1978 and 1988, the principal diseases that affected the population were the following: diarrhea, respiratory infections, chickenpox, measles, and blennorrhagia. In 1988, there was a huge dengue epidemic.

3. The general crude death rate for the period 1986 to 1989 was 12 per 1,000 population; the infant mortality rate was 102.0 per 1,000 live births for the entire country--83.0 in urban areas and 120.0 in rural areas. The maternal death rate for the year 1988 reached 24.7 per 1,000 live births. Among children up to four years of age, the leading causes of death were intestinal infections, septicemias, and pneumonias; 47% of maternal deaths occurred during pregnancy, 28% during delivery, and 25% in the puerperium.

4. Deficiency diseases are encountered frequently now and are normally not subject to being reported. The most significant are: protein and caloric undernutrition, endemic goiter, hypoferric anemias, and vitamin A deficiency. Their estimated impact is as follows: undernutrition is present in 46.5% of children under five; endemic goiter is prevalent in 60% to 65% of the population; and hypoferric anemias appear among 35.7% of women 15 to 49 years of age.

5. With reference to zoonoses, Bolivia presents the highest rates of rabies in the Hemisphere; the prevalences of fascioliasis, taeniasis, cysticercosis, and foot-and-mouth disease are significant.

6. The prevalent diseases represent a serious problem at the regional more than at the national level; the most important are tuberculosis, malaria, yellow fever, Chagas' disease, leprosy, and sexually transmitted diseases.

7. The health services of the public sector are insufficient and are distributed irrationally. The principal deficiency of the system resides in the lack of organization of the District which fulfills the administrative and technical and policy-making functions.

8. The coverage of basic environmental sanitation services in 1989 is expressed in the following indicators: With respect to water supply and sanitation, 52% of the population had water service and 26%, sewerage service or latrines. Few cities had urban sanitation service. The housing shortage at the national level was estimated at 650,000 units, representing 65% of the total required. Because of industrial effluents, mining, and the intensification of the use of chemicals in agriculture, there was a growing degree of contamination of the soil, water, and air. Most of the work sites did not meet the minimum requirements for safety and protection against occupational diseases.

9. Social Security coverage in 1986 was reduced to 21.4%, with a strong downward trend up to the present. Its services are primarily urban and curative and rehabilitative in nature.

10. The public health infrastructure has at present 1.73 beds for every 1,000 inhabitants, 68% in public sector institutions, 26% in social security institutions, and 6% in the private sector; their distribution over the nine departments of the country is not proportional to the numbers of inhabitants there.

11. In 1983 and 1984, an average of 0.6 consultations per inhabitant were provided, structured as follows: 1.8 for the insurance institutions and 0.4 for the Ministry of Health in the urban area and 0.06 in the rural area. The average percentage of beds occupied was 44.7% with a very broad variation: some health centers had utilization rates of only 15%. This figure is explained by several factors: lack of articulation with the network of primary level services, lack of credibility in the quality of the service, poor state of the installations, economic factors in the population, and geographical and cultural inaccessibility.

12. There is a deficiency of medical supplies, basic health technology, and laboratories, a critical area within the health sector; there is still no clear policy for the selection, acquisition, distribution, utilization, and control of drugs, and no regular system for conservation and maintenance.

13. The follow-up and readjustment of the planning of managerial actions in the health area, mainly at the level of the Ministry of Health, face difficulties in the administration of the human and financial resources coming from both external technical cooperation and the central level. The causes are several; they range from the perception of low wages by the staff members of the Ministry and the continuing high rate of turnover of staff, which leaves after receiving training, to the lack of basic materials for the work and of an operating budget.

National health strategies, plans, and policies

14. The Ministry of Social Welfare and Public Health prepared the National Plan for Survival, Child Development, and Maternal Health, which was launched by the President of the Republic through Presidential Decree on 6 November 1989.

15. The objectives of the National Plan are to reduce the maternal death rate (currently 480 per 100,000) and the infant mortality rate (currently 100 per 1,000) by 50% by 1993.

16. The strategies for achieving these objectives are: implementation of primary health care through the operational tactic of local health systems and development of social action.

17. The National Plan comprises six programs and seven lines of action.

18. The programs are for: comprehensive health care for women of reproductive age; comprehensive health care for children under five years of age; a program for comprehensive health care for adolescent students; environmental services; epidemiological surveillance; and institutional strengthening.

19. The lines of action are: logistics and supplies; training; supervision and evaluation; mobilization and social communication; information and research; operational expenditures; and physical infrastructure.

20. The priority activities of the National Plan are geared toward women and children.

21. As a result, with the National Health Plan approved during 1990 and in accordance with the strategic orientations and programming priorities of PAHO/WHO and the framework for regional action, the Government of Bolivia has requested technical cooperation for the following:

21.1 The establishment of a system of continuous analysis and formulation of health policies.

21.2 Institutional strengthening at the central and peripheral levels which includes: a) establishment of subsystems for information, planning, supervision, logistics, and supplies; b) decentralization and transformation of the health services into local health systems; and c) manpower development.

21.3 An increase in regional cooperation in health with the countries of the Andes, Amazon, and Southern Cone.

21.4 The development of social action in health.

21.5 Surveillance and control of preventable diseases.

21.6 Environmental sanitation.

21.7 Coordination of international cooperation.

21.8 Improvement of nutrition.

21.9 Food safety.

21.10 Control of zoonoses.

21.11 Control of foot-and-mouth disease.

GLOBAL STRATEGY OF COOPERATION

22. The Government has stated that the principal health actions should be directed toward women and children.

23. Technical cooperation from PAHO/WHO, for the purpose of responding to the requirements of the country, should focus its efforts on some general strategies, namely:

23.1 At the central, regional, and local levels of the state, strengthening the redimensioning of health as part of a process of development in order to promote priority attention toward health in the political area, with regard to the dialectic interrelationship that exists between this and the development of the people.

23.2 Directing the efforts to support the reorganization of the health sector through the progressive strengthening of decentralization and the development of local health systems in the country, taking into account the strengthening of the national and regional levels as motors of the change.

23.3 Strengthening the state, regional, and local levels so that they can assume and develop their functions and achieve dimensionable results and impact. This aspect requires from technical cooperation skillful management of the knowledge and resources in order to strengthen the scientific and technological basis of the health personnel so that they can develop, produce, adopt, incorporate, and evaluate the knowledge and the technologies essential and appropriate to the sector. In addition, PAHO/WHO can channel the efforts and resources of different institutions and social actors, from the country and from the outside. This is why cooperation among countries, directed toward the search for joint solutions to common problems, the transfer of knowledge and technology at lower cost, and the utilization of the capacities available in the Region, becomes another essential strategy.

23.4 Achieving greater effort toward more equitable sustained development of the standards of living and of the levels of informed participation by the community, in order to contribute to better health service coverage in the country. This can only be obtained to the extent that the concern for health becomes a component of the daily lives of individuals, families, and communities as a right and a shared responsibility. The different aspects of the promotion of health and the utilization of strategies of social communication are very important means to achieve it.

24. PAHO will collaborate in the development of the following specific programs: Public Water Supply and Sanitation Services; Health Services Development; Essential Drugs and Vaccines; Analyses and Development of Health Policies; Health Education and Community Participation; Acquired Immunodeficiency Syndrome; Training of Human Resources in Health; Growth, Development, and Human Reproduction; Support of Management for National Development of Health; General Activities of Prevention and Control of Noncommunicable Diseases; Nutrition; General Activities of Prevention and Control of Communicable Diseases; Promotion and Development of Research; Technical Cooperation among Countries; Zoonoses.

24. PAHO will collaborate in the development of the following specific programs:

MPN: Managerial Support for National Health Development
TCC: Technical Cooperation among Countries
HDP: Health Policy Analysis and Development
DHS: Health Services Development
HED: Health Education and Community Participation
HME: Health Manpower Education
NUT: Nutrition
CWS: Community Water Supply and Sanitation
MCH: Growth, Development and Human Reproduction
OCD: General Communicable Disease Prevention and Control Activities
NCD: Health Promotion and Prevention and Control of Noncommunicable Diseases
ZNS: Zoonosis

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		2,358,600	65.4	2,588,800	64.6	2,959,400	64.8
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		867,900	24.1	760,500	19.0	877,600	19.2
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	867,900	24.1	760,500	19.0	877,600	19.2
TECHNICAL COOPERATION AMONG COUNTRIES		66,200	1.8	76,800	1.9	89,100	1.9
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	66,200	1.8	76,800	1.9	89,100	1.9
HEALTH POLICY DEVELOPMENT		56,500	1.6	91,000	2.3	103,700	2.3
HEALTH POLICY ANALYSIS AND DEVELOPMENT	HDP	56,500	1.6	91,000	2.3	103,700	2.3
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		903,400	25.0	1,168,300	29.1	1,329,700	29.2
HEALTH SERVICES DEVELOPMENT	DHS	903,400	25.0	1,079,600	26.9	1,228,300	27.0
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	0	-	88,700	2.2	101,400	2.2
HUMAN RESOURCES DEVELOPMENT		464,600	12.9	492,200	12.3	559,300	12.2
HUMAN RESOURCES EDUCATION	HME	464,600	12.9	492,200	12.3	559,300	12.2
III. HEALTH SCIENCE AND TECHNOLOGY		1,247,600	34.6	1,411,000	35.4	1,611,000	35.2
FOOD AND NUTRITION		51,100	1.4	106,900	2.7	120,900	2.6
NUTRITION	NUT	51,100	1.4	106,900	2.7	120,900	2.6
ENVIRONMENTAL HEALTH		440,500	12.2	459,200	11.5	520,600	11.4
COMMUNITY WATER SUPPLY AND SANITATION	CWS	440,500	12.2	459,200	11.5	520,600	11.4
MATERNAL AND CHILD HEALTH		97,100	2.7	111,000	2.8	127,100	2.8
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	97,100	2.7	111,000	2.8	127,100	2.8

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
COMMUNICABLE DISEASES		522,400	14.5	538,500	13.5	619,100	13.5
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	522,400	14.5	538,500	13.5	619,100	13.5
HEALTH PROMOTION		56,800	1.6	91,800	2.3	104,900	2.3
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	56,800	1.6	91,800	2.3	104,900	2.3
VETERINARY PUBLIC HEALTH		79,700	2.2	103,600	2.6	118,400	2.6
ZOONOSES	ZNS	79,700	2.2	103,600	2.6	118,400	2.6
GRAND TOTAL		3,606,200	100.0	3,999,800	100.0	4,570,400	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		692,704	17.8	0	-	0	-
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		652,704	16.8	0	-	0	-
HEALTH SERVICES DEVELOPMENT	DHS	283,759	7.3	0	-	0	-
ESSENTIAL DRUGS AND VACCINES	EDV	368,945	9.5	0	-	0	-
HUMAN RESOURCES DEVELOPMENT		40,000	1.0	0	-	0	-
HUMAN RESOURCES EDUCATION	HME	40,000	1.0	0	-	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		3,190,601	82.2	2,926,820	100.0	1,534,900	100.0
FOOD AND NUTRITION		20,000	.5	0	-	0	-
NUTRITION	NUT	20,000	.5	0	-	0	-
ENVIRONMENTAL HEALTH		211,495	5.4	0	-	0	-
COMMUNITY WATER SUPPLY AND SANITATION	CWS	211,495	5.4	0	-	0	-
MATERNAL AND CHILD HEALTH		2,397,689	61.9	2,466,820	84.3	1,534,900	100.0
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	2,397,689	61.9	2,466,820	84.3	1,534,900	100.0
COMMUNICABLE DISEASES		441,232	11.4	460,000	15.7	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	441,232	11.4	460,000	15.7	0	-
HEALTH PROMOTION		120,185	3.0	0	-	0	-
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	5,360	.1	0	-	0	-
PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE	ADA	98,386	2.5	0	-	0	-
OCULAR HEALTH	PBD	16,439	.4	0	-	0	-
GRAND TOTAL		3,883,305	100.0	2,926,820	100.0	1,534,900	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL CONS. MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	1,990,100	72	72	390	829,100	53,800	49	93,100	267,700	265,800	97,300	383,300
WHO - WR	1,616,100	48	0	810	571,200	27,500	71	134,900	436,900	197,500	51,000	197,100
TOTAL	3,606,200	120	72	1200	1,400,300	81,300	120	228,000	704,600	463,300	148,300	580,400
% OF TOTAL	100.0				38.9	2.3		6.3	19.5	12.8	4.1	16.1
1992-1993												
PAHO - PR	2,140,600	72	72	390	821,900	69,500	25	50,000	315,700	265,100	0	618,400
WHO - WR	1,859,200	48	0	780	600,400	13,900	48	96,000	535,100	265,500	0	348,300
TOTAL	3,999,800	120	72	1170	1,422,300	83,400	73	146,000	850,800	530,600	0	966,700
% OF TOTAL	100.0				35.4	2.1		3.7	21.3	13.3	.0	24.2
1994-1995												
PAHO - PR	2,455,600	72	72	390	930,800	80,700	25	52,500	366,500	307,600	0	717,500
WHO - WR	2,114,800	48	0	780	664,800	16,200	48	100,800	620,900	308,000	0	404,100
TOTAL	4,570,400	120	72	1170	1,595,600	96,900	73	153,300	987,400	615,600	0	1,121,600
% OF TOTAL	100.0				34.9	2.1		3.4	21.6	13.5	.0	24.5

ANALYSIS OF THE HEALTH SITUATION

1. Analysis of the various contexts that affect the production of health reveals that Brazil is in the process of adjusting its socioeconomic development, which aspires to the implementation of a new model of health care based on the constitutional precept of health, the right of all and a responsibility of the state, with the basic orientation toward being decentralized, comprehensive, and participatory with respect to the community.

2. The country has engaged in a political process with full exercise of democracy and direct elections of its authorities at all levels of the Federative Republic. A series of economic measures have been undertaken to control inflation, which reached very high levels in the first quarter of 1990. The basic picture includes demographic and epidemiological transitions with simultaneity of communicable and chronic degenerative diseases, with an increase in the number of elderly, and a phenomenon of urbanization of great magnitude (more than 75% of population is urban). The migratory movements toward Amazonia, in the expansion of the agricultural and mining frontiers, determined the increase in tropical diseases, which then spread to other regions of the country as the migrants dispersed.

3. The health indexes indicate that there are significant regional differences; inadequate conditions in the northeast and north in regard to mortality in children, high prevalence of diseases susceptible to prevention and control, and health services with low population coverage and limited access have all been observed.

4. The predominant features of the health situation are centered on an investment per capita which is less than $US 70 per year (3.9% of GDP--public and private); this has not allowed development of basic services at the national level or facilitated accessibility for the low-income population, which is predominant in the rural and urban fringe areas.

5. The Five-year Health Plan for 1990-1995 is oriented toward guaranteeing comprehensive care to the entire population through mobilization of all political, administrative, public, and private parties, in order to raise the investment in health from 3.9% of GDP to 10% toward the end of the five-year period; this involves going from an expenditure of US$ 12.7 billion in 1989 to more than US$ 33.0 billion in 1990. The inclusion of the agency charged with medical care in the Ministry of Health, public financing of 30% of the Social Security budget, the growth of supplementary medicine, and other factors linked to the commitment of the states and municipalities paint a picture of improvement in the investment in health which, it is expected, will reach the levels required to cover the costs for the entire population with greater emphasis on the problems of greater magnitude and technological vulnerability for the groups at greatest risk.

6. To the effort to increase financial resources must be added what should be done in regard to the development of manpower and physical, technological, and institutional resources and the incorporation of the community into the process--all this within a new model of health care, centered on the sanitary districts or local health systems, with a defined commitment to implementing the actions that meet the basic needs of the population.

7. The Five-year Plan has another basic axis in the administrative-managerial development of the health services, aimed at achieving maximum efficiency, in order to obtain results that are manifested in perceptible improvement of the health indexes and providing the programs for economic development with adequate underpinnings.

8. The process of health reform of the 1980s is under way. There are substantive advances in the legal area (National Constitution, Organic Health Law, state and municipal laws), as well as in the integration of efforts at the level of the institution that regulates health in the country. The formulation and implementation of the Five-year Plan is another factor that establishes an important landmark in the process, since it establishes the strategic orientations and the programming priorities of a Government that has granted high priority to the development of health.

National health strategies and plans

9. The new administration has formulated a Five-year Health Plan for 1990-1995 oriented toward achieving broad, radical health reforms that move the country to a level of health compatible with the economic development. For the execution of that vast mission, the Ministry of Health has incorporated into its traditional public health functions the component of medical care, overcoming the classical dichotomy that prevented its engaging in a comprehensive action for the entire population. Objectives and goals, quantified in measurable terms so that they can be continuously controlled and evaluated by all the segments of the society involved in the development of health in the country, have been established.

10. With a view to providing direction to the Plan, it has been established that the fundamental axis of the process will be the implementation of the Unified Health System (mandated in the Constitution of 1988), and political directives have been formulated that will guarantee health as a right of all and a responsibility of the State, respect for universal citizenship, and development of a new model of health care that is decentralized and comprehensive and involves significant community participation. In the same vein, relationships between the public and private sectors, sectoral complementarity, scientific and technological development, manpower development, and measures to protect the environment are established. A basic policy is centered on the administrative and managerial development of the health services at all levels of system.

11. The central strategy of the Five-year Health Plan is the development of the Unified Health System (SUS), which should have three principal components functioning concurrently: legal, institutional, and operational.

12. The legal component corresponds to the application of the basic legal framework that regulates the operation of the SUS: the National Constitution (1988), state constitutions (1988/1989), municipal organic laws (1988/1990), and

the Organic Health Law (1990). Their application should be monitored at all levels of health care, along with the formulation of the complementary mechanisms for regulation and standardization.

13. The institutional component involves the molding of the administrative structures of the various federal agencies, so that there is coherence with the institutional mission to guarantee the basic principles of decentralization, comprehensiveness, social participation, universalization, and equity in health. Institutional reform will be carried out beginning with a new assistance model that involves significant changes in participatory administrative management, management of the health services by the state and the municipality, comprehensive health care, and regionalization.

14. It is in the operational component that the SUS is going to become effective, through the establishment of a direct reciprocal relationship among the units providing services and the population of a specific geographical area. The tactical importance resides in the fact that the legal and institutional framework may be insufficient for the development of the SUS. Laws, acronyms, organizational charts, agreements, or projects say little to the population if they are not accompanied by perceptible deeds that are translated into increases in the delivery of services, the quality of the health care, and the availability of drugs and supplementary examinations, along with timely, humanized care with a high degree of effectiveness and efficiency. This component advocates the reorganization of the health services in the logic of attention to the needs of the population at all administrative and institutional levels.

15. The political directives and the central strategy are involved, in turn, in the mobilization of the national resources. It is noted that the goals can only be reached if there is joint commitment with the states and municipalities to expand financing of health. The public investment should be raised from 1.8% of GDP to 5.4%, and the private, from 2.0% to 4.0%. In addition, demands are formulated for mobilization of other sectors linked to the improvement of employment, income, housing, basic sanitation, universal education, transportation, food production, and basic supplies for health care (critical drugs, immunobiologicals, equipment, and materials).

16. International cooperation is considered important with respect to the complementarity of the national effort and the promotion and support of reciprocal actions with other countries, as elements of solidarity and joint action for the comprehensive development of health and of the people.

17. The Five-year Health Plan of Brazil coincides with the program budgets of the 1992-1993 and 1994-1995 biennia, and contains the essential elements of the PAHO/WHO Strategic Orientations and Programming Priorities for the period 1991-1994. This concurrence of factors enhances technical cooperation and should serve as an appropriate complement to the national effort.

GLOBAL STRATEGY OF COOPERATION

18. The basic strategy will be aimed at supplementing the national effort for the consolidation of the Unified Health System, which will have as a basic tool the 1990-1995 Five-year Health Plan, which, in turn, is in close agreement with the strategic orientations and programming priorities of PAHO/WHO for 1991-1994. Just as the axis of the development of the SUS is the decentralization of the health services in the direction of the municipalities to form health districts to serve as local health systems, the programs for cooperation are defined to support that process, both in the development of the infrastructure of the services and in the health care programs to meet the basic needs of the population, and thus to attain the central goal which is universal accessibility to the health services.

19. Systemic activities are oriented toward the consolidation of the new model of health care, the training of human resources, environmental protection, the analysis of the health situation and its trends, ensuring sufficient financial resources for the activities anticipated in the Five-year Plan, the development of scientific and technological support for all the actions, and the achievement of self-sufficiency with respect to factors critical for the service programs (immunobiologicals, drugs, blood safety, diagnostic media and treatment, equ sources of technical cooperation that might be necessary have been foreseen in the Biennial Program Budget (BPB).

20. The specific activities of the Five-year Plan are oriented toward addressing the problems involving the greatest risk to the populations with limited resources, without stopping attendance to emergencies, violent acts, accidents, disasters, and hospital infections. The actions of greatest relevance will be directed toward the control and prevention of infant mortality, maternal mortality, the most important communicable diseases, chronic degenerative diseases, and deficiencies, and toward adolescent health, occupational health, and the establishment of systems of epidemiological and health surveillance that make it possible to act with knowledge of the causes and under defined directions for control, with the participation of the population as the consumer of health services. The service programs of the BPB are directed toward supporting the various activities indicated, concentrating efforts on the most peripheral levels of care.

21. In the strategy of PAHO/WHO technical cooperation, the support for the development of the state and municipal health plans is included, with a view to consolidating and strengthening the decentralization of the service programs, ensuring community participation through the local health councils and the health conferences which will constitute the basic forums for social participation.

22. Support for the process, now under way, of administrative and managerial training for those responsible for the conduct of the health establishments is considered basic; the intent is to guarantee efficient care, a rational use of resources, and a continuous search for scientific and technical excellence in the provision of services to the community.

23. Another area of importance within the global strategy will be active participation in the strengthening of technical cooperation between Brazil and other countries of the Region, with emphasis on the border countries (10).

24. In addition, support should be recognized for the involvement of the SUS in the overall development of the country, especially in the economic and social regeneration of the most depressed areas, through the increase and export of drugs, immunobiologicals, equipment for diagnosis and treatment, manpower training, specialized technical assistance, and delivery of high-level medical and surgical services.

25. PAHO will collaborate in the development of the following specific programs:

MPN: Managerial Support for National Health Development
TCC: Technical Cooperation among Countries
HST: Health Situation and Trend Assessment
HDP: Health Policy Analysis and Development
DHS: Health Services Development
EDV: Essential Drugs and Vaccines
HME: Health Manpower Education
RPD: Research Promotion and Development
NUT: Nutrition
CWS: Community Water Supply and Sanitation
CEH: Control of Environmental Health Hazards
MCH: Growth, Development and Human Reproduction
OCD: General Communicable Diseases Prevention and Control Activities
MAL: Malaria
NCD: Health Promotion and Prevention and Control of Noncommunicable Diseases
FOS: Food Safety
ZNS: Zoonosis

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		4,446,800	61.1	5,458,000	61.5	6,208,100	61.6
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		1,814,000	24.9	2,417,500	27.3	2,739,900	27.0
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	1,814,000	24.9	2,417,500	27.3	2,739,900	27.0
TECHNICAL COOPERATION AMONG COUNTRIES		109,500	1.5	127,000	1.4	147,400	1.5
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	109,500	1.5	127,000	1.4	147,400	1.5
HEALTH SITUATION AND TREND ASSESSMENT		727,100	10.0	454,700	5.1	515,100	5.1
HEALTH SITUATION AND TREND ASSESSMENT	HST	727,100	10.0	454,700	5.1	515,100	5.1
HEALTH POLICY DEVELOPMENT		225,900	3.1	537,100	6.1	613,400	6.1
HEALTH POLICY ANALYSIS AND DEVELOPMENT	HDP	225,900	3.1	537,100	6.1	613,400	6.1
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		1,326,600	18.2	1,597,800	18.0	1,817,700	18.1
HEALTH SERVICES DEVELOPMENT	DHS	746,100	10.2	963,900	10.9	1,102,800	11.0
ESSENTIAL DRUGS AND VACCINES	EDV	580,500	8.0	633,900	7.1	714,900	7.1
HUMAN RESOURCES DEVELOPMENT		158,700	2.2	232,900	2.6	268,900	2.7
HUMAN RESOURCES EDUCATION	HME	158,700	2.2	232,900	2.6	268,900	2.7
RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT		85,000	1.2	91,000	1.0	105,700	1.1
RESEARCH PROMOTION AND DEVELOPMENT	RPD	85,000	1.2	91,000	1.0	105,700	1.1
III. HEALTH SCIENCE AND TECHNOLOGY		2,833,400	38.9	3,409,900	38.5	3,858,100	38.4
FOOD AND NUTRITION		87,100	1.2	78,100	.9	90,700	.9
NUTRITION	NUT	87,100	1.2	78,100	.9	90,700	.9

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
ENVIRONMENTAL HEALTH		708,500	9.7	812,300	9.1	915,000	9.1
COMMUNITY WATER SUPPLY AND SANITATION	CWS	708,500	9.7	471,100	5.3	529,700	5.3
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	0	-	341,200	3.8	385,300	3.8
MATERNAL AND CHILD HEALTH		580,500	8.0	801,800	9.0	905,000	9.0
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	580,500	8.0	801,800	9.0	905,000	9.0
COMMUNICABLE DISEASES		742,900	10.2	1,023,100	11.6	1,163,400	11.6
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	445,200	6.1	750,800	8.5	853,700	8.5
MALARIA	MAL	297,700	4.1	272,300	3.1	309,700	3.1
HEALTH PROMOTION		0	-	124,800	1.4	141,500	1.4
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	0	-	124,800	1.4	141,500	1.4
VETERINARY PUBLIC HEALTH		714,400	9.8	569,800	6.5	642,500	6.4
FOOD SAFETY	FOS	286,000	3.9	377,800	4.3	426,000	4.2
ZOONOSES	ZNS	428,400	5.9	192,000	2.2	216,500	2.2
GRAND TOTAL		7,280,200	100.0	8,867,900	100.0	10,066,200	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		2,450,648	25.7	0	-	0	-
HEALTH SITUATION AND TREND ASSESSMENT		188,989	2.0	0	-	0	-
HEALTH SITUATION AND TREND ASSESSMENT	HST	188,989	2.0	0	-	0	-
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		1,713,981	18.0	0	-	0	-
HEALTH SERVICES DEVELOPMENT	DHS	1,713,981	18.0	0	-	0	-
HUMAN RESOURCES DEVELOPMENT		513,068	5.4	0	-	0	-
HUMAN RESOURCES EDUCATION	HME	513,068	5.4	0	-	0	-
HEALTH INFORMATION SUPPORT		4,000	.*	0	-	0	-
SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION	HBD	4,000	.*	0	-	0	-
RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT		30,610	.3	0	-	0	-
RESEARCH PROMOTION AND DEVELOPMENT	RPD	30,610	.3	0	-	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		7,064,287	74.3	1,030,950	100.0	246,700	100.0
FOOD AND NUTRITION		156,028	1.6	0	-	0	-
NUTRITION	NUT	156,028	1.6	0	-	0	-
ENVIRONMENTAL HEALTH		2,460,416	25.8	0	-	0	-
COMMUNITY WATER SUPPLY AND SANITATION	CWS	2,429,419	25.5	0	-	0	-
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	30,997	.3	0	-	0	-
MATERNAL AND CHILD HEALTH		3,051,804	32.1	148,000	14.4	171,700	69.6
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	3,051,804	32.1	148,000	14.4	171,700	69.6

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
COMMUNICABLE DISEASES		1,320,888	14.0	882,950	85.6	75,000	30.4
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	1,005,094	10.6	807,950	78.3	0	-
MALARIA	MAL	52,886	.6	0	-	0	-
PARASITIC DISEASES	PDP	262,908	2.8	75,000	7.3	75,000	30.4
VETERINARY PUBLIC HEALTH		75,151	.8	0	-	0	-
ZOONOSES	ZNS	75,151	.8	0	-	0	-
GRAND TOTAL		9,514,935	100.0	1,030,950	100.0	246,700	100.0

* LESS THAN .05 PER CENT

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	3,978,000	168	768	585	2,258,500	146,100	62	117,800	266,000	153,600	62,500	973,500
WHO - WR	3,302,200	216	72	1945	2,018,000	144,900	202	383,800	282,800	135,700	75,400	261,600
TOTAL	7,280,200	384	840	2530	4,276,500	291,000	264	501,600	548,800	289,300	137,900	1,235,100
% OF TOTAL	100.0				58.7	4.0		6.9	7.5	4.0	1.9	17.0
1992-1993												
PAHO - PR	5,427,900	168	768	560	3,360,300	197,200	42	84,000	235,800	220,600	0	1,330,000
WHO - WR	3,440,000	168	72	820	1,903,800	197,200	74	148,000	235,700	156,000	0	799,300
TOTAL	8,867,900	336	840	1380	5,264,100	394,400	116	232,000	471,500	376,600	0	2,129,300
% OF TOTAL	100.0				59.5	4.4		2.6	5.3	4.2	.0	24.0
1994-1995												
PAHO - PR	6,168,400	168	768	560	3,778,300	228,800	42	88,200	273,700	256,100	0	1,543,300
WHO - WR	3,897,600	168	72	820	2,131,700	228,700	74	155,400	273,600	180,900	0	927,500
TOTAL	10,066,200	336	840	1380	5,910,000	457,500	116	243,600	547,300	437,000	0	2,470,800
% OF TOTAL	100.0				58.9	4.5		2.4	5.4	4.3	.0	24.5

ANALYSIS OF THE HEALTH SITUATION

1. Canadians enjoy one of the highest standards of living and status of health in the world. Infant mortality has declined to 7.2 deaths per 1000 live births (1988). Life expectancy has reached 73 years for males and 80 years for females (1985), a gain of 13 and 18 years, respectively, since 1931. Infectious diseases now account for less than 1% of total deaths; heart disease and cancer, among the leading causes of death, account for 58%. According to years of potential life lost before the age of 65, the five leading causes of death in 1988 were accidents, malignant neoplasms, diseases of the heart, suicide and congenital anomalies.

2. The Health and Activity Limitation Survey, conducted in 1986-1987, demonstrated that 13.2% of the population experiences some level of disability, a rate slightly higher than that measured 3 years before. Approximately 5% of children aged 0-14 years had a disabling condition, a prevalence which increased to 45.5% for the population aged 65 and older.

3. Canadians have access to a broad range of health services. The health system emphasizes the importance of well-being and the quality of life, health promotion and disease prevention. Even so, Canadians have access to an extensive network of health services from community-based primary health care to hospital services provided in 1,048 general, teaching, and specialty hospitals with a total of approximately 7 beds per 1000 population. Over 5600 special care facilities offer nursing care, care for the elderly and other services.

4. Human resources, in 1988, included 57,405 physicians (1 for every 451 Canadians), nearly 242,000 nurses, and more than 13,500 dentists. Over half of the active physicians were general practitioners and family physicians.

5. Health care expenditures reached almost CAN$40 billion in 1985 or CAN$1,945 per capita. This represented 8.5% of the Gross National Product. Over half of these expenditures are for institutional and related services. Expenditures for drugs and appliances have risen to nearly 14% of the total.

Strategies and national health plans

6. In 1986, a Federal policy paper entitled "Achieving Health for All: A Framework for Health Promotion" endorsed a broad concept of health and defined three principal challenges to achieving a higher level of health for all Canadians. These challenges were: 1) reducing inequities in the health of low versus high income groups in Canada; 2) increasing the effort to find new and more effective ways of preventing the occurrence of injuries; illness, chronic conditions and their resulting disabilities; and 3) enhancing people's capacity to cope with chronic conditions, disabilities and mental health problems.

7. Health promotion remains the centerpiece of health policy. All sectors of Canadian society have a role in preserving and enhancing health, including fostering public participation to control, more effectively, the factors affecting their health; strengthening community services; and coordinating the health aspects of public policy. Areas in which health promotion efforts are presently underway include family health; adolescent sexuality; nutrition; impaired driving; mental health; alcohol, tobacco and drug use; and social support for seniors.

8. Health is a shared responsibility between the Federal and provincial governments. At the federal level, the Department of National Health and Welfare is the principal agency concerned with health matters. The Department provides preventive health services, occupational and environmental health, emergency health services and immigration medical services. It also funds applied health research, including health services research while the Medical Research Council primarily funds basic biomedical research. Federal laboratories are concerned with regulatory functions to safeguard the quality and safety of foods, cosmetics, pesticides, drinking water and air, and the safety and effectiveness of drugs and medical devices. Surveillance is maintained over chronic and infectious diseases. The health needs of Indians, immigrants, refugees and the residents of the Yukon are met as a Federal responsibility.

9. Health services are primarily a provincial, as is the responsibility for health sciences educational programs, certification of health personnel, allocation and management of health care resources and the delivery of health care in this decentralized system. Provincial departments, in cooperation with regional and local health authorities, administer such services as environmental sanitation, communicable disease control, maternal and child health, school health, nutrition and vital statistics. Federal-provincial cooperation is achieved through various Federal-provincial coordinating mechanisms.

GLOBAL STRATEGY OF COOPERATION

10. The global strategy for technical cooperation addresses two areas of importance to Canada's international public health interests--the development of human resources and technical consultation for international health development.

11. Canada has a large pool of health professionals providing services in health promotion, in prevention, in disease diagnosis and treatment, in rehabilitation, in health care administration and in various public health

fields. Most of the educational resources are provided from Canadian institutions. However, from time to time, specialized training and experience must be obtained from institutions and agencies outside Canada. PAHO will cooperate in meeting these educational needs through the provision of fellowships.

12. As part of its international health activities, the Department of National Health and Welfare provides technical advice and carries out a well-established program of technical information and personnel exchange with developed and developing countries.

Close cooperation is maintained with the Canadian International Development Agency to support its health development assistance efforts. PAHO will cooperate in these endeavors through the support of Canadian consultants and through meetings designed to promote these international exchanges.

13. PAHO will collaborate in the development of the following specific programs:

MPN: Managerial Support for National Health Development
DHS: Health Services Development
HME: Health Manpower Education

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		166,800	100.0	778,000	100.0	875,200	100.0
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		0	-	600,000	77.1	685,500	78.4
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	0	-	600,000	77.1	685,500	78.4
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		41,400	24.8	46,000	5.9	51,100	5.8
HEALTH SERVICES DEVELOPMENT	DHS	41,400	24.8	46,000	5.9	51,100	5.8
HUMAN RESOURCES DEVELOPMENT		125,400	75.2	132,000	17.0	138,600	15.8
HUMAN RESOURCES EDUCATION	HME	125,400	75.2	132,000	17.0	138,600	15.8
GRAND TOTAL		166,800	100.0	778,000	100.0	875,200	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	104,100	0	0	80	20,200	0	33	62,700	21,200	0	0	0
WHO - WR	62,700	0	0	0	0	0	33	62,700	0	0	0	0
TOTAL	166,800	0	0	80	20,200	0	66	125,400	21,200	0	0	0
% OF TOTAL	100.0				12.1	.0		75.2	12.7	.0	.0	.0
1992-1993												
PAHO - PR	712,000	24	0	80	345,700	30,000	33	66,000	95,300	0	0	175,000
WHO - WR	66,000	0	0	0	0	0	33	66,000	0	0	0	0
TOTAL	778,000	24	0	80	345,700	30,000	66	132,000	95,300	0	0	175,000
% OF TOTAL	100.0				44.4	3.9		17.0	12.2	.0	.0	22.5
1994-1995												
PAHO - PR	805,900	24	0	80	398,100	35,000	33	69,300	103,500	0	0	200,000
WHO - WR	69,300	0	0	0	0	0	33	69,300	0	0	0	0
TOTAL	875,200	24	0	80	398,100	35,000	66	138,600	103,500	0	0	200,000
% OF TOTAL	100.0				45.5	4.0		15.8	11.8	.0	.0	22.9

ANALYSIS OF THE HEALTH SITUATION

Demography

1. Details of the demographic picture of the Caribbean countries are provided in the relevant country program budget. A brief summary of the situation for the subregion is presented here.

2. The English-speaking Caribbean region comprises 18 countries, with a population of 5.7 million. The islands are scattered over the vast Caribbean sea, spanning about 3500 km between Belize and Guyana. The countries range in size from Guyana, with an area of 214, 970 sq km, to Anguilla, with an area of 91 sq km. Population densities range from 582.8/sq km in Barbados to 3.8/sq km in Guyana.

3. The Caribbean countries have experienced very rapid population growth during the 20th Century, due to the decline in mortality and an increase in fertility levels. In the 1950s, massive emigration to the metropolitan countries and a decline in fertility rates in the 1960s led to a decline in population in all the countries. As a result of these factors, countries such as Barbados, Guyana, Grenada, Dominica, Antigua, St Kitts/Nevis and Montserrat experienced rates of population growth of less than 1% per year, while the populations of Grenada and St Kitts/Nevis actually decreased.

4. The population structure of the Caribbean countries shows that the populations are relatively young, with the under 15s comprising at least 40% of the total population in most countries. Women of child-bearing age (15-44) make up 20% of the population, with the proportion of elderly (over 65) increasing, particularly in Montserrat and Barbados. Based on current projections of the annual growth rate of 1.02%, the population should remain fairly stable between 1991 and 1993.

Indicators of Health Status

5. The life expectancy at birth has shown an increase in all territories in the 1980s. The general trend in mortality shows that there has been a decline to a significant degree in all countries and patterns of mortality are changing. The main causes of death are cancer, cerebrovascular disease, diabetes mellitus and hypertension. In Trinidad & Tobago, and to a lesser extent in Jamaica, ischemic heart disease is an increasing cause of mortality.

6. Death from accidents are on the rise, with Jamaica in 1980 (28.9/100,000) exceeding those of the United States of America (23.6/100,000).

7. Among women, data show that cancer of the uterus, cervix and breast are important causes of mortality, with cancer of the cervix being unacceptably high. Maternal mortality rates are generally less than 10/10,000 live births in all countries.

8. Between 1980 and 1984, infant mortality rates have declined in all countries, ranging from 47.9/1000 live births in Guyana in 1980 to 11.5/1000 live births in 1984 in Antigua.

9. Among children under the age of 1, the principal cause of death is perinatal causes. In the 1 - 4 year age group, diarrhoeal disease and respiratory infections are the main cause of mortality.

10. Precise information on the incidence of sexually transmitted diseases is not available, but some countries are reporting and increased incidence of STDs. The Caribbean has been affected by the global pandemic of AIDS. Cases are reported from all countries. The highest rates are reported from Trinidad, Bahamas, Barbados and Bermuda.

Factors affecting health status

11. The Caribbean subregion has been severely affected by the global economic crisis of the 1980s, with few exceptions. The countries most severely affected have been Jamaica and Guyana, but all have to some extent adopted structural adjustment policies which have resulted in reduced investments in the social sectors, including health. Studies on effects of these policies have shown that the Governments have tried to maintain current expenditures but have not sufficiently adjusted these for inflation. Every attempt has been made to retain personnel. This has resulted in less funding being available for other recurrent expenditures. Some areas, in particular maintenance, have been seriously affected, with resultant deterioration of the physical plant. There have been shortages of critical supplies, including essential drugs, in many countries.

12. Recent events in the Persian Gulf have the potential of further damaging the economies of the subregion, which is heavily dependent on tourism and, with the exception of Trinidad & Tobago, imported energy.

13. Barbados, whose economy expanded in the second half of the 1980s, suffered a 3.5% decline in 1990, and the Bahamas has recorded, for the first time, a significant decline in tourist arrivals. The recovery in Jamaica is seriously threatened and the Jamaican economy is expected to show no growth or a registered decline during 1991. The likelihood of Guyana mobilizing the massive external resources needed to arrest the decline in that country's economy is now problematic.

14. The Caribbean subregion is prone to national disaster. Jamaica was severely affected by Hurricane Gilbert in 1988, while Montserrat was devastated by Hurricane Hugo in 1989. In the previous decade, there was considerable damage in Dominica by Hurricane David and Soufriere in St Vincent erupted. The island chain lies on a volcanic fault and is prone to earthquakes. Disaster planning is therefore essential.

15. Another major problem affecting the health services of the Caribbean has been the shortage of health manpower. The brain drain for skilled manpower has been accentuated during the last half of the 1980s. This was particularly true for nurses. The countries most affected have been Jamaica and Guyana: Barbados the least. The shortage of nurses is now at a critical level in many countries and will seriously impede the achievement of national and subregional goals.

16. However evidence is slowly accumulating that all Governments are giving attention to taking steps to ameliorate the effects of these adverse trends on health and health services.

17. The countries adopted the Caribbean Cooperation in Health Initiative. This Initiative has been developed jointly by the Pan American Health Organization and the CARICOM Secretariat and seeks to mobilize additional resources for health, to concentrate upon priorities, and to promote greater technical cooperation within the Caribbean. Many Governments have mobilized support for the health sector from the developmental banks and, during the next five years, there should be considerable investment in the health sector, particularly through the Inter-American Development Bank.

18. Alternative methods of financing of the health sector are being investigated in several countries. These include examinations of the role of the private sector and nongovernmental organizations. For the first time, the social security systems are being involved in financing health care delivery in several countries. Attempts are being made to develop innovative methods to deal with the shortage of nurses and there has been increased attention on human resource development activities. It is expected that over the next five years Governments will seek to mobilize national, subregional and external resources to increase the pool of skilled manpower available.

19. The economic problems have focussed attention on the management of the health services. Management deficiencies persist and there is considerable inertia, which has impeded efforts to bring about change. There would appear to be a need to mobilize the political will to ensure that there is change in the way in which the services are managed and that in particular management decisions are made on the basis of the best available information rather than on intuition and on historical experience.

20. Environmental protection remains an area of major concern. The goals of the International Decade of Water & Sanitation were not fully achieved and large segments of Caribbean populations still do not have full access to potable water and basic sanitation services, particularly in rural areas, and the sewerage systems in capital towns and cities are inadequate in many countries. The fragile eco-systems of the Caribbean island states are threatened by inadequate liquid and solid waste disposal, industrialization, and pesticide abuse. There is a need to continue to concentrate on meeting basic needs at the local level while addressing broader environmental issues.

21. Vector-borne disease constitutes a potential threat to the health and economies of Caribbean countries. Malaria is still endemic in Guyana and Belize. Hemorrhagic dengue has been reported in some territories and remains a threat. Recent evidence indicates that leptospirosis associated with rodents is being increasingly reported.

22. The major challenges in the field of Maternal & Child Health are reduction of maternal mortality and morbidity, the improvement of perinatal care, and the development of programs to deal with the burgeoning problems of the adolescent, where young people are increasingly involved in violent crime and drug abuse, STDs and AIDS.

23. The concept of women in health and development has not been fully accepted in all countries, and much remains to be done to ensure that Caribbean women play their full role in health and developmental issues.

24. New approaches to the control of noncommunicable diseases are being developed, but there still remains a need for the formulation and execution of policies on health promotion, which will utilize the full potential of community-based organizations, NGOs and PVOs, as well as the mass media.

25. Although protein-energy malnutrition does not at present constitute a major problem, pockets still remain. Attention must be focussed on eliminating these pockets while developing systems for continuous surveillance of nutritional status and food availability. Further research into the nutritional components of chronic disease is needed.

GLOBAL STRATEGY OF COOPERATION

26. The main thrust of PAHO technical cooperation with the Caribbean subregion will be in relationship to the Caribbean Cooperation in Health Initiative. This Initiative, developed with the support of the CARICOM Secretariat and the Pan American Health Organization, responds to the felt need of the countries to mobilize additional resources for health; to concentrate upon priorities; to promote greater technical cooperation within the Caribbean; and to foster Caribbean integration.

27. The objectives of these Initiatives are:

27.1 To identify and utilize strategic priority areas as entry points for facilitating the more productive use of resources and for promoting TCDC.

27.2 To develop specific projects as vehicles for improving the whole health delivery system and at the same time impacting on the more critical health sector problems.

27.3 To improve technical cooperation in health in the Caribbean by stimulating intercountry, interagency, and inter-institutional collaboration.

27.4 To mobilize national and external resources to address the most important problems of the neediest groups and sectors.

28. Promotion of the Initiative will continue both within the Caribbean and overseas, where every attempt will be made to mobilize resources from traditional and nontraditional sources of support to Caribbean countries. However, the emphasis will shift to emphasize implementation of the projects already developed and funded and to promoting to a greater extent than previously done the preparation of projects of technical cooperation between the countries, and to mobilizing NGO and PVO involvement with the Initiative.

29. The priority areas identified under the Initiative will constitute the strategic foci of PAHO technical cooperation at the subregional level. Within each priority area, the relevant section of the PAHO policies and priorities will be vigorously promoted, and support will be provided to the Governments to enable them to meet the agreed subregional goals and targets.

Development of health services

30. The main focus of this program will be to catalyze the change needed to ensure that the health services can meet the needs and aspirations of the Caribbean peoples in a climate of economic uncertainty. The program will therefore try to generate and support the political will needed to bring about change, in particular, changes in the way that the services are organized and managed. Technical cooperation will emphasize the bringing about a greater degree of social participation and genuine intersectoral articulation. Health and development issues will be continuously brought to the attention of the Governments. PAHO will therefore collaborate very closely with subregional institutions, principally the Caribbean Community Secretariat, the Organization of Eastern Caribbean States, and the University of the West Indies, in trying to ensure that due attention is paid to health issues in the developmental process.

31. There will be renewed emphasis on trying to ensure that there is improvement in the management systems of the health services. The development of adequate management information systems will be accorded a high priority. Improvement in maintenance will be stressed. Special attention will be given to the Nursing Services of the Caribbean, which have been hard hit by migration and by adverse conditions of work in some cases.

32. The technical cooperation will emphasize the need of the Government to develop strategic plans which incorporate policies on the priority areas and address how the available resources can best be utilized in the light of the economic realities. PAHO technical cooperation will facilitate the sharing of experiences within Caribbean countries and will develop TCAC projects which will permit mutual assistance in the development of health services.

33. The health infrastructure team now in place in the Office of Caribbean Program Coordination will be strengthened and the team will concentrate on generating the knowledge and information needed to provide support to the countries. The team will collaborate closely with the PAHO Centers, in particular CAREC and CFNI, in this endeavor and with the University of the West Indies. The documentation center in the CPC's Office will be strengthened and appropriate data banks established. Health service research will be promoted by the team.

34. Support will be provided through the subregional program to Country Offices and Country Programs to enable the countries to achieve the agreed subregional goals and targets in the area of infrastructure development.

35. Resource mobilization will be emphasized and there will be close collaboration with CARICOM in the mobilization of NGO and PVO support.

Human Resource Development

36. Human resource development will remain one of the main priorities of PAHO technical cooperation since, in many cases, the limiting factor affecting the achievement of subregional and national goals and targets is manpower. PAHO technical cooperation will therefore emphasize the need to critically examine the manpower situation in all Caribbean countries. It will emphasize the need to ensure that manpower issues are fully addressed and incorporated into strategic health plans and that the necessary information systems are designed and put in place. The cooperation will also highlight the need for studies on manpower utilization and for the involvement of training institutions in the planning process at an early stage. The production and utilization of nursing manpower will be a special focus of attention. Better utilization of the PAHO fellowship program by the Member States will be emphasized. Leadership development will be promoted. TCAC arrangements in the production and utilization of human resources will be vigorously promoted. Collaboration with other external agencies involved in human resource development will be strengthened.

Environmental health

37. During the biennium, the Environmental Health program will focus attention on the intensification of collaborative efforts with bilateral and multilateral organizations and NGOs in mobilizing resources for the sector together with optimal utilization of existing resources within the Region. The Office of the CPC will seek to mobilize the resources of the specialized PAHO centers, CEPIS and ECO, to support subregional programs. There will be close collaboration with the Caribbean Environmental Health Institute.

38. The program will continue to pursue the objectives of the now-completed International Water Supply and Sanitation Decade, taking into consideration the lessons and experiences learned during that period. Particular attention will be paid to promoting and supporting the formulation of environmental health information management systems, human resources and institutional development. The program will also seek to support an intersectoral approach in program development aimed at circumventing problems arising from urbanization and from

increased agricultural activities in water catchment areas. Along with increased coverage, emphasis will be given, in terms of quality and quantity, to the proper management of existing water supply systems and water conservation.

39. Mindful of the need to minimize impact on the coastal marine environment, promotion of programs for the development of appropriate technology for collection and disposal of liquid waste and excreta will be undertaken. Particular attention will be focussed on the extension of these facilities to peri-urban and rural areas.

40. Technical and management support will be given for the improvement of solid waste management. Priorities will include institutional strengthening and the development of norms, policies and plans, particularly for the development of a model legislation which can be applied in the countries of the subregion. A multi-disciplinary and multi-sectoral approach will be pursued as far as possible for dealing with problems related to solid waste minimisation and disposal. Public awareness of environmental health issues and promotion of social participation will be stressed.

41. Institutional collaboration in monitoring environmental health hazards will be promoted, particularly those associated with agricultural use of pesticides and industrial waste. Information dissemination and technology transfer will constitute important parts of the collaboration and will be of importance for the purposes of formulating and implementing national policies and programs for minimizing environmental health hazards.

42. Support will be given to the development of programs for monitoring the working environment and workers' health, including the elaboration of norms, policies and plans.

Vector Control

43. The program will continue to support the strengthening of national vector and rodent control programs through promotion of integrated pest management strategies in order to reduce the current high potential for disease transmission and to minimize risk of major economic losses, especially in the tourist industry. The strategies will include the use of biological control agents, source reduction and health education in addition to traditional insecticidal methods. Social participation in the management of the peridomestic environment will be encouraged, particularly at the community level. Improvement will be sought in the information systems for program monitoring and evaluation as well as the strategies and plans for epidemic response.

44. Extrabudgetary resources will be mobilized in support of the program.

Food and nutrition

45. This program area will be addressed by the Caribbean Food & Nutrition Institute. The Office of the CPC will continue to assign the CFNI Public Health Nutritionist to facilitate program implementation.

46. The strategy will emphasize inter alia the drafting of a National Food and Nutrition Policy which will include specific reference to ingredients processing, quality and safety of all food products, packaging and labelling requirements and the development of standards consistent with best international practices.

47. The strategy will identify a mechanism for recognition of and conformity to common standards and initiate the implementation of such policies: and will develop programs aimed at preventing and controlling the most prevalent specific nutritional disorders - iron deficiency anaemia, through supplementation and/or fortification projects: energy/protein malnutrition by special direct attention to identified households, through the local district system and in collaboration with the MCH subregional program: chronic noncommunicable diseases by influencing changes in behavior and lifestyles, especially as related to nutrition.

48. The strategy will strengthen educational programs for the population on food and nutrition, including the training of human resources in the health services and other related sectors.

AIDS

49. Responsibility for the implementation of this program area at the subregional level is shared with CAREC. PAHO technical cooperation will stress the development of effective management of national programs. It will emphasize the integration of AIDS Prevention & Control Programs with STD Programs, and the development of subregional reference laboratories, appropriate national and subregional information systems, resource allocation and mobilization.

Noncommunicable diseases and accidents

50. PAHO technical cooperation will be geared towards assisting the countries in developing policies and community-based strategies and programs for the prevention and control of the leading chronic diseases, to mobilize the support of the public, the private sector, and NGOs. It will advocate and support the development of appropriate social policies and legislation which can facilitate the reinforcement and adoption of appropriate lifestyles: it will try to strengthen the capacity of health sector personnel and NGOs in health promotion: it will enable the countries to develop and test functional management and information systems: it will support the implementation of studies on chronic disease and will attempt to strengthen the technical capacity

to utilize the guidelines already established for the control of specific chronic diseases.

51. The maternal and child health strategy will stress the formulation on comprehensive maternal and child health programs and PAHO/WHO will support appropriate research and the development of information systems required. While continuing the present efforts of supporting countries in the implementation of the Expanded Program of Immunization, developing ARI and CDD programs, the cooperation will promote the development of comprehensive adolescent health programs and increased attention to maternal health and the reduction of maternal mortality and morbidity. Specifically, in collaboration with CAREC, the program will assist the countries in ensuring the elimination of poliomyelitis, measles, and neonatal tetanus.

Veterinary public health

52. This program will have three strategic foci:

52.1 Promoting the development of comprehensive food protection programs in all countries and assisting in the mobilization of resources needed to develop and implement these programs.

52.2 Collaborating with CAREC in assisting the countries to improve surveillance of the Zoonoses and in the controlling and where possible elimination of Zoonotic disease.

52.3 The prevention of the importation into the Caribbean of exotic disease through mutual collaborative efforts and collaboration with PANAFTOSA.

53. PAHO will collaborate in the development of the following specific programs:

TTC:	Technical cooperation among countries
DHS:	Health services development
HME:	Health manpower education
NUT:	Nutrition
CWS:	Community Water Supply and Sanitation
MCH:	Development and human reproduction
VBC:	Vector-borne diseases
NCD:	General noncommunicable disease prevention and control activities
ZNS:	Zoonoses

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		1,599,100	48.9	2,053,300	54.6	2,334,500	54.6
TECHNICAL COOPERATION AMONG COUNTRIES		174,600	5.3	377,600	10.0	438,100	10.3
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	174,600	5.3	377,600	10.0	438,100	10.3
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		1,135,900	34.8	1,351,900	36.0	1,528,800	35.7
HEALTH SERVICES DEVELOPMENT	DHS	1,135,900	34.8	1,351,900	36.0	1,528,800	35.7
HUMAN RESOURCES DEVELOPMENT		288,600	8.8	323,800	8.6	367,600	8.6
HUMAN RESOURCES EDUCATION	HME	288,600	8.8	323,800	8.6	367,600	8.6
III. HEALTH SCIENCE AND TECHNOLOGY		1,669,700	51.1	1,710,800	45.4	1,939,000	45.4
FOOD AND NUTRITION		143,700	4.4	183,300	4.9	208,200	4.9
NUTRITION	NUT	143,700	4.4	183,300	4.9	208,200	4.9
ENVIRONMENTAL HEALTH		378,900	11.6	369,400	9.8	418,100	9.8
COMMUNITY WATER SUPPLY AND SANITATION	CWS	378,900	11.6	369,400	9.8	418,100	9.8
MATERNAL AND CHILD HEALTH		234,600	7.2	271,900	7.2	308,200	7.2
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	234,600	7.2	271,900	7.2	308,200	7.2
COMMUNICABLE DISEASES		192,900	5.9	238,500	6.3	270,600	6.3
VECTOR-BORNE DISEASES	VBC	192,900	5.9	238,500	6.3	270,600	6.3
HEALTH PROMOTION		520,600	15.9	608,400	16.2	688,400	16.1
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	520,600	15.9	608,400	16.2	688,400	16.1

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
VETERINARY PUBLIC HEALTH		199,000	6.1	39,300	1.0	45,500	1.1
ZOONOSES	ZNS	199,000	6.1	39,300	1.0	45,500	1.1
GRAND TOTAL		3,268,800	100.0	3,764,100	100.0	4,273,500	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		612,719	25.4	930,000	29.9	0	-
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		530,292	22.0	930,000	29.9	0	-
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	130,292	5.4	0	-	0	-
REHABILITATION	RHB	400,000	16.6	930,000	29.9	0	-
HUMAN RESOURCES DEVELOPMENT		82,427	3.4	0	-	0	-
HUMAN RESOURCES EDUCATION	HME	82,427	3.4	0	-	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		1,794,638	74.6	2,185,100	70.1	350,000	100.0
ENVIRONMENTAL HEALTH		25,868	1.1	0	-	0	-
COMMUNITY WATER SUPPLY AND SANITATION	CWS	25,868	1.1	0	-	0	-
MATERNAL AND CHILD HEALTH		810,403	33.8	1,245,100	39.9	350,000	100.0
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	810,403	33.8	1,245,100	39.9	350,000	100.0
COMMUNICABLE DISEASES		400,000	16.6	940,000	30.2	0	-
VECTOR-BORNE DISEASES	VBC	400,000	16.6	940,000	30.2	0	-
HEALTH PROMOTION		557,700	23.1	0	-	0	-
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	20,200	.8	0	-	0	-
CANCER	CAN	537,500	22.3	0	-	0	-
VETERINARY PUBLIC HEALTH		667	.*	0	-	0	-
ZOONOSES	ZNS	667	.*	0	-	0	-
GRAND TOTAL		2,407,357	100.0	3,115,100	100.0	350,000	100.0

* LESS THAN .05 PER CENT

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL CONS. MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	711,300	48	24	85	400,300	49,400	0	0	68,700	5,700	0	187,200
WHO - WR	2,557,500	264	72	480	2,074,800	225,400	0	0	112,200	46,700	0	98,400
TOTAL	3,268,800	312	96	565	2,475,100	274,800	0	0	180,900	52,400	0	285,600
% OF TOTAL	100.0				75.8	8.4		.0	5.5	1.6	.0	8.7
1992-1993												
PAHO - PR	995,400	48	24	70	479,000	54,400	0	0	62,800	6,600	0	392,600
WHO - WR	2,768,700	240	72	475	2,287,800	231,200	0	0	123,500	49,400	0	76,800
TOTAL	3,764,100	288	96	545	2,766,800	285,600	0	0	186,300	56,000	0	469,400
% OF TOTAL	100.0				73.5	7.6		.0	4.9	1.5	.0	12.5
1994-1995												
PAHO - PR	1,139,000	48	24	70	539,900	63,100	0	0	72,800	7,700	0	455,500
WHO - WR	3,134,500	240	72	475	2,576,400	268,300	0	0	143,300	57,400	0	89,100
TOTAL	4,273,500	288	96	545	3,116,300	331,400	0	0	216,100	65,100	0	544,600
% OF TOTAL	100.0				72.9	7.8		.0	5.1	1.5	.0	12.7

CHILE

ANALYSIS OF THE HEALTH SITUATION

1. With a population of 13.2 million inhabitants (1990), Chile falls in the middle of the range of population sizes among the countries of the Region. It presents a low growth rate (1.7%); 84% of its population is urban. The population is concentrated in the middle third of the country (where agriculture, fruit growing, and forests predominate), in an area of 4,000 km.^{2} Santiago, the capital, has 40% of the total population. In the country, 29.5% of the population are under 15 years of age and 6.7% are over 65 years old.

2. The health situation is reflected by the health indexes. Life expectancy is 71.7 years (1985-1990). The overall death rate is less than 6%; infant mortality is 17.1%, and the maternal death rate is 0.4%. The indicated rates are for 1989. Chile's indexes are favorable with respect to the health of the population.

3. However, the health sector manifests important deficiencies: low investment in the last decade; insufficient provision of personnel; insufficient equipment; and a declining bed ratio over the last decade (from 3.4 per 1,000 population in 1970 to 2.5 in 1989). In this scenario, the population expressed its dissatisfaction in several surveys, indicating: rejection of the professional consultation, postponement of hospitalization, surgical interventions postponed by several months, and a lack of drugs, among other things. The service personnel (60,000 staff members) also manifest dissatisfaction and low morale because of reductions in pay.

4. The epidemiological situation shows a profile with the characteristics of a developed country along with those of a developing country. In the morbidity structure of the population, high prevalences of communicable diseases (typhoid fever, acute respiratory infections, and diarrhea) are still identified; these coexist with chronic diseases such as hypertension, diabetes mellitus, and rheumatism. With respect to mortality, the principal causes of death are cerebrovascular diseases and malignant tumors which together represent 48% of the total.

5. With respect to AIDS, the country presents a sustained increasing trend in the number of cases, located mainly in groups at risk (homo- and bisexual). There is a control program which is based on prevention of the disease, aimed at the group at risk. There is a system of active epidemiological surveillance for the detection of those infected, with adequate control of blood banks.

6. The health sector consists of a public subsector, the National System of Health Services (SNSS), and a private subsector organized by health insurance companies (ISAPRES).

7. The state sector serves 80% of the population which includes low-income beneficiaries. There are 20.6 million consultations per year with a ratio of 1.6 consultations per inhabitant; expenditures are $1.2 million with a rate of $10.2 per 1,000 population. The prevention and treatment components of the all health programs are executed under this system.

8. Twenty percent of the population with moderate to high income is served by the private subsector which provides 5.6 million medical consultations and receives a total of $442,000 in payment.

9. The SNSS is organized in levels: the normative political central level, the Ministry of Health, the executive level, and 27 autonomous health services distributed around the country. The primary level is the responsibility of the municipalities (330 communities). This level serves 47% with different degrees of coverage and complexity.

10. The state expenditure on health, in 1989, was $22 per beneficiary which represents 3.5% of GDP and 9.5% of the fiscal budget.

National health strategies and plans

11. The social development plan of the democratic government of Chile seeks the reduction of the social inequities among the population as the center of its social policy. Social equity in its different categories, of which health is one, will be oriented especially toward protecting the low-income groups and other population groups that have not achieved adequate progress in the social context, in both the urban and rural areas.

12. Health represents the principal instrument of social justice, according to the surveys carried out. The protection, promotion, and recovery of health should be the responsibility not only of the state, but also of the individual together with the community (social participation).

13. The principal defined strategies are:

13.1 To provide social justice in health with greater access and better quality health care for the entire population.

13.2 To succeed in giving more years of life, decreasing avoidable deaths, and increasing life expectancy for the decade.

13.3 To provide better health over the years so that the population in its various age groups achieves the best level of health possible with the technologies and cultural and socioeconomic levels of the population.

14. The policies defined in the Sectoral Plan which constitute the axis of the programs are:

14.1 To improve access to health at the primary care level, for which the coverage of primary care services will be extended from 103 to all the communities in the country (330), over a period of four years; mechanisms will be established for the participation of community organizations with coordination among the health services and other local organizations; and the populations will be provided with health services in a humane, dignified way. All this will be accomplished in compliance with the concept of regionalization and deconcentration, along with a new municipalization law.

14.2 To resolve the hospital crisis, for which the health services will be strengthened with multilateral and bilateral investment projects and with national sector funds in the amount of US$450 million for the period 1991-1995. This will make it possible to provide the hospitals with equipment adequate for the demands for services, in accordance with their epidemiological profiles. The implementation of a system of administrative management and a system combining information with action at all levels (central, the Ministry, intermediates, the services and peripherals, and the municipalities) will constitute the linkage to the process of national strategic planning.

14.3 To strengthen and extend the programs for prevention and those for the protection of health, for which a program will be developed for mass education focused on the high-risk groups, in order to effect changes in lifestyles in an integrated educational process. Active community participation will be facilitated in this program; programs for investigation and treatment of chronic diseases will be included. All these actions will be sustained in an epidemiological analysis that orients the actions toward priority groups and a national-level training program. In addition, the following programs will be strengthened: the Comprehensive Health Program with the National Women's Service, the National Program for Supplementary Feeding, the National Program for Prevention of Occupational Accidents, the Mental Health Program, the Dental Health Program, and the Rehabilitation Program.

14.4 To improve the quality of the environment, for which programs destined to reduce the degree of environmental pollution in all their areas of coverage in the principal cities, tourist areas, and industrial areas will be implemented.

14.5 To retrieve the normative capacity of the Ministry of Health, improving its management processes, reforming the Health Code, and standardizing the work criteria for remuneration and incentives for health workers at the various levels of the system.

14.6 To integrate the private sector into the system with the creation of the ISAPRES (an organization of health insurance companies), responsible for governing their activities, protecting the user from their restrictions, and adapting them to the sector policies, not only with respect to recovery but also prevention. To develop innovative private health benefits formulas for the middle sectors through the National Health Fund; to contract private benefits for the public beneficiaries. To establish agreements for the creation of joint autonomous hospitals, with the participation of the state and the nonprofit private sector. What is desired is to integrate both subsectors in order to expand the coverage of the beneficiaries and to achieve harmonious competition that offers greater institutional productivity.

15. The priorities for the period are:

15.1 In the short term (1991/1992): to satisfy the most felt needs of the population by means of increasing manpower, a higher sector budget and expenditure on national health, extraordinary investment programs, strengthening and restructuring of the primary care level, and initiation of priority health programs: rural, mental, and adult.

15.2 In the medium term (1992/1994): to fulfill the planned objectives oriented toward continuing to increase the provision of manpower; to launch programs for investments in 18 health services with the cooperation of the IDB, the World Bank, and other Governments; to reform the system of medical choice of the National Health Fund, eliminating the current restrictions; to formulate new laws for the organization of health insurance companies (ISAPRES); to promote preventive medicine in the public sector--to formulate an antismoking law and to facilitate actions for the benefit of the environment, especially with respect to water and air; and to achieve rationalization and modernization of public administration.

16. A special effort will be made to mobilize the resources within the sector, with progressive achievement of recovery of the expenditure on health through greater efficiency in the use of the international resources. The axis of future change in the system will be, not the utilization of traditional structures, but new approaches based on studies of the Chilean situation. The international agencies will have a special role in this task.

17. The health sector begins the 1990s with challenges that involve modernization of the entire SNSS: a significant investment of its physical capacity, its human resources, technology, and the improvement of the mechanisms of management.

GLOBAL STRATEGY OF COOPERATION

18. DEICIN. The global strategy for the next biennium, 1992-1993, should be based on the anticipation of realizing the possible national and international scenarios constructed on the basis of the current socioeconomic situation, the demographic and epidemiological trends, and the possible effects of the interventions on the determinants of the current health situation and those defined by the sociopolitical framework that are outside the control of the health sector. They should also be in accordance with the Strategic Orientations and Programming Priorities of the Organization for the 1991-1994 quadrennium.

19. In a first approximation, one can foresee that the political, social, and economic determinants will remain the predominant factors in the change of the behavior of the health situation, the health institutions, and the availability of resources. The most probable hypothesis assumes that the sectoral resources will increase and, consequently, there will be greater financing available for the national programs, particularly in those dependent on the public sector, and possibly a stabilization of supply in the private sector which experienced a great expansion in the last five years.

20. The Organization should have, as a guide to fulfill its mission, the strategic orientations for the quadrennium, strengthening the weakest aspects of the Ministry of Health, the 27 health services, and the 350 communities in the country. It should anticipate a continuing demand for greater cooperation, to the extent that the health sector overcomes the limitations imposed by the current structure inherited from the past which is contrary to the

decentralization of the health services; there is, however, a definite national policy of decentralization.

21. Training health personnel, because of the continuing policy to expand services and based on a broad policy of investments, is one of the tougher tasks that need support because of the magnitude and quality that the country requires. There will be growing requirements for biomedical information that should be matched with a response from the Organization in quantity, quality, and scope.

22. The demographic and epidemiological trends will be in full transition, generating demands for cooperation in the epidemiology of chronic diseases, care for the elderly, mental health (including drug dependence), prevention, care for accident victims, occupational health, and industrial safety, as well as in the planning and organization of the health services, especially everything related to the local health system strategy--all this added to an urgent need to rescue the environment and struggle for its preservation.

23. A priority area in the coming years is related to international cooperation and the arrival of funds simultaneously from bilateral agreements, the IDB, and the World Bank, which are required to support the country in the most sensitive points of its operation.

24. The current sectoral reorganization is generating a change in the mission and functions of the Ministry; consequently, the political decision in favor of a substantial transformation of the National System of Health Services can require support and exchange of experiences with other countries, necessitating the development of Technical Cooperation among Countries (TCC) on a scale not previously carried out. In this field, it is foreseeable that demands will be created within the Ministry or Parliament for innovative social security systems, based on the evolution of the current system known as ISAPRES (organization of health insurance companies) or for the more efficient use and financing of FONASA (National Health Fund) in the public sector.

25. PAHO will collaborate in the development of the following specific programs:

MPN:	Managerial Support for National Health Development
TCC:	Technical Cooperation among Countries
DHS:	Health Services Development
ORH:	Oral Health
RHB:	Rehabilitation
HME:	Health Manpower Education
CEH:	Control of Enfironmental Health Hazards
MCH:	Growth, Development and Human Reproduction
OCD:	General Communicable Disease Prevention and Control Activities
NCD:	Health Promotion and Prevention and Control of Noncommunicable Diseases
CAN:	Cancer

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		1,395,800	70.8	1,740,600	81.6	1,981,500	81.3
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		436,900	22.1	722,300	33.8	824,500	33.8
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	436,900	22.1	722,300	33.8	824,500	33.8
TECHNICAL COOPERATION AMONG COUNTRIES		0	-	23,200	1.1	26,900	1.1
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	0	-	23,200	1.1	26,900	1.1
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		533,900	27.0	745,400	35.0	844,700	34.7
HEALTH SERVICES DEVELOPMENT	DHS	371,000	18.8	641,000	30.1	723,500	29.7
ORAL HEALTH	ORH	0	-	69,600	3.3	80,800	3.3
CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY	CLR	79,400	4.0	0	-	0	-
REHABILITATION	RHB	83,500	4.2	34,800	1.6	40,400	1.7
HUMAN RESOURCES DEVELOPMENT		306,600	15.6	249,700	11.7	285,400	11.7
HUMAN RESOURCES EDUCATION	HME	306,600	15.6	249,700	11.7	285,400	11.7
HEALTH INFORMATION SUPPORT		28,600	1.5	0	-	0	-
SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION	HBD	28,600	1.5	0	-	0	-
RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT		89,800	4.6	0	-	0	-
RESEARCH PROMOTION AND DEVELOPMENT	RPD	89,800	4.6	0	-	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		572,400	29.2	392,400	18.4	453,200	18.7
ENVIRONMENTAL HEALTH		91,300	4.7	139,200	6.5	161,600	6.6
COMMUNITY WATER SUPPLY AND SANITATION	CWS	16,900	.9	0	-	0	-
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	74,400	3.8	139,200	6.5	161,600	6.6

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
MATERNAL AND CHILD HEALTH		170,100	8.7	58,000	2.7	67,300	2.8
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	101,400	5.2	58,000	2.7	67,300	2.8
ADOLESCENT HEALTH	ADH	68,700	3.5	0	-	0	-
COMMUNICABLE DISEASES		201,000	10.2	58,000	2.7	67,300	2.8
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	201,000	10.2	58,000	2.7	67,300	2.8
HEALTH PROMOTION		110,000	5.6	137,200	6.5	157,000	6.5
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	92,800	4.7	80,200	3.8	91,900	3.8
TOBACCO OR HEALTH	TOH	17,200	.9	0	-	0	-
CANCER	CAN	0	-	57,000	2.7	65,100	2.7
GRAND TOTAL		1,968,200	100.0	2,133,000	100.0	2,434,700	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
III. HEALTH SCIENCE AND TECHNOLOGY		668,500	100.0	214,700	100.0	0	100.0
COMMUNICABLE DISEASES		668,500	100.0	214,700	100.0	0	100.0
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	166,681	24.9	0	-	0	100.0
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	501,819	75.1	214,700	100.0	0	-
GRAND TOTAL		668,500	100.0	214,700	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	1,273,700	24	48	620	464,900	6,800	65	123,500	279,400	181,200	67,200	150,700
WHO - WR	694,500	0	0	680	172,100	0	102	193,800	108,500	154,200	29,000	36,900
TOTAL	1,968,200	24	48	1300	637,000	6,800	167	317,300	387,900	335,400	96,200	187,600
% OF TOTAL	100.0				32.5	.3		16.1	19.7	17.0	4.9	9.5
1992-1993												
PAHO - PR	1,242,300	24	48	0	389,100	13,900	10	20,000	263,400	106,800	0	449,100
WHO - WR	890,700	24	0	445	323,400	13,900	20	40,000	82,100	193,700	0	237,600
TOTAL	2,133,000	48	48	445	712,500	27,800	30	60,000	345,500	300,500	0	686,700
% OF TOTAL	100.0				33.4	1.3		2.8	16.2	14.1	.0	32.2
1994-1995												
PAHO - PR	1,425,800	24	48	0	437,900	16,200	10	21,000	305,500	123,900	0	521,300
WHO - WR	1,008,900	24	0	445	354,900	16,200	20	42,000	95,300	224,800	0	275,700
TOTAL	2,434,700	48	48	445	792,800	32,400	30	63,000	400,800	348,700	0	797,000
% OF TOTAL	100.0				32.6	1.3		2.6	16.5	14.3	.0	32.7

ANALYSIS OF THE HEALTH SITUATION

1. In 1990, Colombia, with a population of 32,978,187, was faced with profound political, social, and economic changes that will directly affect its development in the current decade. At the end of the second four-month period, the new political regime, which will govern the country for a quadrennium, introduced a reorganization and a democratic form of government.

2. On 9 December, representatives of the Colombian people to serve in the National Assembly that will reform the Constitution were elected by popular vote. This has created a climate of high expectations, since the reform will attempt to resolve most of the political and social problems that are currently holding back the country's development.

3. Significant steps are being taken in Colombia to reach the targets of Health for All, including promulgation of Law 10 of 1990 and its regulatory decrees. Still, the health sector, which spends 7% of the GDP, has a number of problems. These may be summarized as follows:

3.1 Low health care coverage, especially at the first level.
3.2 Health services focused on curative actions, with little preventive care and health promotion.
3.3 Largely individualized care, with only haphazard efforts to reach the family and the community.
3.4 No articulation between personal health care and environmental services.
3.5 Only limited citizen participation in management and control of the health services.
3.6 Little coordination between the different sectors that contribute to the population's state of health.
3.7 Inefficiency in the management of public resources, resulting in excessive cost of the services.
3.8 Inadequate coordination and complementarity between public institutions and those concerned with social security and welfare.
3.9 Persistence of diseases that can be prevented and controlled.

4. Between 1981 and 1986, general mortality declined from 6.3 to 5.6 per 1,000 population. In that last year, infant mortality was 41.1 per 1,000 live births, maternal mortality was 1.0 per 1,000 live births, and mortality in the population aged 60 and over was 39.5 per 1,000 population. The pattern of infant mortality exhibits marked differences between the different regions. For example, in the Pacific region the rate is twice as high as in Bogotá.

5. In 1986, enteritis and other diarrheal diseases were the leading causes of death in the population 1-4 years old, representing 16.6% of the deaths from defined causes in that age group, followed by pneumonia, corresponding to 12.1% of the deaths. Accidents caused by submersion, suffocation, and foreign bodies were in third place, accounting for 6.9% of deaths from defined causes, and protein-calorie and unspecified malnutrition ranked fourth, with 6.5%. There were 8,980 deaths in this age group, and 7.7% were due to signs, symptoms, and ill-defined conditions.

6. In the 5-14 age group, motor vehicle accidents; accidents caused by submersion, suffocation, and foreign bodies; and "other accidents" were the leading causes of death in 1986, accounting for 12.4%, 7.9%, and 5.8%, respectively, of the deaths from defined causes. Next in importance came leukemia, for 5.3% of the deaths; then pneumonia, 4.7%; and homicide and injury purposely inflicted by other persons, with 4.2%. A total of 3,795 deaths were registered in this age group, 6.3% of them due to ill-defined causes.

7. In the 60-and-over age group, the leading causes of death in 1986 were diseases associated with the circulatory system, which corresponded to 45.8% of all deaths from defined causes: 13.6% due to acute myocardial infarction, 12.7% due to diseases of pulmonary circulation and other forms of heart disease, 12.0% due to cerebrovascular disease, 4.7% due to hypertensive disease, and 2.8% by ischemic heart disease. Of the registered deaths, 63,059 were due to defined causes and another 3,085 were assigned to symptoms and ill-defined conditions.

8. Morbidity treated in hospitals followed basically the same distribution of causes in the population as a whole, between 1981 and 1986. After hospitalization for normal deliveries, abortion was the leading cause in 1981 and 1986, followed (in 1986) by complications occurring mainly in the course of labor and delivery, followed in turn by complications mainly related to pregnancy. The trend for enteritis and other diarrheal diseases declined, going from third place in 1981 to sixth in 1986.

9. Approximately half of all deliveries take place in institutions at various levels of complexity without regard for the type of risk. The leading cause of hospitalization, including high-technology institutions, is normal delivery (23.7%), despite that a risk-based maternal care model is in place.

10. In the last five years, dengue (all four serotypes) has been affecting the populations on the Atlantic and Pacific Coast and the basins of the Middle and Lower Cauca and Magdalena, where 15 million people reside. The situation is cause for concern, since spraying coverage is low and there are high levels of Aedes aegypti infestation in the principal urban centers in these regions.

11. In summary, an analysis of the health situation just described shows that the health problems resulting from poor environmental conditions, which affect the infant population above all, such as infectious and parasitic diseases and respiratory diseases, will continue to prevail unless and until basic service coverage is improved, environmental pollution is controlled, and the service delivery is expanded.

12. Although there is a program for maternal and child care, its actions have not yet been translated into a sizable reduction in perinatal diseases and complications of pregnancy, delivery, and the puerperium, nor has there been any

improvement in the quality and streamlining of care at different levels, based on the classification of risks.

13. Despite the coverage achieved with vaccination in recent years, there is still a high incidence of diseases preventable by vaccination, which indicate a need to strengthen ongoing activities in the regular programs and in epidemiological surveillance, which are responsible for the control and eradication of some of them.

14. Since the high levels of malnutrition that afflict the infant population have been a triggering and an aggravating factor for many of the health problems, it is essential that the health sector foster favorable conditions for case-finding, food supplementation, education, nutritional surveillance, and food conservation and hygiene.

15. Outside the jurisdiction of the Ministry of Health, there is the program for the eradication of foot-and-mouth disease, which at the end of the last decade began to use a strategy based on ecosystems--a methodology developed by the Pan American Foot-and-Mouth Disease Center/HPV and the countries.

16. The health policy seeks to solve these problems through actions that give special importance to prevention and social co-action. This needs to be translated into efforts to increase efficiency in the management and use of national health resources in a way that will guarantee the extension of health service coverage by giving priority to universal access to services at the primary level.

17. On this basis, a series of strategies are proposed for development, within the Four-Year Plan, of a health culture based on community participation and co-action. These are:

17.1 A healthy family in a healthy environment: a comprehensive primary health care strategy focused on the organization and mobilization of resources in the community, at the municipal level, in the public sector, and elsewhere, in order to prevent disease, promote health, and deal with relatively uncomplicated illnesses.

17.2 Unification of the health care system and the universal public insurance system: steps to ensure that the two systems offer services of similar quality and accessibility to all Colombians through the application of effective principles of social security, and reorganization of the tasks currently being done by the public and private institutions that are involved in health service delivery.

17.3 Decentralization and municipalization of health care and the corresponding risk factors: promotion of transfer of responsibility to the municipios for safeguarding health, delivering services, and developing the capacity to take on this responsibility.

17.4 Efficient management in health care institutions: strengthening of their capacity for efficient and effective management at all levels.

17.5 Optimization of the hospital infrastructure and impetus for the production of equipment: strengthening and optimization of the existing hospital infrastructure, strengthening of the services network, decentralization of equipment maintenance, and promotion of the production of equipment.

17.6 Rationalization of the production and distribution of drugs and health inputs in order to guarantee quality and reduce costs: restructuring of the pharmaceutical market in light of health needs, guarantee of the availability of essential drugs, and integration of alternative medicine into the health system.

17.7 Improvement of the quality of the municipal drinking water and sanitation services through administrative decentralization in these areas, expansion of community participation, and expansion of coverage in terms of quality and continuity.

17.8 Promotion of a restructuring of the process and the profiles for professional training and research at all levels: encouragement of new curriculum models for the training of health personnel that lead to development of a preventive scheme, raise the quality of primary care, and strengthen the capacity to conduct research in different areas of human knowledge.

17.9 Financial strengthening through the design and implementation of financial mechanisms that guarantee the delivery of services to all, and at the same time ensure efficient allocation of all the sector's resources.

17.10 Control and surveillance: enhancement of effective control and surveillance mechanisms in the health sector, and unification and centralization of policies, criteria, and instruments for achieving efficiency and transparent management of resources.

GLOBAL STRATEGY OF COOPERATION

18. Pursuant to Resolution XIII of the XXIII Pan American Sanitary Conference, a preliminary version of the document "Estrategias y Líneas de Acción para el Plan Cuadrienal de Salud (1990-1994)" [Strategies and Lines of Action for the Four-Year Health Plan], together with an analysis of the national health situation, has been prepared by the national authorities, and the following global strategy for technical cooperation has been decided on:

18.1 Support for the national health authority in obtaining due recognition of health within national development policies, as well as adequate participation in the implementation thereof.

18.2 Promotion of processes that contribute to improved knowledge of the epidemiological situation, with emphasis on the local level, for the adaptation of intervention strategies. In terms of risk factors, especially as they apply to priority population groups in unfavorable environmental conditions, methodologies applicable to the groups cited will be developed, adapted, and implemented. For this purpose, priority will be given to technical cooperation in the seven large cities of the country: Bogotá, Cali, Medellín, Manizales,

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18.3 Orientation of resources and efforts toward the strengthening of managerial and administrative capacity in the various service-provider units, in order to unify the national health system based on the principle of decentralization being promoted by the national government.

18.4 Promotion and support of efforts to articulate the primary care services offered by the sector's institutions at the national and local levels, with a view to enhancing the benefits they provide by applying principles of equity, coverage, efficiency, and effectiveness.

18.5 Continued encouragement of actions that fulfill national policies for health promotion through the utilization and mobilization of national resources, both technological and social, as elements basic to community participation, coupled with the identification and execution of activities geared to the full integration of women into the health and development process.

18.6 Full support for direct technical cooperation between Colombia and other countries based both on initiatives of countries in the Region and on national contributions.

18.7 Promotion of interagency cooperation for optimizing resources and strengthening the work of national authorities.

19. PAHO will collaborate in development of the following specific programs:

MPN: Managerial Support for National Health Development
TCC: Technical Cooperation among Countries
HST: Health Situation and Trend Assessment
DHS: Health Services Development
CWS: Community Water Supply and Sanitation
MCH: Growth, Development, and Human Reproduction
OCD: General Communicable Disease Prevention and Control Activities
NCD: Health Promotion and Prevention and Control of Noncommunicable Diseases
ZNS: Zoonoses.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		2,158,500	69.0	2,401,000	65.2	2,727,100	65.2
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		695,300	22.2	866,300	23.5	999,900	23.9
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	695,300	22.2	866,300	23.5	999,900	23.9
TECHNICAL COOPERATION AMONG COUNTRIES		76,500	2.4	88,700	2.4	103,000	2.5
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	76,500	2.4	88,700	2.4	103,000	2.5
HEALTH SITUATION AND TREND ASSESSMENT		155,700	5.0	379,800	10.3	432,300	10.3
HEALTH SITUATION AND TREND ASSESSMENT	HST	155,700	5.0	379,800	10.3	432,300	10.3
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		1,231,000	39.4	1,011,500	27.5	1,131,900	27.1
HEALTH SERVICES DEVELOPMENT	DHS	1,231,000	39.4	1,011,500	27.5	1,131,900	27.1
HUMAN RESOURCES DEVELOPMENT		0	-	54,700	1.5	60,000	1.4
HUMAN RESOURCES EDUCATION	HME	0	-	54,700	1.5	60,000	1.4
III. HEALTH SCIENCE AND TECHNOLOGY		969,200	31.0	1,281,100	34.8	1,460,800	34.8
ENVIRONMENTAL HEALTH		327,700	10.5	428,500	11.6	487,100	11.6
COMMUNITY WATER SUPPLY AND SANITATION	CWS	327,700	10.5	428,500	11.6	487,100	11.6
MATERNAL AND CHILD HEALTH		65,000	2.1	74,200	2.0	84,700	2.0
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	65,000	2.1	74,200	2.0	84,700	2.0
COMMUNICABLE DISEASES		204,800	6.5	215,800	5.9	248,000	5.9
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	204,800	6.5	215,800	5.9	248,000	5.9

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
HEALTH PROMOTION		260,600	8.3	437,600	11.9	500,100	11.9
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	260,600	8.3	437,600	11.9	500,100	11.9
VETERINARY PUBLIC HEALTH		111,100	3.6	125,000	3.4	140,900	3.4
ZOONOSES	ZNS	111,100	3.6	125,000	3.4	140,900	3.4
GRAND TOTAL		3,127,700	100.0	3,682,100	100.0	4,187,900	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		173,518	12.6	0	-	0	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		169,918	12.3	0	-	0	100.0
ESSENTIAL DRUGS AND VACCINES	EDV	169,500	12.3	0	-	0	100.0
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	418	.*	0	-	0	-
HEALTH INFORMATION SUPPORT		3,600	.3	0	-	0	-
SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION	HBD	3,600	.3	0	-	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		1,207,059	87.4	190,376	100.0	0	-
ENVIRONMENTAL HEALTH		234,788	17.0	0	-	0	-
COMMUNITY WATER SUPPLY AND SANITATION	CWS	234,788	17.0	0	-	0	-
MATERNAL AND CHILD HEALTH		600,079	43.4	20,876	11.0	0	-
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	600,079	43.4	20,876	11.0	0	-
COMMUNICABLE DISEASES		332,240	24.1	169,500	89.0	0	-
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	37,480	2.7	0	-	0	-
TUBERCULOSIS	TUB	5,352	.4	0	-	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	289,408	21.0	169,500	89.0	0	-
VETERINARY PUBLIC HEALTH		39,952	2.9	0	-	0	-
ZOONOSES	ZNS	39,952	2.9	0	-	0	-
GRAND TOTAL		1,380,577	100.0	190,376	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	1,594,600	72	96	285	677,100	36,600	20	38,000	80,200	157,900	181,500	423,300
WHO - WR	1,533,100	72	24	300	527,300	55,000	100	190,000	438,300	89,100	21,700	211,700
TOTAL	3,127,700	144	120	585	1,204,400	91,600	120	228,000	518,500	247,000	203,200	635,000
% OF TOTAL	100.0				38.5	2.9		7.3	16.6	7.9	6.5	20.3
1992-1993												
PAHO - PR	1,556,700	50	96	260	589,000	63,700	5	10,000	81,200	179,800	0	533,000
WHO - WR	2,125,400	72	24	250	747,300	93,400	106	212,000	511,200	112,600	0	448,900
TOTAL	3,682,100	122	120	510	1,436,300	157,100	111	222,000	592,400	292,400	0	981,900
% OF TOTAL	100.0				39.0	4.3		6.0	16.1	7.9	.0	26.7
1994-1995												
PAHO - PR	1,766,900	48	96	260	761,100	73,900	5	10,500	94,200	208,600	0	618,600
WHO - WR	2,421,000	72	24	250	845,400	108,400	106	222,600	593,100	130,800	0	520,700
TOTAL	4,187,900	120	120	510	1,606,500	182,300	111	233,100	687,300	339,400	0	1,139,300
% OF TOTAL	100.0				38.3	4.4		5.6	16.4	8.1	.0	27.2

COSTA RICA

ANALYSIS OF THE HEALTH SITUATION

1. The population in 1987 was 2,790,634 and in 1988, 2,865,815; 45% live in urban areas and 55% in rural areas. Currently, its natural growth rate is 2.5%. The fertility rate has tended to decline in recent years; it went from 119 per 1,000 in 1984 to 109 in 1988. The declines in the birth and mortality rates are leading to the continuous aging of the population. The proportion under 15 years of age went from 45.7% in 1970 to 36.5% in 1988, while the population over 50 years of age increased from 10% to 12% in that same period.

2. The overall death rate went from 6.6 per 1,000 inhabitants in 1970 to 3.8 in 1988, and infant mortality, 61.5 per 1,000 in 1970, declined to 17.4 in 1987 and 14.7 in 1988. The infectious and parasitic diseases went, in that same period, from first to eighth place as a cause of death, and their rate, from 14 to 1.4 per 10,000. Because of these reductions, life expectancy at birth is estimated at 74.3 years for the period 1985 to 1990.

3. The health situation has experienced important modifications, with a constant increase in morbidity and mortality due to diseases characteristic of adults and the elderly. Cardiovascular diseases have been in first place as causes of death since 1970, and of them, 50% correspond to ischemic heart disease and 25% to cerebrovascular accidents. The risk factors associated with the development of these conditions have become more prevalent, among them, hyperlipoproteinemia, arterial hypertension, smoking, diabetes mellitus, and obesity. The death rate in myocardial infarction, currently responsible for 10% of the deaths in the population over 15 years of age, increased from 23.9 per 100,000 in 1970 to 34.9 in 1985, but then declined, reaching 28.2 in 1987. Second place is now occupied by tumors, with a rate of 7.9 per 10,000 in 1987. In 1986, 25% of the deaths from tumors and 6% of those over 15 years of age were caused by cancer of stomach, which occurs most frequently. Third place among the causes of death is occupied by external causes, trauma and poisoning, with a rate of 4.0 per 10,000. The growing weight of immaturity and certain diseases of the newborn and of congenital origen are manifested by their rise to fourth and fifth places, respectively.

4. The enormous reduction in infant mortality between 1970 and 1980 (from 61.5 to 19.1 per 1,000) was slowed drastically between 1980 and 1985 (to 17.6); it especially affected its neonatal component, which during this period maintained a stable rate of 11.2 per 1,000 and then declined again, reaching 9.3 in 1988. Perinatal mortality has gained great importance, with a rate of 16.9 per 1,000 births in 1987.

5. The reduction of the death rate of children, from one to four years old, went from 5.1 to 1.0 per 1,000 between 1970 and 1980, but slowed thereafter; their mortality was 0.8 per 1,000 in 1987 and 1988.

6. The proportion of all deaths due to deaths in children under five, traditionally associated with a high prevalence of undernutrition and poor sanitary conditions, went from 41% in 1970 to 17% in 1980, then barely declined, to 16% in 1985; it was 13.3% in 1988.

7. Mortality of children under five and that due to communicable diseases have had similar evolutions. Their rates and their participation in mortality declined progressively from 1970 to 1980, and then decreased significantly.

8. The behavior of mortality in the population from five to 14 years of age differs from the rest, since that is the only group whose rate has been reduced markedly and without interruption since 1970. In 1988, this rate was 2.7 per 10,000.

9. Maternal mortality which, like that of children, had been reduced notably between 1970 and 1980 (from 1.0 to 0.2 per 1,000 births) has been maintained around this figure since then, with slight oscillations. Since 1970, abortion has remained as one of the principal causes of death of this population group. In 1987, the principal cause of maternal mortality was obstetrical pulmonary embolism.

10. The most important achievements in the control of communicable diseases have been registered in the area of those reducible by vaccination; their incidence has been reduced notably in the last two decades; there have been no registered cases of poliomyelitis or diphtheria since 1973 and 1975, respectively.

11. Although a significant decline in several waterborne diseases has been effected, an increase is observed in others, such as viral hepatitis, which occurs at a rate of 149.48 cases per 100,000 population, and which demonstrates the need for supplementing the extension of coverage with an improvement in the quality of the water and the continuity of the service.

12. The vector-borne diseases, whose incidence was low until 1982, have been increasing progressively since 1983. Among them, the greatest problem is the risk of increase and dispersion of the cases of malaria, which in 1987 rose to 883 and in 988 to 1,116, with a rate of 36 per 10,000 inhabitants. An additional effort has also been required to maintain the national territory free from Aedes aegypti, due to the discovery on several occasions of some larvae, possibly imported in used materials.

13. Another disease that threatens the country with its growth is AIDS, of which there were 53 cases registered in 1988, among them the first from transmission from mother to child and the first in intravenous drug users.

14. Between the first and second five-year periods of the current decade, potable water service was extended from 84% to 93%; in the urban area, the percentage of coverage was maintained at 100%, while in the rural it was increased from 69% to 82%.

15. For the disposal of excreta, 100% of the urban population and 88% of the rural had sanitary sewerage, septic tanks, or sanitary latrines, which represents an increase in overall coverage over that of 1980, from 87% to 95%.

16. It is estimated that more than 1.5 million kg of refuse are produced in the country daily, of which 60% corresponds to urban localities and 40% to rural communities; 16% is collected regularly, but its final disposal is inadequate and 54% is not collected and is accumulated indiscriminately.

17. With respect to the aspects of animal health that affect public health, it should be noted that in Costa Rica no cases of canine rabies have appeared since 1980 and no human rabies since 1970.

18. The Ministry of Health is responsible for the promotion of health, preventive actions, and care of the environment. The Costa Rican Social Security Fund (CCSS) is responsible for the recovery of health and rehabilitation; it helps in the preventive and promotional activities of the Ministry of Health. The National Insurance Institute (INS) bears responsibilty for the care, rehabilitation, and indemnity of individuals covered by policies for professional risks and compulsory automobile insurance, and the Costa Rican Institute of Water Supply and Sewerage Systems (ICAA) for provision of potable water and sewerage services. The universities and technical schools, responsible for the training of human resources, also participate in the integration of one of the management agencies of the sector.

19. In 1987, there were 313,871 hospital discharges. Of them, the hospitals of the public sector, under the CCSS, accounted for 96.3% of the stays, and all the others, 3.7%, with a rate of 112 discharges per 1,000 population and an average stay of 6 days, with variations from 10 days in medicine to 2.2 days in obstetrics.

20. In 1987, 72% of the consultations were provided by the CCSS, 10% by private services, 8% by the Ministry of Health, 6% by company services, 3% by the INS, and 1% by mixed medicine.

21. The principal sources of financing for the health sector are: the national budget, taxes from the state, employers and workers in social security, collections for services, contributions, income from the national lottery, and various other sources.

22. The health sector had 28,130 staff members in 1987, in three of its principal institutions: the CCSS, with 71% of this personnel, the Ministry of Health with 23.6%, and the INS with 1.3%. Of the employees of the CCSS and the Ministry of Health, 37.9% were found at the central level, with a greater proportion in social security (42.2%) than in the Ministry (22.6%).

National strategies and plans

23. The institutions of the Sector have been organized and function on the basis of criteria for regionalization and sectorialization, in order to concentrate the highly specialized services and decentralize the basic ones, according to need and in a coordinated manner. The Ministry of Health is responsible for promotion and prevention related to health and for the care of the environment; the Costa Rican Social Security Fund (CCSS) for the recovery of health and rehabilitation, and it helps in the prevention and promotion activities of the Ministry of Health; the National Insurance Institute (INS) for the care, rehabilitation, and indemnity of individuals covered by occupational hazard and compulsory automotive insurance policies; and the Costa Rican Institute of Water Supply and Sewerage Systems (ICAA) for the provision of potable water and sewerage services. The universities and technical schools responsible for the training of human resources, also participate in the integration of one of the management agencies in the sector.

24. The health policies of the decade were oriented toward the achievement of universal coverage, through two basic strategies: universalization of social security and the extension of coverage of services, especially to the scattered rural and marginal urban populations, preferably utilizing the primary care approach. The development of the health sector, through the application of the systems theory, has been defined as a political and technical necessity. It involves integration of the institutions of the sector, which, without losing their legal identity nor their administrative autonomy, should accept the uniformity of the technical and administrative procedures in the aspects that require it. The health services, intersectoral activities, social participation, and institutional development will be based on the strategy and approaches of local health systems.

25. The evolution sustained in the social realm, in the last four decades, has permitted Costa Rica to maintain and indeed improve its health conditions, even in times of economic difficulties. However, the policies that have oriented the processes that produced the ordered development in health have been formulated as they were needed without prior exhaustive analysis, since they were maintained within a framework of overall development of the country which did not suffer fundamental alterations.

26. At present, because of the new development models that require structural changes in the country's institutions, an evaluation of the policies of the sector and future approaches consonant with the new scenario becomes indispensable. In order to initiate this process formally, a II National Forum on Health and Development is proposed.

27. In response to the requirements of the Plan for Reform of the State and through the actual evolution of the institutions that comprise the health sector, the functional articulation of the sector under the supervision of the Ministry of Health is proposed, conceptualizing its articulation according to systems theory.

28. This strategy bases its viability on:

28.1 The proposals contained in the 1990-1994 Government Plan;

28.2 The political decision and steps stated by the Ministry of Health in defining the structure and relationships of the sector and the initiation of the adaptation of its own organization as a result;

28.3 The proposal by the CCSS to proceed in the application of the concept of social security and the actions taken to coordinate with the Ministry of Health by means of the local programming in relation to the formation of the local health systems; and

28.4 The progress achieved in the conceptualization by the Ministry of Health and the CCSS of integrated health systems and local programming and the current efforts to confer on those projects the necessary capacity for technical resolution.

GLOBAL STRATEGY OF COOPERATION

29. In Costa Rica, the application of the strategy known as Health in Development has already been initiated, through the support given to the preparation, development, and follow-up of the II Forum National Health and Development. During the 1992-1993 biennium, PAHO will continue to assign a high priority to the development of this strategy, in which the health sector, under the supervision of the Ministry of Health, assumes the responsibility for leadership in regard to the definition and construction of the model of social and economic development. This strategic line of cooperation requires a prolonged sustained effort from PAHO/WHO, and provides a motive for the formulation of a specific project of cooperation.

30. In the 1992-93 biennium, application of the strategic orientation of reorganization of the health sector will also continue. In Costa Rica, this should take the form of functional articulation, under the supervision of the Ministry of Health, with the definition and application of common programming between the Ministry and the Costa Rican Social Security Fund, and advances toward the establishment of integrated health systems.

31. In recent decades, Costa Rica has implemented a process of extension of coverage of medical, economic, and social benefits through the CCSS. At present, the country proposes a significant qualitative leap in indicating the need to pass from the traditional focus on disease and maternity, and on disability, old age, and death to focusing on health promotion, social development, and economic security. This policy indicates the transition toward social security, a feasible, viable process in this country whenever the institution and its framework of policies, legal and administrative, undergo the necessary reforms. It is on this point that it will be necessary to center the efforts of our cooperation for the moment.

32. The participation of the Organization in this strategic line is conceived in three categories; the first, support for the national decision; the second, extension of the experience to the region; and the third, a process of research and learning for the Secretariat itself.

33. Support for the Government in the development of the health of the human environment constitutes another strategic line of technical cooperation for PAHO/WHO in the country.

34. The strategy in this field consists of supporting two lines of action. The first is aimed at supporting the formulation, negotiation, and execution of specific projects for the national solution of the problems of solid wastes, wastewater, and the contamination of the rivers with industrial wastes and the use and control of pesticides with contamination from fixed and mobile sources. The second is directed toward the creation of a system of surveillance and action in the human environment that makes it possible to unite the national resources in a coordinated operation through an intelligence center that, applying the epidemiological method, acts on emerging risk factors, utilizing already existing independent groups of excellence.

35. The impact produced by the achievement of the political objectives of the Plan for Priority Health Needs in Central America (PPS/CAP), the progress in the peace processes in the subregion, and the characteristics of the development of Costa Rica make it possible to propose subregional projects that allow, not only taking advantage of the experience and the local infrastructure in specific technical fields, but also utilizing the country as an educational community that facilitates the practice and the analysis of what was learned under conditions of relative stability and peace. New subregional projects considered possible are in the areas of: i) health policies and legislation; ii) new models of health care and of financing the health services; iii) perinatology; iv) control of losses and leaks in water supply systems; v) safety and energy saving in the maintenance programs for health establishments; and vi) control of pesticides and other agricultural chemicals as it pertains to the environment, occupational safety, and the impact on the health of the family.

36. The development of the PAHO/WHO Representation in Costa Rica will continue to be framed in the orientations, priorities, and policies of the Organization, and will be aimed at giving the most effective and efficient possible response to the aforementioned points.

37. Its political function will be developed in order to support the articulation of the health sector, thus strengthening the leadership of the Ministry of Health and facilitating the mobilization of the multiple but scattered national resources in all the branches of health, in accordance with national priorities and future expectations.

38. With regard to its scientific and technical function, there should be promotion and support for the development of the areas in which the country has already reached levels of excellence, with contributions toward progress that induce still further evolution in these areas; the programmatic interrelationship of the resources of the Organization will be improved, as will coordination in the execution of the projects of cooperation.

39. For this, it is important to achieve a profile of the Representation consonant with the needs for cooperation, a profile that should be continuously amended, making use of the Organization's resources and expeditious mobilization of local resources. This is the area where the greatest effort should be made within this line of action.

40. The administrative function should proceed with the development of flexible integrated subsystems utilized by sufficiently trained and motivated personnel. In addition, emphasis should be placed on the participation of the consultants in the administrative processes indispensable in carrying out the responsibilities of the Representation, in all the stages of the delivery of cooperation.

41. It is important to have the support of collaboration among the Country Representative Offices, and to continue working with the Headquarters in the improvement of the administrative procedures and methods.

42. The Representation should, as a whole, identify and mobilize financial resources in order to support the national priorities.

43. Every project will explore potential sources as a part of its task of cooperation, and, under the coordination of the PAHO/WHO Representative (PWR) and with the approval of the Director, agreements will be reached.

44. The PWR should promote this strategy with the consultants in Costa Rica. It should also expand and deepen the relations with agencies, embassies, and nongovernmental organizations, to the same end. In addition, it will provide special attention to the possibilities of self-financing of priority programs by the institutions of the sector, by means of subsidies to the Organization.

45. PAHO will collaborate in the development of the following specific programs:

MPN:	Managerial Support for National Health Development
TCC:	Technical Cooperation among Countries
HST:	Health Situation and Trend Assessment
DHS:	Health Services Development
HME:	Health Manpower Education
CWS:	Community Water Supply and Sanitation
MCH:	Growth, Development and Human Reproduction
OCD:	General Communicalbe disease Prevention and Control Activities
NCD:	Health Promotion and Prevention and Control of Noncommunicable Diseases
ZNS:	Zoonoses

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		1,495,300	69.9	1,670,900	71.4	1,893,200	71.2
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		525,000	24.5	649,700	27.7	741,600	27.8
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	525,000	24.5	649,700	27.7	741,600	27.8
TECHNICAL COOPERATION AMONG COUNTRIES		45,800	2.1	53,100	2.3	61,600	2.3
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	45,800	2.1	53,100	2.3	61,600	2.3
HEALTH SITUATION AND TREND ASSESSMENT		169,400	7.9	202,900	8.7	230,700	8.7
HEALTH SITUATION AND TREND ASSESSMENT	HST	169,400	7.9	202,900	8.7	230,700	8.7
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		560,000	26.3	589,600	25.2	665,700	25.1
HEALTH SERVICES DEVELOPMENT	DHS	560,000	26.3	589,600	25.2	665,700	25.1
HUMAN RESOURCES DEVELOPMENT		195,100	9.1	175,600	7.5	193,600	7.3
HUMAN RESOURCES EDUCATION	HRE	195,100	9.1	175,600	7.5	193,600	7.3
III. HEALTH SCIENCE AND TECHNOLOGY		647,600	30.1	671,100	28.6	762,100	28.8
ENVIRONMENTAL HEALTH		253,100	11.8	266,900	11.4	304,400	11.5
COMMUNITY WATER SUPPLY AND SANITATION	CWS	253,100	11.8	266,900	11.4	304,400	11.5
MATERNAL AND CHILD HEALTH		240,700	11.2	255,000	10.9	289,100	10.9
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	240,700	11.2	255,000	10.9	289,100	10.9
COMMUNICABLE DISEASES		26,400	1.2	26,000	1.1	28,800	1.1
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	26,400	1.2	26,000	1.1	28,800	1.1

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
HEALTH PROMOTION		99,200	4.6	94,800	4.0	108,400	4.1
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	99,200	4.6	94,800	4.0	108,400	4.1
VETERINARY PUBLIC HEALTH		28,200	1.3	28,400	1.2	31,400	1.2
ZOONOSES	ZNS	28,200	1.3	28,400	1.2	31,400	1.2
GRAND TOTAL		2,142,900	100.0	2,342,000	100.0	2,655,300	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		2,230,410	62.4	1,032,082	83.9	0	100.0
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		198,942	5.6	144,963	11.8	0	100.0
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	198,942	5.6	144,963	11.8	0	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		2,031,468	56.8	887,119	72.1	0	-
HEALTH SERVICES DEVELOPMENT	DHS	349,609	9.8	287,119	23.3	0	-
ESSENTIAL DRUGS AND VACCINES	EDV	1,330,123	37.1	600,000	48.8	0	-
ORAL HEALTH	ORH	195,744	5.5	0	-	0	-
DISASTER PREPAREDNESS	DPP	155,992	4.4	0	-	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		1,342,200	37.6	198,650	16.1	0	-
ENVIRONMENTAL HEALTH		57,418	1.6	0	-	0	-
COMMUNITY WATER SUPPLY AND SANITATION	CWS	57,418	1.6	0	-	0	-
MATERNAL AND CHILD HEALTH		8,790	.2	0	-	0	-
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	8,790	.2	0	-	0	-
COMMUNICABLE DISEASES		1,275,992	35.8	198,650	16.1	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	566,508	15.9	98,650	8.0	0	-
MALARIA	MAL	709,484	19.9	100,000	8.1	0	-
GRAND TOTAL		3,572,610	100.0	1,230,732	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	1,208,800	96	96	120	762,700	25,300	12	22,800	71,300	57,700	0	269,000
WHO - WR	934,100	48	0	575	427,800	14,900	90	171,000	157,200	77,300	0	85,900
TOTAL	2,142,900	144	96	695	1,190,500	40,200	102	193,800	228,500	135,000	0	354,900
% OF TOTAL	100.0				55.5	1.9		9.0	10.7	6.3	.0	16.6
1992-1993												
PAHO - PR	1,417,900	96	96	20	881,600	28,100	12	24,000	75,700	63,700	0	344,800
WHO - WR	924,100	48	0	455	470,800	15,000	69	138,000	163,600	66,100	0	70,600
TOTAL	2,342,000	144	96	475	1,352,400	43,100	81	162,000	239,300	129,800	0	415,400
% OF TOTAL	100.0				57.9	1.8		6.9	10.2	5.5	.0	17.7
1994-1995												
PAHO - PR	1,618,300	96	96	20	998,500	32,700	12	25,200	87,900	73,800	0	400,200
WHO - WR	1,037,000	48	0	455	526,300	17,400	69	144,900	189,900	76,700	0	81,800
TOTAL	2,655,300	144	96	475	1,524,800	50,100	81	170,100	277,800	150,500	0	482,000
% OF TOTAL	100.0				57.3	1.9		6.4	10.5	5.7	.0	18.2

ANALYSIS OF THE HEALTH SITUATION

1. The Cuban public health system entered the present decade by achieving unquestionable progress in the state of health of the population and shoring up an important potential in resources and experience.

2. Infant mortality rates diminished from 16.5 to 11.9 per 1,000 live births between 1985 and 1988, and, with a single exception, in 1988 all the provinces chalked up rates lower than 15 per 1,000.

3. Among the factors that influenced the decline of perinatal and child mortality are: the reduction of low birthweight, from 8.2% in 1985 to 7.5% in 1988; the program for the reduction of infant mortality; the establishment in 1985 of the family physician and nurse program, which has made it possible to improve primary care; the birth in recent years of more than 99.5% of all children in hospitals; implementation of the program for early detection of birth defects; and, finally, the structuring of a new perinatology program that includes the provision of perinatology rooms in the maternity hospitals.

4. The leading causes of death in the group from 1 to 4 years of age and from 5 to 14 years of age has remained constant for years. In 1988, accidents occupied first place in the 1 to 4-year age group, with a rate of 2.3 per 1,000, followed by birth defects with 1.1, malignant tumors with 0.7, and influenza and pneumonia with 0.5. In the 5 to 14-year age group, first place was occupied by accidents with a rate of 20.4 per 1,000, followed by malignant tumors with 5.0, birth defects with 3.5, meningococcic infections with 1.6, and coronary disease with 1.0.

5. Maternal mortality has evolved from 5.3 deaths per 10,000 live births in 1980 to 2.6 in 1988.

6. In 1988, accidents, which starting from the first year of life are the leading cause of death, continued to be the leading cause in those up to 50 years of age. The second cause in the group from 15 to 49 years of age is malignant tumors, followed by suicide, coronary diseases, and cerebrovascular diseases. Between 50 and 64 years of age, the leading causes are coronary disease, followed by malignant tumors, cerebrovascular diseases, accidents, and diabetes mellitus, the latter mainly among females.

7. The percentage of deaths in those 65 years of age and over increased from 61.8% of the total in 1985 to 63.9% in 1988.

8. The reduction of diseases preventable by vaccination is explained by the high vaccination coverage, which at the national level reaches more than 88% in the various age groups and schooling levels studied.

9. As of June 1989, 308 seropositive AIDS cases had been detected among 4,748,731 persons examined.

10. The international conditions created by aggravation of the economic crisis, the situation in the countries that formerly made up the socialist bloc in Eastern Europe, and the recrudescence of the blockade imposed on Cuba for more than 30 years mark the beginning of a new stage in the development of the country's political, economic, and social model, a stage in which not only is survival at stake but the very continuance of development is threatened during a very difficult period that is forcing the country to undertake a series of measures as part of what is known as the Special Peacetime Period.

11. In this new situation, important activities have been assigned priority at the national level which will require close scrutiny by the Cuban people and their government, concretely expressed in improving the use of national and international resources.

12. In this period, the Government of Cuba considers the following areas to be of a priority nature: development of the dietary program, development of the medical and pharmaceuticals industry, biotechnological and research centers, and the development of tourism.

13. These priorities will form the basis for continuing to develop Cuba's social programs--particularly those that assist in maintaining the health programs that have been set up--as a means of improving the results obtained by raising living standards, reducing mortality, gradually increasing life expectancy at birth, and maintaining the trend toward reducing mortality and morbidity from infectious diseases.

14. These programs have brought about changes in the structure of Cuban morbidity and mortality and a commensurate increase in the efforts to develop the services and train human resources to deal with chronic diseases, promote preventive treatment, and implement rehabilitation programs that ensure safe and secure old age.

15. In recent years, progress has been made in improving the primary care model based on the family physician and nurse, the general aim of which is to improve the state of health of the population through comprehensive actions closely linked to and directed toward families and the environment in which the people live, study, and work.

16. In parallel, development of the secondary and tertiary care levels has continued through programs planned until the year 2000 for 35 medical specialties, and the introduction of advanced health technology, which, combined with the expansion, modernization, and construction of health units, will make it possible to supplement and support the goals formulated for primary care.

17. After a period of maturation, scientific research in the field of health has in recent years produced an explosion of results in fields such as biotechnology and the production of vaccines, drugs, and medical equipment.

18. Work has continued with the Institute of Veterinary Medicine on an integrated program for the control of zooneses, which, in conjunction with the the efforts being made with intersectoral participation to conserve the environment and natural resources, is making it possible to improve human health.

19. This has led to a transformation in study plans and programs in keeping with new concepts, policies, and requirements that have emerged, and created a direct linkage between medical care, hygiene, epidemiology, education, and research, both aimed at raising the quality of medical care and satisfying the needs of the population by better organizing health actions and putting them on a sounder and more efficient basis.

20. These efforts, conducted under the leadership of the government and carried out by the Ministry of Public Health and other related sectors with broad participation by the people, are proving to be successful and indicate that the current situation is encouraging.

National health strategies and plans

21. It may be said that in recent years a new and qualitatively superior stage in public health has begun whose most notable characteristic has been the preparation of a strategy designed to advance the biomedical sciences toward the highest international levels, with the aim of maintaining and preserving the health of the people and increasing their life expectancy to the greatest possible extent as an ongoing challenge of prime social importance in the country.

22. In this connection, the strategic projection contained in the plans and programs of the Cuban National Health System and in the program documents of the Cuban Government and State proposes the following:

22.1 The National Health System will be expanded and improved, placing particular stress on prevention methods and the promotion of health. Special importance will also be given to raising the level of the people with regard to health education, good eating habits, and a more healthy lifestyle. This will be based on the strengthening of primary care through the family physician and nurse program and the development of comprehensive general medicine by raising its scientific level until it becomes the most universal of all the specialties.

22.2 By the year 2000, the entire population of the country will be covered by a network of family physicians and nurses. In addition, the factories, schools, kindergartens, cooperatives, merchant and fishing vessels, and other work centers will be provided with basic health care equipment in the form of physicians and nurses, which will constitute a giant step forward for the health services.

22.3 The Maternal and Child Health Program will continue to receive attention with a view to raising the quality of the services provided to women, children, and adolescents and to reducing the mortality of infants, preschool children, schoolchildren, and mothers. For this purpose, it will be necessary to make a positive contribution to reducing early pregnancy by extending sex education so as to prepare the new generations for love, marriage, and family life.

22.4 The quality of the services of the hospital network will be increased to the greatest possible degree. In this regard, special attention will be given in this program to developing more than 35 clinical, surgical, and diagnostic specialties and to promoting emergency medical services and care for seriously ill patients.

22.5 In order to ensure safe and secure old age, the network of elderly persons' homes and senior citizen centers will be expanded, and geriatrics, gerontology, and other specialities associated with protection of the elderly will be developed at all levels of the system. Work will also be focused on developing institutions for the care of the physically and mentally handicapped. Both actions will be based on community rehabilitation.

22.6 Efforts will be made to preserve the environment and the natural resources from contamination as a means of protecting the health of the people. The regulations required for this purpose will be established and educational activities will be increased in which the masses may participate actively in their own care and protection.

22.7 The development of hygiene and epidemiology will be continued, taking into consideration the current profile of morbidity and mortality and improving hygienic and sanitary conditions in urban and rural population centers.

22.8 In order to attain these goals, it will be necessary to train medical personnel in sufficient quantities, and in the required specialties to train physicians, stomatologists, nurses, and other technicians at the highest international level and at the same time to provide assistance and collaboration to other needy countries. For this purpose, education in the field of medicine will continue to be extended throughout all the medical institutions. Research will also be generalized so as to impart a spirit of creation and improvement at all levels of the Cuban National Health System.

22.9 Efforts will be made to advance science and biomedical technology by incorporating the most modern methods for prevention, diagnosis, treatment, and rehabilitation of diseases through broadbased research for the medical sciences and medical practice, particularly in the fields of tropical medicine, medical genetics, biotechnology, and the production of drugs, reagents, and medical equipment.

23. These elements and decisions will enable Cuba, an underdeveloped country of Latin America and of the Third World, to continue to achieve notable advances and positive changes in the state of health of its population.

24. It is an unquestionable scientific truth that neither the changes in the state of health of the population nor the priority assigned to the development of the state public health system can be conceived as an isolated phenomena; rather, they are part of the general process of changes taking place in Cuban society.

GLOBAL STRATEGY OF COOPERATION

25. The basis for formulating this strategy lay in the priorities established during the process of reformulating cooperation, which took place in 1983, together with the PAHO Strategic Orientations and Program Priorities for the present Quadrennium. In addition, the experience gained from the development of the Cuban public health system were taken into account and translated into plans for the year 2000 on the basis of current conditions.

26. In coordination, the Ministry of Public Health and the Country Representative Office have defined the following national priorities for PAHO/WHO cooperation in the present period: Management Process for National Health Development; Technical Cooperation Among Countries; Health Situation and Trend Assessment; Health Policies Development; Organization of Health Services Based on Primary Care; Human Resources Development; Health Information support; Promotion and Development of Research; Food and Nutrition; Environmental Health; Maternal and Child Health; Communicable Diseases; Health of Adults; Veterinary Public Health.

27. Similarly, in formulating comprehensive orientation of PAHO/WHO cooperation in Cuba, a conceptual and methodological approximation was made so that cooperation projects would respond to the main thrusts of interprogram action, regardless of their particular content, as follows:

27.1 Local health systems and quality of the care provided.

27.2 The epidemiological approach, emphasizing promotion.

27.3 Improvement of the training of health personnel as an ongoing process in the health services.

27.4 Economic analysis as a component of health management in relation to the quality of the services.

27.5 Use of the results of scientific and technical research for the harmonious progress of the National Health System and the industrial development of new technologies, diagnostic means, medical equipment, drugs, etc.

28. The priority lines of work that should be carried out by the Country Representive Office with the aim of developing PAHO-Country technical cooperation are:

28.1 Technical support in defining policies and strategies of cooperation with PAHO in keeping with national health priorities and with PAHO/WHO programs and their regional and global goals.

28.2 Identification of new sources of technical and financial resources for cooperation, in addition to better use of the regular resources of PAHO.

28.3 Impetus to coordinating actions with other cooperation agencies, particularly United Nations agencies.

28.4 Support for the development of comprehensive and intersectoral health actions.

28.5 Development of technical evaluation, both with regard to country programs and to PAHO cooperation.

28.6 Development of multicountry technical cooperation programs, basically in the area of health technology. Special support will be given to regional, subregional, and country initiatives in the proposals formulated in the framework of regional technical cooperation known as Project Convergences.

28.7 Development of cost, efficiency, and effectiveness studies for optimization of the use of resources, which are factors that, inter alia, involve the level of development of the infrastructure and management of the National Health System and are consonant with the socioeconomic and political structure of the country.

29. For these purposes, strengthening of the administrative capacity of the Representation will be continued, placing special emphasis on automation of the administrative process and personnel improvement.

30. These strategies will make it possible to respond directly to the objectives proposed for improving the Cuban National Health System.

31. The Organization will collaborate in the development of the following specific programs:

MPN:	Managerial Support for National Health Development
TCC:	Technical Cooperation among Countries
HST:	Health Situation and Trend Assessment
HDE:	Health Economics and Financing
DHS:	Health Services Development
HED:	Health Education and Community Participation
RHB:	Rehabilitation
HMC:	Coordination and Support of Human Resources Development
HBD:	Scientific and Technical Information Dissemination
RPD:	Research Promotion and Development
HDT:	Health Technology Policies and Development
NUT:	Nutrition
CEH:	Control of Environmental Health Hazards
MCH:	Growth, Development and Human Reproduction
OCD:	General Communicable Disease Prevention and Control Activities
NCD:	Health Promotion and Prevention and Control of Noncommunicable Diseases
ZNS:	Zoonoses

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		1,404,200	71.8	1,607,400	71.1	1,795,500	70.9
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		276,900	14.2	370,300	16.6	411,500	16.1
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	276,900	14.2	370,300	16.6	411,500	16.1
TECHNICAL COOPERATION AMONG COUNTRIES		53,900	2.7	62,500	2.8	72,500	2.9
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	53,900	2.7	62,500	2.8	72,500	2.9
HEALTH SITUATION AND TREND ASSESSMENT		120,800	6.2	126,700	5.6	141,400	5.6
HEALTH SITUATION AND TREND ASSESSMENT	HST	120,800	6.2	126,700	5.6	141,400	5.6
HEALTH POLICY DEVELOPMENT		93,400	4.8	98,200	4.3	109,800	4.3
HEALTH ECONOMICS AND FINANCING	HDE	93,400	4.8	98,200	4.3	109,800	4.3
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		375,600	19.2	443,500	19.5	496,300	19.7
HEALTH SERVICES DEVELOPMENT	DHS	272,000	13.9	335,200	14.8	376,100	14.9
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	35,000	1.8	37,300	1.6	42,100	1.7
REHABILITATION	RHB	68,600	3.5	71,000	3.1	78,100	3.1
HUMAN RESOURCES DEVELOPMENT		258,700	13.2	269,700	11.9	299,100	11.8
COORDINATION & SUPPORT OF HUMAN RESOURCES DEVELOP.	HMC	258,700	13.2	269,700	11.9	299,100	11.8
HEALTH INFORMATION SUPPORT		97,200	5.0	102,700	4.5	115,600	4.6
SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION	HBD	97,200	5.0	102,700	4.5	115,600	4.6
RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT		127,700	6.5	133,800	5.9	149,300	5.9
RESEARCH PROMOTION AND DEVELOPMENT	RPD	34,200	1.7	35,700	1.6	39,700	1.6
HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT	HDT	93,500	4.8	98,100	4.3	109,600	4.3

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
III. HEALTH SCIENCE AND TECHNOLOGY		556,000	28.2	653,700	28.9	733,400	29.1
FOOD AND NUTRITION		52,000	2.7	54,600	2.4	60,900	2.4
NUTRITION	NUT	52,000	2.7	54,600	2.4	60,900	2.4
ENVIRONMENTAL HEALTH		81,100	4.1	84,400	3.7	93,300	3.7
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	81,100	4.1	84,400	3.7	93,300	3.7
MATERNAL AND CHILD HEALTH		98,900	5.0	104,600	4.6	117,800	4.7
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	98,900	5.0	104,600	4.6	117,800	4.7
COMMUNICABLE DISEASES		98,800	5.0	173,900	7.7	197,500	7.8
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	98,800	5.0	173,900	7.7	197,500	7.8
HEALTH PROMOTION		190,900	9.7	200,200	8.9	223,900	8.9
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	190,900	9.7	200,200	8.9	223,900	8.9
VETERINARY PUBLIC HEALTH		34,300	1.7	36,000	1.6	40,000	1.6
ZOONOSES	ZNS	34,300	1.7	36,000	1.6	40,000	1.6
GRAND TOTAL		1,960,200	100.0	2,261,100	100.0	2,528,900	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		36,000	20.1	0	-	0	100.0
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		36,000	20.1	0	-	0	100.0
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	36,000	20.1	0	-	0	100.0
III. HEALTH SCIENCE AND TECHNOLOGY		143,305	79.9	113,522	100.0	0	-
MATERNAL AND CHILD HEALTH		29,783	16.6	0	-	0	-
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	16,282	9.1	0	-	0	-
ADOLESCENT HEALTH	ADH	13,501	7.5	0	-	0	-
COMMUNICABLE DISEASES		113,522	63.3	113,522	100.0	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	113,522	63.3	113,522	100.0	0	-
GRAND TOTAL		179,305	100.0	113,522	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	787,000	24	0	285	259,200	14,700	85	161,500	163,900	187,100	0	600
WHO - WR	1,173,200	0	0	685	173,300	0	163	309,700	282,900	361,300	0	46,000
TOTAL	1,960,200	24	0	970	432,500	14,700	248	471,200	446,800	548,400	0	46,600
% OF TOTAL	100.0				22.1	.7		24.0	22.8	28.0	.0	2.4
1992-1993												
PAHO - PR	977,200	24	0	265	342,800	15,100	78	156,000	130,900	199,200	0	133,200
WHO - WR	1,283,900	0	0	685	182,900	0	151	302,000	309,400	386,200	0	103,400
TOTAL	2,261,100	24	0	950	525,700	15,100	229	458,000	440,300	585,400	0	236,600
% OF TOTAL	100.0				23.2	.7		20.3	19.5	25.8	.0	10.5
1994-1995												
PAHO - PR	1,091,200	24	0	265	372,600	17,500	78	163,800	151,700	231,100	0	154,500
WHO - WR	1,437,700	0	0	685	193,900	0	151	317,100	358,800	448,000	0	119,900
TOTAL	2,528,900	24	0	950	566,500	17,500	229	480,900	510,500	679,100	0	274,400
% OF TOTAL	100.0				22.4	.7		19.0	20.2	26.8	.0	10.9

ANALYSIS OF THE HEALTH SITUATION

Demography

1. The population of Dominica as recorded in the 1980-1981 census was seventy three thousand, seven hundred and ninety five (73,795). The mid-year population for 1989 was estimated at eighty one thousand and six hundred (81,600). It is estimated that the population during the 1992-1993 biennium should reach eighty two thousand and five hundred (82,500).

2. Over the period 1981-1989 there has been no relative increase in the 0-4 age group, but there was an increase in the 65+ age group and females aged 15-44.

Indicators of health status

3. The life expectancy at birth is expected to rise from 68 years at birth to 74 years for females and from 61 years to 66 for males by 1990.

4. The principal causes of overall mortality for 1988 were heart disease, hypertensive disease, malignancies, diseases of the respiratory system including pneumonia, cerebrovascular disease and diabetes mellitus.

5. The three principal causes of infant deaths (1988) were perinatal causes, pneumonia, and sudden infant death syndrome in that order. Deaths from perinatal causes accounted for more than fifty percent (50%) of the total infant deaths.

6. Among children 1-4 years, diseases of the respiratory system are the principal causes of death.

7. Deaths from accidents in the young male population has shown significant percentage increase in the recent years.

8. Maternal mortality continues to be low, with no deaths recorded for 1989. An investigation of the causes of deaths of females aged 15-44 from 1985-1989 confirms the statistical report.

9. Twelve cases of AIDS have been documented in Dominica from 1987 to November, 1990. All of the cases have died, resulting in a hundred percent (100%) case fatality rate. Two of the cases were females, with one infant recorded.

10. Under-nutrition in 0-5 year age group is no longer a problem. Obesity is being encountered increasingly in this age group. Routine surveillance of nutritional status of 0-5 year age group is done. Less than three percent (3%) of all children 0-5 years were below the WHO standard (1988, 1989). A recent survey 1987, revealed deficiencies in iron and calcium intakes in pregnant and lactating mothers.

Factors affecting health status

11. The environmental situation remains critical particularly as regards to solid and liquid waste disposal and vector control. As of 1989, coverage with potable water extended to eighty percent (80%) of the total population. Agricultural activity above catchment areas are a major source of contamination of water supplies.

12. Methods of excreta disposal are septic tanks, pit latrines and disposal fields and public conveniences. Forty six percent (46%) are served by pit latrines and twenty five percent (25%) by septic tanks. The Roseau City Council remains the only area in Dominica with a sewage system, which serves thirteen percent (13%) of the households. The sewage outfalls discharge directly into the sea, without any treatment.

13. A solid waste program introduced in 1990 provides for temporary storage and collection of garbage. This serves the West Coast and has proved to be an essential service.

14. The Aedes aegypti index remain high and an emergency program was conducted in 1990, when the index was at sixty percent (60%). However, maintenance programs are constrained by lack of resources. A recent outbreak of leptospirosis has prompted the initiation of a rat control program.

15. The economic situation over the last five years has remained stable. Dominica has recorded a four percent (4%) net average increase in GDP over the last five years. The consumer price index has risen to an average of 3.7 percent in this period. The recent increase in petroleum prices is expected to adversely affect the consumer price index. Recurrent expenditure on health remains at approximately fourteen percent (14%) of the total central government recurrent expenditure.

16. Unemployment in 1989 was estimated at 11%, and expected to decline. The 15-24 age group experiences a 60% unemployment rate. Among females of all ages, the unemployment rate is 17%.

17. National elections took place in 1990, with a re-election of the government. Government has restated its commitment of health for all through sustained primary health care coverage and with an emphasis on improving the secondary care services. Health services continue to be of high quality. Rural communities are well served, with good access to health services.

18. Tertiary care is not provided on the island, and patients are referred to neighboring islands, Martinique, Barbados and Jamaica. Government can only contribute minimally to the cost of these services, and hence access to this level of care is limited.

19. There exists a major shortage of trained nurses on the island and the attrition rate has increased sharply over the last 3 years. The introduction of a collegiate type program is expected to provide a continuous pool of graduates to alleviate this problem.

20. Chronic conditions, diabetes, hypertension and heart disease are increasing in prevalence. Obesity in adults and children is emerging as an important health problem. A survey is scheduled to be undertaken in 1991.

National health strategies, policies and plans

21. The Ministry of Health from July 1990 includes the Department of Social Security. However, the Social Security Scheme is administered by a Board guided by Statuary Regulations, but responsible to the Minister of Health.

22. All persons who contribute to the Social Security Scheme are eligible to receive "free" hospital care.

23. The three (3) year National Health Plan of Dominica (1989-1992) details the National Health Policy and priority health programs for that period.

24. The major priorities established by this policy are:

24.1 Continuing emphasis and strengthening of the Primary Health Care Approach.

24.2 Development of the main secondary care facilities

24.3 Improvement in the self-financing capacity of the health sector.

24.4 Strengthening of intersectoral coordination and collaboration.

24.5 Strengthening of national programs in environmental health, dental health, mental health, AIDS prevention and the control of chronic diseases.

25. Decentralization and community participation have been actively promoted for the past ten years, and these continue to be the main elements of the Primary Health Care strategy.

26. The process of decentralization has been facilitated by a comprehensive health information system which provides management information at district level for improved team management strategies.

27. However, it has been recognized that significant improvement and streamlining of the Health Information Service is required to ensure effective use of the information, both at the local and regional level.

28. Reorganization of the health system has been identified as a major management strategy and has commenced with a restructuring of the Primary Care System. The seven health districts have been further grouped into two (2) regions, and are supervised by four (4) regional managers, who report to the Director of Primary Health Care Services. This approach is consistent with the Ministry of Health's policy of decentralization.

29. It is anticipated that ongoing efforts at restructuring will strengthen health administration, particularly in planning, evaluation, supervision and coordination at both primary and secondary care levels.

30. The focus on vulnerable groups is specific in relation to mothers, children, the elderly and the mentally ill. Norms and standards for the provision of the services have been established and are continually being revised. The manual for the Maternal and Child Care has recently been revised and updated by a committee of professionals.

31. Coverage targets for the ante and post natal care have not been fully realized and the control of gastroenteritis and diarrheal disease is to be strengthened.

32. Plans for 1992-1993 which requires support include the following areas:

32.1 Distribution of a manual for the control/management of diabetes and hypertension.

32.2 Strengthening the system's capacity for epidemiological analysis, identifying causes, establishing reliable surveillance systems and appropriate interventions for: nutritionally related chronic diseases; AIDS; Tuberculosis; Perinatal mortality; Cancer, especially among women; and Accidents.

32.3 Improvement in the diagnostic capability of the secondary referral care hospital and the availability of specialists' services.

32.4 Strengthening of the financing capacity of the system through operations research and development. Identifying and developing support linkages with the Social Security System.

32.5 Continuing development of the local health systems through ongoing in-country training and management restructuring.

32.6 Improvement of the health information system through the computerization of records and the development of an efficient data base.

32.7 Promotion of community participation to prevent and solve environmental health hazards and the development of appropriate technology to achieve improved coverage and quality of environmental health services.Note: For some of these priority areas it is expected that PAHO will cooperate with NGO's and other Agencies for Technical Cooperation.

GLOBAL STRATEGY OF COOPERATION

33. The Government has identified some priority areas in which technical cooperation is required in order to achieve the health objectives. The Technical Cooperation in the areas identified will be pursued in keeping with the spirit of the Caribbean Cooperation in Health Initiative. The strategies which will be employed would be in keeping with those agreed on for the various areas in the Initiative.

34. Special focus will also be given to the twin strategies of Promotion and Project Development with linkages to Resource Mobilization and Technical Cooperation among countries as important activities in the pursuit of the objectives. PAHO/WHO has been asked to promote technical cooperation in the following areas: chronic diseases; reorganization of the health sector; environmental health; maternal and child health, and communicable diseases.

35. PAHO/WHO strategies for providing technical cooperation in these priority areas will be implemented through: training; operation research in relation to financing; development of policies, programs and norms for relevant systems to strengthen the managerial capabilities at the local level; and direct assistance for implementation of systems.

Development of health services

36. In the area of reorganization of the health sectors, technical cooperation provided by the organization will be characterized by strengthening of the management information system; improved epidemiological analysis for all programs at the local level. In addition, special focus will be on the training of health personnel in management using the tools aforementioned. Support will also be in strengthening the financial system through operations research and development.

Environmental health

37. In the area of environmental health, technical cooperation will be characterized by an emphasis on community participation as a means of preventing and solving environmental hazards. In addition, appropriate technology will be promoted to improve coverage and the quality of the environmental health service.

Chronic non communicable diseases

38. In the area of chronic non communicable diseases, the technical cooperation provided by the organization will be characterized by supporting the development of appropriate interventions for the nutritional related chronic diseases and cancer with special emphasis on women.

Maternal and child health

39. In the area of maternal and child health the technical cooperation of the organization will be characterized by the establishment of a system for the early recognition and management of high risk pregnancies. Strengthening of the acute respiratory disease control program will also be a focus. Dominica will collaborate with its neighbors to eliminate poliomyelitis and measles.

Communicable diseases

40. In the area of communicable diseases, technical cooperation of the organization will be characterized by establishing reliable surveillance systems for AIDS/STD and Tuberculosis.

41. TCAC will be given special focus in the programs to allow common approaches to be developed and common problems solved.

42. PAHO will collaborate to the development of the following specific programs:

DHS: Health services development
CWS: Community water supply and sanitation
MCH: Growth, development and human reproduction

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		192,900	73.9	209,700	73.6	230,200	73.3
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		192,900	73.9	209,700	73.6	230,200	73.3
HEALTH SERVICES DEVELOPMENT	DHS	192,900	73.9	209,700	73.6	230,200	73.3
III. HEALTH SCIENCE AND TECHNOLOGY		68,100	26.1	75,500	26.4	84,000	26.7
ENVIRONMENTAL HEALTH		40,200	15.4	44,000	15.4	48,200	15.3
COMMUNITY WATER SUPPLY AND SANITATION	CWS	40,200	15.4	44,000	15.4	48,200	15.3
MATERNAL AND CHILD HEALTH		27,900	10.7	31,500	11.0	35,800	11.4
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	27,900	10.7	31,500	11.0	35,800	11.4
GRAND TOTAL		261,000	100.0	285,200	100.0	314,200	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		247	.2	0	-	0	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		247	.2	0	-	0	100.0
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	247	.2	0	-	0	100.0
III. HEALTH SCIENCE AND TECHNOLOGY		109,258	99.8	80,206	100.0	0	-
MATERNAL AND CHILD HEALTH		15,311	14.0	0	-	0	-
ADOLESCENT HEALTH	ADH	15,311	14.0	0	-	0	-
COMMUNICABLE DISEASES		93,947	85.8	80,206	100.0	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	93,947	85.8	80,206	100.0	0	-
GRAND TOTAL		109,505	100.0	80,206	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	233,100	0	0	135	39,900	0	57	108,300	32,200	17,300	0	35,400
WHO - WR	27,900	0	0	0	0	0	0	0	11,500	16,400	0	0
TOTAL	261,000	0	0	135	39,900	0	57	108,300	43,700	33,700	0	35,400
% OF TOTAL	100.0				15.3	.0		41.5	16.7	12.9	.0	13.6
1992-1993												
PAHO - PR	253,700	0	0	145	44,500	9,300	55	110,000	33,300	20,900	0	35,700
WHO - WR	31,500	0	0	30	8,000	0	0	0	13,300	10,200	0	0
TOTAL	285,200	0	0	175	52,500	9,300	55	110,000	46,600	31,100	0	35,700
% OF TOTAL	100.0				18.4	3.3		38.6	16.3	10.9	.0	12.5
1994-1995												
PAHO - PR	278,400	0	0	145	47,800	10,800	55	115,500	38,700	24,200	0	41,400
WHO - WR	35,800	0	0	30	8,500	0	0	0	15,500	11,800	0	0
TOTAL	314,200	0	0	175	56,300	10,800	55	115,500	54,200	36,000	0	41,400
% OF TOTAL	100.0				17.9	3.4		36.7	17.3	11.5	.0	13.2

ANALYSIS OF THE HEALTH SITUATION

1. The Dominican Republic shares the universal condition of economic and social deterioration that is translated into stagnation, a setback in economic growth, and an accumulation of unmet social needs. Since 1990, the great national discussion has been centered on the theme "marginality and modernity", and faithfully reflects the particular challenge that the country presents in the general situation of the continent. In contrast to enclaves of great economic dynamism, incorporating advanced technological elements and sharing the latest contributions of the science and lifestyles of the most developed countries, large sectors of the nation maintain semifeudal production systems and scarcely reach minimum levels of subsistence.

2. There is an awareness of the pressing need to incorporate the large marginalized masses (40% do not vote, 40% are unemployed, 33% are illiterate, 35% are below the poverty line) in any attempt to direct the country toward a pathway of sustained growth. But the actual legal, political, and administrative structure of the country needs to be modified if any result in that vein is to be expected.

3. The overall mortality data of the country show perinatal deaths as first. Among the causes of those deaths are hypoxia and anoxia, slow fetal growth, and retardation of intrauterine growth. Several studies carried out in the country agree that low birthweight (10% to 14%) is the principal determinant of perinatal mortality.

4. These same studies have identified the following factors associated with low birth weight: chronic maternal undernutrition; toxemia of pregnancy; chronic hypertension; and the age of the mother less than 18 or more than 35 years. In addition, it has been demonstrated that prematurity is a factor in 24% of the children with low birthweight, which suggests that the incident factors are particularly related to fetal undernutrition.

5. The principal causes of infant mortality in the Dominican Republic are diarrheal diseases and acute respiratory infections. Together they account for over 90% of infant mortality in the country. The diarrheal diseases also occupy a significant place among the causes of mortality in children under five.

6. A direct relationship is observed between the high rates of diarrheal diseases and the population areas without potable water services. On the other hand, it is pointed out that the regions of the country with higher rates of diarrheal diseases coincide, in turn, with those with higher percentages of women without an education and with populations in extreme poverty.

7. Infections of the respiratory tract represent the greatest reason for use of the health establishments and the second cause of mortality in children under five. In the territories with greater incidence of these diseases, there are high percentages of homes with critical overcrowding, poverty, and women without an education.

8. Maternal mortality from avoidable causes is one of the principal problems that should be addressed. The most recent information available identifies toxemia, abortions, hemorrhage in pregnancy and delivery, and infections as the principal causes of mortality. Pregnancies and induced abortions in adolescents are of great concern.

9. All the national studies of the last five years on protein and energy undernutrition point out the high prevalence of children under five (variations between 29% and 41%) who are underweight for their age and size. The same studies point out the association of this condition with economic poverty, poor hygienic and environmental conditions, and deterioration of the cultural and educational aspects of the population.

10. The high rates of prevalence of acute diarrheal diseases, infections of the respiratory tract, and low birthweight also appear associated with advanced states of undernutrition in children and pregnant women. Few studies have been done on nutritional deficiencies but it is estimated that there is a significant prevalence of iron deficiency anemias, endemic goiter, and also vitamin A deficiency.

National health strategies, plans, and policies

11. In the health sector, there has been a virtual immobilization of the services, which have not responded sufficiently in the face of emergency situations despite the increase in human, material, and financial resources; the model is one of self-consumption in the support of its own infrastructure, combined with an inability to respond to the demands of the population. There is a growing conviction that it is necessary to reorganize the sector to include coordination among the subsystems (private, public, social security, training institutions, nongovernmental; and benevolent agencies), in order to be able to impact on the deficiencies in the basic conditions of life in the communities and marginal groups. The national priorities in health are identified as: 1) the relevance of health within the social policies and in the process of development (third place within the national budget and emergence of the fund for social emergencies); 2) improvement of the capacity to analyze the situation and identify high-risk groups; 3) formulation of policies and programs that extend coverage, ensuring equity in health; 4) concentration of resources in groups of greater vulnerability to provide effective interventions; 5) and reorganization of the sector, affecting the organization, conduct, financing, and intersectoral relations.

12. The decade of the 1990s was initiated with a profound crisis in the health care system and a marked deterioration of its managerial capacity, which will have important repercussions in the development of health plans and programs in the coming years. The development of health services represents one of the principal priorities, as a part of the efforts that are carried out through modernization and the pluralistic participation of Dominican society.

13. The Government, through the Ministry of Public Health and Social Welfare (SESPAS), has reiterated its decision to continue to work in the 1992-1993 biennium to achieve an effective transformation in the organization and operation of the health services, renew the positive experiences of previous years, and incorporate new initiatives for the overall development of health.

14. In this context, the national health policies emphasize care of the neglected or marginal population groups, among whom morbidity and mortality are several times greater than in other population sectors, such as, for example, the inhabitants of the sugar plantations, the population of the free trade zones, the border territories with Haiti, the tourist areas, and the marginal districts of the cities.

15. In addition, the aim is to contribute to the recovery of the management role of SESPAS in the National System of Health Services, and to achieve the coordination of the intentions of the different public institutions that have an impact on health problems, mainly the Dominican Social Security Institute (IDSS), but also other nongovernmental organizations and the private sector.

16. There is, at the level of SESPAS, the political will to grant more independence in budgetary implementation and the use of alloted funds to the regions, areas, and hospital complexes. The PAHO project of cooperation will support this effort aimed at creating the conditions necessary for the adoption and application of a policy of effective decentralization of the health services, along with promotion of social participation and the design and implementation of local health systems based on the provincial jurisdiction of the state.

17. Priority has been assigned to the development of the capacity to analyze the health situation and identify vulnerable groups and risk factors, in order to achieve the greatest efficiency of the activities in health as well as to increase the capacity to respond to outbreaks and epidemiological crises.

18. The Ministry of Public Health and Social Welfare (SESPAS) and other national institutions concerned with the health problems of mothers and children agree that the activities to provide care to women during and between pregnancies, to children under five years of age, and to adolescents need to be strengthened and reorganized, in order to achieve a greater impact. Thus, the health of mothers and children and human reproduction have been defined by the national authorities as one of the principal priorities for the country, in the program for cooperation with PAHO/WHO, in the 1992-1993 biennium.

19. The priority components of the program of cooperation are: maternal health, perinatal health, diarrheal diseases, and acute respiratory infections.

20. It is recognized that the health services of the Ministry of Public Health and Social Welfare (SESPAS) have direct responsibility for activities of prevention and treatment of the prevalent nutritional diseases; but there is beginning to be recognition of the need for SESPAS to promote, orient, and advise the other sectors and institutions that have a significant responsibility in the comprehensive systemic confrontation of the problems of food and nutrition. The formulation and execution of national policies in this field should be one component to strengthen, in the 1992-93 biennium.

21. Continuing analysis of the food and nutrition situation of the Dominican population, study of the principal nutritional deficiencies, training of personnel, and institutional development for the multicausal approach to these problems are components that are considered to have high priority, in beginning to turn the prevailing situation around, and being able to contribute more effectively to the decisions made by the higher authorities of the government in the field of food and nutrition.

22. The national health authorities recognize that just treating undernutrition as a disease will not resolve the problems; it is necessary to promote better levels of income, education, and nutrition with a view to obtaining significant and lasting results in the attainment of an optimum nutritional status for the entire population.

23. The various institutions that comprise the health sector are aware of their need for pertinent, up-to-date scientific and technical information, for which they exert efforts to have in their respective institutions duly organized information units that meet the information needs of their technical personnel.

24. This need to have information resources is felt even more in the various regions in the interior of the country, where information is accessible only with difficulty. Efforts in this regard have been carried out in the face of some obstacles, among which should be noted: the limited economic resources and scarcity of personnel qualified in library science and documentation, at both the professional and technical levels.

25. In addition, there is a felt need to formulate public opinion and to provide the different sectors of national life with pertinent information on the health problems that affect the majority of the people, and the proper way to control and prevent these, in order to improve the living conditions of the population.

GLOBAL STRATEGY OF COOPERATION

26. Strengthening the capacity of the state to exercise its leadership in the reorganization of the sector, formulating regulatory policies for the overall development of the system to guarantee its equity and efficiency.

27. Strengthening the capacity of SESPAS to conduct and coordinate international cooperation for development and for the health sector, including cooperation among countries and participation in regional initiatives (PPS/CAP, Lomé IV, Bush Plan).

28. Strengthening the capacity to analyze the situation and utilize the resources in the most vulnerable groups and communities.

29. Integration of women, the training institutions, and the scientific and technological potential into health and development.

30. Motivation of innovative actions for decentralization of the management and operation of the system with social participation, in order to ensure intersectoral articulation at the local level.

31. Development of the legal and political aspects and the administrative procedures that legitimize these processes.

32. Reorientation of the health programs in consonance with the previous lines of cooperation, focusing on the activities that ensure the strengthening and integration of the health services and accelerate the fulfillment of the regional goals guaranteeing the continuity of the progress made in the accomplishments achieved.

33. PAHO will collaborate in the development of the following specific programs:

MPN:	Managerial Support for National Health Development
TCC:	Technical Cooperation among Countries
HST:	Health Situation and Trend Assessment
DHS:	Health Services Development
DPP:	Disaster Preparedness
HME:	Health Manpower Education
HBD:	Scientific and Technical Information Dissemination
NUT:	Nutrition
CWS:	Community Water supply and Sanitation
MCH:	Growth, Development and Human Reproduction
OCD:	General Communicable Disease Prevention and Control Activities
ZNS:	Zoonosis

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		1,726,800	72.7	1,935,600	70.2	2,193,500	70.5
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		501,500	21.1	624,700	22.7	714,000	22.9
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	501,500	21.1	624,700	22.7	714,000	22.9
TECHNICAL COOPERATION AMONG COUNTRIES		54,900	2.3	63,700	2.3	73,900	2.4
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	54,900	2.3	63,700	2.3	73,900	2.4
HEALTH SITUATION AND TREND ASSESSMENT		218,700	9.2	305,600	11.1	343,700	11.0
HEALTH SITUATION AND TREND ASSESSMENT	HST	218,700	9.2	305,600	11.1	343,700	11.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		697,500	29.4	684,500	24.7	770,100	24.8
HEALTH SERVICES DEVELOPMENT	DHS	697,500	29.4	659,900	23.8	742,400	23.9
DISASTER PREPAREDNESS	DPP	0	-	24,600	.9	27,700	.9
HUMAN RESOURCES DEVELOPMENT		155,000	6.5	158,900	5.8	179,500	5.8
HUMAN RESOURCES EDUCATION	HME	155,000	6.5	158,900	5.8	179,500	5.8
HEALTH INFORMATION SUPPORT		99,200	4.2	98,200	3.6	112,300	3.6
SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION	HBD	99,200	4.2	98,200	3.6	112,300	3.6
III. HEALTH SCIENCE AND TECHNOLOGY		648,600	27.3	820,200	29.8	918,700	29.5
FOOD AND NUTRITION		23,200	1.0	58,800	2.1	65,900	2.1
NUTRITION	NUT	23,200	1.0	58,800	2.1	65,900	2.1
ENVIRONMENTAL HEALTH		278,300	11.7	337,800	12.3	378,300	12.2
COMMUNITY WATER SUPPLY AND SANITATION	CWS	278,300	11.7	337,800	12.3	378,300	12.2

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
MATERNAL AND CHILD HEALTH		126,500	5.3	139,300	5.1	155,800	5.0
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	126,500	5.3	139,300	5.1	155,800	5.0
COMMUNICABLE DISEASES		158,800	6.7	195,700	7.1	220,900	7.1
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	158,800	6.7	195,700	7.1	220,900	7.1
VETERINARY PUBLIC HEALTH		61,800	2.6	88,600	3.2	97,800	3.1
ZOONOSES	ZNS	61,800	2.6	88,600	3.2	97,800	3.1
GRAND TOTAL		2,375,400	100.0	2,755,800	100.0	3,112,200	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		3,493	.6	0	-	0	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		3,493	.6	0	-	0	100.0
HEALTH SERVICES DEVELOPMENT	DHS	3,493	.6	0	-	0	100.0
III. HEALTH SCIENCE AND TECHNOLOGY		612,003	99.4	590,800	100.0	0	-
MATERNAL AND CHILD HEALTH		11,426	1.9	0	-	0	-
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	11,426	1.9	0	-	0	-
COMMUNICABLE DISEASES		600,577	97.5	590,800	100.0	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	600,577	97.5	590,800	100.0	0	-
GRAND TOTAL		615,496	100.0	590,800	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	1,418,800	48	72	760	623,800	48,800	41	77,900	161,100	170,800	0	336,400
WHO - WR	956,600	48	24	890	559,500	25,700	23	43,700	130,300	87,700	0	109,700
TOTAL	2,375,400	96	96	1650	1,183,300	74,500	64	121,600	291,400	258,500	0	446,100
% OF TOTAL	100.0				49.8	3.1		5.1	12.3	10.9	.0	18.8
1992-1993												
PAHO - PR	1,651,000	48	72	660	730,700	58,200	38	76,000	160,000	193,700	0	432,400
WHO - WR	1,104,800	48	24	605	616,200	30,200	28	56,000	123,200	87,000	0	192,200
TOTAL	2,755,800	96	96	1265	1,346,900	88,400	66	132,000	283,200	280,700	0	624,600
% OF TOTAL	100.0				48.8	3.2		4.8	10.3	10.2	.0	22.7
1994-1995												
PAHO - PR	1,870,300	48	72	660	810,800	67,500	38	79,800	185,700	224,800	0	501,700
WHO - WR	1,241,900	48	24	605	681,100	35,000	28	58,800	143,000	100,900	0	223,100
TOTAL	3,112,200	96	96	1265	1,491,900	102,500	66	138,600	328,700	325,700	0	724,800
% OF TOTAL	100.0				47.8	3.3		4.5	10.6	10.5	.0	23.3

EASTERN CARIBBEAN TERRITORIES: ANGUILLA, BRITISH VIRGIN ISLANDS, MONTSERRAT

ANALISIS OF THE HEALTH SITUATION

Demography

1. Anguilla, British Virgin Islands and Montserrat are three dependencies with respective populations of 6,806, 11,733 and 12,240. The effect of migration in all three countries have resulted in a similar population structure where approximately 33% of the population is under 15 years old and approximately 10% over 65 years old. The birth rate ranges between 22 and 26 per 1000 for three territories.

Indicators of health status

2. There is a wide range among the infant mortality rates in the three countries with 11.0 per 1000 in Montserrat; 25.0 per 1000 in Anguilla and 20.4 per 1000 for British Virgin Islands. Common to all is the fact that more than 75% of the infant deaths are within the neonatal period. British Virgin Islands had only 1 death in the 1-4 year age group and none were reported for Anguilla and Montserrat; acute respiratory infections and gastroenteritis are the two principal causes of morbidity and hospital admissions for children under 5 years.

3. The Expanded Program on Immunization in children under 1 year old for Diphtheria, Pertussis, Tetanus, Polio, Tuberculosis, Measles, Mumps and Rubella was between 85% to 100% for all three countries.

4. Among the adult population, the leading causes of mortality are cardiovascular disease, cerebrovascular disease and malignant neoplasm with hypertension and diabetes being the major contributors to the first two causes identified.

Factors affecting health care

5. In all three countries the environmental situation is a common concern. Anguilla has received funding from UNDP to address some of its problems, whereas Montserrat and British Virgin Islands have problems in the area of solid waste disposal, Environmental Legislation, Food Protection and Vector and Rodent Control. In the case of Montserrat, the situation is even more critical since the after math of Hurricane Hugo.

6. Shortage of manpower has plagued the health system of all three countries, hence the difficulty which the territories face is the sustainability of the improvements due to the shortage of manpower. All three countries have identified the need to have their health workers at the local level trained in management. Hence, they have identified the need for improvement in the information system. In the area of Infrastructure, the Glendon Hospital of Montserrat was extensively damaged by Hurricane Hugo and all energies are directed to its rehabilitation with support from the British Overseas Development Agency.

Health strategies, policies and plans

7. There are common areas of need for technical cooperation in the three territories: Environmental Health, Human Resource Development, AIDS/STD Control-Communicable Diseases, Development of Health Infrastructure, and Maternal and Child Health.

Environmental health

8. The management and monitoring of the environment would be improved through the development of environmental health information system; strengthening of legislation; intersectoral linkages and the development of solid waste plan with resource mobilization for same. Development of integrated vector and rodent control program.

Human resource development

9. The small size of these countries and the constant migration of manpower, demand an analysis of the structure and utilization of manpower in the community health service and hospital to determine the appropriate mix of health personnel that is required for the functions to be performed.

AIDS/STD communicable diseases

10. Vital to the effective prevention and control of AIDS/STD in these territories is the need for greater community involvement and social communication in the programs. Counselling at all levels and training in Ethics and Confidentiality are areas where assistance is important because of the small populations. Increased surveillance and improved Diagnostic capability of the laboratories remain priorities.

Development of health infrastructure

11. All countries have identified improved managerial capability at the local and central levels through training coupled with an improved management information system; support is required for increased social participation in planning; evaluation and epidemiological analysis at the local level.

Maternal and child health

12. Assistance is needed to: establish a system for the early recognition and management of high risk pregnancies; strengthen intersectoral linkages; upgrade skills at the levels of hospital and community; improve Growth and Development monitoring and infant feeding practices with emphasis on breast feeding.

Country-specific areas of need for technical cooperation

Anguilla

13. A strategic health plan, which takes into consideration the financial resources available is required to guide the efforts to improve the overall efficiency of the health service.

Montserrat

14. Support is needed in health promotion through education and social communication which is to be used to modify lifestyles for chronic diseases and AIDS/STD program.

15. Operational research will be needed in the area of financing health care with special reference to linkages with the Social Security System.

British virgin islands

16. Assistance is required for the evaluation of the present Dental Health program as a prerequisite to developing a new program for increased coverage and integration at the local level.

GLOBAL STRATEGY OF COOPERATION

17. PAHO/WHO is being asked to provide technical cooperation in all areas of need.

18. The working areas identified for Technical Cooperation with PAHO/WHO are as follows: Development of Health Infrastructure System, Environmental Health, Maternal and Child Health, AIDS/STD, Human Resource Development, Operations Research-Financing, and Dental Health.

19. These will be pursued within the framework of three of the priority areas of CCH: Strengthening of Health Systems, Environmental Health and Maternal and Child Health. Efforts will focus on resource mobilization at the national levels through the NGOs, in addition to developing projects as identified through the TC activities in general. Technical cooperation among countries will be increased to address critical health care delivery problems.

20. Strategic approaches for providing PAHO's technical cooperation in these countries will include training, development of plans and establishing systematic approaches. Support will be provided by subregional advisors as well as STCs. Training at subregional courses and workshops will be optimized.

Environmental health

21. Technical cooperation will be given in collaboration with CFNI to develop environmental health information systems to increase the capacity to identify priorities; intersectoral linkages will be promoted for the development of an integrated vector and rodent control program.

Health services development

22. In this area, activities will contribute to the development of local health systems in the three territories with a view to improving the efficiency and effectiveness of the health system and sustaining the improvements recently achieved.

23. Technical cooperation will be provided to all the territories to strengthen the management information system and for the training of health personnel at all levels in planning, programming and evaluation.

24. An analysis of the manpower needs will be undertaken, fellowships and other training provided to address those needs. TCAC will be promoted in this area.

25. In the area of AIDS/STD, CAREC and CPC will collaborate to develop systems and train persons to improve the surveillance systems. Training of health personnel and the community will be required to use health promotion as a means of modifying lifestyles. Technical cooperation will be characterized by the development of the capacity of the health sector and NGO to assess and apply health promotion and social communication at the local level.

26. Further direct support from CPC will be employed to assist Anguilla with the development of a strategic health plan.

27. In MON, operation research will be supported in Montserrat for the financing of health care, linking it to the Social Security System.

28. Regional support will guide the evaluation of the Dental Health program in British Virgin Islands.

Maternal and child health

29. PAHO will work with the MOH to reduce the number of infant deaths in the perinatal period and also reduce child morbidity. Training of health personnel at both local and central levels, increased social communication and promotion of intersectoral linkages at the local level will be employed to:

29.1 Establish a system for early recognition and management of high risk pregnancies.

29.2 Improve the monitoring of growth.

29.3 Develop and promote breastfeeding as an integral part of infant feeding.

30. PAHO will collaborate to the development of the following specific programs:

DHS: Health Services Development
CWS: Community Water Supply and Sanitation
MCH: Growth, Development and Human Reproduction

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		179,300	86.6	182,900	82.2	200,900	81.4
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		179,300	86.6	182,900	82.2	200,900	81.4
HEALTH SERVICES DEVELOPMENT	DHS	172,500	83.3	182,900	82.2	200,900	81.4
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	6,800	3.3	0	-	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		27,700	13.4	39,700	17.8	45,900	18.6
ENVIRONMENTAL HEALTH		27,700	13.4	32,100	14.4	37,400	15.2
COMMUNITY WATER SUPPLY AND SANITATION	CWS	27,700	13.4	32,100	14.4	37,400	15.2
MATERNAL AND CHILD HEALTH		0	-	7,600	3.4	8,500	3.4
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	0	-	7,600	3.4	8,500	3.4
GRAND TOTAL		207,000	100.0	222,600	100.0	246,800	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		1,542	.3	0	-	0	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		1,542	.3	0	-	0	100.0
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	1,542	.3	0	-	0	100.0
III. HEALTH SCIENCE AND TECHNOLOGY		588,748	99.7	428,638	100.0	0	-
ENVIRONMENTAL HEALTH		157,063	26.6	49,737	11.6	0	-
COMMUNITY WATER SUPPLY AND SANITATION	CWS	157,063	26.6	49,737	11.6	0	-
MATERNAL AND CHILD HEALTH		39,780	6.7	0	-	0	-
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	10,624	1.8	0	-	0	-
ADOLESCENT HEALTH	ADH	29,156	4.9	0	-	0	-
COMMUNICABLE DISEASES		391,905	66.4	378,901	88.4	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	391,905	66.4	378,901	88.4	0	-
GRAND TOTAL		590,290	100.0	428,638	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	6,800	0	0	0	0	0	0	0	0	3,400	0	3,400
WHO - WR	200,200	0	0	30	13,300	0	41	77,900	29,800	31,600	0	47,600
TOTAL	207,000	0	0	30	13,300	0	41	77,900	29,800	35,000	0	51,000
% OF TOTAL	100.0				6.4	.0		37.7	14.4	16.9	.0	24.6
1992-1993												
PAHO - PR	7,600	0	0	12	3,200	0	0	0	4,400	0	0	0
WHO - WR	215,000	0	0	60	18,100	11,600	44	88,000	37,600	34,800	0	24,900
TOTAL	222,600	0	0	72	21,300	11,600	44	88,000	42,000	34,800	0	24,900
% OF TOTAL	100.0				9.6	5.2		39.5	18.9	15.6	.0	11.2
1994-1995												
PAHO - PR	8,500	0	0	12	3,400	0	0	0	5,100	0	0	0
WHO - WR	238,300	0	0	60	19,400	13,500	44	92,400	43,600	40,400	0	29,000
TOTAL	246,800	0	0	72	22,800	13,500	44	92,400	48,700	40,400	0	29,000
% OF TOTAL	100.0				9.2	5.5		37.4	19.7	16.4	.0	11.8

ECUADOR

ANALYSIS OF THE HEALTH SITUATION

1. The predominant features of the health situation in Ecuador are the reflection of the economic and social crisis of recent years which is characterized by accentuated external dependence, concentration of wealth in small groups, marginalization of the majority, unjust distribution of the land, monopolization of economic activity, social marginality, disorganization of public services, inadequate economic growth, considerable increases in open unemployment and underemployment, expansion of the fiscal deficit, and serious deterioration of the quality of life of the population, especially low-income groups that live in the rural areas and the urban fringe of the large cities.

2. The health-disease situation offers large contrasts, depending on the social sector and geographical region. The health-disease phenomenon has an indisputable socioeconomic context; the general average demonstrates the enormous differences that exist between the social strata at higher economic levels and those of the marginal urban districts or the rural areas.

3. The statistics of the Ministry of Health indicate that in 1989 the coverage of children under five did not surpass 20%; it was 65% for those under one year and 9% for children from one to four years old. Maternal care coverage is less than 50% for the prenatal and less than 15% in the postnatal period. This limited coverage, combined with the low concentrations, describes in a dramatic way the state of health care in the health services.

4. The vital indicators reflect this situation. Thus, we find that the overall death rate is 5.5%; infant mortality, 40%; neonatal mortality, 22.4%, postneonatal mortality, 30.4%; and maternal mortality, 1.5%. Infectious diseases remain the leading cause of death in the entire population and are aggravated by the great problem of undernutrition. In recent years, there has been an increase in overall mortality due to cardiac ischemias, cancer of the stomach and cervix, traffic accidents, and homicides, shaping a profile of mortality that reflects the mixture of backwardness and modernity that characterizes morbidity in Ecuador.

5. The greatest contributions to the indicator hospital discharges come from the infectious diseases of the digestive system. Also noted in recent years is the rise in the incidences of tuberculosis and vector-borne diseases, especially malaria, leishmaniasis, and classical dengue.

6. The provision of basic sanitation services is inadequate; this deficit is significantly greater in the rural area, both for drinking water and for sewerage (in urban areas coverage of potable water is 81% and of sewerage, 64%, while in the rural areas the coverages only reach 36% and 13%, respectively).

7. Approximately 55,000 Ecuadorians die annually from various causes, which affect especially mothers and children; most of these deaths are occasioned by deficiencies in the drinking water services, by the poor management of solid wastes, by the diseases preventable by vaccination, and by acute respiratory infections, undernutrition, and diarrhea, pathologicaland deficiency processes that constitute the priority health problems of Ecuador.

National health strategies, policies, and plans

8. The health strategies and plans for the transformation of the national systems, as part of the development of the sector, are centered on the progressive implementation of a new model of individual and collective health care that envisages the extension of coverage through comprehensive care to the families at greatest biological, social, and economic risk, with special emphasis on the promotion and protection of the health of children and pregnant mothers.

9. In order to achieve this, the model anticipates the expansion and improvement of the network of services with new units, based on epidemiology and risk, in a context of reorganization of the health areas and establishment of microareas, with the objective of intensifying actions in the residences themselves and within the community.

10. This programmatic line is not a rigid scheme of activities or tasks to be developed; it is a dynamic process that, although it follows general principles, has to be adapted to the reality of every community, to its needs, to its intellectual level, to its traditions, and to its problems. Thus, it requires the active responsible participation of the family and the community which should be converted from passive receptors of medical care into active agents for their own health and well-being. It also requires the mobilization of national and international resources and complete intra- and intersectoral coordination.

11. This model of health care, called Comprehensive Family and Community Health, received the official support of the National Government in 1990, through an Executive Decree that designated the program as an outstanding aspect of the National Health Plan of Ecuador for the 1991-1992 biennium.

12. The implementation and development of this new model requires reorientation and utilization of the strategies of regionalization, social participation, in-service training, communication, and popular education, and also involves the development of local health systems and a change of the profile of the activities of physicians and all the other health workers at the operational as well as the technical and administrative levels.

13. In order to reach these health objectives, the Social Front of Ecuador, composed of the Ministries of Health, Education, Social Welfare, and Labor, has requested credit from the World Bank, in order to develop a project aimed at improving the living conditions of the populations groups with the greatest need. The Ministry of Health, as a member of the Social Front, has deemed it desirable to include as the central activity the development and consolidation of the Model of Comprehensive Family and Community Health Care, including actions in related fields, such as: food and nutrition, provision of drugs and supplies, basic rural and periurban-marginal sanitation, human resources, construction, remodeling, provision and maintenance of the basic service institutions, and strengthening of local health systems.

14. These actions are carried out through professional teams, auxiliaries, and community personnel with the appropriate training, continuing education, and supervision; special emphasis is placed on family and community education with the objective of strengthening self-care with respect to health, through changes in attitudes and practices that can signify risks to health or inadequate use of the health care services.

15. The Pan American Sanitary Bureau, as well as several international cooperation agencies (USAID, UNICEF, UNFPA, UNESCO, and UNDP) are collaborating actively in this project, through the mobilization of national and international resources oriented toward obtaining equity in access to the basic services and modernization of health policies and programs, in order to solve the basic problems of the majority of Ecuadorians.

National priority areas for technical cooperation

16. The government has requested priority technical cooperation in five large programmatic lines envisaged in the 1989-1992 National Health Plan: i) Comrehensive family and community Health; ii) food and nutrition; iii) basic sanitation; iv) drug supply; and v) improvement of hospital care.

17. Below the principal characteristics of these five priority programs are summarized:

Comprehensive family health

18. This programmatic line has the general objective of contributing to the improvement of the health conditions and the lives of the Ecuadorian population, through the progressive implementation of a new model of individual and collective health care, whose essential principles are: comprehensive care, that is, both preventive and curative, with special emphasis on the promotion and protection of health, with actions aimed at the family and the community; prioritization of the population groups exposed to greater biological, economic, and social risks, especially children and pregnant mothers; supplementation of health care provided in spontaneous consultations with programmed care that is given in the health centers and subcenters, as well as in the individual homes and within the community; humanized health actions of better quality, offered to individuals, families, and the community; and permanent incorporation of the active informed participation of the community and of other development sectors in a process of comanagement of the health services.

19. The development and implementation of the new model of health care require the reorientation and intensive utilization of the strategies of regionalization, social participation, in-service training, and communication and popular education; they also involve the development of what are called local health systems.

20. This type of health care requires the formation of a health team, consisting initially of a physician and a nurse, with the addition of other health professionals and the inclusion of others sectors in accordance with the local needs. In addition, it requires the implementation of a network of services of progressive and interrelated complexity.

Food and Nutrition

21. Undernutrition, as a cause of disease or death, is determined by, and is the result of, social and economic processes that have led to the crisis that affects the third world and which has intensified in Ecuador in recent years. This situation, with increasing unemployment and underemployment and the deterioration of the purchasing power of wages, has appreciably restricted the possibility of the population, especially those with lower income, to have access to a proper, ample, and nutritionally balanced diet.

22. Therefore, a coherent nutritional policy should integrate the global strategies of economic development and increased production with the social objectives of a redistributive nature, among which is improvement of the nutrition of the Ecuadorian population.

23. The nutrition programs and actions include, on the one hand, the control of some of the immediate causes of undernutrition, such as the infectious diseases, particularly in children under five; on the other hand, they are directed specifically toward the elimination of the underlying causes of this social disease, among the most important of which are inadequate family food security, insufficiency and low quality of the health services, inadequate child care, and deficient popular knowledge concerning the nutritive value of foods.

24. Concretely, this nutritional policy proposes the development of programs for urgent care of undernourished children and mothers, food and nutrition surveillance, supplementary feeding of mothers and children, integration of the training component, and food and nutrition education into the programs for formal and nonformal education, identification and recovery of the cultural traditions and values of the rural and indigenous communities in the area of food and nutrition, control and promotion of the utilization of iodized salt, especially in the goitrogenic areas, and delivery of iron supplements and other food to pregnant women, particularly those with low incomes.

Basic sanitation

25. This programmatic line begins to recognize the presence of a series of negative factors in the institutions belonging to the basic sanitation subsector which have resulted in slow growth of drinking water and sewerage coverage, particularly at the rural level, and a deterioration in the quality of the installed services.

26. The new basic sanitation policy proposes to increase the coverage of potable water and sewerage services, monitor the maintenance of the ecological equilibrium, and effectively control environmental pollution.

27. The achievement of these objectives will require from the Ecuadorian Institute of Sanitary Works (IEOS), as the specialized entity attached to the Ministry of Health, the implementation of the following operational strategies, among others:

27.1 Integration of the efforts and resources of all the institutions that carry out environmental sanitation activities into a single national program that establishes population priorities in relation to biological, economic, and social risk factors.

27.2 Motivation for the development of appropriate low-cost technologies for the design and construction of water systems, and especially for excreta disposal, that make it possible to compensate for the current deficiency of sanitary sewerage and latrines.

27.3 Provision of drinking water and sewerage or sanitary devices to the Health Centers and Subcenters of the Ministry, as well as to the schools, especially those in rural areas, that lack these services.

27.4 Promotion of community participation in the construction, use, and maintenance of the water supply and excreta disposal systems.

27.5 Development of systems for diagnosis, surveillance, and control of the principal elements that contaminate the environment and threaten the ecologogical system.

Drug supply

28. This programmatic line recognizes the priority character of timely provision of drugs in health programs, especially in the current situation of economic crisis, in which increasingly broad strata of the population lack any real possibility of acquiring drugs for the treatment of their health problems.

29. The drug review policy must address a complex problem that includes factors such as production, quality control, registration, marketing, supply, and utilization at different levels. Many of these factors are related to sectors and institutions that are outside the direct control of the Ministry of Health, as is the case with private industry, the professional unions, and the users, which makes the design of overall solutions difficult.

30. In this context, the national drug policy proposes as objectives that the entire population have access to essential drugs (National Drug List) that are safe and of good quality and verified therapeutic effectiveness, and that they be available in all places of distribution when needed, in sufficient quantity, and at accessible prices, by means of the agreement with the production and marketing sectors of the pharmaceutical industry.

31. This same policy points out the need for promoting the rational use of drugs, so that they are prepared, prescribed, dispensed, and administered correctly, in the proper dosage, at the necessary intervals, and for the indicated period.

Improvement of hospital care

32. The operations of the hospital units belonging to the official health entities have been affected by several difficulties, among which are: congestion in the hospitals of greater complexity and underutilization of the smaller ones; rapid obsolescence of equipment; differences and deficiencies in the administrative and managerial systems; insufficient funds budgeted for operation and for investments; and lack of, or deficiencies, in the maintenance of installations and medical equipment.

33. In order to address this situation, the new health policy proposed the adoption of the following basic strategies:

33.1 To adapt alternative solutions that harmonize the basic functions of the units, for both inpatient and outpatient care, with the strategies of primary health care, community participation, and comprehensive family health.

33.2 Design, implementation, and execution of the national system of maintenance, which covers the areas of prevention and repair of the physical installations and equipment of the health establishments; this will include decentralization of the units for maintenance and repair of hospital equipment.

33.3 Improvement of the managerial capacity of the different management levels by means of the introduction of decision-making models and the implementation of procedures for management of personnel, financial resources, and supplies.

33.4 Progressive implementation of the decentralized systems of management of personnel, financial resources, and supply of the units, with a view to achieving the regionalization of the health services and their administrative decentralization.

33.5 Integration of hospitals, health centers, and subcenters into the primary care system and development of the system of referral and back-referral.

GLOBAL STRATEGY OF COOPERATION

34. The global strategy of PAHO technical cooperation in Ecuador, taking into account the strategic orientations and the programming priorities of the Organization, the postulates of the Government, and the recommendations of the Joint PAHO/Country Evaluation, centers its support on the new model of comprehensive family care. It establishes criteria for coordination among the programs for infrastructure and for science and technology, as much at the local as at the regional level, that permit the development of the model that reorients the efforts and resources toward the population groups at greatest risk because of their social and economic marginality and their biological vulnerability, harmonizing the promotion and protection of health, control of the environment, attention to disease, and the rehabilitation of the patients.

35. The strategy is directed toward guaranteeing timely accessibility for all users and functionally integrating networks of services in geographical areas and defined populations--all this within the framework of local health systems.

36. This strategy is defined in the following list of activities: 1) development of the infrastructure of the health services with emphasis on primary care, 2) addressing the priority health problems present in vulnerable human groups, and 3) administration of the knowledge necessary for carrying out the above activities. Its purpose is to contribute to the achievement of the following objectives: 1) to improve the epidemiological profiles and indicators of well-being in the neglected groups, 2) to increase the coverage, quality, and comprehensive nature of the actions, including the control of risk factors through intersectoral efforts, and 3) to develop local health systems through the articulation of the potential resources, decentralization, and social participation. In order to achieve this purpose and these objectives, strategic lines of interprogrammatic action are developed, aimed at identifying, prioritizing, and addressing the problems.

37. Included among the lines of action is the development of the capacity for epidemiological analysis of the health situation, programmatic analysis, and analysis of other determining factors systematically, reflectively, critically, and with the participation of community and extrasectoral organizations, with the objective of analyzing the priority problems and focusing the wills, efforts and resources for their control.

38. It also envisages interprogrammatic support for the formulation of broad, local, comprehensive participatory programs that, beginning with the priority needs and problems of the most vulnerable social groups and their biological, socioeconomic, cultural, and environmental risk factors, define and coordinate the actions to be carried out by the different social agents, motivate and articulate all the institutional, sectoral, extrasectoral, nongovernmental, community, and external resources, and establish joint mechanisms for surveillance and evaluation.

39. Special attention is to the conceptual and methodological development of models of comprehensive health care of individuals, families, social groups, communities, and the environment that improve the capacity to capture the population through extramural actions that strengthen the capacity to resolve problems and extend the scope of the actions, taking into consideration the needs of the population, its injuries, and its risk factors.

40. A great deal of importance is also given to the development and improvement of the technical, managerial, and support processes and systems and those for social participation, especially at the level of the local health systems, so that they assume growing responsibilities in the analysis and solution of the local problems, in the coordination of the local social infrastructure, and in its management.

41. In order to induce and energize this significant change in institutional performance, a significant component of support is developed for the motivation, orientation, training, supervision, and advising of the personnel, and of the human resources in general, including the community, in order to achieve the efficient application, surveillance, and evaluation of the policies in effect. Special importance is given to training in general at all the levels in order to achieve adequate participatory management of the local systems. These efforts, especially those of planning and training, are carried out with the broad participation of the educational institutions and the services.

42. In addition, within the framework of democratization, development is encouraged and promoted of styles of participatory leadership that promote the coordination and mobilization of resources, including social participation, intersectoral complementarity, functional articulation with the traditional health systems, and the growing sectoral coordination beneficial to the national health system.

43. In order to maintain the directionality of the efforts in accordance with the established policies and in order to promote consensus and support for the national plan, the goal is set to strengthen the analytical capacity and broadly disseminate the information pertinent to monitoring and evaluation so that they respond to the needs of the different social agents.

44. Finally, as a part of the priority lines of action, research is promoted and supported and oriented toward the study and solution of the priority problems, so that it serves as a scientific support to the development, adaptation, and application of the knowledge required for the implementation of the new models of developmenmt and health care, oriented toward the payment of the social and health debts to the population, with emphasis on the unprotected sectors.

45. PAHO will collaborate in the development of the following specific programs:

MPN:	Managerial Support for National Health Development
TCC:	Technical Cooperation among Countries
HST:	Health Situation and Trend Assessment
DHS:	Health Services Development
HME:	Health Manpower Education
CWS:	Community Water Supply and Sanitation
MCH:	Growth, Development and Human Reproduction
OCD:	General Communicable Diseases Prevention and Control Activities
NCD:	Health Promotion and Prevention and Control of Noncommunicable Diseases

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		1,680,700	68.1	1,852,400	67.3	1,994,500	66.3
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		457,700	18.5	560,300	20.3	643,400	21.4
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	457,700	18.5	560,300	20.3	643,400	21.4
TECHNICAL COOPERATION AMONG COUNTRIES		51,500	2.1	59,700	2.2	69,300	2.3
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	51,500	2.1	59,700	2.2	69,300	2.3
HEALTH SITUATION AND TREND ASSESSMENT		213,300	8.6	251,600	9.1	285,600	9.5
HEALTH SITUATION AND TREND ASSESSMENT	HST	213,300	8.6	251,600	9.1	285,600	9.5
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		773,800	31.4	810,700	29.5	808,000	26.8
HEALTH SERVICES DEVELOPMENT	DHS	773,800	31.4	810,700	29.5	808,000	26.8
HUMAN RESOURCES DEVELOPMENT		184,400	7.5	170,100	6.2	188,200	6.3
HUMAN RESOURCES EDUCATION	HME	184,400	7.5	170,100	6.2	188,200	6.3
III. HEALTH SCIENCE AND TECHNOLOGY		789,100	31.9	903,800	32.7	1,014,700	33.7
ENVIRONMENTAL HEALTH		215,200	8.7	251,500	9.1	283,300	9.4
COMMUNITY WATER SUPPLY AND SANITATION	CWS	215,200	8.7	251,500	9.1	283,300	9.4
MATERNAL AND CHILD HEALTH		151,200	6.1	169,100	6.1	189,500	6.3
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	151,200	6.1	169,100	6.1	189,500	6.3
COMMUNICABLE DISEASES		380,900	15.4	416,200	15.1	465,600	15.5
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	380,900	15.4	416,200	15.1	465,600	15.5
HEALTH PROMOTION		41,800	1.7	67,000	2.4	76,300	2.5
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	41,800	1.7	67,000	2.4	76,300	2.5
GRAND TOTAL		2,469,800	100.0	2,756,200	100.0	3,009,200	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		630,861	57.5	541,044	66.7	0	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		630,861	57.5	541,044	66.7	0	100.0
HEALTH SERVICES DEVELOPMENT	DHS	99,520	9.1	0	-	0	100.0
ESSENTIAL DRUGS AND VACCINES	EDV	505,741	46.1	541,044	66.7	0	-
ORAL HEALTH	ORH	25,600	2.3	0	-	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		466,738	42.5	270,371	33.3	0	-
ENVIRONMENTAL HEALTH		113,170	10.3	0	-	0	-
COMMUNITY WATER SUPPLY AND SANITATION	CWS	113,170	10.3	0	-	0	-
MATERNAL AND CHILD HEALTH		42,228	3.8	76,864	9.5	0	-
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	42,228	3.8	76,864	9.5	0	-
COMMUNICABLE DISEASES		261,810	23.9	193,507	23.8	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	261,810	23.9	193,507	23.8	0	-
VETERINARY PUBLIC HEALTH		49,530	4.5	0	-	0	-
ZOONOSES	ZNS	49,530	4.5	0	-	0	-
GRAND TOTAL		1,097,599	100.0	811,415	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	737,000	48	0	75	337,400	32,700	30	57,000	189,300	13,200	0	107,400
WHO - WR	1,732,800	120	96	405	927,600	56,300	130	247,000	213,900	28,300	10,300	249,400
TOTAL	2,469,800	168	96	480	1,265,000	89,000	160	304,000	403,200	41,500	10,300	356,800
% OF TOTAL	100.0				51.3	3.6		12.3	16.3	1.7	.4	14.4
1992-1993												
PAHO - PR	899,300	48	0	140	435,000	38,800	27	54,000	139,700	24,400	0	207,400
WHO - WR	1,856,900	109	96	340	974,800	72,700	94	188,000	227,800	44,000	11,900	337,700
TOTAL	2,756,200	157	96	480	1,409,800	111,500	121	242,000	367,500	68,400	11,900	545,100
% OF TOTAL	100.0				51.2	4.0		8.8	13.3	2.5	.4	19.8
1994-1995												
PAHO - PR	1,022,700	48	0	140	489,800	45,100	27	56,700	162,200	28,300	0	240,600
WHO - WR	1,986,500	96	96	340	983,900	84,300	94	197,400	264,300	51,000	13,900	391,700
TOTAL	3,009,200	144	96	480	1,473,700	129,400	121	254,100	426,500	79,300	13,900	632,300
% OF TOTAL	100.0				49.0	4.3		8.4	14.2	2.6	.5	21.0

ANALYSIS OF THE HEALTH SITUATION

Demography

1. The total population of the country in 1990, estimated in accordance with the projections of the 1991 census, was 5,252,000. The growth rate of the population for the period 1985-1990 was 1.9%, and projection for the decade 1991-2000 is 2.5%. The urban population accounts for 44% of the total, showing a tendency toward increase, particularly as a result of the population displacements brought on by the war. It is estimated that there are 500,000 displaced persons in the country, most of whom reside in the outskirts of the capital city.

Health indicators

2. Life expectancy at birth of Salvadorans in 1990 was 63.5 years. Among males, it is 59.8 years, and in females, 67.2 years. The figures for males have certainly undoubtedly been influenced by the armed conflict.

3. The overall death rate, which in 1980 was 11 per 1,000, declined in 1990 to 8.4 per 1,000. The infant mortality rate, at 73 per 1,000 live births in 1980, was estimated in 1990 at 55 per 1,000. The maternal death rate was 14 per 10,000 live births in 1989.

4. The general and specific death rates have been influenced by the armed conflict, which has caused a large number of deaths from violent causes, basically among males and younger people.

5. The prime causes of child mortality in the 1 to 4-year age group continue to be gastrointestinal and respiratory infections, including some diseases preventable by vaccination, such as measles. The exception is poliomyelitis, which has not appeared either as a cause of disease nor of death in recent years. Protein-energy undernutrition also contributes to the causes of child and preschool-child mortality, since it continues to be prevalent (50.1%) among children under the age of 5. The same is true of the nutritional anemias that affect 23% of this population. Vitamin A deficiency and iodine deficiency are prevalent in 36% and 38% of schoolchildren, respectively. The diet is inadequate in the nutrients indicated.

Factors affecting the health situation

6. The environmental sanitation situation is deficient: coverage of the population with drinking water is 47% in rural areas and 76% in urban areas. Adequate excreta disposal services in the country is 50%, broken down to 85% in urban areas and 39% in rural areas.

7. El Salvador has made a special effort in recent years to improve its immunization programs; during the last three years, there has been no reported presence of the wild poliomyelitis virus.

8. Immunization coverage of the population under 5 years of age is as follows: DPT, 76%; measles, 76%; poliomyelitis, 76%; BCG, 58%; tetanus among pregnant women, 43%.

9. A recent study of the demand for health services shows that, with regard to outpatient consultation, the population uses the health services in the following manner: private sector, 45.2%; Ministry of Health, 39.8%; Social Security (ISSS), 12.7%; other institutions, 2.3%. The demand for hospitalization services is structured as follows: private sector, 9.4%; Ministry of Health, 75.5%; Social Security, 12.6%; other institutions, 2.5%.

10. The coverage of maternal and child care shows the following structure: prenatal control, 69%; delivery by trained personnel, 66%; child care, 45%. These figures include care deliverd by auxiliary and community personnel. A recent study of care by trained midwives demonstrated that the care provided was of low quality.

11. The resources assigned to the health budget have not been increased in recent years. The structure of the expenditure on health demonstrates that a high proportion of the costs is directed toward the recovery of health.

12. To the foregoing must be added the socioeconomic and political situation of the country, which has been characterized by moderate economic growth in recent years. The gross domestic product per capita is $US940 for the period 1968-1990. Nevertheless, the population living in conditions of poverty has increased. In 1990, the proportion of the population living in such conditions was 63% (half in critical poverty), and that of the non-poor population, 37%.

13. The economic situation, especially that of the poor, has been affected by unemployment, inflationary trends, and the measures deriving from the structural adjustment that has affected the budgets of the social sectors, although the government has taken some steps to diminish the impact by setting up the Social Investment Fund (FIS) and other compensatory measures. With regard to education, illiteracy among the population in general is 50%, and among the economically active population, 57%. Schooling in the urban area amounts to 4.7 years, and in rural areas, 2.8 years.

14. The above information points to a very difficult situation for the country, since the traditional deficient socioeconomic structures are compounded by the impact of 10 years of internal war that has caused more than 70,000 deaths and affected large population groups or refugees and displaced persons.

National health strategies and plans

15. The Ministry of Health has prepared a National Health Plan for 1991-1994 whose basic objective is to improve the state of health of the population. For this purpose, programs have been developed that are directed toward the priority

problems relating to the risk factors of vulnerable groups through actions to promote health, prevent disease, and promote recovery and rehabilitation. The following basic strategies have been adopted:

15.1 Extension of coverage to the entire population, which implies access of the entire population to the services and its effective incorporation into the health system by assigning priority to the satisfaction of basic needs.

15.2 Improvement of the resolution capacity of the various levels of care, including the scientific, technical, and administrative improvement of the health services, in order to ensure effective coverage of the population and good quality in the provision of services at all levels, with emphasis on the first level.

15.3 Decentralization, which refers to the delegation of authority to the operational levels of the organization. It implies changes in the administrative processes of planning, standardization, and administration of human, material, and financial resources.

15.4 Institutional development, which refers to improvement of the organizations and their operation through the incorporation of managerial technology to increase efficiency, and thereby provide a better response to health needs.

15.5 Strengthening of financing: Financing sources will be studied and resources will be reassigned by care levels, seeking alternative sources of financing, taking advantage of community resources, and carrying out financial planning through all stages up through operational, regional, and local execution.

15.6 Interinstitutional and intersectoral coordination: Since health is both a part of, and the result of social development in which other sectors participate, such as education, agriculture, economy, public utility companies, municipalities, and private entities, coordination as a means of joining efforts becomes a matter of priority. Coordination should be interpreted as the identification of ends and means by the various public organizations, in order to achieve a better level of health within the context of overall development.

15.7 Coordination of international cooperation: Given that international cooperation is an important source of technical and economic resources for the development of the country's health programs, such cooperation will be oriented basically to fulfilling the policies of the National Health Plan.

16. The technical cooperation priorities of the sector are: support for the development of the National Health System; development of health services, with emphasis on local health systems; training of human resources and dissemination of scientific technical information; interinstitutional coordination; support for the process of decentralization and deconcentration; development of information systems; essential drugs; improvement of the environment; support for maternal and child health and nutrition programs; support for programs for communicable disease control, assigning priority to EPI, AIDS, and malaria; providing care for handicapped and elderly persons; incorporation of women; care for the displaced population; and prevention in cases of disaster.

17. PAHO cooperation will be oriented toward supporting the priorities defined by the Ministry with emphasis on local health systems, the process of decentralization, coordination with the Social Security system, essential drugs, training of human resources, improvement of the environment, nutrition, control of AIDS, EPI, participation of women, the health of displaced persons, and prevention in cases of disaster. In accordance with the seventh strategy of the Ministry, this cooperation will be provided in coordination with other agencies.

GLOBAL STRATEGY OF COOPERATION

18. In support of the strategies of the Health Plan for 1991-1994 and of the Ministry's priority programs, PAHO/WHO will develop the following strategies:

18.1 At the national level, support will be maintained for the Ministry and other institutions in the sector so that the health problem will be considered at the highest level of the economic and social cabinet, and at the level of the Assembly as a priority issue and consequently integrated into the economic and social development of the country, in an attempt to achieve multisectoral coordination and political and legal support for comprehensive improvement of the population. Support will be given to actions aimed at effective participation of the country in the subregional initiative Plan for Priority Health Needs in Central America and Panama.

18.2 Support will be given to implementing the Health Plan with an approach based on multisectoral participation and development integrated into other productive actions, education, development of the infrastructure, and environmental improvement, through community participation in the priority areas defined by the country by levels of poverty. This support will be provided in coordination with the Social Investment Fund (FIS), and in coordination with other bilateral United Nations agencies and international banks.

18.3 Support will be given to country strategies aimed at reorganizing the health sector through the establishment of a national health system so structured that it will permit the incorporation of the Social Security system as an important resource for the expansion of coverage and actions to promote health, prevent disease, and promote recovery and rehabilitation. Support will be provided to the strategy of decentralization of the health services, the development of local health systems, and improvement of the resolution capacity of the other levels. Emphasis will be placed on studies and support for proposals to improve the financial capacity of the sector. With regard to external financing, support will be given to the country in the preparation of priority projects at both the bilateral level and at the level of the subregional initiative Plan for Priority Health Needs in Central America.

18.4 Support will be given to the capacity of the sector to develop health education in order to improve the lifestyles of the population, assist in preventing disease, and attain a higher standard of living. This includes the use of new methodologies of education, including mass communications. Communicable disease control will be supported with priority on AIDS, diseases preventable by vaccination, vector-borne diseases, and control of other diseases, such as specific nutritional deficiencies. Support will be given to

actions directed toward displaced population groups and the prevention of disasters.

18.5 Support will be given to the training and development of human resources, placing emphasis on continuing education, development of the National Network of Scientific and Technical Information, and support for research.

18.6 Support will be continued for the program Women, Health, and Development, at the level of the health sector, the Secretariat of the Family, and other sectors.

19. Full support by the PAHO/WHO Representation will be given through direct technical assistance, training of personnel, research, dissemination of scientific and technical information, and support for mobilization of national and international resources, including the preparation of specific projects that will assist in implementing the priority programs. Cooperation between countries will also be promoted, particularly within the framework of the subregional initiative. Coordinated efforts will be made in conjunction with the other bilateral, international, and United Nations agencies existing in the country.

20. PAHO will collaborate in the development of the following specific programs:

MPN:	Managerial Support for National Health Development
TCC:	Technical Cooperation among Countries
HST:	Health Situation and Trend Assessment
DHS:	Health Services Development
HME:	Health Manpower Education
CWS:	Community Water Supply and Sanitation
MCH:	Growth, Development and Human Reproduction
OCD:	General Communicable Disease Prevention and Control Activities
NCD:	Health Promotion and Prevention and Control of Noncummunicable Diseases
ZNS:	Zoonoses

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		1,401,400	68.7	1,496,200	67.0	1,704,700	67.1
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		559,700	27.4	619,100	27.7	710,000	27.9
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	559,700	27.4	619,100	27.7	710,000	27.9
TECHNICAL COOPERATION AMONG COUNTRIES		45,800	2.2	53,100	2.4	61,600	2.4
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	45,800	2.2	53,100	2.4	61,600	2.4
HEALTH SITUATION AND TREND ASSESSMENT		21,200	1.0	42,500	1.9	46,800	1.8
HEALTH SITUATION AND TREND ASSESSMENT	HST	21,200	1.0	42,500	1.9	46,800	1.8
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		710,800	35.0	706,100	31.6	798,800	31.6
HEALTH SERVICES DEVELOPMENT	DHS	710,800	35.0	706,100	31.6	798,800	31.6
HUMAN RESOURCES DEVELOPMENT		63,900	3.1	75,400	3.4	87,500	3.4
HUMAN RESOURCES EDUCATION	HME	63,900	3.1	75,400	3.4	87,500	3.4
III. HEALTH SCIENCE AND TECHNOLOGY		640,800	31.3	737,400	33.0	836,000	32.9
ENVIRONMENTAL HEALTH		338,400	16.6	344,600	15.4	389,300	15.3
COMMUNITY WATER SUPPLY AND SANITATION	CWS	338,400	16.6	344,600	15.4	389,300	15.3
MATERNAL AND CHILD HEALTH		57,900	2.8	51,800	2.3	57,500	2.3
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	57,900	2.8	51,800	2.3	57,500	2.3
COMMUNICABLE DISEASES		229,300	11.2	265,500	11.9	306,800	12.1
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	229,300	11.2	265,500	11.9	306,800	12.1

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
HEALTH PROMOTION		0	-	53,900	2.4	58,400	2.3
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	0	-	53,900	2.4	58,400	2.3
VETERINARY PUBLIC HEALTH		15,200	.7	21,600	1.0	24,000	.9
ZOONOSES	ZNS	15,200	.7	21,600	1.0	24,000	.9
GRAND TOTAL		2,042,200	100.0	2,233,600	100.0	2,540,700	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		3,777,335	82.6	1,409,994	87.6	0	100.0
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		28,288	.6	0	-	0	100.0
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	28,288	.6	0	-	0	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		3,749,047	82.0	1,409,994	87.6	0	-
HEALTH SERVICES DEVELOPMENT	DHS	3,749,047	82.0	1,409,994	87.6	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		795,624	17.4	200,000	12.4	0	-
ENVIRONMENTAL HEALTH		225,554	4.9	0	-	0	-
COMMUNITY WATER SUPPLY AND SANITATION	CWS	225,554	4.9	0	-	0	-
MATERNAL AND CHILD HEALTH		8,935	.2	0	-	0	-
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	8,935	.2	0	-	0	-
COMMUNICABLE DISEASES		547,566	12.0	200,000	12.4	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	512,513	11.2	200,000	12.4	0	-
MALARIA	MAL	35,053	.8	0	-	0	-
HEALTH PROMOTION		13,569	.3	0	-	0	-
OCULAR HEALTH	PBD	13,569	.3	0	-	0	-
GRAND TOTAL		4,572,959	100.0	1,609,994	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	861,800	48	0	120	367,600	14,800	72	136,800	134,800	40,000	78,500	89,300
WHO - WR	1,180,400	72	72	270	656,100	27,500	76	144,400	103,800	38,300	0	210,300
TOTAL	2,042,200	120	72	390	1,023,700	42,300	148	281,200	238,600	78,300	78,500	299,600
% OF TOTAL	100.0				50.1	2.1		13.8	11.7	3.8	3.8	14.7
1992-1993												
PAHO - PR	1,001,300	48	0	115	437,300	30,100	76	152,000	206,700	57,900	0	117,300
WHO - WR	1,232,300	72	72	170	671,400	32,600	60	120,000	78,900	46,600	0	282,800
TOTAL	2,233,600	120	72	285	1,108,700	62,700	136	272,000	285,600	104,500	0	400,100
% OF TOTAL	100.0				49.6	2.8		12.2	12.8	4.7	.0	17.9
1994-1995												
PAHO - PR	1,133,200	48	0	115	495,400	35,100	76	159,600	239,800	67,200	0	136,100
WHO - WR	1,407,500	72	72	170	769,700	37,900	60	126,000	91,600	54,100	0	328,200
TOTAL	2,540,700	120	72	285	1,265,100	73,000	136	285,600	331,400	121,300	0	464,300
% OF TOTAL	100.0				49.8	2.9		11.2	13.0	4.8	.0	18.3

FRENCH ANTILLES AND GUIANA

ANALYSIS OF THE HEALTH SITUATION

1. Although the populations of the French Departments of Martinique, Guadeloupe and French Guiana are all relatively young, there is a marked difference in the population densities.

2. French Guiana has a very low population density, 1.03 km2, while that of Guadeloupe and Martinique in 1990 was 201 and 312 per km2, respectively.

3. The 1990 estimates of total population for French Guiana, Guadeloupe and Martinique are 95,540, 339,672 and 337,101, respectively.

Indicators of Health Status

4. The life expectancy at birth is estimated at 68 years for men and 75 years for women in Guadeloupe, 72 years for men and 76 years for women in Martinique, and 65 years for men and 74 years for women in French Guiana. All three territories show an increase in the birth rate: French Guiana is 31.04 per 1,000 population, Guadeloupe 21 per 1,000 and Martinique 19.0 per 1,000.

5. The infant mortality rate however have decreased in all instances in 1988: 24.6 per 1,000 in French Guiana; 8.6 per 1,000 in Martinique, and 12.9 per 1,000 in Guadeloupe. Although there is a decrease in IMR, analysis has shown that the major causes are within the perinatal period. Among the children 0-14 years, accidents and pediatric AIDS are major concerns.

6. Infectious Diseases continue to pose serious health threats, Dengue fever in particular, and Malaria. Dengue is endemic in French Guiana and in that territory the incidence of malaria increased with 3,000 chloroquin resistant cases in 1988.

7. The main causes of morbidity in the adult population are cardiovascular disease, hypertension and diabetes, cancer and disorders due to alcoholism and accidents.

8. Sexually transmitted diseases, including AIDS, continue to be of public health concern. AIDS is becoming a major concern with 537 cases in the Region as of the 31 March 1990, an incidence of 68.8 per 100,000. The majority of the cases are within the 30-39 year age group with the mode of transmission being primarily heterosexual.

Factors Affecting Health Status

9. The populations in these territories are served by a wide range of primary care and secondary care services but certain groups, specifically the immigrant populations of St. Martin and Guadeloupe administrated by French Guiana are not covered by the social security system.

GLOBAL STRATEGY OF COOPERATION

10. Inspection Regionale de la Sante des Antilles Guiana has identified two major priority areas for technical cooperation: the development of human resources and the strengthening of health promotion. Technical cooperation activities between the Eastern Caribbean and the French Territories are to be increased.

11. PAHO/WHO will support the attachment of health personnel from the French Territories to English-speaking Caribbean Institutions and other extraregional training facilities when appropriate.

12. In the area of health promotion, PAHO will assist with the development of culturally relevant educational materials, specifically for the immigrant population.

13. PAHO will collaborate in the development of the following specific program:

DHS: Health Services Development

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		69,100	100.0	73,800	100.0	81,000	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		69,100	100.0	73,800	100.0	81,000	100.0
HEALTH SERVICES DEVELOPMENT	DHS	69,100	100.0	73,800	100.0	81,000	100.0
GRAND TOTAL		69,100	100.0	73,800	100.0	81,000	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
WHO - WR	69,100	0	0	30	20,400	6,900	15	28,500	4,600	3,400	0	5,300
TOTAL	69,100	0	0	30	20,400	6,900	15	28,500	4,600	3,400	0	5,300
% OF TOTAL	100.0				29.5	10.0		41.2	6.7	4.9	.0	7.7
1992-1993												
WHO - WR	73,800	0	0	30	20,500	8,000	18	36,000	5,400	3,900	0	0
TOTAL	73,800	0	0	30	20,500	8,000	18	36,000	5,400	3,900	0	0
% OF TOTAL	100.0				27.8	10.8		48.8	7.3	5.3	.0	.0
1994-1995												
WHO - WR	81,000	0	0	30	23,000	9,300	18	37,800	6,300	4,600	0	0
TOTAL	81,000	0	0	30	23,000	9,300	18	37,800	6,300	4,600	0	0
% OF TOTAL	100.0				28.4	11.5		46.6	7.8	5.7	.0	.0

ANALISYS OF THE HEALTH SITUATION

Demography

1. The population is estimated to have grown from 96,030 in 1984 to 103,400 in 1987; annual population growth was estimated to be 1.2% in 1987. The population is young, with 37.2% being under 15 years old and only 7.1% over the age of 65.

2. Birth rates have remained above 30 per 1,000 population. The estimated birth rate was 30.3 per 1,000 population in 1987 and 30.9 in 1985. Fertility rates are relatively high, reaching about 140 per 1,000 women aged 15-44 in 1987.

Health indicators

3. The infant mortality rate has decreased from 18.1 per 1,000 live births in 1985 (56 deaths) to 14.7 in 1987 (45 deaths). The leading causes of infant death are prematurity, congenital anomalies, and respiratory infections. The main reasons for hospital admissions in children under 5 years of age are gastroenteritis, respiratory infection, and hernias.

4. Immunization coverage for children under 1 year old rose dramatically from 61% for DPT and 77% for polio in 1985 to 98% and 92%, respectively, in 1987. Measles coverage was 77%. Rubella immunization for school children has been established.

5. The increasing adult population has paved the way for the predominance of chronic noncommunicable diseases as the leading causes of mortality and morbidity. In descending order of importance, heart disease, cerebrovascular disease, and malignant neoplasms rank as the leading causes of death. Diabetes and hypertension are the fifth and eighth causes of death, respectively, but their contribution to both heart and cerebrovascular diseases should not be underestimated. Accident-related deaths are increasing. Cervical cancer has been identified as the leading malignancy among females. Among males, the leading malignancies are gastric cancer and prostate cancer.

6. Maternal deaths (two per year in 1985, 1986, and 1987) are equivalent to a maternal mortality rate of 6.4 per 10,000 live births. The percentage of total births delivered to teenage mothers was 23% in 1985 (726 births),21% in 1986 (677 births), and 25.7% in 1987 (800 births). Family Planning services have become available at all the country's clinics.

Factors affecting health status

7. The Environmental health situation continues to dominate the concerns. Particularly in the area of Sewerage Disposal, there still remain some rural communities where all areas of environmental concerns remain a priority. Although Grenada experienced increased economic growth to 5.9% in 1989, inflation moderated and the unemployment situation eased slightly, fiscal and external balances remained weak.

8. There is urgent need to bring more efficiencies to the Public Sector in the area of management and to achieve optimal utilization of resources.

9. The health service continues to maintain a relatively high coverage, however, there is urgent need to seek alternate means of financing for the health care system. In addition, the management systems within the Ministry of Health and at the level of the hospital urgently need improving.

National health strategies policies and plans

10. The Ministry of Health along with the private sector and the National Insurance scheme comprise the health sector. The Ministry of Health in the budget identified the strengthening of the Community Health Services as a major priority. The other priorities identified by the Ministry of Health are as follows: environmental Health, financing health care, human resource development, communicable diseases, maternal and child health, chronic non-communicable diseases and health promotion.

11. The strategies proposed to strengthen the community health services will be the strengthening of the health services of Carricou and Petit Martinique. This system will be seen as a local health system. The Coordination of the health system in Carricou and Petit Martinique will be strengthened by the appointment of the Administrator of the Community Health Services.

12. The Community Health Services will be strengthened by improving the management capability of the District Health Staff. This will include the development of the information system and the use of this to increase the capacity for epidemiological analysis.

13. Improvement in the environment is seen as a priority - an Environmental Protection Officer would be appointed to bring in special focus to the marine environment. In addition, sewerage system of St George and Grand Anse be improved by addressing the physical infrastructure such as pumping stations and connecting lines. Efforts will also be directed toward the improvement of sewage and solid waste disposal in the rural communities. Food protection will be strengthen through the training of food handlers.

14. Increased financing of the health care in Grenada will be addressed by focusing on the efficiency of the financial management system. Accountability will be stressed and collaboration with PAHO and Stony Brook University in the development of cost centers will continue. Also, the possible funding of some aspects of the health care delivery system by the incorporation of the National Insurance Scheme will be examined.

15. The development of human resources will be addressed by training and an examination of the production/ utilization axis in all programs of the Ministry of Health.

16. In the prevention and control of Communicable Diseases AIDS/STD these national efforts will aim at the strengthening of the laboratory capability by training of staff. Also the involvement of NGOs in the establishment of community support groups for counseling of patients and their families will be encouraged.

17. In the Maternal and child health program, there will be an intensified focus on the improvement of coverage and family planning with a special emphasis on teenagers. Improved perinatal care will be pursued at all levels.

18. Chronic non-communicable diseases continue to be a major cause of morbidity and mortality. The promotion of healthy lifestyles will be pursued. In addition, efforts will be made to strengthen the integration at the local level.

19. Health promotion will increasingly be used to support the efforts in the priority areas. This will be pursued through education and community participation to promote changes in individual and community behavior deleterious to health. Special focus will be on chronic and noncommunicable (diabetes and hypertension) diseases and AIDS/STD.

GLOBAL STRATEGY OF COOPERATION

20. The Government identified eight major priority areas in which technical cooperation will be required: strengthening community health services, environmental health, human resource development, financing health care, maternal and child health, chronic diseases: diabetes, hypertension, cancer, health promotion and communicable diseases.

21. The Technical Cooperation in the areas identified will be pursued in keeping with the spirit of the Caribbean Cooperation in Health Initiative. The strategies which would be employed would be in keeping with those agreed on for the various areas of the Initiative.

22. PAHO/WHO strategies for the provision of technical cooperation in the areas identified will be based on strengthening the management capability, training, intensifying community participation in all programs and the strengthening of the local health system by the establishment of monitoring and evaluation mechanisms.

23. PAHO's cooperation aims to strengthen the community health services with a view to its functioning more effectively as the focal point of the local health system. Efforts will be directed to the improvement of the information system and training of the local staff to analyze and use the information available to them. In addition, support will be provided for the evaluation and improved management of the District Health Service with special reference to the Cariacou and Petit Martinique.

24. In the area of Environmental Health, the technical cooperation will assist the development of an environmental health information system; improve the knowledge base of food handlers; and support the expansion of the pit latrine project in the rural community. Support will also be provided for the development of monitoring mechanisms for the marine environment and the enactment of environmental legislation. CPC and CAREC will collaborate in the integration of vector and rodent control programs at the local level, promoting intersectoral linkages.

25. In the area of human resource development, the technical cooperation will include the provision of fellowships to assist in the addressing of the manpower needs. Assistance will be provided to examine and evaluate the production/utilization axis and support the development of the continuing education program for all categories of health personnel.

26. Technical cooperation to improve the financial management system will be to continue a complement the activities of Stony Brook University in the development of cost centers. In addition, PAHO/WHO will work with the Ministry in incorporating the full potential of the National Insurance Scheme.

27. PAHO will give support to the Maternal and Child Health program by cooperating in the establishment of a system for early recognition and management of high risk pregnancies. Family planning programs will be intensified to improve coverage. Training for district staff will be undertaken by PAHO. The Organization will support the Ministry of Health in its efforts to eliminate poliomyelitis and measles.

28. In the area of chronic diseases the technical cooperation will assist the development of a national register for tumors; study the dimensions and trends in chronic diseases and work with NGOs and other relevant organizations to promote healthy lifestyles.

28.1 The goal of health promotion will be to achieve changes in behavior to improve the control of diabetes, hypertension and AIDS.

28.2 PAHO's technical cooperation will seek to promote and support the development of policy guidelines to orient implementation of various components of health promotion.

28.3 Training will be provided for the health sector staff and NGOs in health promotion concepts and methods.

28.4 Support the development of innovative projects aimed at fostering change at the community level and within various sectors.

29. In the area of communicable diseases, technical cooperation will be provided to improve the diagnostic capability of the laboratory, to strengthen the capacity of NGO's in the area of counselling for patients and families; support the continuing education for professionals in relation to management of AIDS patients.

30. PAHO will collaborate to the development of the following specific programs:

DHS: Health Services Development

CWS: Community Water Supply and Sanitation

MCH: Growth, Development and Human Reproduction

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		117,400	80.1	124,200	79.0	134,800	78.3
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		117,400	80.1	124,200	79.0	134,800	78.3
HEALTH SERVICES DEVELOPMENT	DHS	117,400	80.1	124,200	79.0	134,800	78.3
III. HEALTH SCIENCE AND TECHNOLOGY		29,100	19.9	33,000	21.0	37,400	21.7
ENVIRONMENTAL HEALTH		22,400	15.3	25,200	16.0	28,300	16.4
COMMUNITY WATER SUPPLY AND SANITATION	CWS	22,400	15.3	25,200	16.0	28,300	16.4
MATERNAL AND CHILD HEALTH		6,700	4.6	7,800	5.0	9,100	5.3
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	6,700	4.6	7,800	5.0	9,100	5.3
GRAND TOTAL		146,500	100.0	157,200	100.0	172,200	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
III. HEALTH SCIENCE AND TECHNOLOGY		191,635	100.0	127,191	100.0	0	100.0
MATERNAL AND CHILD HEALTH		47,051	24.6	0	-	0	100.0
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	47,051	24.6	0	-	0	100.0
COMMUNICABLE DISEASES		144,584	75.4	127,191	100.0	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	144,584	75.4	127,191	100.0	0	-
GRAND TOTAL		191,635	100.0	127,191	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	146,500	0	0	40	15,800	0	36	68,400	23,900	14,000	0	24,400
TOTAL	146,500	0	0	40	15,800	0	36	68,400	23,900	14,000	0	24,400
% OF TOTAL	100.0				10.8	.0		46.6	16.3	9.6	.0	16.7
1992-1993												
PAHO - PR	157,200	0	0	60	17,200	9,300	39	78,000	24,300	16,800	0	11,600
TOTAL	157,200	0	0	60	17,200	9,300	39	78,000	24,300	16,800	0	11,600
% OF TOTAL	100.0				10.9	5.9		49.6	15.5	10.7	.0	7.4
1994-1995												
PAHO - PR	172,200	0	0	60	18,300	10,800	39	81,900	28,200	19,500	0	13,500
TOTAL	172,200	0	0	60	18,300	10,800	39	81,900	28,200	19,500	0	13,500
% OF TOTAL	100.0				10.6	6.3		47.6	16.4	11.3	.0	7.8

ANALYSIS OF THE HEALTH SITUATION

Demography

1. The population of the country was estimated at 9,197,351 in 1990. The maternal and child group made up almost 65% of the population, women being slightly more numerous in all age groups.

2. Growth of the adult and elderly population is estimated to follow a sustained upward trend over the next decade, mainly in urban areas, due to the increase in life expectancy.

3. It is estimated that the indigenous population represents 43.78% of the country's total population.

4. The rural population represents 61.9%, and it is estimated that the economically active population represents only 25.2% of the total population.

5. Projections for the year 2000 seem to point to the same trends described above, with an accentuation of the phenomenon of urbanization.

Health situation

6. The overall mortality rate in 1989 was estimated at 13.7 deaths per 1,000 population.

7. Access to health services continues to be an unsolved problem, with 75.6% of deaths occurring at home, 19.1% in hospitals, 4% in public places, and 1.3% in convalescent homes; 42.9% of the population does not receive medical care prior to death.

8. The leading causes of death are diarrhea (at a rate of 14.4 per 100,000), acute respiratory infections (11.2), malnutrition (5.2), disorders of fluid, electrolyte, and acid-base balance (2.3), and acute myocardial infarction (1.6). Infectious diseases are responsible for over 40% of the deaths.

9. The leading causes of morbidity, based on demand for services from the Ministry of Public Health and Social Welfare in 1986, were acute respiratory infections, intestinal parasitism, diarrheal syndrome, nutritional deficiency, and skin diseases. These causes made up approximately 47% of consultations.

10. Infant mortality in 1988 was reported at 51.3 per 1,000 live births. The maternal death rate in 1989 was 20.22 per 10.000 live births, which is higher than the rate reported in previous years, and attributed to registration difficulties. Complications occurring mainly in the course of labor and delivery account for over 50% of maternal mortality. Only 25% of pregnant women in rural areas receive prenatal care, a proportion that declines to 17% among indigenous women. Among pregnant women without education, only 18% receive professional prenatal care, while among those who have attended high school, the percentage is 86%.

11. Pulmonary tuberculosis continues to be a significant health problem. In 1990, 2,142 cases were reported, which represents an increase of more than 12%, compared with the previous year.

12. In the period 1989-1990, the country was swept by a measles epidemic with more than 4,000 casualties, mostly children under the age of 5. Vaccination coverage is still insufficient to guarantee complete protection of the population. Three cases of wild poliovirus were reported in 1990, and the country is endemic for malaria. Of the national territory, 51.5% is classified as a risk area for Aedes aegypti, and the appearance of cases of dengue fever could affect 64% of the country's total population.

13. The number of reported cases of HIV infections, patients with AIDS-related complex, and confirmed cases of AIDS has been increasing rapidly, beginning in the second half of 1984 with only two cases. By 1990, this figure had already increased to 131 cases.

14. There has been an increase in the number of accidents, primarily work-related and in the 15-44 age group, affecting three times more men than women. The accident rate by Department ranges from 5 to 68 per 10,000 inhabitants (the figures represent Huehuetenango and Santa Rosa, respectively).

15. Cerebrovascular disease (rate of 4.5 per 100,000 inhabitants), diabetes mellitus (2.7), uterine cervical cancer (1.9), and arterial hypertension (1.6) are the leading causes of death from chronic diseases reported in 1989.

16. Over the last decade, the country has suffered a deterioration in the quality of the environment, which is attributed mainly to problems of industrialization and urbanization. The following having been identified as the most important ones: deforestation, air pollution, toxic chemical substances (in the rural sector, mainly pesticides), and the increase in noise levels.

17. According to an evaluation conducted in March 1990, drinking water supply services cover 41.2% and excreta disposal services, 47.9% of the rural area.

18. Much more ethnographic information and data on social aspects are required to be able to better characterize the population and its health needs.

19. In 1989, 95.7% of the economically active population was classified as living in a state of poverty. Of this percentage, 80.1% was listed as living in conditions of extreme poverty (with an annual or monthly income lower than the cost of the basic food basket). For that same year, unemployment was estimated at 61%, of which 10% represents open unemployment and 51%, "invisible" unemployment.

Health services system

20. The health system, which has not undergone any structural changes in recent years, is made up of the following: the Ministry of Public Health and Social Welfare; the Institute of Social Security of Guatemala; municipalities (water supply and waste disposal); military health; the private sector, primarily in the capital; health care through the traditional system (it is estimated to cover over 50% of the population); and training institutions for human resources in health.

21. It is estimated that there are approximately 600 nongovernmental organizations devoted to providing health services, which, in turn, are estimated to serve almost 20% of the population. The Ministry of Public Health and Social Welfare serves only 24% and the Guatemalan Institute of Social Security, 15% of the population.

22. Some of the more serious problems that have been identified in the services sector are: the lack of managerial capacity, inadequate coverage (over 40% of the population does not have access to the health services), low operating capacity, lack of critical supplies (such as drugs and surgical medical material), serious deficiencies in infrastructure maintenance, and the lack of financial resources to operate the services, which is reflected in the hospital crisis that the country is currently experiencing.

23. While no information is available on the problem-solving capacity of the services, there is on their productivity. They provide 16 consultations per each 100 inhabitants (1987), of which 61.4% are first consultations attributed to the following: pediatric program, 50%; maternal program, 12%; general program, 38%. The bed occupation rate was 55%, with an average stay of six days and a turnover of 35.8 patients per bed. The average cost per occupied bed was Q36.74 per day.

24. There are 216 health posts, 184 type B health centers (without beds), 32 type A health centers (with beds), and a total of 35 district, area, regional, and national hospitals. These services are organized into 24 health areas, which are in turn subdivided into eight regions. In the 35 hospitals, the Ministry of Public Health has 8,035 beds, 42% of which are located in the Department of Guatemala. The Guatemalan Institute of Social Security has 2,332 beds, the armed forces 500 beds, and the private sector 2,500 beds.

Sector financing

25. The country's public sector accounts for less than 8% of the gross national product, this proportion being the lowest in America and one of the lowest worldwide. The social sector as a whole accounts for only 24% of the national budget, of which one-third is allocated to health.

26. The central government's per capita health expenditure during the period 1972-1979 was $12.06, with a slight increase to 12,58% in 1980-1986. If inflation and the process of general deterioration are taken into account, that allocation actually decreased.

27. The budgetary allocation for the Ministry of Public Health in 1989 and 1990 was US$63.2 million and for the Guatemalan Institute of Social Security, US$56 million, during that same period.

National health strategies and plans

28. The new Government of the Republic is now in the process of defining development priorities for the short and medium term. To date, the following general objectives have been determined for the health sector:

28.1 Reduction of infant mortality.

28.2 Elimination of the wild polio virus.

28.3 Extension of basic coverage of primary care services to the entire population, with emphasis on underserved groups.

28.4 Increase in the problem-solving and operational capacity of the services network, particularly with regard to the intermediate hospital level and outpatient care.

28.5 Improvement of the availability and accessibility of drugs and other critical supplies for health care of the population.

29. In order to achieve these goals, the following strategies have been outlined and are in the process of being developed:

29.1 To strengthen sector management and develop effective intersectoral coordination mechanisms through establishment of the National Health Council.

29.2 To promote the participation of the nongovernmental and private sector in the delivery of health services to the population.

29.3 To improve health services management by strengthening the Local Health Systems.

29.4 To establish and strengthen operational coordination mechanisms between the Ministry of Health and the Guatemalan Institute of Social Security.

29.5 To rationalize and optimize the mobilization and utilization of the technical and financial, national and international resources available for sector development.

30. The new government has determined that achievement of the enunciated goals is a national priority in terms of technical cooperation; technical

cooperation is also expected in the application of established strategies. The Ministry of Health has requested that PAHO provide the greatest possible amount of cooperation in these areas. In some of them, the work will be coordinated with other agencies.

GLOBAL STRATEGY OF COOPERATION

31. The following strategic processes will be at the center of the PAHO program for cooperation during the biennium:

31.1 To improve the identification of and care provided to higher-risk and underserved groups, including refugees and displaced persons, migrants, marginal urban dwellers, and indigenous women. This requires the implementation and extension of comprehensive services oriented at meeting the most basic needs of the population at risk in terms of food and nutrition, primary care level and health promotion, water supply services and basic sanitation, and other interventions of the Primary Care Strategy.

31.2 To support the development of Local Health Systems as well as of the decentralization process and local programming of health services management, as an operational mechanism for achieving the best possible utilization of available resources at national and local level in terms of health care for the population. This process will facilitate incorporation of nongovernmental and private sectors in the management and delivery of services at the community level, including social security.

31.3 To develop effective approaches and methods for analyzing, evaluating, and adapting the operational capacity of the network of services at its different levels, including hospitals and first-referral outpatient services.

31.4 To promote the national capacity for analyzing and formulating effective mechanisms and schemes for health sector financing, including coordination and complementation of the public and private sectors.

32. The previous processes will serve as a basis for the essential task the country faces in achieving the goals indicated and implementing the strategies that have been described, i.e., reorganizing the health sector. It will be on the basis of a strategic redefinition of the health model, taking into account probable future scenarios in terms of the country's technical, administrative, political, and economic capabilities, that the different components that make up the health sector will be articulated in a new health development scheme for the medium and long term. This process will require strengthening of the sector's management capacity, especially with regard to strategic planning and the incorporation of health in the country's overall development policy.

33. The strategies of PAHO/WHO for providing technical cooperation in these areas will be based on the development of the following strategic approaches:

33.1 Mobilization of technical and financial resources.

33.2 Dissemination of scientific and technical information.

33.3 Technical advisory services for the formulation of policies, plans, programs, and standards.

33.4 Promotion of applied research, generation of knowledge, and transformation of priority health problems.

33.5 Manpower education and training.

33.6 Use of mass media to inform public opinion and the population in general on health issues that have a high priority and a great impact.

33.7 Promotion of technical cooperation among countries with a view to resolving common problems.

33.8 Encouragement for decision-makers and public opinion to try to include their concern for achieving greater equity in health in Government plans and programs for stabilization and structural adjustment as well as economic and social development.

34. The following health problems or programs will be given priority in terms of technical cooperation, because they are most closely associated with the above-mentioned strategic processes, and/or because they respond more directly to the problems and priorities derived from the current epidemiological profile and its trends:

34.1 Continuing formation, training, and education of area epidemiologists in charge of updating and monitoring local epidemiological trends and establishing effective epidemiological surveillance.

34.2 Support for the development process involving the extension of coverage of the Ministry of Health and Social Security to underserved groups and risk groups.

34.3 Continuing formation and education for managers of the services network at its different levels.

34.4 Facilitation of a national development process for human resources, using a strategic approach, and strengthening of the leadership and management capacity of human resource training units.

34.5 Support for developing the capacity of different sector institutions (MSPAS, IGSS, universities, NGOs, private sector) in strategic analysis, and the generation and dissemination of knowledge regarding national health problems.

34.6 Support for the national capacity to produce, supply, distribute, and make accessible drugs and other critical health intervention supplies, as well as to adequately maintain the existing infrastructure.

34.7 Improvement of health care and health promotion services for mothers and children.

34.8 Promotion of the gender approach in identifying and formulating interventions to meet the population's health demands.

34.9 Support for the execution, monitoring, and evaluation of the National Rural Water Plan and formulation of the National Water and Urban Sanitation Plan.

34.10 Promotion for and strengthening of the national capacity to reduce and control health risks derived from environmental pollution.

34.11 Improvement of veterinary public health and food safety programs.

34.12 Better control and prevention of communicable diseases having the greatest incidence or highest risk potential: malaria, dengue, tuberculosis, diseases preventable by vaccination, urban rabies, AIDS.

34.13 Promotion of the prevention of noncommunicable diseases on the rise (accidents and violence, cancer, smoking, disabilities, cardiovascular, mental disorders, drug addiction, alcoholism) through their epidemiological characterization and the promotion of adequate lifestyles and habits.

35. PAHO will collaborate in the development of the following specific programs:

MPN:	Managerial Support for National Health Development
TCC:	Technical Cooperation among Countries
HST:	Health Situation and Trend Assessment
DHS:	Health Services Development
HME:	Health Manpower Education
CWS:	Community Water Supply and Sanitation
CEH:	Control of Environmental Health Hazards
MCH:	Growth, Development, and Human Reproduction
OCD:	General Communicable Disease Prevention and Control Activities
NCD:	Health and Promotion and Prevention and Control of Noncommunicable Diseases
FOS:	Food Safety

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		2,736,100	75.4	2,821,200	71.1	3,169,500	71.0
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		919,900	25.3	1,075,500	27.1	1,240,500	27.6
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	919,900	25.3	1,075,500	27.1	1,240,500	27.6
TECHNICAL COOPERATION AMONG COUNTRIES		101,100	2.8	117,300	3.0	136,100	3.1
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	101,100	2.8	117,300	3.0	136,100	3.1
HEALTH SITUATION AND TREND ASSESSMENT		605,000	16.7	368,800	9.3	418,500	9.4
HEALTH SITUATION AND TREND ASSESSMENT	HST	605,000	16.7	368,800	9.3	418,500	9.4
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		1,033,800	28.5	1,136,700	28.6	1,233,100	27.7
HEALTH SERVICES DEVELOPMENT	DHS	1,002,200	27.6	1,136,700	28.6	1,233,100	27.7
ESSENTIAL DRUGS AND VACCINES	EDV	31,600	.9	0	-	0	-
HUMAN RESOURCES DEVELOPMENT		76,300	2.1	122,900	3.1	141,300	3.2
HUMAN RESOURCES EDUCATION	HME	76,300	2.1	122,900	3.1	141,300	3.2
III. HEALTH SCIENCE AND TECHNOLOGY		893,100	24.6	1,142,200	28.9	1,290,000	29.0
ENVIRONMENTAL HEALTH		383,700	10.6	342,300	8.7	388,000	8.7
COMMUNITY WATER SUPPLY AND SANITATION	CWS	383,700	10.6	267,900	6.8	304,200	6.8
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	0	-	74,400	1.9	83,800	1.9
MATERNAL AND CHILD HEALTH		0	-	130,300	3.3	148,100	3.3
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	0	-	130,300	3.3	148,100	3.3
COMMUNICABLE DISEASES		356,400	9.8	340,500	8.6	387,600	8.7
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	356,400	9.8	340,500	8.6	387,600	8.7

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
HEALTH PROMOTION		0	-	45,400	1.1	51,600	1.2
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	0	-	45,400	1.1	51,600	1.2
VETERINARY PUBLIC HEALTH		153,000	4.2	283,700	7.2	314,700	7.1
FOOD SAFETY	FOS	153,000	4.2	283,700	7.2	314,700	7.1
GRAND TOTAL		3,629,200	100.0	3,963,400	100.0	4,459,500	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		1,360,925	62.9	1,165,933	78.8	0	100.0
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		40,762	1.9	0	-	0	100.0
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	40,762	1.9	0	-	0	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		1,320,163	61.0	1,165,933	78.8	0	-
HEALTH SERVICES DEVELOPMENT	DHS	1,036,491	47.9	1,165,933	78.8	0	-
ESSENTIAL DRUGS AND VACCINES	EDV	283,672	13.1	0	-	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		802,265	37.1	313,000	21.2	0	-
MATERNAL AND CHILD HEALTH		80,786	3.7	0	-	0	-
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	80,786	3.7	0	-	0	-
COMMUNICABLE DISEASES		721,479	33.4	313,000	21.2	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	687,484	31.8	313,000	21.2	0	-
MALARIA	MAL	33,995	1.6	0	-	0	-
GRAND TOTAL		2,163,190	100.0	1,478,933	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	3,067,900	144	264	635	1,639,000	46,200	90	171,000	384,800	91,400	103,600	631,900
WHO - WR	561,300	48	24	90	373,300	28,700	12	22,800	10,600	111,800	0	14,100
TOTAL	3,629,200	192	288	725	2,012,300	74,900	102	193,800	395,400	203,200	103,600	646,000
% OF TOTAL	100.0				55.4	2.1		5.3	10.9	5.6	2.9	17.8
1992-1993												
PAHO - PR	3,206,400	125	192	905	1,539,000	57,000	69	138,000	496,700	162,200	0	813,500
WHO - WR	757,000	48	24	210	434,000	16,800	25	50,000	94,500	46,400	0	115,300
TOTAL	3,963,400	173	216	1115	1,973,000	73,800	94	188,000	591,200	208,600	0	928,800
% OF TOTAL	100.0				49.8	1.9		4.7	14.9	5.3	.0	23.4
1994-1995												
PAHO - PR	3,601,700	120	192	905	1,681,800	66,200	69	144,900	576,400	188,300	0	944,100
WHO - WR	857,800	48	24	210	488,400	19,600	25	52,500	109,700	53,900	0	133,700
TOTAL	4,459,500	168	216	1115	2,170,200	85,800	94	197,400	686,100	242,200	0	1,077,800
% OF TOTAL	100.0				48.7	1.9		4.4	15.4	5.4	.0	24.2

ANALYSIS OF THE HEALTH SITUATION

1. Guyana has been seriously affected by the economic crisis of the eighties which in turn has adversely affected the health care of the population. The economy experienced real growth of less than 1% in 1986 and 1989, and this rate dropped to -3% in 1988. The economy has been affected by below normal production of critical exports such as bauxite and sugar. There is a shortage of foreign exchange and inflation is more than 25% per annum. Negotiations were started with the IMF and an agreement signed in 1990. An economic recovery programme is in place and a social impact amelioration programme is in early stages of implementation.

2. The total population of Guyana was estimated at 756,072 in 1986. The crude birth rate was 23 per 1,000 population, and the total fertility rate 2.8. The percentage population under 15 years of age was 40.8% in 1985. The annual population growth rate has declined steadily since 1960 from 3.25% in 1960 to 0.78% in 1986. Emigration represents a significant drain on the younger and more educated sector of the population.

3. Life expectancy at birth in Guyana has increased steadily over the last 40 years to a level in 1986 of 65.8 years in males and 70.8 years in females. In 1986, the infant mortality rate was 49 per 1,000 live births; for children 1-4 years of age, it was 4.4 per 1,000, and the crude death rate was 8 per 1,000.

4. The five principal causes of death in 1984 (the latest year for which data is available) were: cerebrovascular accidents (12.4%), diseases of the digestive system including gastro-enteritis (11.5%), symptoms, signs and ill-defined conditions (10.7%), diseases of the pulmonary circulation and other forms of heart disease (8.8%) and other diseases of the respiratory system (6.0%).

5. Nutrition related problems are responsible for significant mortality and morbidity among all age groups. Of the ten (10) major causes of death in 1984, five (5) were due to nutrition related diseases namely, cerebrovascular diseases, ischaemic heart disease, diabetes and hypertensive disease and protein calorie malnutrition, the last being the principal cause of death in children 1-4 years of age. Of the chronic noncommunicable diseases which are nutritionally related, diabetes, hypertension and obesity have a high prevalence in the population.

6. The prevalence of anaemia is high among all age groups and sexes. During 1983-86, an average of 57% of children up to 5 years old attending clinic were in their normal grade according to the Gomez classification. In 1986, the differences in nutritional status between first and second years of life were notable, for all grades of nutrition classification. For that year the number of children in the normal grade was 32% lower in the 12-23 month group than in the 0-11 month age group. In 1985, 40% of the women attending antenatal clinics were anaemic. A study in 1981 concluded that iron deficiency was the major factor contributing to anaemia.

7. A survey carried out in 1987 showed that 28.5% of the 0-5 year olds were malnourished and 5.5% obese. Malnutrition increased as a cause of admissions between 1981 and 1985. At the main hospital, malnutrition was responsible for 34% of all pediatric deaths in 1985 and 26.5% in 1986.

8. The percentage of low birth weight babies is quite high, comprising 18.4% and 19.4% of births in 1982 and 1984 respectively. A sample survey carried out in 1986 showed that 5.4% of pregnant women had hemoglobin levels of lower than 8g/100ml (severe anaemia) 25.5% were 8g/100ml and 10g/100ml (moderate anaemia) and 27.5% between 10g/100ml and 11g/100ml (mild anaemia).

9. Of food-borne diseases, gastroenteritis accounted for approximately 40% of admissions and deaths at the pediatric ward for 1981-1985. During 1984-88, gastroenteritis was responsible for 39.2% of hospital paediatric deaths with a case fatality rate of 22%. Seventy-two percent of households have water supply connections. The average household size in 1986 was 3.5 per 1,000 inhabitants. The provision of drinking water is however hampered by electricity outages and shortage of chemicals for purifying the water. The environmental health sector's main problems are in water supply, sanitation, solid waste, drainage and food protection. This sector suffers from inadequate management systems and lack of financial resources (including foreign exchange) to replace existing equipment. Animal surveillance is becoming increasingly important as a result of the proposed road between Guyana and Brazil.

10. The percentage of coverage of the EPI diseases in 1989 was DPT 77%, polio 79%, measles 69% and BCG 76%. Guyana participates fully in the regional programmes to eliminate polio and measles and has a strong EPI programme.

11. The cumulative figure for AIDS cases up to December 1990 was 145 of which 114 was male and 31 female. So far there have been 60 deaths. The highest prevalence is among homosexuals and bi-sexuals and in the 25-29 year age group.

12. In the public sector, there are two ministries involved in carrying out health policies, they are the Ministry of Health and the Guyana Agency for Health Sciences Education, Environment and Food Policy (GAHEF). The Prime Minister assumes the overall portfolio for health. Health Services are decentralized into ten regions managed by the Ministry of Regional Administration. A major thrust of the government is to strengthen these local health systems.

13. The Inter-American Development Bank (IDB) has started implementation of a project of US$32 million aimed at improving the out-patient and casualty facilities of the Georgetown Hospital.

14. From 1985 to 1988, malaria was the most infectious parasitic disease. Malaria rose from 3,006 cases in 1984 to 35,451 cases in 1988.

15. The ratio of doctor/population in the country is around 2 per 10,000 inhabitants (1987). As a result of a technical cooperation program with Cuba, 66 doctors, 11 dentists and 32 technicians have been added to the health care delivery system. 50% are at Georgetown Hospital and the rest scattered throughout the country. Between 1976-1986, a total of 124 students were sent by the government abroad to study medicine. In 1985, the government opened a medical school in Guyana, and the first graduation of students will take place in 1991 (12 graduates).

16. The Medex program has resulted in significant increases in availability of medical care. In 1987, there were 126 medexes distributed in the 10 regions and in the Ministry of Health, as well as in other large care provider facilities. All nurses training is local and carried on in four nursing schools. The nurse population ratio is 10 per 10,000 in 1987 compared to 6 per 10,000 in 1980. In the assistant nurse category, about 10.9 per 10,000 in 1987, is gradually assuming more of the responsibilities of registered nurses. The midwife population ratio in 1987 was 5.1 per 10,000.

National health strategies and plans

17. The broad objectives for the national health system are: improve the health services; reduce the mortality and morbidity rates (especially maternal and child mortality) and to increase the life expectancy; reorganize the health services administrative structure and system; improve the planning capacity, and information system; undertake human resources development, reduce the incidence of communicable diseases and eradicate those where the incidence is very low; improve the nutritional status of the population on the whole; improve and extend dental health services (especially preventive aspects); bring the benefits of improved environmental sanitation to communities and effective insect vector control program; develop veterinary public health programs, particularly in the light of the national agriculture thrust; develop a program of health education and community participation; improve and expand diagnostic, treatment and rehabilitative services and facilities; provide services to special groups, such as the aged and the handicapped; improve the quality and accessibility of psychiatric coverage to the population.

18. Reorganization of the health system is envisaged to facilitate implementation of the 1980 health plan, concurrently with development of the facilities. Management support sub-systems developed with assistance from Medex-Hawaii have been partially implemented. The central directorate of regional health services and the regional health administration units headed by a regional health officer, were established in 1986.

19. A priority focus has been on local medical education as evidenced by first the creation of a special Ministry and now an agency, to deal with this matter. The medical education program is designed to suit the country's needs, community based and be innovative, in its approach to bridge the professional gap and the brain drain. Scientific excellence and research will be stressed on as well as problem based learning.

20. The Faculty of Health Sciences carries out Allied Health programs in radiography, pharmacy, medical technology and environmental health. The Medex program now fully established and government supported has been attached to it. The health service managers and health sciences tutors are offered as certificate programs. A center for health educational technology, established in 1986 produces teaching materials to support education for health and training. It is allied with the medical school and organizes many in service and public seminars, courses and workshops.

21. Resource mobilization: many projects have been supported through external financing: malaria control, the Georgetown Hospital project, AIDS project, Immunization and Health Learning Materials.

GLOBAL STRATEGY OF COOPERATION

22. The PAHO/WHO strategy is based on the development of a sustained, medium or long term process following the guidelines of the general priorities for the quadrennium and the goal of HFA 2000. Specific priorities will be those of the Caribbean Cooperation in Health Initiative (CCH) as determined to be appropriate through the analysis of the health situation of the country and the strengthening of the local health systems will be further developed at the regional level.

Specific areas of technical cooperation

Managerial process for national health development

23. This program is intended to provide the managerial and administrative support required for the efficient delivery of the PAHO/WHO technical

cooperation program in the country. It is concerned with the management and operations coordination of the country office.

24. Efforts are being directed towards providing adequate administrative services to support the technical programs, including computerization of the programming/budgeting process, fellowship management and the accounting process. Effective management of information is being pursued by the development of a well-organized documentation center.

25. A primary concern of this program is the coordination and execution of PAHO/WHO's technical cooperation policy in Guyana. This is done by analyzing and interpreting the health policies of PAHO/WHO and promoting their application in each national program in concert with the socioeconomic development policies and health policies of the country.

26. Assisting the PAHO/WHO representative are technical advisers and administrative support staff. The number of technical advisers needed in Guyana will vary from time to time depending on the priority needs of the country. These officers will primarily be catalysts stimulating the development process in their respective program areas and trainers, transferring their expertise and knowledge to their national counterparts. Optional use will be made of short-term consultants and fellowships.

Technical cooperation among countries

27. This program will continue to facilitate technical cooperation between Guyana and neighbouring countries, particularly in the areas of infectious disease and vector control. The TCC arrangements between Cuba and Guyana in the area of human resources development and the provision of critical specialist services will be supported in a final phase while a plan is developed for ensuring increased national capacity. Initiatives have already been taken to establish TCC links with Suriname, Venezuela and Brazil. These will be finalised in 1991. In Solid Waste Management, a TCC programme was established on solid waste management between the Solid Waste Management Company in Trinidad and Tobago and the Mayor of Georgetown. One phase of this TCC has been completed.

Organization of health services based on primary health care

28. PAHO/WHO will assist in the development of the sector's infrastructure, in particular the regionalization process, reorganization of the central administration, supporting information systems, health education, resources mobilization, human resources development. PAHO/WHO's technical cooperation will provide expertise, in-country training, overseas fellowships, supplies and materials.

Human resources development

29. The purpose of this program is to support the national program to identify and develop innovative programs to address the country's health and medical manpower needs. Support will be given to on-going training of allied health workers, to the development of learning resources and educational technology and to the institutional development of the medical faculty. In addition, on-going programs of in-country upgrading of health workers, and provision of external fellowships in critical areas will continue. The Faculty of Health Sciences, University of Guyana, will be strengthened as a WHO Collaborating Centre while links will be forged between the Faculty and the University of Galveston.

Environmental health

30. The program is aimed at reducing health hazards from the environment. This involves the provision of adequate water supply and the sanitary disposal of wastes in urban and rural areas. Occupational health is also a concern of the program. PAHO/WHO technical cooperation will assist in all these areas through provision of in-country expertise and short-term consultants. Special attention will be paid to strengthening environmental health services at the regional level. Emphasis will be given to courses and seminars to stimulate community participation, in particular the participation of women. PAHO/WHO will assist in mobilization of resources in the form of financial assistance from other agencies and governments.

Maternal and child health

31. PAHO/WHO will assist in the strengthening of maternal and child health services, the program components which are: control of diarrheal diseases through the promotion of oral rehydration therapy; immunization, adolescent health care; perinatal disease prevention; acute respiratory infections and tuberculosis.

Communicable diseases

32. The main components of the national program are malaria and other vector control including Aedes aegypti. PAHO/WHO will cooperate in developing the

national capability for epidemiological assessment and stratification of malarious areas; improving the skills for selecting and implementing the appropriate strategies for these areas; strengthening planning and management capabilities; maximizing involvement of health resource personnel in the Regional Health Services; and developing programs for greater involvement of nongovernmental organizations, e.g., community service groups, through expertise, training and the provision of supplies and materials.

33. The government is also placing emphasis on programs to address the problem of AIDS. A short-term program has been prepared for 1989-1991 and funding approved WHO. In addition, a medium term program 1992-1994, will be completed and submitted to WHO for funding under the global program. PAHO/WHO will seek to assist in coordinating the execution of the main components of the program: epidemiological surveillance, prevention of sexual transmission through infected blood, reduction of the impact of the HIV infection on individual and family, information education and communication and prevention of perinatal transmission.

Food and nutrition

34. This program is closely integrated with the Maternal and Child Health program and will address nutrition problems faced by the child and pregnant woman. In addition, it has supported the development of a Food and Nutrition Policy. A Plan is being prepared based on the Policy.

35. PAHO will collaborate in the development of the following specific programs:

MPN:	Managerial Support for National Health Development
TCC:	Technical Cooperation among Countries
DHS:	Health Services Development
HME:	Human Resources Education
NUT:	Nutrition
CWS:	Community Water Supply and Sanitation
MCH:	Growth, Development and Human Reproduction
OCD:	General Communicable Disease Prevention and Control Activities

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		643,000	56.2	874,500	63.2	998,400	63.6
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		328,800	28.7	391,300	28.4	450,500	28.7
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	328,800	28.7	391,300	28.4	450,500	28.7
TECHNICAL COOPERATION AMONG COUNTRIES		43,500	3.8	50,500	3.6	58,600	3.7
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	43,500	3.8	50,500	3.6	58,600	3.7
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		216,200	18.9	329,700	23.8	373,300	23.8
HEALTH SERVICES DEVELOPMENT	DHS	216,200	18.9	329,700	23.8	373,300	23.8
HUMAN RESOURCES DEVELOPMENT		54,500	4.8	103,000	7.4	116,000	7.4
HUMAN RESOURCES EDUCATION	HME	54,500	4.8	103,000	7.4	116,000	7.4
III. HEALTH SCIENCE AND TECHNOLOGY		500,900	43.8	510,000	36.8	571,000	36.4
FOOD AND NUTRITION		51,200	4.5	57,400	4.1	64,400	4.1
NUTRITION	NUT	51,200	4.5	57,400	4.1	64,400	4.1
ENVIRONMENTAL HEALTH		208,600	18.2	118,600	8.6	130,100	8.3
COMMUNITY WATER SUPPLY AND SANITATION	CWS	208,600	18.2	118,600	8.6	130,100	8.3
MATERNAL AND CHILD HEALTH		46,500	4.1	51,100	3.7	56,200	3.6
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	46,500	4.1	51,100	3.7	56,200	3.6
COMMUNICABLE DISEASES		194,600	17.0	282,900	20.4	320,300	20.4
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	194,600	17.0	282,900	20.4	320,300	20.4
GRAND TOTAL		1,143,900	100.0	1,384,500	100.0	1,569,400	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		121,691	20.5	0	-	0	100.0
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		70,000	11.8	0	-	0	100.0
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	70,000	11.8	0	-	0	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		49,200	8.3	0	-	0	-
HEALTH SERVICES DEVELOPMENT	DHS	49,200	8.3	0	-	0	-
HUMAN RESOURCES DEVELOPMENT		2,491	.4	0	-	0	-
HUMAN RESOURCES EDUCATION	HME	2,491	.4	0	-	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		472,558	79.5	464,054	100.0	0	-
MATERNAL AND CHILD HEALTH		1,501	.3	0	-	0	-
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	1,501	.3	0	-	0	-
COMMUNICABLE DISEASES		464,054	78.0	464,054	100.0	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	464,054	78.0	464,054	100.0	0	-
HEALTH PROMOTION		7,003	1.2	0	-	0	-
OCULAR HEALTH	PBD	7,003	1.2	0	-	0	-
GRAND TOTAL		594,249	100.0	464,054	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	266,300	24	0	30	167,100	11,500	13	24,700	13,700	5,200	0	44,100
WHO - WR	877,600	72	96	285	537,700	19,400	55	104,500	48,300	43,000	0	124,700
TOTAL	1,143,900	96	96	315	704,800	30,900	68	129,200	62,000	48,200	0	168,800
% OF TOTAL	100.0				61.6	2.7		11.3	5.4	4.2	.0	14.8
1992-1993												
PAHO - PR	390,900	24	0	30	234,400	13,300	6	12,000	15,900	32,500	0	82,800
WHO - WR	993,600	48	96	370	510,600	25,300	45	90,000	69,300	83,400	0	215,000
TOTAL	1,384,500	72	96	400	745,000	38,600	51	102,000	85,200	115,900	0	297,800
% OF TOTAL	100.0				53.7	2.8		7.4	6.2	8.4	.0	21.5
1994-1995												
PAHO - PR	445,800	24	0	30	265,600	15,500	6	12,600	18,400	37,600	0	96,100
WHO - WR	1,123,600	48	96	370	573,100	29,400	45	94,500	80,300	96,800	0	249,500
TOTAL	1,569,400	72	96	400	838,700	44,900	51	107,100	98,700	134,400	0	345,600
% OF TOTAL	100.0				53.4	2.9		6.8	6.3	8.6	.0	22.0

HAITI

ANALYSIS OF THE HEALTH SITUATION

1. The population of Haiti is currently estimated at about 6.5 million as compared with 5.0 million in 1982. The average annual rate of increase is estimated at 1.8%, with a very high index of fertility averaging 6.8 children alive per woman. With 71% living in rural zones, rural population density per square kilometer of arab land is about 500. Since 1982 the rural exodus has accelerated. An average annual rate of increase of 8.6% is swelling the marginal areas of Port-au-Prince and bringing its population to over one million with a projected 2 million by the year 2000. Slower rates of increase of about 4% are observed in secondary cities. There is also considerable external migration.

2. The crude birthrate is about 36 per 1,000 population with only about 5% of rural women found to be using some form of modern contraception. Children under 15 years of age make up 40% of the population, 17% are under 5 years of age. The elderly over age 64 make up about 6% of the population. Life expectancy at birth is estimated to be between 48-54 years of age. The crude death rate is 16.5 per 1,000 population. Infant mortality is generally cited at about 116 per 1,000 live births although individual studies range from 35 to over 200 depending on the socio-economic group and access to medical care. Much of infant mortality is concentrated in the perinatal period. Maternal mortality is officially 32 per 10,000 population.

3. The major causes of childhood mortality remain malnutrition, diarrheal diseases and acute respiratory infections, with chronic malnutrition (stunting) reported in one third of the child population, and 17% of newborns weighing less than 2,500 kgs at birth. The prevalence of active tuberculosis is about 2% of the population (120,000 cases). Since the discovery of Acquired Immune Deficiency Syndrome (AIDS) in 1981, this disease has become a public health concern along with other sexually transmitted diseases. End 1990 around 3000 cases had been officially reported with an estimated 6-8% of the sexually active population seropositive for Human Immune Deficiency Virus (HIV). The malaria situation remains unclear, and malaria statistics are notoriously incomplete.

4. With an annual GNP per capita of $380, Haiti is one of the poorest countries in the world. Rural farmers have an estimated annual income of less than $100 and, in the capital, the formal unemployment rate for the active population has increased to over 60%. Illiteracy is high, reaching 62% among adults. In 1989 potable water was available to 60% of urban populations and only 35% of rural ones. Only 14% of rural populations have latrines as compared with 42% in urban zones.

5. About 480 facilities, run by the Government and/or the private sector provide the institutional base for the national medical services. The State University Hospital (HUEH) in the capital is often filled to overflowing, while many rural hospitals, even with a relatively low number of beds vis-a-vis their catchment areas, do not attain 50% occupancy rates. The number of health professionals remains extremely limited: 1.7 physicians per 10,000 population; 0.2 dentists per 10,000 population; 1.4 nurses per 10,000 population, and 3.7 auxiliaries per 10,000 population, and 6 matrons per 10,000 population.

6. An estimated 60% of the population has adequate geographic access to modern medical care. Virtually everyone in rural as well as marginal urban areas uses traditional healers, be it birth attendants, herbalists or voodoo priests. There are also thousands of "piquristes" providing injections of allopathic medicine, a form of indigenized medicine.

7. Indicators of primary health care (PHC) services suggest that one of two pregnant women receives at least two prenatal visits. 50% of deliveries are attended by personnel with modern training (30% by professional medical personnel and 20% by traditional birth attendants with upgraded basic skills and a cord cutting kit). Immunization coverage of children was greatly improved through an expanded Program on Immunization, including national vaccination days in 1988 and 1989 followed by institutional strengthening and local programming in 1990. Complete coverage at age one is now estimated to be at 60% nationwide with wide regional variations. The Commission to certify eradication of paralytic poliomyelitis has been constituted and no cases have been confirmed in recent years.

8. In 1975, the Government of Haiti produced it last National Health Plan. It recognized the need to prioritize and increase the coverage provided by its health services. In spite of the attention given to the rural population and prevention, urban curative service continued to be favored both in the allocations of budget and the assignment of personnel. Port-au-Prince with 20% of Haiti's population routinely receives over 60% of the health budget and is served by 50% of the health personnel. For 1990-1991 the budget of the Ministry of Public Health and Population (MSPP) was set at around 140 million Gourdes, representing 15% of the Government's total budget and 1.4% of Haiti's GDP. Over 90% of the budget is required to cover salaries, leaving no room for operating expenses.

National health strategies and plans

9. The principles of Primary Health Care that evolved from Alma-Ata in 1978 have been supported in national planning exercises.

10. In 1982, the MSPP issued a major policy document, "New Orientations", reaffirming health as an individual right, calling for a reform of the health

delivery system, planning and identification of priority programs aimed at the most vulnerable groups, improving decision-making and efficiency through decentralized management, and encouraging communities to share responsibilities for the health of their members.

11. The last National Program and Budget for the development of health services, (1987-1991), contains two major elements. The first is the improvement and extension of health facilities to increase access to services and decentralization of decision-making. The second element is the definition of seven priority health programs: the control of diarrheal diseases; an expanded program on immunization; a nutritional program for children under five; improved maternal and child care and family planning services; the control of endemic diseases (malaria); the control of tuberculosis; the fight against sexually transmitted diseases, particularly AIDS. Leprosy, acute respiratory infections and prevention of blindness were included in the priority program approach, as outlined above.

12. Priority Programs:

12.1 There are three major components of the diarrheal disease control program: potable water and sanitation; oral rehydration and encouragement of breastfeeding. Since 1981, the Government has subscribed to and participated in the goals of the program of the International Drinking Water Supply and Sanitation Decade notably with the creation of an interministerial council of Water and Sanitation (CONADEPA). An evaluation of the Decade and its results was published late 1990. The National Program for the Control of Diarrheal Diseases and Maternal Alimentation (PRONACODIAM) was begun in 1983. This was heavily based on social marketing and on massive accessibility of oral rehydration salts. While today 60% of rural women recognize packets of rehydration salts only a minority of mothers and/or health clinics are reported to actually use oral rehydration salts in case of diarrhea and/or dehydration. A strategy is being developed to increase clinic use and ORS availability in rural areas as well as to encourage mothers to breastfeed exclusively for at least 3 months.

12.2 The government has followed WHO guidelines for the expanded Program on Immunization (EPI) since 1979 and officially launched a national program in 1985. The program objective is universal immunization, with polio eradication also adapted as a national objective. The strategy includes the decentralization of specific targeted work plans, the integration of immunization into all health institutions and special intensive immunization days, on a local or national basis.

12.3 Nutrition surveillance for early detection of problems is being increased, with the adoption of a Road to Health-growth chart as a monitoring instrument for all priority programs. There is a consensus that a better understanding of malnutrition and its determinants is necessary to orient an integrated control program.

12.4 In the priority area of maternal health and family planning, the objectives set for 1991 called for 80% of pregnant women to receive prenatal care and tetanus immunization and 60% to be assisted in delivery by trained personnel in order to reduce the maternal mortality. At least 30% of couples would be using effective contraception and the infant mortality rate was to be reduced from 124 to 90 per 1,000 live births. By end 1990 an initiative developed to present an integrated maternal and child health program focusing on coverage and quality of care using the risk approach.

12.5 A main endemic disease of concern is malaria, with at least 60% of the population living in malarious zones. With the breakup in 1988 of the semiautonomous National Service for Major Endemic Diseases (SNEM), malaria control is being integrated in Primary Health Care Services and executed in a decentralized fashion, with first attention to appropriate diagnosis and treatment followed by epidemiological analysis of available data.

12.6 In the area of sexually transmitted diseases, AIDS is of particular concern, with 3,000 cases officially reported by the end of 1990 and acknowledged wide under reporting. In 1987 a National Commission to coordinate an AIDS Control Program was created and in 1988 a Medium-Term Plan was prepared for international funding. The objectives and strategies adapted aim to: reduce sexual perinatal transmission; have a safe blood supply; install standardized case detection, monitoring and treatment; and strengthen epidemiological surveillance and research on transmission. A major part of the Control Program relies on information and education campaigns aimed at specific high risk groups.

12.7 For tuberculosis the objective is aggressive case detection and treatment, relying on a network of private and public institutions. The cooperation between the national control program and CAT, an NGO which had an extensive BDG vaccination campaign in the 70's and has since become actively involved in other areas of TB control, is a model for other programs, and was also adopted in a World Bank funded project to facilitate the introduction of short term drug treatment regimens.

12.8 No formal control programs are yet in place for leprosy and/or acute respiratory infections but they are being addressed as priority health problems.

12.9 As in other Caribbean countries with morbidity and mortality due to infectious diseases being reduced, cancer, diabetes and hypertension have become

more prominent. No formal strategies, except those evolving in non-governmental organizations, have been adopted.

13. Most of the major external donors are involved in varying degrees in one or more of the priority program areas. In addition, within Haiti, there are numerous nongovernmental organizations, some indigenous, others linked with foreign parent groups, working in priority areas. The need for more effective mechanisms for coordination is gradually being addressed, as it is estimated there are 277 NGO's active in the health field.

14. In recent years cooperation between the government and several non-governmental organizations was strengthened, with the government contracting NGO's to take full responsibility for delivery of health services to defined populations or geographical territories. In some cases the NGO's also take on management responsibility for state-owned health facilities as well as public service personnel. As part of their commitment the NGO's promise to undertake at least the national priority health programs. There has been scant attention to issues of organization, financing and/or management of the health sector, leaving room for wide experimentation and variation in this regard by private as well as public sector groups.

15. There is currently no single national health council. However, national intersectoral coordinating committees have been developed in response to program planning and execution of different national priority programs. Examples are diarrheal diseases, the Expanded Program on Immunization, AIDS, and Family Planning. From these, the strategy which has evolved is that virtually every priority program has one or several "multisectoral" committees to oversee general policy, programming, operations and evaluation. Donor agencies are heavily represented in these interagency coordinating committees (CCI).

National priority areas for technical cooperation

16. Based on the major priorities identified, the government has decided to ask for technical cooperation in the following priority areas:

16.1 Analysis of the health sector and further development of policies and implementation aiming at increased efficiency in the use of resources and identification and mobilization of a higher level of resources from national and international sources, including the possibility of a Haiti Health Initiative.

16.2 Support for the decentralization process in the areas of gathering and analysis of information and management of local health systems and services.

16.3 Support for the process of coordination and, where possible, integration of the different institutions that comprise the health sector including, the Ministry of Health, other national institutions, Non-Governmental Organizations and international cooperation to achieve increased coverage, better quality of services and better use of resources.

16.4 Improvement of the environment through increased coverage of potable water and particularly sewerage. Implementation of national policies regarding environmental health including design of training and introduction of appropriate technology; establishment of norms and standards for solid waste disposal; coordination of international support to the Environmental Health sector.

16.5 Strengthening of the capacity for epidemiological analysis, aiming at identifying causes, establishing reliable surveillance systems and contributing to the design of priority program interventions to reduce inter alia: maternal mortality; AIDS and other communicable diseases as malaria and tuberculosis; infant and perinatal mortality; as well as focus on priority vulnerable groups.

16.6 Analysis of the health work force (structure, distribution, utilization) and development of national policies pertaining to their formation and utilization. Identification of the issues in which gender plays a significant role.

GLOBAL STRATEGY OF COOPERATION

17. In support of the MSPP emphasis on the implementation of priority programs, paying careful attention to the important issues of effectiveness, equity and efficiency, the PAHO/WHO country program will concentrate its technical cooperation on health infrastructure development necessary to implement specific subprogram interventions. PAHO/WHO, with its mission in the management of knowledge, will accord priority to health interventions and program implementation where Ministry and other operational resources are sufficient for sustained action, where targeted objectives have been defined and where a substantial health impact can be anticipated. As the responsibility for program implementation is overseen by the MSPP Health Departments, PAHO/WHO activities will increasingly be brought to bear in support of the development of these institutions and particularly on the health systems infrastructure components of the decentralization process, following an orientation of local health systems (SILOS). This will include adequate attention to health as an intersectoral process and an essential part of development, including the role of women in Health and Development.

18. A key role in the country program will be accorded to those activities which serve to assist in the coordination and mobilization of national and international resources for health program implementation. National and regional strategies to encourage more coordination and integration between public and private sector health institutions, especially non-governmental organizations, will receive priority attention by PAHO/WHO.

19. Health manpower development and training will continue to be a primary intervention strategy of the PAHO/WHO country program in Haiti. In the coming two biennia priority will be accorded to national training workshops, seminars and courses to develop appropriate skills needed for primary health care interventions and where the national health system has an evident capacity to use effectively newly trained and motivated manpower. Long-term foreign fellowships will continue to be supported only in specific areas of necessity. In all training programs, priority will be given to training of trainers where an enhanced multiplier effect can be expected.

20. Supplies and materials provided in the country program will continue to be limited and tied to critical needs directly associated with other PAHO/WHO technical cooperation.

21. Special attention will be given in PAHO/WHO's Country Program to promote technical cooperation among countries (TCC), in order to facilitate contacts and access to expertise in neighboring countries.

Specific areas of technical cooperation

22. Managerial Process for National Health Development. It is proposed in this project that the PAHO/WHO Country Office continue its representation and management structure to interface directly with the MSPP on policy development and coordination. It will also interact with all other national and international actors to position health in /and development. The Office of the Representative will seek to coordinate the country program in a fashion to meet essential program and infrastructure development needs of the MSPP programs in conformity with the global, regional and subregional goals and strategies of PAHO/WHO as well as priorities set forth in the strategic Orientations and Program Priorities for PAHO During the Quadrennium 1991-1994. It will also be the responsibility of this project to oversee the appropriate development of the country office including the essential function of a documentation center. This documentation center will provide access to HAITI health professionals of a complete collection of PAHO and WHO books and documents, as well as selected public health literature. It will also build a collection of reference material, published and unpublished on HAITI health problems and programs.

23. Technical Cooperation Among Countries. It will be the effort of the PWR to assist the MSPP to identify potentials for TCC, as they may present themselves in technical programs in the future. Potential areas are epidemiological surveillance and malaria and AIDS control with the Dominican Republic, as well as integration of Haiti into the general programming of the CARICOM Health Section and promotion of subregional project linkages with the Caribbean Cooperation in Health initiative and the Central American Bridge for Peace Initiative.

24. Organization of Health Services Based on Primary Health Care. PAHO/WHO will assist in the identification and development of critical infrastructure components of national program activities and particularly as regards the decentralization process including cooperation between public and private sector for effective and efficient delivery of health services. Policy dialogue and technical cooperation on issues of organization, financing and management of health services will be the broad focus of the project. An appropriate training program will be developed as well as technical consultation, material and supplies for catalytic support. It will also maintain the dialogue with the two development banks as well as major bilateral agencies involved in the development of this sector.

25. Environmental Health. The water and sanitation sector of Haiti's health development program is heavily supported by national (e.g., Autonomous Drinking Water Supply Agency for Metropolitan Area (CAMEP), National Drinking Water Service (SNEP), Community Facilities for Hygiene and Water Supply (POCHEP) and international agencies (e.g., BID, UNICEF, Agency for Technical Cooperation of the Federal Republic of Germany (GTZ), German Development Bank (KFW), World Bank, USAID, Caisse Centrale de Cooperation Economique (CCCE, France), PNUD) and non-governmental organizations. In view of the extensive support from national and external assistance agencies in Haiti's national program, the PAHO/WHO technical cooperation will especially work to assure effective coordination of policies through the CONADEA as well as in effective and efficient program implementation. In this regard, PAHO/WHO will assist in select training programs to meet both the manpower training needs and to promote community participation, as well as provide expertise for the organization and conduct of operational research, and the introduction of appropriate technology.

26. Identification and evaluation of priority health problems and control programs. It is the strategy of the MSPP to fully integrate different control programs as part of primary health care. The last vertical program to disappear as a semiautonomous structure was SNEM, responsible for malaria control. PAHO/WHO will assist with the process of identifying priority health problems, the definition of appropriate control programs, as well as their evaluation. This process will be based on principles of epidemiology as well as economic analysis (e.g. cost-effectiveness and cost-benefit). PAHO/WHO will continue to execute its field epidemiology training program as well as the provision of both local and external expertise, fellowships, in-country training, supplies and materials. These will address malaria, tuberculosis, AIDS as well as the different elements of a maternal and child health program presented in a separate project.

27. Maternal and Child Health. The MSSP has long had a national goal of promoting and making available adequate maternal and child health services, including family planning services, to the Haitian population. PAHO/WHO will provide support to assist with the process of integrating different aspects of existing priority programs as EPI, CDD, FP, ARI in a national program of maternal and child health.

28. It is proposed that PAHO/WHO continue to serve as the executing agency for the UNFPA and USAID programs of support. These projects are also aimed specifically at the reduction of maternal mortality, eradication of poliomyelitis and elimination of neonatal tetanus. To help fulfill this mission, the country program will provide for the administration and oversight of the program, and in preparing joint plans of action reflecting the interest and presence of all donor agencies in an integrated manner.

29. PAHO will continue to collaborate in the development of the following specific programs:

MPN: Managerial Support for National Development
TCC: Technical Cooperation among Countries
HST: Health Situation and Trend Assessment
DHS: Health Services Development
CWS: Community Water Supply and Sanitation
MCH: Growth, Development and Human Reproduction

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		2,613,800	68.8	3,069,200	70.5	3,491,400	70.5
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		591,000	15.5	717,300	16.5	822,400	16.6
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	591,000	15.5	717,300	16.5	822,400	16.6
TECHNICAL COOPERATION AMONG COUNTRIES		144,000	3.8	167,000	3.8	193,800	3.9
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	144,000	3.8	167,000	3.8	193,800	3.9
HEALTH SITUATION AND TREND ASSESSMENT		812,600	21.4	1,058,700	24.3	1,199,300	24.2
HEALTH SITUATION AND TREND ASSESSMENT	HST	812,600	21.4	1,058,700	24.3	1,199,300	24.2
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		1,066,200	28.1	1,126,200	25.9	1,275,900	25.8
HEALTH SERVICES DEVELOPMENT	DHS	1,066,200	28.1	1,126,200	25.9	1,275,900	25.8
III. HEALTH SCIENCE AND TECHNOLOGY		1,188,500	31.2	1,287,600	29.5	1,461,800	29.5
ENVIRONMENTAL HEALTH		750,100	19.7	915,700	21.0	1,030,300	20.8
COMMUNITY WATER SUPPLY AND SANITATION	CWS	750,100	19.7	915,700	21.0	1,030,300	20.8
MATERNAL AND CHILD HEALTH		320,600	8.4	371,900	8.5	431,500	8.7
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	320,600	8.4	371,900	8.5	431,500	8.7
COMMUNICABLE DISEASES		117,800	3.1	0	-	0	-
MALARIA	MAL	117,800	3.1	0	-	0	-
GRAND TOTAL		3,802,300	100.0	4,356,800	100.0	4,953,200	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		125,214	2.8	0	-	0	-
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		77,214	1.7	0	-	0	-
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	77,214	1.7	0	-	0	-
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		48,000	1.1	0	-	0	-
DISASTER PREPAREDNESS	DPP	48,000	1.1	0	-	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		4,429,462	97.2	2,805,325	100.0	649,000	100.0
MATERNAL AND CHILD HEALTH		3,086,249	67.7	975,869	34.8	549,000	84.6
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	1,927,160	42.3	836,023	29.8	549,000	84.6
IMMUNIZATION	EPI	1,095,373	24.0	139,120	5.0	0	-
DIARRHEAL DISEASES	CDD	63,716	1.4	726	.*	0	-
COMMUNICABLE DISEASES		1,320,613	29.0	1,829,456	65.2	100,000	15.4
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	967,158	21.2	1,175,200	41.8	0	-
MALARIA	MAL	264,411	5.8	650,000	23.2	100,000	15.4
SEXUALLY TRANSMITTED DISEASES	VDT	89,044	2.0	4,256	.2	0	-
HEALTH PROMOTION		22,600	.5	0	-	0	-
OCULAR HEALTH	PBD	22,600	.5	0	-	0	-
GRAND TOTAL		4,554,676	100.0	2,805,325	100.0	649,000	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	2,697,300	96	120	720	1,130,100	48,100	82	155,800	388,500	333,700	0	641,100
WHO - WR	1,105,000	72	24	240	601,700	30,900	120	228,000	80,600	85,900	0	77,900
TOTAL	3,802,300	168	144	960	1,731,800	79,000	202	383,800	469,100	419,600	0	719,000
% OF TOTAL	100.0				45.6	2.1		10.1	12.3	11.0	.0	18.9
1992-1993												
PAHO - PR	3,185,300	96	120	600	1,278,400	55,800	60	120,000	466,300	354,000	0	910,800
WHO - WR	1,171,500	48	24	240	516,200	35,800	110	220,000	151,500	122,800	0	125,200
TOTAL	4,356,800	144	144	840	1,794,600	91,600	170	340,000	617,800	476,800	0	1,036,000
% OF TOTAL	100.0				41.2	2.1		7.8	14.2	10.9	.0	23.8
1994-1995												
PAHO - PR	3,635,400	96	120	600	1,436,200	64,800	60	126,000	541,000	410,600	0	1,056,800
WHO - WR	1,317,800	48	24	240	581,700	41,600	110	231,000	175,800	142,500	0	145,200
TOTAL	4,953,200	144	144	840	2,017,900	106,400	170	357,000	716,800	553,100	0	1,202,000
% OF TOTAL	100.0				40.7	2.1		7.2	14.5	11.2	.0	24.3

HONDURAS

ANALYSIS OF THE HEALTH SITUATION

1. The country reinitiated its process of democratization in 1982, strengthened by internal and subregional changes, although subject to intense pressure originating from the political processes taking place in neighboring Nicaragua and El Salvador. The external debt crisis and economic readjustment programs, compounded by the world economic crisis and the clear vulnerability of the Honduran economy, have resulted in a decline of productive activity, an increase in unemployment, an acceleration of inflation, desequilibria in the balance of payments and the public finances, a decline in investments, and a deterioration in real income for an important segment of the population, especially groups with limited economic resources.

2. According to the National Agricultural Survey of 1980, 90% of the workers employed in agriculture are seasonal employees and can be described as underemployed.

3. From 1982 to 1989, with the financial support of the International Monetary Fund and subsequently of the Agency for International Development (AID) of the United States, the Government of Honduras adopted a policy of stabilization and made an attempt at reducing external and fiscal imbalances.

4. However, the country's growth continued to be financed through medium and long-term internal and external debt.

5. Beginning in 1990, the current government of the Republic, in response to the acute economic crisis experienced by the country, initiated a process of economic structural adjustment, one of whose goals is the reduction of imbalances such as the fiscal deficit, balance of payments difficulties, inflation, and the lack of foreign exchange. Although they demand economic sacrifices from all sectors of the population, these measures essentially aim at an economic recovery in the medium and long term, by producing substantial changes in the productive apparatus.

6. Recognizing that the implementation of economic adjustment programs has a more severe effect on the most neglected social groups, the government, in an attempt to alleviate that impact, has introduced a series of social compensation measures, some of which are listed in the following: the creation of the Honduran Social Investment Fund (FHIS), whose resources are basically aimed at supporting public services and generating sources of employment, subsidizing urban transportation and the basic food basket; tax exemptions for individuals with low incomes, and a maternal and child bonus designed for pregnant women, lactating mothers, and children under the age of 5 belonging to underserved segments of the population.

7. Health and nutrition indicators reflect high morbidity rates resulting from communicable diseases, deficient environmental sanitation, low health services coverage, and point to a notable association between the death rates of children and mothers and their respective educational level and economic situation. This is reflected by an infant mortality rate that is three times higher among children of illiterate mothers, and reaches figures of 100 and above in regions with large underserved populations, compared with the national average of 63 per 1,000 live births, according to surveys in sentinel sites.

8. Thus, it is not surprising to find recent nutritional surveys showing that undernutrition affects 40% of children under the age of 5, and that, in some of the poorest areas, these rates exceed 60%.

9. In addition, in recent years, cardiovascular diseases, cancer, diabetes, accidents, and violent acts have gained importance as causes of disease, disability, and death.

10. With regard to the availability of water, the national average points to a coverage of 50% of all homes, while in the rural areas of some regions the coverage is only 5%. The national average for the coverage of excreta disposal services was 75% in 1990, while the poorer areas showed rates of less than 50%.

11. Among health problems induced by communicable diseases, special mention should be made of the enormous importance of and problem presented by AIDS (Honduras, country of highest incidence in Central America) and the continuous threat of vector-borne diseases (dengue, malaria).

12. Periodically, the country bears the brunt of tropical depressions, which, because of the gusty winds and abundant rains that accompany them, cause much damage not only to agriculture but also to the channels of communication, causing death and suffering among the inhabitants of the affected regions. In 1990, over 50,000 persons were affected and the damage was estimated at around Lp 400 million.

13. Despite this scenario, there has been some progress. Special mention should be made of the enormous efforts invested in the Immunization Programs, whose coverage has increased considerably, thus reducing related morbidity and virtually eliminating poliomyelitis. Considerable strides have also been made toward social participation, and there is great political determination to improve health system management. Furthermore, there have been advances in interinstitutional articulation, mainly between IHSS and MPH, with a subsequent increase in the coverage of IHSS and the health system in general.

National health strategies and plans

14. The unique historical situation that the country is experiencing makes it necessary for the Ministry to concentrate its attention, in the short and medium term, on reducing the high social costs that economic adjustment is imposing on our society, just as the Honduran people are on their way to developing a democratic process of harmonious political, economic, and social relations. There are signs that the social cost of economic adjustment will be unusually severe for the country's poorer population groups, which makes it necessary to assess conditions under which the burden of this adjustment could be alleviated. Within this process of democratization, as an end in itself and as a means for living together, and within the framework of the model of

economic adjustment that has been adopted, compensation of the social costs of adjustment becomes just as pressing a need, with a view to future economic growth and social equilibrium.

15. Recognition of the fact not only that the social costs of adjustment will affect the poorest segments of the population, with the resulting risk of an even greater deterioration of their health, but that the Ministry of Health, as a policy instrument of the Government, is obliged to implement measures aimed at diminishing that social cost, provides the framework for formulation of the following guidelines, which point to the global option of the Ministry in the face of this situation. The design and practice of the policy of compensation should take into account that the social costs are not distributed homogeneously among the different social groups, but rather that they have a much greater impact on the more neglected population groups.

16. In this context, the Ministry of Health has the responsibility of reviewing its policies and strategies so as to contribute, together with other Government instruments, to ensure the success of the structural adjustment program. In doing so, it should acknowledge the substantive (although synergistic) difference that exists between these short-term, urgently needed compensatory measures and unavoidable and pressing long-term measures aimed at reducing chronic inequities.

17. Within this general framework, the global option establishes the following main courses of action, which become interarticulated programs with defined durations and clearly identified human groups as objects and subjects of the corresponding actions: food security and local development; access to health services by underserved human groups; basic sanitation; adaptation of hospitals as members of the health services network; functional and financial articulation of the Ministry of Health with the Honduran Institute of Social Security; development of administrative capacity at the local level; development of leadership as well as logistical, political, and technical support for high management and intermediate administrative levels, as well as the creation of a strategic monitoring capacity for practical development of the option.

18. Access to the health services as the main course of action includes the identification, in each and every one of the productive units of the services network, of human groups according to their state of poverty, living conditions, and access to the health services. The adjustment of the model of care, as a response to the health-specific problems of these groups, requires a readjustment in the capacity of the services offered, in such a way that access to the health services is guaranteed.

19. Through this process, impetus will be given to the development of the capacity for programming and local administration, using the approach of social participation. In this particular context, it seems appropriate to point out that Honduras has adopted the organization of Local Health Systems (SILOS) as a strategy aimed at combining the insertion of the health services with the ongoing evolution of democracy. These systems are areas of articulation between the State and civil society, whose central objective is the democratization of the health systems through participation and social control of the administration of the health systems by the communities. These local health systems, democratization instruments that they are, must meet another necessary condition of the notion of democracy: social solidarity. Therefore, they should collaborate effectively with regional and national systems in order to achieve equity.

GLOBAL STRATEGY OF COOPERATION

20. Within the Framework of the National Government Plan, and on the occasion of the conclusion of activities of the National Congress, the President of the Republic noted that while 1990 had been the year of economic adjustment, 1991 would be the year of economic strengthening and reactivation and of social compensation, 1992 would bring economic recovery and local development, and 1993 would be the year of consolidation of democracy.

21. The definitions and actions of the Government planned for the biennium 1992-1993 point to a possible reorganization of its demands, in accordance with the recommendations of Resolution XIII of the XXIII Pan American Sanitary Conference. Starting now, the Ministry is reorienting its own activities in accordance to what was agreed upon at the VI RESSCA (Belize) for the following subject areas: Health Infrastructure, Health Promotion and Disease Control, and programs aimed at special groups and at the environment.

22. It is the country's intention, reflected by its actions, to promote the strengthening of Local Health Systems, as integrating axes of local economic and social development.

23. The country is making progress in the area of prioritizing actions aimed at underserved human groups, in concrete areas, and is attempting to integrate actions that are the domain of the health sector with those of other sectors in the strategic framework of Primary Health Care (HFA 2000).

24. PAHO/WHO, in its capacity as cooperation agency, plans to redirect its technical and financial resources in order to improve its efficiency and achieve better results.

25. PAHO/WHO technical cooperation in the biennium 1992-1993 will be embedded in the strategic orientations and programming priorities of the quadrennium 1991-1994.

26. An attempt will be made at channeling Government support through two areas of action: Health Services and Human Resources, since, in view of the situations proposed, it becomes necessary to readjust the services network, the models of care, and their problem-solving capacity. Furthermore, we should strengthen the search for and implementation of innovative mechanisms for continuing personnel training, social participation, and achievement of a consensus, so that every service is able to improve or develop the attitudes and aptitudes required to identify problems and find solutions capable of resolving the specific problems of equally specific human groups.

27. The actions of different programs directed at health-specific problems as well as at especially vulnerable groups will be channeled through Health Services and Human Resources, seeking to follow a comprehensive approach in the support that we lend.

28. By applying the previously mentioned concept of local health systems adopted by Honduras, technical cooperation has been provided in very close collaboration with MSH (AID), UNICEF, UNDP, UNHCR, WFP, PRODERE, NGOs, and others.

29. The development of the PWR has facilitated cooperation, which will be continued through international consultants, in support of priority national programs, or through contracted national experts, whose experience in Honduras has been satisfactory on the whole. There will be support for the mobilization of national resources with a view to transforming the health care system; CTP, basically of the countries of the subregion; and the support of the Centers (INCAP, CLAP, PASCAP, ECO, CEPIS, CEPANZO, PANAFTOSA, BIREME); cooperation of experts from Headquarters in support of the PWR as well as the subregional projects, such as MASICA, WHD, AIDS, RRHH, Occupational Health, and others.

30. The permanent support of PED in paving the way for a reduction in the effects of natural disasters has been, and will hopefully continue to be, very important.

31. Implementation of the "Francisca de Canales" Documentation Center System (PAHO) and CEDIDOS is expected to be completed, so as to be able to provide relevant and updated scientific and technical information to the Health Regions and, from these, to the hospitals and services, with the support of BIREME (Resolutions XIII and XXIII PSC).

32. Support is expected to continue for the National Autonomous Service of Water Supply and Sewerage Systems (SANAA), Local Governments, and Schools of the UNAH.

33. We believe that the crisis and the adjustment have been a challenge for the Government as well as for PAHO/WHO in terms of rationalizing and defining cooperation and the delivery of services at the local level in a more efficient manner.

34. PAHO will collaborate in the development of the following specific programs:

MPN:	Managerial Support for National Health Development
TCC:	Technical Cooperation among Countries
HST:	Health Situation and Trend Assessment
HDP:	Health Policy Analysis and Development
WHD:	Women, Health and Development
DHS:	Health Services Development
DPP:	Disaster Preparedness
HME:	Health Manpower Education
HBD:	Scientific and Technical Information Dissemination
CWS:	Community Water Supply and Sanitation
MCH:	Growth, Development and Human Reproduction
OCD:	General Communicable Disease Prevention and Control Activities
VBC:	Vector-Borne Diseases
NCD:	Health Promotion and Prevention and Control of Noncomunicable Diseases
ZNS:	Zoonoses

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		1,523,300	60.8	1,771,000	65.7	2,019,400	65.7
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		590,600	23.6	556,200	20.6	646,500	21.0
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	590,600	23.6	556,200	20.6	646,500	21.0
TECHNICAL COOPERATION AMONG COUNTRIES		28,600	1.1	33,200	1.2	38,500	1.3
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	28,600	1.1	33,200	1.2	38,500	1.3
HEALTH SITUATION AND TREND ASSESSMENT		36,200	1.4	195,700	7.3	224,300	7.3
HEALTH SITUATION AND TREND ASSESSMENT	HST	36,200	1.4	195,700	7.3	224,300	7.3
HEALTH POLICY DEVELOPMENT		43,500	1.7	94,200	3.5	106,600	3.4
HEALTH POLICY ANALYSIS AND DEVELOPMENT	HDP	43,500	1.7	47,800	1.8	52,800	1.7
WOMEN, HEALTH AND DEVELOPMENT	WHD	0	-	46,400	1.7	53,800	1.7
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		717,600	28.7	640,800	23.8	718,200	23.4
HEALTH SERVICES DEVELOPMENT	DHS	581,300	23.2	626,900	23.3	702,100	22.9
DISASTER PREPAREDNESS	DPP	0	-	13,900	.5	16,100	.5
CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY	CLR	21,700	.9	0	-	0	-
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	114,600	4.6	0	-	0	-
HUMAN RESOURCES DEVELOPMENT		106,800	4.3	133,100	4.9	147,500	4.8
HUMAN RESOURCES EDUCATION	HME	106,800	4.3	133,100	4.9	147,500	4.8
HEALTH INFORMATION SUPPORT		0	-	117,800	4.4	137,800	4.5
SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION	HBD	0	-	117,800	4.4	137,800	4.5

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
III. HEALTH SCIENCE AND TECHNOLOGY		978,800	39.2	927,600	34.3	1,056,500	34.3
ENVIRONMENTAL HEALTH		349,200	14.0	377,500	14.0	429,400	14.0
COMMUNITY WATER SUPPLY AND SANITATION	CWS	349,200	14.0	377,500	14.0	429,400	14.0
MATERNAL AND CHILD HEALTH		0	-	75,400	2.8	87,500	2.8
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	0	-	75,400	2.8	87,500	2.8
COMMUNICABLE DISEASES		547,700	21.9	336,600	12.4	383,800	12.4
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	210,100	8.4	116,700	4.3	133,700	4.3
TUBERCULOSIS	TUB	20,600	.8	0	-	0	-
VECTOR-BORNE DISEASES	VBC	264,800	10.6	219,900	8.1	250,100	8.1
MALARIA	MAL	52,200	2.1	0	-	0	-
HEALTH PROMOTION		45,500	1.8	116,500	4.3	131,100	4.3
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	45,500	1.8	116,500	4.3	131,100	4.3
VETERINARY PUBLIC HEALTH		36,400	1.5	21,600	.8	24,700	.8
ZOONOSES	ZNS	36,400	1.5	21,600	.8	24,700	.8
GRAND TOTAL		2,502,100	100.0	2,698,600	100.0	3,075,900	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		249,046	10.9	114,468	11.3	0	100.0
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		39,663	1.7	0	-	0	100.0
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	39,663	1.7	0	-	0	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		209,383	9.2	114,468	11.3	0	-
HEALTH SERVICES DEVELOPMENT	DHS	174,900	7.7	114,468	11.3	0	-
DISASTER PREPAREDNESS	DPP	34,483	1.5	0	-	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		2,034,615	89.1	900,000	88.7	0	-
MATERNAL AND CHILD HEALTH		103,426	4.5	0	-	0	-
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	103,426	4.5	0	-	0	-
COMMUNICABLE DISEASES		1,915,934	83.9	900,000	88.7	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	667,471	29.2	400,000	39.4	0	-
MALARIA	MAL	1,248,463	54.7	500,000	49.3	0	-
HEALTH PROMOTION		15,255	.7	0	-	0	-
OCULAR HEALTH	PBD	15,255	.7	0	-	0	-
GRAND TOTAL		2,283,661	100.0	1,014,468	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	1,702,400	72	96	375	809,500	61,700	87	165,300	223,700	113,600	75,000	253,600
WHO - WR	799,700	48	0	240	381,800	25,200	55	104,500	192,700	73,700	0	21,800
TOTAL	2,502,100	120	96	615	1,191,300	86,900	142	269,800	416,400	187,300	75,000	275,400
% OF TOTAL	100.0				47.6	3.5		10.8	16.6	7.5	3.0	11.0
1992-1993												
PAHO - PR	1,916,700	72	120	465	790,900	62,600	87	174,000	332,000	223,200	0	334,000
WHO - WR	781,900	48	0	270	400,800	17,400	36	72,000	183,300	64,300	3,500	40,600
TOTAL	2,698,600	120	120	735	1,191,700	80,000	123	246,000	515,300	287,500	3,500	374,600
% OF TOTAL	100.0				44.1	3.0		9.1	19.1	10.7	.1	13.9
1994-1995												
PAHO - PR	2,189,200	72	120	465	901,800	72,700	87	182,700	385,300	259,000	0	387,700
WHO - WR	886,700	48	0	270	452,500	20,200	36	75,600	212,700	74,600	4,000	47,100
TOTAL	3,075,900	120	120	735	1,354,300	92,900	123	258,300	598,000	333,600	4,000	434,800
% OF TOTAL	100.0				44.2	3.0		8.4	19.4	10.8	.1	14.1

ANALYSIS OF THE HEALTH SITUATION

Geography

1. Jamaica is the largest of the Commonwealth Caribbean Islands with a total area of 4,411 square miles.

2. The Island is divided into three Countries and fourteen parishes. There are two cities; Kingston the capital on the south-east coast and Montego Bay on the north-west coast.

Demography

3. The 1982 census reported a population of 2,190,357 and by 1989 this was estimated at 2,392,000. It is expected to increase further to 2,757,000 by the year 2000. The rate of population growth is 1.4% per annum and the natural rate of increase is 1.89%.

4. In 1989, the crude birth rate was 24.9/1000 and is projected to decline to about 20/1000 by the year 2000. The total fertility rate declined from 3.5 in 1983 to 2.9 in 1989 and the highest fertility rates are to be found in the 20-29 age groups followed by the 15-19 age group.

5. The death rate in 1990 was 5.8/1000 and is expected to stabilize at this level to the end of the decade. The infant mortality rate in 1989 was recorded as 27/1000 live births but there is significant underregistration of early infant deaths. Maternal mortality was 11.5/10,000 live births.

6. External migration contributes significantly to population loss as it is estimated that 20,000 persons migrate annually of which some 20% are highly skilled personnel.

7. There is a narrowing base to the population pyramid which suggests a declining fertility and an ageing population. The age groups under 14 years account for 33% of the population; the labor force (i.e. 15-64 years) account for 58.7% while the 65 years and over account for 7.5% of the population.

Indicators of health status

8. Life expectancy at birth in 1989 was 70.8 years (male/female). The leading causes of death for all ages in 1984 were malignant neoplasms, heart disease, cerebrovascular disease, hypertension, and diabetes mellitus; while for the under 1 year age group these were: certain intestinal diseases, conditions originating in the perinatal period, nutritional deficiencies, congenital abnormalities and pneumonia and influenza. Accidents violence and their adverse effects featured predominantly in all groups 5 years of age and over.

9. Since 1984, with the introduction of the Oral Rehydration Therapy program, there has been a decline in deaths from diarrhoeal diseases among infants. Case fatality has been reduced to 0.15 per 100 admissions to hospitals. In 1989 malnutrition among the under fives was 8.2% compared with 14.6% in 1985, and has consequently become a lower determinant of infant and early childhood mortality.

10. The problem of drug abuse has increased; so, too, has the incidence of traffic accidents and violence, which latter has contributed to a growing number of admissions to hospitals.

11. There was an increase of 5% in total cases of syphilis between 1985 and 1989. Many cases occurred among pre-natal women which points to major implications for maternal and child health. At the same time, there has been a decrease in the population of syphilis occurring in adolescents and young adults. The incidence of gonorrhoea has shown a decrease between in 1988 and 1989.

12. At the end of December 1989, a total of 137 cases of AIDS was reported, beginning with the first case in December 1982. 64 cases were reported in 1989 compared with 30 in 1988. Of the total of 137 cases, 97 (70%) were male and 41 (30%) were female. The majority of the cases (i.e. 97), is within the age group 20-24 years.

Factors affecting health status

13. A principal factor affecting health status is the state of the economy. For some time now, the country has been experiencing acute balance of payment problems which have resulted in the implementation of structural adjustment programs. Concomitantly, the Jamaican dollar has been consistently devalued in recent years to J$1.00 = US$0.125 in 1990.

14. This has had direct implications for health in that the sector has been consistently underfinanced. In 1989/90 the government health sector accounted for approximately 2.9% of GDP and government per capita expenditure reflected in the health budget was $186.64 which in constant terms was just below what was spent in 1985/86. This situation was further exacerbated by significant shortfalls below the annual requests and receipts of approved Ministry of Health budgets and the persistent vacancies in critical areas of the health services.

15. As a consequence of the financial constraints adversely affecting the levels of remuneration, the Ministry of Health faces the problem of severe shortage of human resources which seriously threatens its ability to deliver health care to the nation. In 1989 there was 60% vacancy rate among pharmacists, 57% among medical technologists and 43%, 40% and 42% respectively among registered nurses, enrolled assistant nurses and public health inspectors. However, aggressive and innovative strategies are being employed to mitigate the effects of the situation.

16. The environmental situation remains critical especially in the area of waste disposal. There are episodes of poisoning in animals and man from indiscriminate disposal of toxic waste. Excreta disposal in the majority of parishes has not yet returned to an acceptable standard since the hurricane of 1988. Although some parishes have intensified their latrine construction programs, large numbers of households are still without latrine facilities. The transmission of faeco-oral diseases such as gastroenteritis and typhoid remains a problem with two outbreaks of the latter in 1990. There are 107 sewage treatment plants in Jamaica located mainly in urban areas. In 1989 only 38% of these were found to be in a satisfactory condition. Twenty one percent of the urban population is served by this system.

17. Solid wastes disposal is also a problem. Poor disposal practices exist which create the potential for adverse effects on the health of the individual as well as on the community. There is also dumping on wet lands with subsequent loss of the productivity of those environments with their delicately balanced ecosystems, and the potential for ground and surface water contamination from indiscriminate dumping in gullies, sinkholes and mined out limestone pits.

18. Problems in the area of water also exists both in regard to supply and water quality. Supplies to all major urban centers are treated and in 1989, 81% of the population received treated water; 12% received untreated water and 7% are not reached by public supply. Approximately 25% of samples were bacteriologically positive and approximately 29% had no residual chlorine.

National health strategies, policies and plans

19. The Ministry of Health's policy as enunciated in the national Five Year Plan 1990-1995 is "to seek to provide comprehensive, efficient and acceptable health services which incorporate both the public and private sectors and provide at least a basic level of health care for all people, with facilities for easy transfer of people to all levels of care as necessary."

20. The overall objective is to endeavor that by the year 2,000, all people of Jamaica will have attained a level of health which will permit them to lead a socially and economically productive life. It is, however, understood that the goals for Health for all cannot be achieved without effective intersectoral collaboration.

21. The immediate objective is to seek to establish a comprehensive efficient and acceptable health system that incorporates both public and private sectors and provides equal access for all people to at least a basic level of health care which includes preventive, promotive, curative and rehabilitative health services and allows for the easy transfer of people to all levels of care as necessary.

22. The strategies for achieving the policy objectives include but are not limited to: Research of new initiatives for financing health care; expansion and improvement of the quality of family planning counselling and general services in collaboration with the National Family Planning Board to facilitate the achievement of the National Population Policy target; raising the management and support services to the same high level of competence; improving physical facilities and equipment to encourage high standards of care; and collaboration with the private sector and Non-Governmental Organizations.

23. The health sector is engaged in the following activities in an effort to achieve its overall objective:

23.1 Decentralization of health services. Scheduled to begin in April 1991 with the decentralization of hospitals, additional phases will include establishment of five regional health authorities and the corresponding functional and organizational restructuring of the Ministry of Health (HQ). Each health region will have the potential for development as a local health system offering the basic primary and secondary service to a defined population in a specific geographical area through the integrated management of district health systems and decentralized secondary institutions.

23.2 Establishment of a comprehensive health information system as infrastructural to the establishment and maintenance of efficient management systems centrally and peripherally, to support the decentralized administration of the health services.

23.3 Improvement and maintenance of physical infrastructure. Various projects (IADB, World Bank, Italian Government) will address upgrading of physical infrastructure in the primary, secondary and tertiary services and in parallel with these, the Ministry of Health intends to introduce an effective maintenance service based on a comprehensive asset management system and the establishment of in-country basic training programs.

23.4 Manpower. The Ministry will continue to address manpower shortages in critical staff groups through improved conditions of service, increases in the nurses trained and the introduction of new staff categories Aggressive and innovative recruitment strategies will also continue to be employed.

23.5 Health programs. Emphasis will be given to the following health programs, targeting high risk group and intensifying health promotional efforts, including public health education: maternal and child health; nutrition and chronic diseases; mental health and oral health. Mental health care will be integrated with the primary health care services. In addition to the upgrading of staff skills for the diagnosis and control of chronic diseases, the cancer screening program will be reoriented in light of recent data.

23.6 Veterinary Public Health. Food Safety and Protection is being promoted through the formation of a National Committee. National attention has been drawn to foodborne disease surveillance as a priority and this is expected to be strengthened during the biennium. An Animal Health Plan of Action is being prepared for integration into the National Disaster Management Plan.

23.7 Environmental Health. The sustainable management of the natural resource based economy is the basic policy goal. It requires that the environmental health and natural resources be managed in such a way that it does not compromise the welfare of present or future generations. The priorities of the Ministry of Health are: Improve the drinking water quality by proper monitoring, reporting and by setting standards; minimize the pollution of water, both surface and underground water, by improper excreta/sewage disposal; minimize the impact of solid wastes on the human environment, especially those infectious and hazardous wastes; reduce the impact of air pollutants on the human environment; improve the working conditions of factory and farm workers.

23.7.1 Strategies to achieve the objectives will include (1) decentralization of the environmental health activities; (2) promotion of community participation in the detection and solution of environmental health problems; (3) development of a Environmental Health Management Information System; (4) Public education both formal and informal; (5) resource development, both human resources and physical; (6) enactment of laws and regulations and (8) the introduction of new economic and financial mechanisms.

National priority areas for technical cooperation

24. Technical cooperation in the following priority areas has been requested by the government based on the major priorities identified in the Joint Review of 1990:

24.1 Assistance with the development of norms, procedures, standards in relation to the decentralization of the health services and development of local health systems, including the strengthening of management information systems.

24.2 Assistance with the design and implementation of a comprehensive training program relating to decentralization.

24.3 Assistance with project implementation as required to ensure the effective use of resources and technology.

24.4 Assistance with the development of systems and training programs in maintenance.

24.5 Assistance with strengthening of existing training institutions and the development of training programs for new staff categories.

24.6 Assistance with training in disaster preparedness and management, and the development of training materials.

24.7 Strengthening of health education programs, promotion of community participation and enhancement of information dissemination to create awareness regarding healthy lifestyles.

24.8 Strengthening of management of dental health information through development of library and support human resource development to enhance delivery of oral health services.

24.9 Strengthening Women, Health and Development programs to create greater sensitivity to women's health needs and maximize scarce resources accordingly.

24.10 Support for development of norms, procedures and standards in relation to Drinking Water, Excreta Disposal, Sewerage, Water Pollution, Air Pollution, Solid Waste Management, Approval of Sub-divisions and occupational health.

24.11 Strengthening of Epidemiological surveillance systems.

24.12 Strengthening of the Veterinary Public Health Services such as food protection through the development of a surveillance system in vulnerable areas. Zoonoses Prevention and Control activities, with emphasis on Brucellosis eradication and the development of an Animal Emergency Plan and Proposal.

24.13 Maximizing the effectiveness of existing national resources for the extension of coverage to all groups, with special emphasis on high risk groups in relation to the delivery of services for Maternal and Child Care, Nutrition, Mental Health and control of Chronic Diseases.

24.14 Strengthening of health information system.

24.15 The assessment of health manpower problems and issues and preparation of implementation of a Draft Manpower Policy and Plan.

24.16 Collaboration between countries in relation to sharing of expertise is also an important area of technical cooperation.

GLOBAL STRATEGY OF COOPERATION

25. Arising out of the Joint Evaluation exercise and subsequent discussions, the Government has identified a number of areas out of its national list of priorities in which it is seeking PAHO/WHO concerted technical cooperation in the next biennium. These include health planning, management information system, health information, health facilities maintenance, human resources development, environmental health, food safety, STD/AIDS, and decentralization of the health services. PAHO/WHO will, in addition, continue to maintain a number of other programs in accordance with the mandates of the Governing Bodies.

26. PAHO/WHO strategies will be based on (a) direct technical cooperation utilizing in-country, sub-regional and regional resources as well as resources provided through WHO intensive program of collaboration with Jamaica; (b) resource mobilization including external funding, TCC and collaboration with nongovernmental organizations; (c) development of policies, plans and norms for the sustained upgrading of service delivery; (d) research to determine needs and status for development and implementation of health programs and (e) information dissemination to optimize the utilization of resources.

27. Health planning. Technical cooperation will be provided for the development of a Health Plan. This will provide the strategic, tactical and operational framework for the delivery of health services to mid-decade and beyond. Arising out of the exercise, it is envisaged that a manpower plan will also be developed./PAHO/WHO input will be in technical assistance and will be complementary to anticipated extra-budgetary bi-lateral funding.

28. Management information system. The Government has taken a policy decision to decentralize its operations. A concomitant of this will be the need to develop adequate information systems for effective management decision making as well as information dissemination among, and thus the strengthening of the decentralized units. This has direct implication for the further development and strengthening of Local Health Systems (SILOS). PAHO/WHO will be involved, together with anticipated support from WHO, in assisting the Ministry of Health in sustained expertise at Country level by way of an in-country consultancy.

29. Health information. PAHO/WHO will provide support for the development of research capacity, to assist in the development of methodologies for survey, standardization and analysis of hospital and health center records and to identify training needs. PAHO/WHO resource in health management information systems is expected to be utilized to provide assistance in this area as well as the funding of short term consultancies.

30. Health facilities maintenance. This is an under-served area and yet one that is critical to the effective functioning of a decentralized system of delivery. PAHO/WHO strategy will be to fund short term consultancies, to collaborate with WHO for the provision of intensified assistance program and to support resource mobilization by way of extra-budgetary bi-lateral resources.

31. Human resource development. An objective of this program is to assist the Ministry in meeting the short, medium and long term need for the development and retention of personnel in the health sector. This is a significant component of PAHO/WHO joint program of technical collaboration with the government. Assistance will also be given for the review of programs in the training institutions in regard to the appropriateness as well as to the support of activities for the further strengthening of these institutions.

32. Environmental health. The goals of the environmental health program area (a) the enhancement and development, and in some cases, the monitoring, assessment of the capacity of the Ministry of Health in the area of environmental health control; (b) the improvement in efficiency and effectiveness of service delivery through the coordination of activities with other executive and regulatory agencies; (c) increase in community participation and (d) through increase in technical cooperation with other countries in the Region.

33. PAHO/WHO strategy will employ direct technical cooperation through resident and sub-regional technical personnel to assist the Ministry of Health to achieve its objectives in this area. PAHO will work with national agencies to mobilize external resources in support of the program. PAHO can facilitate the critical multisectoral coordination required.

34. Food safety. It is envisaged that this area will grow in importance during the next biennium. PAHO/WHO strategy optimizes the use of subregional resources including CFNI and CAREC. This collaboration will ensure a sub-regional approach in the future strengthening and development of the program.

35. Decentralization. PAHO/WHO strategy will be to assist the Ministry of Health in structuring the decentralized system, in the mobilization of resources through the improvement of community groups and NGO's to assist in the enhancement of information dissemination and management and in the development of human resources relevant to the reorganization.

36. PAHO will collaborate in the development of the following specific programs:-

MPN: Managerial Support for National Health Development;
TCC: Technical Cooperation among Countries;
HST: Health Situation and Trend Assessment;
DHS: Health Services Development;
HME: Health Manpower Education;
CWS: Community Water Supply and Sanitation;
MCH: Growth, Development and Human Reproduction;
OCD: General Communicable Disease Prevention and Control Activities;
NCD: General Noncommunicable Disease Prevention and Control Activities; and
FOS: Food Safety and Protection

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		1,585,700	71.0	1,749,800	70.9	2,013,600	71.1
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		640,700	28.7	742,400	30.0	866,700	30.6
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	640,700	28.7	742,400	30.0	866,700	30.6
TECHNICAL COOPERATION AMONG COUNTRIES		72,100	3.2	83,600	3.4	97,000	3.4
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	72,100	3.2	83,600	3.4	97,000	3.4
HEALTH SITUATION AND TREND ASSESSMENT		126,000	5.6	128,900	5.2	146,600	5.2
HEALTH SITUATION AND TREND ASSESSMENT	HST	126,000	5.6	128,900	5.2	146,600	5.2
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		651,400	29.2	697,300	28.3	792,300	28.0
HEALTH SERVICES DEVELOPMENT	DHS	651,400	29.2	697,300	28.3	792,300	28.0
HUMAN RESOURCES DEVELOPMENT		95,500	4.3	97,600	4.0	111,000	3.9
HUMAN RESOURCES EDUCATION	HME	95,500	4.3	97,600	4.0	111,000	3.9
III. HEALTH SCIENCE AND TECHNOLOGY		644,900	29.0	716,600	29.1	817,400	28.9
ENVIRONMENTAL HEALTH		265,800	11.9	280,600	11.4	319,300	11.3
COMMUNITY WATER SUPPLY AND SANITATION	CWS	265,800	11.9	280,600	11.4	319,300	11.3
MATERNAL AND CHILD HEALTH		130,700	5.9	132,400	5.4	150,100	5.3
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	130,700	5.9	132,400	5.4	150,100	5.3
COMMUNICABLE DISEASES		112,800	5.1	147,700	6.0	172,800	6.1
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	112,800	5.1	147,700	6.0	172,800	6.1

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
HEALTH PROMOTION		100,000	4.5	109,100	4.4	122,000	4.3
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	100,000	4.5	109,100	4.4	122,000	4.3
VETERINARY PUBLIC HEALTH		35,600	1.6	46,800	1.9	53,200	1.9
FOOD SAFETY	FOS	35,600	1.6	46,800	1.9	53,200	1.9
GRAND TOTAL		2,230,600	100.0	2,466,400	100.0	2,831,000	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		186,358	24.6	0	-	0	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		186,358	24.6	0	-	0	100.0
HEALTH SERVICES DEVELOPMENT	DHS	182,466	24.1	0	-	0	100.0
CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY	CLR	3,892	.5	0	-	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		570,787	75.4	621,500	100.0	0	-
COMMUNICABLE DISEASES		569,941	75.3	621,500	100.0	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	569,941	75.3	621,500	100.0	0	-
HEALTH PROMOTION		846	.1	0	-	0	-
PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE	ADA	846	.1	0	-	0	-
GRAND TOTAL		757,145	100.0	621,500	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL CONS. MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	740,100	24	0	390	264,500	22,900	41	77,900	166,800	90,400	36,100	81,500
WHO - WR	1,490,500	72	144	390	805,700	22,900	74	140,600	96,500	78,000	48,100	298,700
TOTAL	2,230,600	96	144	780	1,070,200	45,800	115	218,500	263,300	168,400	84,200	380,200
% OF TOTAL	100.0				48.0	2.1		9.8	11.8	7.5	3.8	17.0
1992-1993												
PAHO - PR	731,600	24	0	125	235,900	31,500	48	96,000	134,600	75,700	0	157,900
WHO - WR	1,734,800	72	144	220	886,700	36,800	68	136,000	195,300	109,100	0	370,900
TOTAL	2,466,400	96	144	345	1,122,600	68,300	116	232,000	329,900	184,800	0	528,800
% OF TOTAL	100.0				45.5	2.8		9.4	13.4	7.5	.0	21.4
1994-1995												
PAHO - PR	838,700	24	0	125	266,100	36,600	48	100,800	156,200	88,000	0	191,000
WHO - WR	1,992,300	72	144	220	1,023,100	42,700	68	142,800	226,700	126,600	0	430,400
TOTAL	2,831,000	96	144	345	1,289,200	79,300	116	243,600	382,900	214,600	0	621,400
% OF TOTAL	100.0				45.6	2.8		8.6	13.5	7.6	.0	21.9

MEXICO

ANALYSIS OF THE HEALTH SITUATION

1. Mexico has 81,140,922 inhabitants whose health conditions and well-being have improved during the present century, leading to a notable epidemiological and demographic transition which has been characterized by a decline in mortality and an increase in life expectancy from 40 to 67.1 years between 1930 and 1989.

2. The epidemiological transition is also reflected in a new mortality profile. In 1950, heart disease, cerbrovascular disease, accidents, and malignant neoplasms accounted for 8.9% of total deaths, while in 1986 they represented a proportion of 32.7%. Infectious diseases, on the other hand, have shown a declining trend, in spite of the fact that they are still prevalent in certain population groups.

3. Infant mortality also shows a steady declining trend; in 1986 the rate was 23.6 per 1,000 registered live births. However, due to an almost 40% rate of underreporting, indirect methods have been used to estimate that the actual figure was 38.7 per 1,000. Similarly, and although the rate remains high, maternal mortality has also decreased; in 1980 it was 9.5 per 10,000 registered live births, while in 1985 it was 6.4 per 10,000.

4. In the case of communicable diseases, diseases preventable by immunization experienced a declining trend between 1984 and 1988, reflecting the favorable impact of the National Program on Immunization. Particularly notable is the reduction in the number of municipalities having cases of poliomyelitis, from 151 in 1985 to 11 in 1989. In 1988, 74 cases of human rabies were reported, which represents a rate of 0.9 per 1 million inhabitants.

5. According to the information provided by the National Nutrition Survey which was conducted in 1987, the prevalence of chronic illness and disability in the population of persons aged 15 years and above is 11.2 per 100 inhabitants. The highest frequency is found for arterial hypertension, followed by arthritis and diabetes mellitus.

6. The data from the 1988 National Nutrition Survey indicates that Mexico has 2.6 million children under the age of 5 who show some degree of undernutrition. Acute undernutrition is found in 18.2% of children, and chronic undernutrition in 14.8%. Of those, 2.4% show both types of undernutrition at the same time, with the most serious situation occurring in the southwestern and central portions of the country.

7. The National Health System is set up as the unit responsible for dovetailing the services provided by public agencies and entities, both federal and state, as well as by individuals and associations in the social or private sectors, with the goal of making the right to health protection effective, as stipulated in Article 4 of the Political Constitution of the country. In 1989, the potential coverage of the health services reached approximately 94% of the population. It is estimated that 54.6% of the inhabitants are covered by social security; 35.1% receive care from institutions for an open population; 4.3% make use of private services on a permanent basis; and 6% have no easy access to the permanent installations in the system.

8. In spite of the efforts on the part of the Mexican government to provide satisfactory health services to the entire population, there are still sectors that are subject to considerable risks. New problems have arisen and others have gotten worse. The urban migration, which has been encouraged by the industrialization process and the growing unemployment found in the rural setting, coupled with the limited purchasing power of many population sectors, has caused the demand for health services to overwhelm the installed capacity of the institutions. The problem of air and environmental pollution, in general, has grown worse, and demographic growth continues to generate health needs. Clearly, if the high birth rates and the increase in life expectancy remain unchecked, in the near future there will be considerable growth of the age groups that include elderly persons, as well as those that contain women of reproductive age and children, all of whom need care that requires a greater quantity of resources.

9. Outstanding among public health problems are the persistence of habits that are injurious to health; the predominance of the curative approach in the health services; deterioration of the environment with deficiencies in basic sanitation, domestic hygiene, and drinking water supply; elimination of garbage and excreta and control of vectors; and the slow progress in public health procedures and technologies for health surveillance and monitoring.

GLOBAL STRATEGY OF COOPERATION

10. The technical cooperation strategy of the PAHO/WHO Representative Office in Mexico is designed in accordance with the Strategic Orientations and Program Priorities of the Organization for 1991-1994, and in support of fulfillment of the National Health Program for 1990-1994.

11. The dialogue between the health authorities and the Representative Office will be the basic premise, and the framework will provided by the country's health situation as well by the degree of development of the health services. The tone will be one of mutual confidence, respecting Mexico's commitments in the governing bodies of PAHO and WHO. The strategic approaches that are important for the 1992-1993 biennium, with regard to policies, plans, and standards, encompass consolidation of the health sector reorganization through the development of health jurisdictions, both model and in progress, in the operation of local health systems, installation of the local programming process, and human resources development, as appropriate to full implementation of the primary health care strategy. In the case of resource mobilization, it will be sought to more fully integrate federal efforts with those carried out at the state and municipal levels, in an attempt to share responsibilities and resources. It is planned to continue the decentralization of health services and the involvement of non-traditional players in fulfilling the National Health

Program, such as those from the private sector and the municipal level. An attempt will be made to seek PAHO/WHO participation in important projects with financial institutions such as the World Bank, while the association with IDB will continue through projects in the area of drinking water and sanitation. When it comes to training, Mexico receives many fellowship students in a variety of fields from Latin American countries, for which reason more coordination is needed with the institutions that train human resources, particularly the National Autonomous University of Mexico (UNAM), and the School of Public Health of Mexico, as well as those in Guadalajara, Jalapa, Monterrey, and the Autonomous Metropolitan University (UAM). In the same way, it will be sought through catalytic action to facilitate their integration into the service-providing function of health services. In the area of research promotion, support will continue for various projects in the fields of AIDS, tropical diseases, and human reproduction, all of which have received substantial aid from the Organization; at the same time, more contact with, and support of, public health research will be developed, particularly with the National Institute of Public Health, because of its potential influence in Latin America. In the case of information dissemination, the role of the Representative Office's Documentation Center will be strengthened, along with collaboration in the establishment of networks of the specialized systems promoted by the Organization. At the same time, the effort to document important experiences through publications will continue.

12. The PAHO/WHO Representative Office in Mexico, in order to fully realize the above goals, as well as to provide high level technical cooperation which serves such program priorities as local health systems and local programming, technological development, human resources development, maternal and child health, health and the environment, AIDS, and food and nutrition, which have been identified by the National Health Program, must strengthen its technical groups and modernize the administrative support systems. At the same time, it is essential to supplement the Organization resources that are allocated to the country with additional resources coming from other levels of the Organization. Along these lines, it is appropriate to mention the successful relationship--one which should be strengthened-- with the Pan American Center for Human Ecology and Health, as well as with the El Paso Field Office.

13. Finally, it will be attempted to collaborate with Mexico's decision to have a broader presence in, and relationship with, the Latin American countries. It is considered important to support the joint work in health between Belize, Guatemala, and Mexico, to promote the country's participation in important programs under certain subregional initiatives, particularly the Southern Tier Initiative, and to continue to facilitate the joint health efforts carried out by the United States and Mexico.

14. PAHO will collaborate in the development of the following specific programs:

MPN:	Managerial Support for National Health Development
TCC:	Technical Cooperation among Countries
HST:	Health Situation and Trend Assessment
DHS:	Health Services Development
HME:	Health Manpower Education
CEH:	Control of Environmental Health Hazards
MCH:	Growth, Development and Human Reproduction
QCD:	General Communicalbe Disease Prevention and Control Activities
NCD:	Health Promotion and Prevention and Control of Noncommunicable Diseases
FOS:	Food Safety
ZNS:	Zoonoses

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		2,538,100	59.4	2,768,700	55.2	3,164,300	56.4
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		1,103,400	25.8	1,214,600	24.2	1,392,900	24.8
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	1,103,400	25.8	1,214,600	24.2	1,392,900	24.8
TECHNICAL COOPERATION AMONG COUNTRIES		106,700	2.5	123,800	2.5	143,600	2.6
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	106,700	2.5	123,800	2.5	143,600	2.6
HEALTH SITUATION AND TREND ASSESSMENT		170,500	4.0	213,300	4.3	242,600	4.3
HEALTH SITUATION AND TREND ASSESSMENT	HST	170,500	4.0	213,300	4.3	242,600	4.3
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		888,100	20.8	930,000	18.5	1,061,200	18.9
HEALTH SERVICES DEVELOPMENT	DHS	705,800	16.5	930,000	18.5	1,061,200	18.9
ESSENTIAL DRUGS AND VACCINES	EDV	40,800	1.0	0	-	0	-
CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY	CLR	44,800	1.0	0	-	0	-
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	96,700	2.3	0	-	0	-
HUMAN RESOURCES DEVELOPMENT		216,800	5.1	287,000	5.7	324,000	5.8
HUMAN RESOURCES EDUCATION	HME	216,800	5.1	287,000	5.7	324,000	5.8
RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT		52,600	1.2	0	-	0	-
RESEARCH PROMOTION AND DEVELOPMENT	RPD	52,600	1.2	0	-	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		1,737,000	40.6	2,249,300	44.8	2,442,500	43.6
ENVIRONMENTAL HEALTH		549,300	12.8	534,600	10.7	596,300	10.6
COMMUNITY WATER SUPPLY AND SANITATION	CWS	325,100	7.6	0	-	0	-
SOLID WASTES AND HOUSING HYGIENE	RUD	47,700	1.1	0	-	0	-
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	158,000	3.7	534,600	10.7	596,300	10.6
WORKERS' HEALTH	OCH	18,500	.4	0	-	0	-

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
MATERNAL AND CHILD HEALTH		0	-	206,100	4.1	126,100	2.2
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	0	-	206,100	4.1	126,100	2.2
COMMUNICABLE DISEASES		838,500	19.6	789,100	15.7	901,400	16.1
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	674,400	15.8	789,100	15.7	901,400	16.1
TUBERCULOSIS	TUB	164,100	3.8	0	-	0	-
HEALTH PROMOTION		71,900	1.7	347,900	6.9	396,200	7.1
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	71,900	1.7	347,900	6.9	396,200	7.1
VETERINARY PUBLIC HEALTH		277,300	6.5	371,600	7.4	422,500	7.6
FOOD SAFETY	FOS	55,800	1.3	112,300	2.2	126,500	2.3
ZOONOSES	ZNS	221,500	5.2	259,300	5.2	296,000	5.3
GRAND TOTAL		4,275,100	100.0	5,018,000	100.0	5,606,800	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		203,827	6.8	200,000	4.0	0	-
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		203,827	6.8	200,000	4.0	0	-
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	203,827	6.8	200,000	4.0	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		2,806,930	93.2	4,820,881	96.0	2,590,300	100.0
ENVIRONMENTAL HEALTH		386,679	12.8	34,800	.7	40,400	1.6
COMMUNITY WATER SUPPLY AND SANITATION	CWS	386,679	12.8	34,800	.7	40,400	1.6
MATERNAL AND CHILD HEALTH		1,637,750	54.4	4,342,580	86.5	2,549,900	98.4
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	1,637,750	54.4	4,342,580	86.5	2,549,900	98.4
COMMUNICABLE DISEASES		782,501	26.0	443,501	8.8	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	782,501	26.0	443,501	8.8	0	-
GRAND TOTAL		3,010,757	100.0	5,020,881	100.0	2,590,300	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	3,468,000	72	384	1425	1,297,500	52,400	79	150,100	623,200	289,200	122,500	933,100
WHO - WR	807,100	96	0	80	634,700	15,100	22	41,800	56,400	28,200	0	30,900
TOTAL	4,275,100	168	384	1505	1,932,200	67,500	101	191,900	679,600	317,400	122,500	964,000
% OF TOTAL	100.0				45.2	1.6		4.5	15.9	7.4	2.9	22.5
1992-1993												
PAHO - PR	3,978,500	84	360	1105	1,642,000	67,100	114	228,000	631,100	344,800	78,100	987,400
WHO - WR	1,039,500	96	0	45	792,000	38,500	6	12,000	29,200	17,800	0	150,000
TOTAL	5,018,000	180	360	1150	2,434,000	105,600	120	240,000	660,300	362,600	78,100	1,137,400
% OF TOTAL	100.0				48.4	2.1		4.8	13.2	7.2	1.6	22.7
1994-1995												
PAHO - PR	4,417,800	72	360	1105	1,732,000	77,800	114	239,400	732,200	400,100	90,600	1,145,700
WHO - WR	1,189,000	96	0	45	903,100	44,700	6	12,600	33,900	20,700	0	174,000
TOTAL	5,606,800	168	360	1150	2,635,100	122,500	120	252,000	766,100	420,800	90,600	1,319,700
% OF TOTAL	100.0				47.0	2.2		4.5	13.7	7.5	1.6	23.5

NETHERLANDS ANTILLES

ANALYSIS OF THE HEALTH SITUATION

1. In 1987, the estimated population of the islands, excluding Aruba, was 192,036. A total of 40% of the population (composed of young people under 15 years of age and those over 60) is economically dependent. In Aruba, the population was estimated at 59,881 in 1987. The age structure indicates an aging population.

2. The health services of the islands are financed by the Kingdom of the Netherlands, the social security system, the governments of the islands, private agencies, and private insurance companies. The federal government finances medical and health services for public employees, their family members, and retired persons. Social security covers medical expenditures for employees of private companies with yearly salaries of less than 20,000 guilders.

3. There are 35 health establishments in the islands with a total of 2,698 beds; this represents one bed for every 90 inhabitants. Most of the establishments are in the private sector. The psychiatric hospital, owned by the government, is in Curacao. Each island pays for the use of the services provided.

4. Life expectancy at birth in 1985 was 71.1 years for men, 75.8 years for women, and for both sexes, 72.8 years.

5. The principal health problems expressed in terms of mortality refer basically to chronic and degenerative diseases. Infectious and parasitic diseases represent only 3.7% of overall diagnosed mortality. Malignant neoplasms occupy second place in mortality, with a rate of 125.8 per 100,000 for the islands and 101.2 per 100,000 for Curacao, representing almost one-fourth of all diagnosed mortality. Among the cancers, those of the digestive system, respiratory tract, and genitourinary system occupy the first three places. Of the total number of deaths from these causes, the island of Curacao accounts for 90.5%.

6. Cardiovascular diseases are the principal cause of death, both in Aruba and in the Netherlands Antilles, with a rate of 119.0 per 100,000 for all the islands and 113 for Curacao. These diseases account for one-third of diagnosed mortality, and the island of Curacao accounts for 70% of all deaths from this cause. This group includes ischemic heart disease, responsible for the highest number of deaths. The third place in mortality is represented by the cerebrovascular diseases, with rates of approximately 72 per 1,000 for the Netherlands Antilles and Curacao; this disease accounts for 13% of diagnosed mortality. If diseases of the heart and cerebrovascular diseases were considered jointly, they would occupy first place as the causes of death.

7. Accidents occupy fourth place in mortality with a rate of 47.6 per 100,000 for the five islands and 35.0 for Curacao; they account respectively for 8.7% and 6.4% of diagnosed mortality.

8. The four groups of causes indicated above account for almost two-thirds of diagnosed mortality.

National health strategies and plans

9. Health policy is centered on the following aspects: increasing the coverage of preventive medicine actions for the population, with emphasis on maternal and child health and workers' health; improvement of registration of morbidity and mortality; increasing the coverage of ambulatory care; and maintaining and increasing the high percentage of those who have access to basic sanitation services, all with strictly controlled costs.

10. The mobilization of national human resources in the islands is being promoted, as well as the recent Agreement between the Medical and Health Service of Curacao and Bonaire, in order to contribute to better training and utilization, through seminars, workshops, courses, etc. In addition, cooperation networks are being promoted between public and private institutions. The principal source of technical cooperation in health for the islands has come from the Netherlands.

11. On 1 January 1986, Aruba was granted Separate Status within the Kingdom of the Netherlands, and, as a consequence, a government separate from the rest of the Netherlands Antilles was set up with its own Ministry of Public Health. Curacao has now initiated a similar process.

12. The difficult economic situation continues to affect the islands and it has consequently been necessary to emphasize the organization of some components of tertiary care.

National priority fields for technical cooperation

13. Based on the principal problems, the government has requested technical cooperation in the following areas:

13.1 Development of the health services infrastructure, with emphasis on local health systems through the strategy of primary health care, promoting community participation in the solution of local problems, and decentralization of primary level services to the ambulatory care network.

13.2 Development of the epidemiology services so as to analyze the trends in health problems at the local level, and to optimize the use of resources for preventive actions, such as the risk approach, in order to reduce early pregnancy and conseqently infant mortality in low income areas.

13.3 Evaluation of local immunization coverage, in order to detect areas of low coverage for the purpose of eradicating measles.

13.4 Promotion of community participation in mental health.

13.5 Promotion of health and early detection in oral health.

13.6 Improvement of the environment through support of the formulation of policies and standards for environmental management and control of drinking water and vectors.

13.7 Prevention of food-borne diseases and preparation of educational programs for: food handlers, hotels, restaurants, and homes, utilizing SIPAL; hazard analysis and critical points; study of the harm produced by food-borne diseases; and strengthening of the concept of health and tourism.

GLOBAL STRATEGY OF COOPERATION

14. Both in the Netherlands Antilles and in Aruba, technical cooperation is directed toward optimizing the expenditure on health through the strengthening of local health systems, preparation of their local health profiles for the purpose of emphasizing the risk approach, and utilization of the strategy of primary health care for the solution of local problems.

15. The technical cooperation proposed will be concentrated in three areas: Health Services Development (DHS), Environmental Health (CEH), and Food Safety (FOS) through the strategies of mobilization of resources; formulation of standards, policies and plans; training; local research and technical cooperation between the islands. The specific areas of cooperation are:

16. Health Services Development, with the following components:

16.1 Maternal and Child Health, assigning priority to the control of early pregnancy, mainly among the underprivileged and those who do not exercise pregnancy control. This means that support should be given to optimizing the use of the resources of this program, and making use of a broadbased mass communications program.

16.2 Oral Health. The situation of the population in this area is deficient with regard to oral hygiene and periodic dental control. The water fluoridation program is being carried out, but in concentrations too low to be effective. Emphasis should be placed on dental control programs in the schools and on strengthening government programs to benefit the marginalized population.

16.3 Health Systems Infrastructure. Community participation should be promoted in implementing the strategy of primary health care, basically at the level of educational programs.

16.4 Immunization. The immunization index is approximately 75%. These figures should be increased, since measles should also be eliminated by 1995. Support should be given to studies of lost opportunities and to promoting the establishment of coverage information systems for the purposes of coverage evaluation.

16.5 Epidemiology. The Netherlands Antilles has initiated the establishment of a Department of Epidemiology, designed to evaluate the use of morbidity information for the execution of programs, using the risk strategy.

16.6 Mental Health. Restructuring of psychiatric care should be promoted by increasing community participation to reintegrate and rehabilitate psychiatric patients, as well as those being treated as part of the program for drug and alcohol addiction.

17. Environmental Health, with two components:

17.1 Environmental management, providing technical cooperation relating to: oil spills, environmental and maritime pollution, and monitoring of drinking water.

17.2 Vector Control.

18. Food Safety, improving the registration of all imported food, promoting the use of epidemiological information and studies of critical points of control, in order to eliminate the risk of food-borne diseases, through educational programs to strengthen the concept of health and tourism, which are so important for the islands.

19. The Organization will collaborate in developing the following specific programs:

DHS: Health Services Development
CEH: Control of Environmental Health Hazards
FOS: Food Safety

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		73,100	59.0	92,000	65.8	103,700	65.5
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		73,100	59.0	92,000	65.8	103,700	65.5
HEALTH SERVICES DEVELOPMENT	DHS	73,100	59.0	92,000	65.8	103,700	65.5
III. HEALTH SCIENCE AND TECHNOLOGY		50,800	41.0	47,900	34.2	54,600	34.5
ENVIRONMENTAL HEALTH		31,500	25.4	27,000	19.3	30,700	19.4
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	31,500	25.4	27,000	19.3	30,700	19.4
VETERINARY PUBLIC HEALTH		19,300	15.6	20,900	14.9	23,900	15.1
FOOD SAFETY	FOS	0	-	20,900	14.9	23,900	15.1
ZOONOSES	ZNS	19,300	15.6	0	-	0	-
GRAND TOTAL		123,900	100.0	139,900	100.0	158,300	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	50,800	0	0	30	7,600	5,700	10	19,000	12,800	5,700	0	0
WHO - WR	73,100	0	0	60	15,200	2,300	20	38,000	11,900	5,700	0	0
TOTAL	123,900	0	0	90	22,800	8,000	30	57,000	24,700	11,400	0	0
% OF TOTAL	100.0				18.4	6.5		46.0	19.9	9.2	.0	.0
1992-1993												
PAHO - PR	47,900	0	0	30	8,000	0	1	2,000	18,100	6,900	0	12,900
WHO - WR	92,000	0	0	45	12,000	1,200	8	16,000	29,000	12,800	0	21,000
TOTAL	139,900	0	0	75	20,000	1,200	9	18,000	47,100	19,700	0	33,900
% OF TOTAL	100.0				14.3	.9		12.9	33.6	14.1	.0	24.2
1994-1995												
PAHO - PR	54,600	0	0	30	8,500	0	1	2,100	21,000	8,100	0	14,900
WHO - WR	103,700	0	0	45	12,700	1,300	8	16,800	33,700	14,800	0	24,400
TOTAL	158,300	0	0	75	21,200	1,300	9	18,900	54,700	22,900	0	39,300
% OF TOTAL	100.0				13.4	.8		11.9	34.6	14.5	.0	24.8

NICARAGUA

ANALYSIS OF THE HEALTH SITUATION

1. During the last decade, the changing political, economic, and social environment has introduced factors, which, by having a positive or negative impact on the living conditions of the population, have in turn generated substantial change in the health status of the population, which is reflected in the epidemiological profile.

2. One of the most important factors has been the ability to put an end to a prolongued state of war. Although its consequences will continue to wreak havoc for many years to come, peace makes it possible to channel the national effort toward reconstructing the country and eliminating from health registers all causes of disability and death caused by war.

3. As a result of both the damage done by the war and the ensuing social imbalances reflected by migrations, resettlements, repatriations, demobilizations, etc., the population is now particularly vulnerable in the face of new risk factors, which evoke predictions of negative changes in the already deteriorated health profile.

4. The main health problems, according to the priorities set by the Ministry, are the following:

4.1 Maternal and child morbidity and mortality.

4.2 Morbidity of higher-risk groups (demobilized, repatriated, resettled, etc.), care for the disabled and for rural and urban workers.

4.3 Morbidity and mortality from communicable diseases, which affect the entire population and generate great demand for the health services.

4.4 Morbidity and mortality from those noncommunicable diseases that have the greatest impact on the population and the services.

4.5 Potentially epidemic diseases.

5. Despite the fact that estimates by INEC-CELADE and the National System of Vital Statistics indicate a downward trend, mortality of children under the age of 1 continues to be high and ranks first among the priorities of the Ministry.

6. The estimated rate of 64.1 per 1,000 live births is unevenly distributed throughout the country, affecting mainly rural and urban fringe populations. The determining causes are the following: acute diarrheal diseases; neonatal diseases; acute respiratory infections; birth defects; and malnutrition.

7. The maternal death rate of 9.7 per 10,000 live births is a priority problem. Its principal causes, associated with reproductive risk (pregnancies at extreme ages, short intervals between them, a high pregnancy rate) and with limited coverage as well as poor quality of care during pregnancy and the puerperium, are: abortion, delivery-related hemorrhages and infections, and hypertension.

8. The social dynamics associated with the national peace process have created new risk groups and areas, for which the country had neither the necessary infrastructure nor the resources for their care. This has forced national authorities to establish exceptional measures that allow the services to meet this additional demand in a comprehensive manner.

9. The same is true in the area of care for the disabled, whose treatment is particularly difficult because of the limited knowledge available regarding the affected population and the type of disabilities.

10. Because they are a national priority and owing to the importance they have in terms of the development of the country, comprehensive care for workers and the reduction of occupational risk factors have become one of the main problems to be resolved by the Ministry.

11. As a result of the above-mentioned risk factors, communicable diseases continue to have an impact on many population groups, evidenced particularly by the following: epidemic outbreaks of diseases preventable by immunization, particularly measles, tetanus, and whooping cough; persistence of high indexes of malaria; persistence of the incidence of food- and water-borne diseases, such as amebiasis, infectious hepatitis, typhoid fever, and bacillary dysentery; increase in morbidity and mortality from tuberculosis; and persistently high incidence of sexually transmitted diseases.

12. The behavior of some noncommunicable diseases has been influenced both by the social tensions springing from the imbalances and the crisis that the country is experiencing, and by the inadequate lifestyles of the population (sedentary lifestyle, smoking, alcoholism). The following are considered to be health problems: increase in mental illnesses; increase in mortality from malignant neoplasms; and dental caries.

13. The hygienic-sanitary deterioration, internal and external migrations devoid of any sanitary control, and the increase in the susceptible population heighten the risk of diseases that exhibit epidemic behavior. The country is at special risk for AIDS and dengue.

14. The Ministry of Health has responded in a relatively efficient manner in facing the problems relating to infant mortality and some communicable diseases, by defining clear policies, establishing priorities, and developing a system of epidemiological surveillance that makes it possible to monitor the pathologies that are part of the system. This, however, is not the case when it comes to dealing with noncommunicable diseases and the most important chronic pathologies.

15. The organization of the first level of care has revealed a need for some programs to redefine their approach and work strategy, and to articulate themselves fully with the municipal services network.

16. Development of the information system has been insufficient and it has not yet been possible to make maximum use of the resources available in order to ensure that these are concentrated on priority areas, reach adequate productivity levels, achieve the desired impact, and provide better-quality services.

National health strategies and plans

17. The main health policy consists in concentrating national efforts with a view to both counteracting the negative impact that the deterioration, caused by the war and compounded by the economic situation and the social imbalances experienced by the country, is having on the population, and recovering, or in some cases improving, the level of health that had been achieved. This will require enormous organizational efforts, which will make it possible to adapt the services to new and changing circumstances, making them more efficient with a view to maintaining and improving the coverage achieved for the general population as well as more accessible, so as to provide adequate care for the new risk groups and areas. This would be done also with a view to both generating community participation, which would multiply the social capacity to deal with problems, and developing the interinstitutional coordination required for achieving a comprehensive approach of damages and risks.

18. The complexity of dealing with this task originates not only in the need for having the necessary capacity to analyze situations and identify risk groups and areas, but in the selection of strategies and alternatives that pave the way for action and make the sector less vulnerable vis-à-vis the impact of economic measures.

19. In the midst of existing restrictions, the Ministry of Health has prepared the following strategic lines of action:

19.1 To guarantee equity in the administration of care, consolidate the National Health System, and strengthen the leadership of the Ministry.

19.2 To focus the main efforts on guaranteeing better health conditions for the population, concentrating care on priority groups such as mothers and children, the disabled, as well as paid, demobilized, and repatriated workers.

19.3 To maintain and, in some areas, expand the coverage of services with a view to reducing infant mortality, controlling endemic diseases, and preventing undernutrition, while performing a leadership role in the establishment of national policies and actions aimed at improving the state of health of the population and facilitating community participation.

19.4 To provide priority programs with the basic requirements for improving both the situation of the physical infrastructure of the health services network and its equipment and the education network for the training of human resources.

19.5 To strengthen multisectoral and interinstitutional actions in order to obtain better and greater results in terms of the standard of living of priority groups and the population in general, preserve their health, and make positive changes in the environment.

19.6 To increase the level of efficiency of the sector, promote strengthening of the Health Systems, and develop strategies and alternatives in order to make them less vulnerable vis-à-vis the impact of economic measures and restrictions.

19.7 To modernize the structure, organization, and operation of the National Health System, so as to guarantee its operational and management capacity and achieve integration of private services with a view to achieving homogeneity regarding direction and objectives.

19.8 To promote policies and actions that will result in the scientific and technical improvement of the sector, including drugs, biologicals, instruments and equipment, procedures for prevention, diagnosis, treatment, and rehabilitation, as well as techniques for planning, managerial organization, and health services information.

19.9 To achieve sufficient internal and external visibility to be able to improve formulation of the country's social policies and enlist the support of external sources of financing.

GLOBAL STRATEGY OF COOPERATION

20. The axes of cooperation established with the country respond to the strategic orientations and programming priorities of PAHO for the quadrennium 1991-1994, as well as to the political directions that the government is promoting in terms of social issues.

21. The global strategy of cooperation tends to provide the authorities of the country in question with the technical support required for establishing organizational measures that make it possible to make more efficient use of the limited allocated resources and facilitate strong mobilization of external resources aimed at resolving the country's main health problems.

22. In this context, the Ministry, with support of PAHO, is developing activities aimed at consolidating the National Health System and strengthening its leadership, promoting Local Health Systems, and ensuring their coherence through the preparation of standards and instruments for management processes and the execution of activities, as well as for the implementation of the Master Plan.

23. Also implicit in this process, whose ultimate goal is to organize the first level of care by applying the epidemiological approach, is the organization of the second level and the articulation of both. For this

purpose, and taking into account the existence of an insufficient and inadequate infrastructure of hospital services, the government has considered these services in terms of their articulation with the Municipal Health Systems.

24. This organizational process, which tends to increase the capacity to focus actions on higher-risk groups with priority health problems, revolves around the achievement of effective interventions aimed at reducing, controlling, or eliminating health problems, particularly in the maternal and child group, in addition to facilitating a positive change in terms of social, environmental, occupational, and behavioral risk factors.

25. With regard to maternal and infant mortality, comprehensive activities are organized in the areas of family planning, prenatal control, care during delivery and to the newborn, growth and development control, and the struggle against the principal causes of disease and death, such as acute diarrheal diseases, acute respiratory infections, diseases preventable by vaccination, perinatal causes, and nutritional problems.

26. Another important area of cooperation is the search for a solution to the main health problems of other population groups considered particularly vulnerable. Some of the more important ones are disabilities, diseases preventable by vaccination, specific nutritional problems, and potentially epidemic diseases such as AIDS, dengue, and malaria.

27. In the search for a comprehensive solution to the most important health problems, the main areas of cooperation will be those aimed at changing environmental conditions, supplying and distributing essential drugs, maintaining health equipment and units, and training personnel, as the only possible alternative for improving the quality of care. These areas of cooperation are supplemented by the participation of PAHO in strengthening the legal bases of the system, gathering information, selecting indicators, and in the important task of making knowledge available to users by way of information dissemination.

28. Finally, areas of cooperation are established aimed at strengthening equal participation of women in the overall development of the country and the necessary measures are established for structuring the second phase of the Health Priority Plan for Central America (PPS/CAP), "Health and Peace for Development", based on the firm conviction that peace and social justice are inseparable.

29. PAHO will collaborate in the development of the following specific programs:

MPN:	Managerial Support for National Health Development
TCC:	Technical Cooperation among Countries
HDP:	Health Policy Analysis and Development
DHS:	Health Services Development
HMC:	Coordination and Support of Human Resources Development
CEH:	Control of Environmental Health Hazards
MCH:	Growth, Development and Human Reproduction
OCD:	General Communicable Disease Prevention and Control Activities
MAL:	Malaria
NCD:	Health Promotion and Prevention and Control of Noncommunicable Diseases
FOS:	Food Safety

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		1,577,000	80.0	1,855,100	77.9	2,123,800	77.7
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		535,300	27.1	762,000	31.9	861,300	31.4
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	535,300	27.1	762,000	31.9	861,300	31.4
TECHNICAL COOPERATION AMONG COUNTRIES		126,000	6.4	146,200	6.1	169,600	6.2
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	126,000	6.4	146,200	6.1	169,600	6.2
HEALTH SITUATION AND TREND ASSESSMENT		89,000	4.5	0	-	0	-
HEALTH SITUATION AND TREND ASSESSMENT	HST	89,000	4.5	0	-	0	-
HEALTH POLICY DEVELOPMENT		52,300	2.7	100,000	4.2	116,000	4.3
HEALTH POLICY ANALYSIS AND DEVELOPMENT	HDP	52,300	2.7	100,000	4.2	116,000	4.3
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		408,200	20.7	503,200	21.2	580,300	21.3
HEALTH SERVICES DEVELOPMENT	DHS	198,600	10.1	503,200	21.2	580,300	21.3
ESSENTIAL DRUGS AND VACCINES	EDV	115,800	5.9	0	-	0	-
ORAL HEALTH	ORH	10,100	.5	0	-	0	-
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	16,100	.8	0	-	0	-
REHABILITATION	RHB	67,600	3.4	0	-	0	-
HUMAN RESOURCES DEVELOPMENT		182,700	9.3	343,700	14.5	396,600	14.5
COORDINATION & SUPPORT OF HUMAN RESOURCES DEVELOP.	HMC	182,700	9.3	343,700	14.5	396,600	14.5
HEALTH INFORMATION SUPPORT		64,900	3.3	0	-	0	-
SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION	HBD	64,900	3.3	0	-	0	-
RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT		118,600	6.0	0	-	0	-
RESEARCH PROMOTION AND DEVELOPMENT	RPD	67,500	3.4	0	-	0	-
HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT	HDT	51,100	2.6	0	-	0	-

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
III. HEALTH SCIENCE AND TECHNOLOGY		390,600	20.0	522,500	22.1	604,300	22.3
FOOD AND NUTRITION		66,400	3.4	0	-	0	-
NUTRITION	NUT	66,400	3.4	0	-	0	-
ENVIRONMENTAL HEALTH		62,600	3.2	111,000	4.7	127,200	4.7
COMMUNITY WATER SUPPLY AND SANITATION	CWS	25,000	1.3	0	-	0	-
SOLID WASTES AND HOUSING HYGIENE	RUD	26,100	1.3	0	-	0	-
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	0	-	111,000	4.7	127,200	4.7
WORKERS' HEALTH	OCH	11,500	.6	0	-	0	-
MATERNAL AND CHILD HEALTH		96,200	5.0	54,500	2.3	63,300	2.3
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	44,500	2.3	54,500	2.3	63,300	2.3
IMMUNIZATION	EPI	28,700	1.5	0	-	0	-
DIARRHEAL DISEASES	CDD	23,000	1.2	0	-	0	-
COMMUNICABLE DISEASES		93,700	4.8	280,900	11.9	325,400	12.0
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	0	-	253,500	10.7	293,600	10.8
MALARIA	MAL	93,700	4.8	27,400	1.2	31,800	1.2
HEALTH PROMOTION		55,700	2.8	46,400	2.0	54,000	2.0
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	40,100	2.0	46,400	2.0	54,000	2.0
ACCIDENT PREVENTION	APR	15,600	.8	0	-	0	-
VETERINARY PUBLIC HEALTH		16,000	.8	29,700	1.2	34,400	1.3
FOOD SAFETY	FOS	0	-	29,700	1.2	34,400	1.3
ZOONOSES	ZNS	16,000	.8	0	-	0	-
GRAND TOTAL		1,967,600	100.0	2,377,600	100.0	2,728,100	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		6,088,408	48.0	3,436,965	53.9	0	100.0
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		42,603	.3	0	-	0	100.0
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	42,603	.3	0	-	0	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		6,045,805	47.7	3,436,965	53.9	0	-
HEALTH SERVICES DEVELOPMENT	DHS	4,900,851	38.7	2,436,965	38.2	0	-
REHABILITATION	RHB	1,144,954	9.0	1,000,000	15.7	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		6,636,569	52.0	2,938,405	46.1	0	-
FOOD AND NUTRITION		233,622	1.8	0	-	0	-
NUTRITION	NUT	233,622	1.8	0	-	0	-
ENVIRONMENTAL HEALTH		504,659	3.9	1,000,000	15.7	0	-
COMMUNITY WATER SUPPLY AND SANITATION	CWS	4,659	.*	0	-	0	-
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	500,000	3.9	1,000,000	15.7	0	-
MATERNAL AND CHILD HEALTH		3,225,208	25.3	1,045,548	16.4	0	-
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	2,752,197	21.6	898,548	14.1	0	-
ACUTE RESPIRATORY INFECTIONS	ARI	417,579	3.3	147,000	2.3	0	-
IMMUNIZATION	EPI	55,432	.4	0	-	0	-
COMMUNICABLE DISEASES		2,671,842	21.0	892,857	14.0	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	791,771	6.2	292,857	4.6	0	-
MALARIA	MAL	1,880,071	14.8	600,000	9.4	0	-
HEALTH PROMOTION		1,238	.*	0	-	0	-
OCULAR HEALTH	PBD	1,238	.*	0	-	0	-
GRAND TOTAL		12,724,977	100.0	6,375,370	100.0	0	100.0

* LESS THAN .05 PER CENT

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	1,141,000	24	0	200	223,200	16,000	52	98,800	233,700	275,000	20,000	274,300
WHO - WR	826,600	24	48	45	197,800	0	27	51,300	113,400	259,000	0	205,100
TOTAL	1,967,600	48	48	245	421,000	16,000	79	150,100	347,100	534,000	20,000	479,400
% OF TOTAL	100.0				21.4	.8		7.6	17.6	27.2	1.0	24.4
1992-1993												
PAHO - PR	1,448,900	24	0	135	287,000	27,800	10	20,000	410,300	332,500	0	371,300
WHO - WR	928,700	24	48	80	257,700	8,700	0	0	203,600	180,000	0	278,700
TOTAL	2,377,600	48	48	215	544,700	36,500	10	20,000	613,900	512,500	0	650,000
% OF TOTAL	100.0				22.9	1.5		.8	25.8	21.6	.0	27.4
1994-1995												
PAHO - PR	1,665,600	24	0	135	319,500	32,300	10	21,000	476,000	385,900	0	430,900
WHO - WR	1,062,500	24	48	80	284,000	10,100	0	0	236,200	208,900	0	323,300
TOTAL	2,728,100	48	48	215	603,500	42,400	10	21,000	712,200	594,800	0	754,200
% OF TOTAL	100.0				22.1	1.6		.8	26.1	21.8	.0	27.6

ANALYSIS OF THE HEALTH SITUATION

Bermuda

1. The population of Bermuda was estimated at 58,820 in 1988. Twenty percent is under 15 years of age, 9.5% is 65 years of age and over and 57% over age 21. Annual population growth is approximately 1%.

2. Life expectancy at birth is estimated at 73 years. The crude mortality rate in 1988 was 75 per 1,000 population.

3. The leading causes of mortality in 1983 were cardiovascular diseases; cancer; respiratory diseases; accidents and violence. Cardiovascular disease accounts for more than 50% of all deaths.

4. In 1988, the infant mortality rate was 3.2 per 1,000 live births. Around 90% of children in the 0-5 and 5-15 years age groups have acceptable weight for their age. Some obesity is seen in the 5-15 age group.

5. As in the case of the Cayman Islands and Turks and Caicos Islands, drug abuse and the spread of AIDS are increasing areas of concern. Accidents are a significant cause of morbidity and mortality and constitute a major public health problem.

6. The infrastructure of the health services is good. A quality of life survey conducted in 1984 indicated an overall satisfaction with the health services which are widely available and easily accessible.

Cayman Islands

7. The estimated population of the Cayman Islands in 1988 was 24,900, of which 94% lives in Grand Cayman. Of the total population, 8.6% is under 5 years of age and 23.8% under 15 years. Women of childbearing age comprise 27.0% of the population. The population growth per annum (1979-1988) is estimated at 4.9%.

8. The general fertility rate in 1988 was 54 per 1,000 women. The birth rate was 15.8 per 1,000 population in 1987 and 15.3 in 1988. Based on 1983 calculations, life expectancy at birth is 74.5 years.

9. The crude mortality rate per 1,000 population was 6.1 in 1986, 4.5 in 1987, and 4.4 in 1988. There was one infant death in 1987 and two in 1988, all of them neonatal.

10. The leading causes of death in 1988 were malignant neoplasms, ischemic heart disease, cerebrovascular disease, accidents, and pneumonic influenza. Diseases of the heart, malignant neoplasms, cerebrovascular disease, and accidents accounted for nearly 70.5% of deaths during the period 1984-1988. The high death rate due to traffic accidents is of continuing concern. Important causes of morbidity are diabetes and hypertension. One in every four clinic patients suffer from one or both conditions.

11. In the Cayman Islands, current issues affecting health status include problems such as drug abuse and inadequate bed complement at the Georgetown Hospital, which currently does not meet international standards.

12. There is also concern about the spread of AIDS and STDs-- particularly gonorrhoea and syphilis. By April 1989, there were 13 HIV seropositive including 4 AIDS cases. Two deaths were reported. In 1988, the reported incidence of syphilis per 1,000 population was 3.7. The reported incidence of gonococcal infection per 1,000 population was 4.5.

Turks and Caicos Islands

13. In 1989, the total population was estimated at 14,000. The age distribution of the population was assessed as follows: under 5 years 1,780 (12.7%); 5-14 years 4,370 (31.2%), and 15 years and over 7,850 (56.1%). It is estimated that there are 3,220 women at child bearing age (15-44 years).

14. Between 1980 and 1987, population growth was estimated at 7.5% per year. The increase is mainly due to migration of workers from Haiti and the Dominican Republic.

15. Life expectancy at birth is estimated at 66 years. The crude birth rate for 1986 was 23.1 per 1,000 population and the crude death rate for 1985 was 6.1. The infant mortality rate was 22 per 1,000 live births in 1986.

16. The leading causes of death are cerebrovascular diseases, accidents, congestive heart failure, cancer and myocardial infarction. The leasing causes of morbidity are cardiovascular disorders, hypertension, diabetes mellitus, influenza and urinary tract infection.

17. In 1987, the incidence of gonorrhoea was 42 per 10,000 population and of syphilis, 30 per 10,000.

18. Nine cases of AIDS have been diagnosed and 143 persons were found and later confirmed to be HIV seropositive by Western Blot Assay.

19. Environmental sanitation in Turks & Caicos Islands continues to be a critical issue. This is due to the following factors:

19.1 No public sewerage system exists in Grand Turk. In general, the rocky ground formation makes installation of tanks expensive and difficult. This situation contributes to the pollution of shallow surface wells.

19.2 There is no public piped water system in the island and the main sources of water supply for over 90% of the population are from rain water roof catchment and shortage cisterns. Water treatment and quality analysis need upgrading.

19.3 There is increasing concern over drug abuse and the spread of AIDS.

National health strategies, policies and plans

Bermuda

20. According to the national health policy, emphasis is placed on maternal and child health, health of school-age children, community nursing for the elderly, dental health, control of communicable diseases including AIDS, mental health and alcohol and drug abuse prevention and control. Population groups designated for special attention include mothers and infants, school age children, and the elderly.

21. The health and welfare of all Bermuda residents is the main responsibility of the Ministry of Health and Social Services which undertakes health planning, programming, budgeting and evaluation.

22. The major strategies employed to achieve maximum health coverage nationally are the administering of public health clinics, overall monitoring of food and drug administration, environmental health inspection, preventive and educational promotions and reports to the public, immunization programs, quarantine services and the reorganization of social welfare. A preventive dental care program for infants and children also exists.

Cayman Islands

23. The Health Services Department is responsible for all government health care, including the public health and hospital services.

24. The public health service has two divisions, one administers the community health service, provides primary care through the district health centers, and handles other functions specified in the public health laws.

25. Although the health service is available equally to all people of the islands, the government focuses efforts on school-age children, civil servants and their immediate relatives, the indigent and the physically and mentally handicapped.

26. Emphasis is placed on rodent control, water quality surveillance, meat and food inspection, monitoring of food handling establishments, and solid waste management.

27. Grand Cayman has a good comprehensive solid waste management service. Evidence of this lies in the clean and health environment. There are some air pollution problems, however, the Environmental Health Division and the pollution sources are working jointly to solve them.

28. Food protection is also given attention through routine inspection of the sanitary conditions and water quality in food handling establishments, and examination of animals destined for local consumption before and after slaughter.

29. The safety of sanitary conditions and waste disposal are assured through the application of the building code which requires better local plumbing and waste disposal practices, certification and licensing of plumbers, and approval of sanitary arrangements.

Turks and Caicos

30. The Chief Medical Officer is Director of the Health Department, and also serves as Hospital Medical Director. There are three other Medical Officers in Grand Turks, one in Providenciales and one in South Caicos.

31. According to the national health plan, the major areas of emphasis are: improvement of the health information system, availability and training of human resources, improved maintenance of facilities and equipment, improvement of health clinics, provision of more health facilities in Providenciales, and continued upgrading of Gran Turks Hospital.

GLOBAL STRATEGY OF COOPERATION

32. PAHO/WHO is to provide technical cooperation in the following priority areas identified by the Governments:

32.1 Health Manpower Development in all territories.

32.2 Assistance with HIV/AIDS and Drug Abuse Prevention and Control programs. In the case of HIV/AIDS, the assistance for the implementation of the AIDS short term and medium term plans is greater for Caymen and Turks and Caicos Islands than Bermuda.

32.3 Strengthening of epidemiological surveillance, especially in Bermuda.

32.4 Strengthening of Environmental Health, particularly in TCI.

33. Resouces will be mobilized for the provision of advisory services and equipment. Information dissemination will be the major thrust to creating awareness on HIV/AIDS and drug abuse problems among target groups. There will be an emphasis on human resources development, through training and workshops for upgrading health care delivery services and research. The capacity for epidemiological surveillance will be strengthened through the development of policies, plans and norms and the upgrading of skills of investigation and monitoring of disease trends. Technical cooperation between these territories and other CARICOM states will be promoted and the activities available through the CCH will be optimized.

34. PAHO will collaborate in the development of the following specific program:

DHS: Health Services Development

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		117,300	100.0	125,800	100.0	139,800	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		117,300	100.0	125,800	100.0	139,800	100.0
HEALTH SERVICES DEVELOPMENT	DHS	117,300	100.0	125,800	100.0	139,800	100.0
GRAND TOTAL		117,300	100.0	125,800	100.0	139,800	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		13,422	5.2	0	-	0	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		13,422	5.2	0	-	0	100.0
HEALTH SERVICES DEVELOPMENT	DHS	13,422	5.2	0	-	0	100.0
III. HEALTH SCIENCE AND TECHNOLOGY		244,459	94.8	235,819	100.0	0	-
MATERNAL AND CHILD HEALTH		5,135	2.0	0	-	0	-
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	5,135	2.0	0	-	0	-
COMMUNICABLE DISEASES		239,324	92.8	235,819	100.0	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	239,324	92.8	235,819	100.0	0	-
GRAND TOTAL		257,881	100.0	235,819	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	117,300	0	0	150	38,000	21,800	14	26,600	25,200	5,700	0	0
TOTAL	117,300	0	0	150	38,000	21,800	14	26,600	25,200	5,700	0	0
% OF TOTAL	100.0				32.3	18.6		22.7	21.5	4.9	.0	.0
1992-1993												
PAHO - PR	125,800	0	0	110	29,400	25,500	15	30,000	29,000	11,900	0	0
TOTAL	125,800	0	0	110	29,400	25,500	15	30,000	29,000	11,900	0	0
% OF TOTAL	100.0				23.4	20.3		23.7	23.1	9.5	.0	.0
1994-1995												
PAHO - PR	139,800	0	0	110	31,100	29,600	15	31,500	33,700	13,900	0	0
TOTAL	139,800	0	0	110	31,100	29,600	15	31,500	33,700	13,900	0	0
% OF TOTAL	100.0				22.2	21.2		22.5	24.2	9.9	.0	.0

ANALYSIS OF THE HEALTH SITUATION

1. The economic situation of Panama has been overshadowed by a growing financial crisis, with a decline in GDP of up to 20% over the last two years, accompanied by growing unemployment of up to 25%. Internal political factors, associated with the international economic crisis, have contributed to this deterioration in the national economy. The events of December 20, 1989, caused profound changes in institutional structures, which are reflected by the governing and administrative bodies.

2. In 1990, the external debt exceeded US$6 billion, while this year commitments for debt and interest payments amount to almost US$1,000 million. Despite the intention of the National Government to make health and education two priority areas in the National Development Plan, the necessary fiscal resources are insufficient in order to meet current social demands, including health and education.

3. The economic deterioration has affected the health sector severely. Health services are clearly unable to extend sufficient coverage, owing to a lack of medical-surgical input, drugs, reagents, maintenance, transportation, and human resources, which leaves important social groups without protection. The high level of unemployment and the decline in family income cause underserved groups to be at even greater risk. Approximately 40.6% of those under the age of 6 suffer some degree of undernutrition, there being a high prevalence of undernutrition of the third degree and deficiency diseases caused by lack of iron, iodine, and vitamin A. Of the national population, 17% lives in a condition of critical poverty.

4. The infant mortality rate is 26 per 1,000 live births and fluctuates between 9 and 30. The main causes of infant mortality continue to be acute diarrheal diseases, respiratory diseases, acute infections associated with undernutrition, and traumatisms. While tetanus, measles, and whooping cough are not among the 10 leading causes of death, they still produce cases and deaths in the more neglected groups.

5. Besides these health problems, which are characteristic for poor and underdeveloped areas, the 10 leading causes of death are malignant tumors, accidents, suicides, homicides and other violent acts, ischemic heart disease, and cardiovascular diseases. Prevention and care for all these health problemes require considerable efforts and significant economic resources.

6. The overall death rate is 4 per 1,000 population, while maternal mortality is estimated at 5 per 10,000, with a high incidence of deliveries in adolescents between 15 and 19 years of age.

7. There are 208 cases of AIDS, with a mortality rate of more than 50%. There is also a high incidence of HIV seropositivity.

8. During the last three years, there has been a reinfestation with Aedes aegypti, especially in the capital. Malaria, tuberculosis, and meningococcal meningitis, which had already been under control, have once again emerged as public health problems. Also on the rise are mental diseases, alcoholism, drug addiction, and family and social violence.

9. Coverage of water and environmental sanitation services has declined due to a lack of input and maintenance. Periurban populations have neither water nor adequate excreta and waste disposal systems. The water supply in urban areas is inefficient due to the large volume of commercial losses and leaks. It is estimated that air/water/soil pollution is a serious problem, however, the necessary means are not available to either monitor or correct it. The same holds true for the deterioration of flora, fauna, and natural reserves.

10. No information system is available that would provide data on the effects of adverse conditions of workers and their exposure to traumatisms and chemical substances and waste, such as pesticides, insecticides, and gases.

11. The Health Sector has enormous operational and development problems: a large national and sectoral economic deficit; a network of highly deteriorated health establishments; a 40 to 60% deterioration of medical-surgical and hospital equipment due to a lack of maintenance; a scarcity of drugs and medical-surgical inputs; a large concentration of services in the metropolitan area; a deficient national health information and epidemiological surveillance system; limited managerial preparation for health center and hospital administrators; poorly structured levels of complexity in medical care and a poorly articulated hospital network; high costs in hospital care at the expense of primary care; deficient coordination between the Ministry of Health and the Social Security Fund; a Social Security Fund with a severe operational budget deficit due to high national unemployment and deficient registration and quota collection systems; a highly scattered rural population with difficult access and low health services coverage; institutional fragmentation and lack of coordination in the environmental health subsector.

National health strategies and plans

12. In January 1990, the Ministry of Health of Panama formulated the "National Health Policy of the Government for Reconstruction and National Reconciliation." The conceptual bases of this policy are embedded in the country's current Political Constitution, which, in Article 105, states that it is an essential function of the State to care for the health of the population of the Republic. This means that all government institutions, and not only the Ministry of Health and the Social Security Fund, by law, have the responsibility to protect, promote, and restore the health of all inhabitants of the country, in their respective areas of competence.

13. The overall objective of the health policy is to achieve, for all Panamian citizens, a level of well-being and health that allows them to lead a better and more productive life within their family and the entire national community. It is the responsibility of the Ministry of Health to perform a leading role regarding this policy and to coordinate any national plans derived from it.

14. The National Health Policy, and the National Health Plan that will be used as an instrument for its implementation, are part of the National Development Plan of the Government for achieving the important objectives of reconstruction and reconciliation.

15. The general principles of this policy are listed below:

15.1 To provide comprehensive care, with a dynamic balance between promotion, prevention, recovery, and rehabilitation activities, according to the needs of the individual, his/her family, and the community.

15.2 To prioritize the health system's resources and efforts so as to provide care for population groups who are at greater risk due to their social and economic marginality and their biological vulnerability, giving absolute priority to children, mothers, and disabled persons.

15.3 To provide equitable health care for all individuals and families, including those who live in remote areas, thus overcoming problems of geographical, cultural, and economic accessibility.

15.4 To promote, create, and enhance sanitary legal instruments.

15.5 To follow-up on national demographic variables, in order to establish a national policy that, with a view to the future, responds to the country's social and economic development needs.

15.6 To improve on the schemes of utilization and manipulation of community participation and promote general participatory education, which involves Panamanian men and women in the generation of their own health and the management of health services.

15.7 To promote the integration of global economic development strategies and the increase in socially-oriented production, so as to ensure an adequate availability of accessible food and a balanced diet for all sectors of the population.

15.8 To implement coverage extension programs in the area of water services, latrines, and sewerage systems, emphasizing the use of alternative technologies and community participation, as well as the channeling of national and external funds for medium and long term projects; promulgation of legislation controlling and halting the destruction of the ecological balance, and regulating and controlling the disposal of wastewater, refuse, pesticides, and toxic wastes.

15.9 To promote coordination with universities, especially with Health Science departments, and to design manpower development policies for sector professionals, in order to determine national needs, both quantitatively and qualitatively.

15.10 To provide for intra and intersectoral coordination, including the private sector.

15.11 To seek and coordinate international cooperation for application of the above-mentioned principles.

GLOBAL STRATEGY OF COOPERATION

16. PAHO/WHO technical cooperation for the biennium 1992- 1993 is oriented toward supporting the Ministry of Health, the Health Sector and, in general, all public and private institutions as well as nongovernmental organizations (NGOs) that undertake health development activities, in accordance with national health policies, the National Health Plan, and Strategic Orientation and Programming Priorities of PAHO for the biennium.

17. Health authorities have defined a national health policy, and preparations are underway for the National Health Plan, which will become part of the National Development Plan for the period 1990-1994, in which health and education are two of the highest priority areas.

18. The National Health Plan, proposed as the national strategy for dealing with national sanitary problems with a view to solving the main prevailing problems, gives consideration to those orientations and strategies that are in keeping with the strategic orientations and program priorities of PAHO/WHO for the biennium 1992-1993.

19. Thus, the efforts undertaken by our Office in Panama during the next biennium will be oriented toward strengthening and cooperating with the country in the development of strategic orientations and priority programs.

20. The strategies are basically oriented as follows:

20.1 Reorganization of the Health Sector through strengthening of local health systems. In this regard, our support will be aimed at promoting the National Strategy, adoption of the policy at all levels, decentralization, advisory services and training at local operational levels, basically in information systems; local programming; promoting a comprehensive health approach, with social and multisectoral participation, and also motivating and promoting the participation of Social Security in coordination with the Ministry of Health and other involved institutions and sectors.

20.2 Incorporation of the potential of Social Security in health care at the national level. In order to achieve this, it is important to work very closely together with Social Security, providing the necessary support to promote its development and concentrating our cooperation in highly problematic areas, such as: training of human resources in areas like Health Services Admininistration (management), maintenance, statistics, administration of drugs, supply systems, etc. An increase in the efficiency of the social security system will, in turn, stimulate an increase in coverage and better coordination with the Ministry of Health.

20.3 Focusing actions on high-risk groups. Strengthening and support of the identification of and concentration on high-risk human groups, and chanelling of resources toward effective interventions aimed at controlling and reducing environmental, occupational, and other high-risk factors.

20.4 Promotion of health and community participation by strengthening actions relating to health education, sanitary information, large-scale social communication, and promulgation of legislation contributing to the solution of sanitary problems (Aedes aegypti, AIDS, environmental pollution, water, etc.).

20.5 Integration of women in health and development: support will be geared toward collaborating with national public and private organizations that promote comprehensive development of women, avoid discrimination by sex, abuse, and violence toward women, speak up in favor of women, and strengthen actions aimed at re-evaluating women's decision-making capabilities.

20.6 Management of knowledge: support for the development of scientific and technical information through the implementation of new systems for the purpose of searching, storing, and disseminating information, and establishment of a national network for the exchange of national and international information.

20.7 Mobilization of resources: support for and strengthening of the national capacity for preparation, management, and evaluation of development projects in the area of health, so that, during years to come, it will be possible to identify the mobilization of external financial resources, including both consessionary funds and favorable loans, aimed at the transformation of the national health systems, seeking the kind of sector development that will be oriented toward caring for the neediest groups and dealing with priority problems through the national health services network.

20.8 Cooperation between countries: strengthening of national technical cooperation programs among countries, supporting the identification of possible areas of cooperation, and mobilizing the technical resources necessary in searching for joint solutions to common problems, mainly with neighboring countries that have similar sanitary problems.

21. Similarly, during the next biennium, the Organization will provide technical support for Panama in the development of health programs aimed at resolving priority health problems, both in terms of the population and the environment. Through our technical assistance, we will be supporting programs in the areas of health and environment, food and nutrition, prevention and health promotion, control of preventable diseases, maternal and child health, workers' health, drug abuse, and AIDS.

22. PAHO will collaborate in the development of the following specific programs:

MPN: Managerial Support for National Health Development
TCC: Technical Cooperation Among Countries
DHS: Health Services Development
HMC: Coordination and Support of Human Resources Development
CWS: Community Water Supply and Sanitation
OCH: Worker's Health
OCD: General Communicable Disease Prevention and Control Activities
NCD: Health Promotion and Prevention and Control of Noncommunicable Diseases

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		1,552,000	90.2	1,679,700	88.8	1,911,900	88.7
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		632,100	36.7	646,400	34.2	749,200	34.8
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	632,100	36.7	646,400	34.2	749,200	34.8
TECHNICAL COOPERATION AMONG COUNTRIES		40,800	2.4	47,300	2.5	54,900	2.5
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	40,800	2.4	47,300	2.5	54,900	2.5
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		799,900	46.5	907,300	47.9	1,022,000	47.4
HEALTH SERVICES DEVELOPMENT	DHS	799,900	46.5	907,300	47.9	1,022,000	47.4
HUMAN RESOURCES DEVELOPMENT		79,200	4.6	78,700	4.2	85,800	4.0
COORDINATION & SUPPORT OF HUMAN RESOURCES DEVELOP.	HMC	79,200	4.6	78,700	4.2	85,800	4.0
III. HEALTH SCIENCE AND TECHNOLOGY		169,900	9.8	212,700	11.2	241,900	11.3
ENVIRONMENTAL HEALTH		88,300	5.1	98,600	5.2	110,300	5.2
COMMUNITY WATER SUPPLY AND SANITATION	CWS	63,500	3.7	69,800	3.7	76,900	3.6
WORKERS' HEALTH	OCH	24,800	1.4	28,800	1.5	33,400	1.6
COMMUNICABLE DISEASES		36,700	2.1	52,600	2.8	61,000	2.8
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	36,700	2.1	52,600	2.8	61,000	2.8
HEALTH PROMOTION		44,900	2.6	61,500	3.2	70,600	3.3
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	44,900	2.6	61,500	3.2	70,600	3.3
GRAND TOTAL		1,721,900	100.0	1,892,400	100.0	2,153,800	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		46,568	6.9	0	-	0	-
HEALTH POLICY DEVELOPMENT		386	.1	0	-	0	-
HEALTH POLICY ANALYSIS AND DEVELOPMENT	HDP	386	.1	0	-	0	-
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		46,182	6.8	0	-	0	-
HEALTH SERVICES DEVELOPMENT	DHS	46,182	6.8	0	-	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		631,938	93.1	226,671	100.0	64,582	100.0
MATERNAL AND CHILD HEALTH		268,100	39.5	126,671	55.9	64,582	100.0
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	6,916	1.0	0	-	0	-
ADOLESCENT HEALTH	ADH	261,184	38.5	126,671	55.9	64,582	100.0
COMMUNICABLE DISEASES		363,838	53.6	100,000	44.1	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	363,838	53.6	100,000	44.1	0	-
GRAND TOTAL		678,506	100.0	226,671	100.0	64,582	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	730,600	24	0	495	311,800	12,100	84	159,600	155,100	0	0	92,000
WHO - WR	991,300	72	72	80	795,200	25,100	0	0	0	25,200	0	145,800
TOTAL	1,721,900	96	72	575	1,107,000	37,200	84	159,600	155,100	25,200	0	237,800
% OF TOTAL	100.0				64.2	2.2		9.3	9.0	1.5	.0	13.8
1992-1993												
PAHO - PR	809,700	24	0	275	297,200	14,000	73	146,000	200,000	10,300	0	142,200
WHO - WR	1,082,700	72	96	80	861,800	18,600	0	0	0	22,400	0	179,900
TOTAL	1,892,400	96	96	355	1,159,000	32,600	73	146,000	200,000	32,700	0	322,100
% OF TOTAL	100.0				61.3	1.7		7.7	10.6	1.7	.0	17.0
1994-1995												
PAHO - PR	909,700	24	0	275	331,200	16,300	73	153,300	231,800	12,000	0	165,100
WHO - WR	1,244,100	72	96	80	987,900	21,500	0	0	0	25,900	0	208,800
TOTAL	2,153,800	96	96	355	1,319,100	37,800	73	153,300	231,800	37,900	0	373,900
% OF TOTAL	100.0				61.1	1.8		7.1	10.8	1.8	.0	17.4

ANALYSIS OF THE HEALTH SITUATION

1. In 1989, Paraguay had an estimated population of 4,157,287 inhabitants, distributed irregularly over its 406,752 km2 territory. The majority of the population is found in the eastern region, on the left bank of the Paraguay River, which cuts across the territory from north to south, while in the western region, or Chaco Paraguayo, a mostly undeveloped, semi-deserted area on the river's right bank, the number of inhabitants is only around 78,000.

2. It is considered that if the current growth rate, estimated at 2.8% for 1989-1990, remains unchanged, by the year 2015 the population will have grown close to 8 million. It is estimated that 46% percent of the total population live in urban areas, of which 25% reside in Greater Asuncion, the capital, 25% in localities having more than 25,000 inhabitants, and 50% in localities with fewer than 25,000 inhabitants. Most of the rural population (56%) is found in scattered small communities.

3. The population is predominantly young and is undergoing a slow aging process. The group of children under the age of 15 years accounts for 42.2% of the total; the group from 15 to 64 years of age represents 54.9%; and the elderly account for 3.5%. Women of reproductive age represent 25% of the total population. The demographic profile for 1989 shows a life expectancy at birth of 66.9 years; a crude birth rate of 33.8 per 1,000 inhabitants; a crude mortality rate of 6.6 deaths per 1,000 inhabitants; and an infant mortality rate of 32.1 deaths per 1,000 live births.

4. The estimated figure for literacy in 1989 is 79%. The economically active population numbers 1,433,432 persons (1989), with an official unemployment rate of 4%. The gross domestic product per capita for 1989 (provisional figures) in today's dollars, and in constant 1982 dollars, is US$ 971 and US$ 1594 respectively, with an average rate of 1.144 guarani per dollar in 1989 and 136 in 1982.

5. As in other countries of the Region, which have similar characteristics, the country's health profile presents a structure in which different population groups suffer from a predominance of health problems that are rooted in the low level of socioeconomic development, as reflected in the population's health education, the limited availability and accessibility of adequate health and social security services, the limited availability of basic food for a wide sector of the population, and the extremely limited availability of critical supplies and inputs for health. At the same time, there is chronic and degenerative health impairment, together with that caused by accidents and violence, which results from social and technological development, as well as the increased longevity.

6. The principal health problems are diarrheal diseases, parasitic diseases, nutritional diseases, diseases preventable by immunization, and acute respiratory infections in children. Of particular importance are diarrheal diseases, first place among causes of death in children under the age of 1 year; acute respiratory infections, which are in third place in that age group; and endemic goiter and protein-calorie malnutrition, which affect the population in specific geographic areas of the country, and in low socioeconomic strata.

7. Complications of pregnancy, childbirth, and the puerperium and conditions of the newborn, which are related to poor care of both mother and child and are largely preventable, continue to be the cause of high mortality.

8. Sexually transmitted diseases remain on the increase, and the traditional diseases have been joined by AIDS, which has presented a fair number of clinical cases and an undetermined number of asymptomatic infections, which pose a hidden threat.

9. In the group of adults, there is a predominance of chronic and degenerative diseases, with diseases of the circulatory system in first place among causes of overall mortality and mortality, and neoplasms in third place. Accidents are in sixth place among causes of death, and 63% of these are traffic accidents. It is estimated that a fair number of adolescents are drug users (25% of secondary school students in the capital, and 18% of those in the interior of the country).

10. Zoonoses are also important in the country's epidemiological scenario. Diseases such as canine rabies, foot-and-mouth disease, brucellosis, and bovine tuberculosis are of extreme importance because of the harm done to the human population and the national economy.

11. The health sector is regulated by the Ministry of Public Health and Social Welfare, and coordinated with the other institutions through the recently created National Health Council. The country's health structure, although relatively extensive, reveals serious problems in the areas of structure, operations, and efficiency. The establishments structured by level of complexity within the principal institutions of the public subsector (Ministry of Health and Social Security Institute) suffer from insufficient equipment and insufficient provision of human and financial resources and basic supplies, which leads to limited response capacity and reduced impact on activities. There is also insufficient operative coordination of resource utilization.

12. The health programs have not yet achieved useful coverage through basic activities for health protection, promotion, and recovery for those groups who are most exposed to specific risks. Community involvement in health activities is limited and relatively unstructured.

13. Health human resources are insufficient, above all in the categories of technicians for diagnostic support and treatment services, and nursing professionals and aides. The basic training of this personnel and other health professionals is not appropriate in relation to the population's needs.

14. Drinking water, sewerage, and cleaning services are in short supply, particularly in rural areas, and at a time when the urban areas themselves reveal serious problems. Environmental pollution is on the increase, particularly pollution of surface water reservoirs, and solving this problem is one the sector's greatest challenges.

15. The sector's principal policy orientations are directed toward improving the quality of life in the population through the following strategic approaches:

15.1 Extending health and social security coverage to traditionally neglected groups in the rural areas and cities, and improving the efficacy and efficiency of the services.

15.2 Incorporating the population on an active and structured basis into the development of health activities.

15.3 Extending the coverage of environmental health services to groups and areas at greater risk.

15.4 Strengthening the organization, efficacy, and efficiency of the health services and the programs for control of the principal diseases that affect the population, with emphasis on preventable, acute, and chronic diseases, important noncommunicable diseases, and the zoonoses, through surveillance, investigation, and treatment of cases.

15.5 Developing the national legislation in the health sector.

15.6 Developing human resources in health.

15.7 Promoting sectoral coordination and the development of local health systems.

15.8 Improving the mechanisms for attracting, allocating, and administering the sector's financial resources.

15.9 Improving and strengthening the activities of training and health promotion.

GLOBAL STRATEGY OF COOPERATION

16. In accordance with the Strategic Orientations and Program Priorities of the Organization for the 1991-1994 quadrennium, and based on the priorities defined by the country for the 1992-1993 biennium, during which time the current national government will leave office, the Representative Office, in joint agreement with the Ministry of Public Health and Social Welfare, and based on the findings of the Second Meeting for the Joint Evaluation of Technical Cooperation held in June 1990, has decided to center cooperation activities and resources on the areas of Health Services Development and Primary Care, Environmental Health, Veterinary Public Health, Disease Prevention and Control, Development of Health Human Resources, and Maternal and Child Health.

17. The cooperation to be provided in these areas will place special emphasis on the development of a participatory planning process, as well as development of the instruments needed for the formulation, execution, and evaluation of health programs and activities; the development of health regions, local health systems, and local programming; the training and administration of human resources; the identification and formulation of health development projects; the mobilization of national resources for health; the development of national conditions for improving the availability and dissemination of scientific and technical information; as well as the regulation of research and the incorporation of new technologies.

18. Technical cooperation will also be provided in the area of social welfare, where the activities will fundamentally be oriented toward promoting identification and care of the main human risk groups; formulating and implementing a national policy and plan for community involvement in health which allows the community to become fully incorporated into the health process on a progressive basis; and increasing awareness of a new approach in health promotion activities, seeking to give health a place in the formulation of policy in other social and productive sectors that are relevant to health.

19. The promotion of care and fulfillment of the bilateral agreements and the Southern Tier Initiative will be encouraged and provided support for the activities they give rise to; it will also be attempted to encourage and seek out effective operative mechanisms to help the country take on and develop activities within the framework of technical cooperation among countries.

20. There will be promotion of legal updating and functional reorganization of the health sector through strengthening of the National Health Council and the creation of other effective coordination mechanisms that can be easily applied in the operative levels. There will also be continued promotion of the extension of social security to unprotected groups and inter-institutional articulation of health delivery.

21. In addition, in joint agreement with the Ministry of Health, and through its mediation, cooperation will continue to be provided to other national institutions that have some significant relationship with health, and efforts will continue to be made to link them to the official organizations.

22. The activities that are oriented toward fulfillment of the Regional commitments will be strengthened, including eradication of the wild polio virus, and the fight against AIDS and vector-borne diseases.

23. In the Representative Office's internal sphere of operations, it will be attempted to consolidate the process of inter-program articulation in order to serve the priority areas of cooperation, in such a way as to strengthen the utilization of the available human and financial resources; and within each project it will be sought to concentrate critical resources on activities that have the potential to launch effective and efficient processes that have a greater impact on the transformation of the health situation.

24. There will be continued strengthening of the programming and evaluation process of technical cooperation in accordance with the scheme formulated during the last evaluation meeting of the cooperation program. The evaluation meeting in 1992 will be a formal event and an institutionalized process of continuous analysis and dialogue which strengthens the relationship with the government and allows greater participation in the organization.

25. The activities and resources of cooperation will be channeled directly into the health regions and local health systems, and will be used in an attempt to make delivery more timely and appropriate to the local situation and conditions.

26. There will also be continued development of the internal administrative systems so as to optimize the use of cooperation resources and to ensure their timely delivery to the country.

27. PAHO will collaborate in the development of the following specific programs:

MPN:	Managerial Support for National Health Development
TCC:	Technical Cooperation among Countries
DHS:	Helath Services Development
HME:	Health Manpower Education
CWS:	Community Water Supply and Sanitation
MCH:	Growth, Development and Human Reproduction
OCD:	General Communicable disease Prevention and Control Activities
NCD:	Helath Promotion and Prevention and Control of Noncommunicable Diseases
ZNS:	Zoonoses

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		1,177,000	68.5	1,272,400	62.3	1,446,700	62.5
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		411,300	23.9	443,100	21.8	508,900	22.0
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	411,300	23.9	443,100	21.8	508,900	22.0
TECHNICAL COOPERATION AMONG COUNTRIES		47,200	2.7	54,800	2.7	63,500	2.7
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	47,200	2.7	54,800	2.7	63,500	2.7
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		621,400	36.3	647,300	31.6	731,200	31.6
HEALTH SERVICES DEVELOPMENT	DHS	621,400	36.3	647,300	31.6	731,200	31.6
HUMAN RESOURCES DEVELOPMENT		97,100	5.6	127,200	6.2	143,100	6.2
HUMAN RESOURCES EDUCATION	HME	97,100	5.6	127,200	6.2	143,100	6.2
III. HEALTH SCIENCE AND TECHNOLOGY		542,000	31.5	764,700	37.7	870,400	37.5
ENVIRONMENTAL HEALTH		261,700	15.2	316,900	15.6	359,800	15.5
COMMUNITY WATER SUPPLY AND SANITATION	CWS	261,700	15.2	316,900	15.6	359,800	15.5
MATERNAL AND CHILD HEALTH		0	-	22,000	1.1	24,300	1.0
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	0	-	22,000	1.1	24,300	1.0
COMMUNICABLE DISEASES		241,200	14.0	318,900	15.7	364,400	15.7
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	241,200	14.0	318,900	15.7	364,400	15.7
HEALTH PROMOTION		0	-	40,000	2.0	46,000	2.0
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	0	-	40,000	2.0	46,000	2.0

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
VETERINARY PUBLIC HEALTH		39,100	2.3	66,900	3.3	75,900	3.3
ZOONOSES	ZNS	39,100	2.3	66,900	3.3	75,900	3.3
GRAND TOTAL		1,719,000	100.0	2,037,100	100.0	2,317,100	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
III. HEALTH SCIENCE AND TECHNOLOGY		1,624,098	100.0	633,143	100.0	0	100.0
MATERNAL AND CHILD HEALTH		1,034,933	63.7	215,043	34.0	0	100.0
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	1,034,933	63.7	215,043	34.0	0	100.0
COMMUNICABLE DISEASES		577,438	35.6	418,100	66.0	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	577,438	35.6	418,100	66.0	0	-
HEALTH PROMOTION		11,727	.7	0	-	0	-
OCULAR HEALTH	PBD	11,727	.7	0	-	0	-
GRAND TOTAL		1,624,098	100.0	633,143	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	1,267,900	80	48	135	590,400	33,300	17	32,300	184,000	159,100	15,200	253,600
WHO - WR	451,100	42	0	180	290,600	6,900	16	30,400	113,800	3,700	0	5,700
TOTAL	1,719,000	122	48	315	881,000	40,200	33	62,700	297,800	162,800	15,200	259,300
% OF TOTAL	100.0				51.3	2.3		3.6	17.3	9.5	.9	15.1
1992-1993												
PAHO - PR	1,351,600	72	48	285	715,500	47,600	27	54,000	196,900	110,700	0	226,900
WHO - WR	685,500	48	0	315	460,100	8,000	16	32,000	141,200	4,300	0	39,900
TOTAL	2,037,100	120	48	600	1,175,600	55,600	43	86,000	338,100	115,000	0	266,800
% OF TOTAL	100.0				57.8	2.7		4.2	16.6	5.6	.0	13.1
1994-1995												
PAHO - PR	1,541,500	72	48	285	809,400	55,300	27	56,700	228,500	128,500	0	263,100
WHO - WR	775,600	48	0	315	517,600	9,300	16	33,600	163,800	5,000	0	46,300
TOTAL	2,317,100	120	48	600	1,327,000	64,600	43	90,300	392,300	133,500	0	309,400
% OF TOTAL	100.0				57.2	2.8		3.9	16.9	5.8	.0	13.4

PERU

ANALYSIS OF THE HEALTH SITUATION

1. The widespread crisis which Peru is curently experiencing began during the latter half of the 1970s and became most acute in 1988. It is the most severe and prolonged crisis in history, generating instability and desperation; regressive redistribution of wealth and growing impoverishment of the neediest classes due to the 60% decline in real wages between 1987 and 1990; an increase in underemployment and unemployment as a result of the acute shrinking of the GDP by 23% in recent years; and problems with the traffic in narcotics, which subjugates peasants either economically or through violence, and exercises a destructive influence over institutions, as well as fosters drug addiction, generating a serious health problem, especially among young people. The crisis has also led to an increase in political violence, which is reflected in subversive activities and terrorism.

2. Peru's estimated population for 1990 is 22,332,000, with a birth rate of 32.8%, a growth rate of 2.5%, and a fertility rate of 4.4 children per woman. The process of migration from the country to the city and the rapid development of human settlements along the periphery of large cities has altered the spatial distribution of the population, thus decreasing the relative importance of the rural population, which is estimated at 35% of the total. In Lima, a city which has more than 6 million inhabitants, the poverty belts encompass around 50% of the population.

3. For 1990, overall mortality is estimated at 8.3 per 1,000 inhabitants, infant mortality at 80.7 per 1,000 live births, maternal mortality at 29.8 per 10,000 live births, and life expectancy at birth is 63.4 years.

4. Only 58% of the country's population is covered by systems that supply water for human consumption, while just 47% have sanitary sewerage services. Coverage in the rural area is extremely low.

5. Garbage collection is deficient in most of the cities in the country, and in final disposal sanitary techniques are not employed.

6. Communicable diseases such as tuberculosis, malaria, jungle yellow fever, viral hepatitis, and intestinal parasitosis are still serious health problems, while acute respiratory infections and diarrheal diseases are ranked first and second among causes of death in children under the age of 5 years. At the same time, diseases preventable by immunization continue to be a significant problem.

7. Maternal mortality, with a rate of 29.8%, is most frequently caused by hemorrhage of pregnancy and childbirth, which is responsible for 33% of the deaths. The principal causes of overall mortality, responsible for 54.5% of deaths in 1987, were acute respiratory infections, diseases of the circulatory system, perinatal diseases, accidents, and violence.

8. The health service system retains its characteristics of institutional dearticulation and limited coordination among providers. The health services are deteriorating, with a conspicuous state of immobility, a loss of governability of the system, and a serious decline in the operative capacity of the services.

9. The production of final services continues to uphold sizeable and unfair differences that favor Lima and the urban area over the rural population.

10. The rate of hospital beds continues its declining trend, going from 1.52 to 1.48 beds per 1,000 inhabitants during this period.

11. The population's access to drugs and the difficulties with availability constitutes one of the most critical areas of the health service system.

12. The maintenance and preservation of the physical plant in the establishments under the Ministry of Health has been poor. It is estimated that around 40% of hospital equipment is not in working order.

13. The availability of human resources increased between 1985 and 1989. In spite of this, these resources continue to be concentrated in Lima and other large cities.

14. The economic resources allocated to the social sectors, including health, have undergone a conspicuous decline since 1985 to a level of less than 5% of the national budget. In 1985 the Ministry's expenditure was 2.1% of the GDP, and in 1989 it was only 0.91%.

Strategies, policies, and national health plans

15. The Ministry of Health, under Peru's new government, has defined its contingent and medium-term policies with explicit reference to the grave economic and social crisis which is affecting the country, the process of political regionalization, and the situation of political and military violence.

16. In this context, the Ministry of Health has defined the following general objectives for its work over the medium term (1990-1995): a) defense of the life and health of the Peruvian population; b) the democratization of health, and reconstruction; and c) reevaluation of the health sector. Toward this end, the Ministry is establishing 10 substantive policies for the sector: promotion of comprehensive health and the development of health services that are equitable, efficient, and participatory, and which provide universal coverage; health, a responsibility for all; decentralization and regionalization; prioritization of the local setting; restoration of the installed capacity and infrastructure and equipment of health establishments; establishment and development of an adequate policy for basic drugs and inputs; encouragement of comprehensive and interdisciplinary development of human resources; reorientation of the Social Security; coordination and reorientation of national and international technical and financial cooperation; and promotion of research and technological production in health.

17. In order to fulfill these policies, the following strategic lines are indicated: a) social participation and mobilization; b) social unification for the change in health; c) reconstruction and reassessment of the health sector; d) development and strengthening of human resources; e) reorientation of health action, based on readaptation of the service network, intersectoral activity, and technological innovation; and f) dissemination and exchange of knowledge and of health experiences gained in confronting the country's principal health problems.

18. The Ministry of Health has defined 7 areas of interest for technical cooperation: a) the Regionalized and Integrated National Health System; b) Human Resource Development; c) Health Situation and Trend Assessment; d) Strengthening of the Regionalization Process; e) Technical Cooperation to Health Regions/Programs Integrated into Services; f) Science and Technology; and g) Technical Cooperation Among Countries.

GLOBAL STRATEGY OF COOPERATION

19. PAHO/WHO cooperation covers the 7 priority areas defined by the national authorities; for the development of activities for the coming bienniums (1990-1995), the following strategic axes have been identified:

19.1 Support for the regionalization process based on technical and administrative decentralization, intersectoral activity, and social participation. The principal target of the strategy consists of PAHO support for, and participation in, the establishment and operation of a "Regionalized and Integrated National Health System," towards which end consideration should be given to cooperation activities for health services development, strengthening of leadership capacity at the central level, and the organization and operation of the regional level; operationalization of the service network; organization of the technical assistance process from the central level to the regions, and increasing awareness in, and training of, personnel at all levels; as well as development of the capacity for management, standardization, and leadership of the national and regional levels.

19.2 Within the context of regionalization, the development and operation of integrated local health systems, based on social participation and organization. The basic components of the strategy would be promotion of social involvement in seeking areas for unified effort and the development of self-management processes.

19.3 Support for the execution of priority programs aimed at populations at risk, within the framework of regionalization and integrated local health systems: programs oriented toward family health, mothers-children-adolescents; immunization, environmental health, and food safety; zoonoses; communicable diseases; occupational health; prevention and control of drug addiction; and noncommunicable diseases. Within this context, consideration is given to establishing the capacity for health situation assessment and developing systems for epidemiological surveillance and health information.

19.4 Inclusion of PAHO technical and administrative cooperation in the Program for Social Compensation and Development, which will continue to be of greatest importance during the coming biennium, since it will make it possible to measure PAHO's role in the interinstitutional setting, favoring comprehensive knowledge of cooperation needs and reducing the risk of duplication of activities.

19.5 The development and strengthening of institutions for training human resources as well as scientific associations, which will make it possible to incorporate these important social agents into the development of health services and programs.

19.6 PAHO's development of a program of social communication in support of health activities, since it allows for the dissemination of health information to the population and the development of technologies and approaches for social communication in the health field.

19.7 In the area of science and technology, using a strategy which is oriented toward identifying technology as a strategic priority; strengthening and orienting basic health services research and making prompt use of it; strengthening the institutions in charge of health technology development; and promoting and developing the National Network of Health Sciences Information and Documentation.

19.8 The mobilization of national resources as well as those from other agencies of cooperation, and the strengthening of subregional and intercountry activities as an important line of cooperation which will be developed with emphasis on the next biennium. Thus, through Technical Cooperation Among Countries, the binational agreements with Ecuador, Bolivia, Brazil, Cuba, and Colombia will be strengthened. In addition, under Andean Cooperation in Health (ACH), there will be strengthening of the initial projects as well as those to be prepared during the coming biennium.

20. The Organization will collaborate in the development of the following specific programs:

MPN: Managerial Support for National Health Development
TCC: Technical Cooperation among Countries
HST: Health Situation and Trend Assessment
HDP: Health Policy Analysis and Development
DHS: Health Services Development
DPP: Disaster Preparedness
HMC: Coordination and Support of Human Resources Development
HBD: Scientific and Technical Information Dissemination
RPD: Research Promotion and Development
NUT: Nutrition
CWS: Community Water Supply and Sanitation
OCH: Workers' Health
MCH: Growth, Development and Human Reproduction
EPI: Immunization
OCD: General Communicable Disease Prevention and Control Activities
HIV: Acquired Immunodeficiency Syndrome
NCD: Health Promotion and Prevention and Control of Noncommunicable Diseases
FOS: Food Safety

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		2,555,200	67.6	3,227,300	72.3	3,670,300	72.3
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		861,700	22.9	1,009,900	22.6	1,152,700	22.7
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	861,700	22.9	1,009,900	22.6	1,152,700	22.7
TECHNICAL COOPERATION AMONG COUNTRIES		99,300	2.6	115,200	2.6	133,700	2.6
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	99,300	2.6	115,200	2.6	133,700	2.6
HEALTH SITUATION AND TREND ASSESSMENT		339,400	9.0	429,200	9.6	486,700	9.6
HEALTH SITUATION AND TREND ASSESSMENT	HST	339,400	9.0	429,200	9.6	486,700	9.6
HEALTH POLICY DEVELOPMENT		88,500	2.3	279,700	6.3	316,500	6.2
HEALTH POLICY ANALYSIS AND DEVELOPMENT	HDP	88,500	2.3	279,700	6.3	316,500	6.2
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		909,000	24.0	1,000,300	22.4	1,129,000	22.3
HEALTH SERVICES DEVELOPMENT	DHS	861,700	22.5	975,900	21.9	1,100,700	21.7
ESSENTIAL DRUGS AND VACCINES	EDV	34,400	.9	0	-	0	-
DISASTER PREPAREDNESS	DPP	22,900	.6	24,400	.5	28,300	.6
HUMAN RESOURCES DEVELOPMENT		213,400	5.6	258,000	5.8	295,000	5.8
COORDINATION & SUPPORT OF HUMAN RESOURCES DEVELOP.	HMC	213,400	5.6	258,000	5.8	295,000	5.8
HEALTH INFORMATION SUPPORT		17,600	.5	19,700	.4	22,900	.5
SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION	HBD	17,600	.5	19,700	.4	22,900	.5
RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT		26,300	.7	115,300	2.6	133,800	2.6
RESEARCH PROMOTION AND DEVELOPMENT	RPD	26,300	.7	115,300	2.6	133,800	2.6

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
III. HEALTH SCIENCE AND TECHNOLOGY		1,231,400	32.4	1,235,500	27.7	1,412,300	27.7
FOOD AND NUTRITION		67,300	1.8	71,500	1.6	81,000	1.6
NUTRITION	NUT	67,300	1.8	71,500	1.6	81,000	1.6
ENVIRONMENTAL HEALTH		502,000	13.2	397,700	8.9	450,600	8.9
COMMUNITY WATER SUPPLY AND SANITATION	CWS	470,700	12.4	363,100	8.1	410,900	8.1
WORKERS' HEALTH	OCH	31,300	.8	34,600	.8	39,700	.8
MATERNAL AND CHILD HEALTH		255,200	6.7	377,700	8.4	434,500	8.5
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	113,400	3.0	220,900	4.9	254,500	5.0
IMMUNIZATION	EPI	141,800	3.7	156,800	3.5	180,000	3.5
COMMUNICABLE DISEASES		222,400	5.9	228,900	5.2	261,800	5.1
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	52,900	1.4	213,200	4.8	244,500	4.8
TUBERCULOSIS	TUB	84,300	2.2	0	-	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	14,600	.4	15,700	.4	17,300	.3
MALARIA	MAL	70,600	1.9	0	-	0	-
HEALTH PROMOTION		65,900	1.7	73,900	1.7	85,700	1.7
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	31,500	.8	73,900	1.7	85,700	1.7
PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE	ADA	34,400	.9	0	-	0	-
VETERINARY PUBLIC HEALTH		118,600	3.1	85,800	1.9	98,700	1.9
FOOD SAFETY	FOS	118,600	3.1	85,800	1.9	98,700	1.9
GRAND TOTAL		3,786,600	100.0	4,462,800	100.0	5,082,600	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		5,309,110	57.5	661,100	15.6	625,900	16.5
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		565,093	6.1	590,100	13.9	625,900	16.5
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	565,093	6.1	590,100	13.9	625,900	16.5
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		4,744,017	51.4	71,000	1.7	0	-
HEALTH SERVICES DEVELOPMENT	DHS	3,644,869	39.6	0	-	0	-
ESSENTIAL DRUGS AND VACCINES	EDV	22,600	.2	0	-	0	-
ORAL HEALTH	ORH	314,895	3.4	71,000	1.7	0	-
DISASTER PREPAREDNESS	DPP	761,653	8.2	0	-	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		3,944,013	42.5	3,578,782	84.4	3,176,300	83.5
FOOD AND NUTRITION		1,289,545	13.9	0	-	0	-
NUTRITION	NUT	1,289,545	13.9	0	-	0	-
ENVIRONMENTAL HEALTH		96,905	1.0	16,968	.4	0	-
COMMUNITY WATER SUPPLY AND SANITATION	CWS	12,400	.1	0	-	0	-
WORKERS' HEALTH	OCH	84,505	.9	16,968	.4	0	-
MATERNAL AND CHILD HEALTH		1,995,893	21.5	3,106,900	73.3	3,176,300	83.5
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	1,585,974	17.1	3,106,900	73.3	3,176,300	83.5
DIARRHEAL DISEASES	CDD	409,919	4.4	0	-	0	-
COMMUNICABLE DISEASES		561,670	6.1	454,914	10.7	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	561,670	6.1	454,914	10.7	0	-
GRAND TOTAL		9,253,123	100.0	4,239,882	100.0	3,802,200	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	2,603,700	96	264	1105	1,221,900	73,200	46	87,400	425,300	240,900	0	555,000
WHO - WR	1,182,900	48	72	385	468,100	39,200	34	64,600	276,400	155,400	0	179,200
TOTAL	3,786,600	144	336	1490	1,690,000	112,400	80	152,000	701,700	396,300	0	734,200
% OF TOTAL	100.0				44.6	3.0		4.0	18.5	10.5	.0	19.4
1992-1993												
PAHO - PR	2,934,100	96	240	305	1,377,300	63,500	26	52,000	429,600	262,900	0	748,800
WHO - WR	1,528,700	48	72	545	690,900	66,100	36	72,000	203,400	149,000	0	347,300
TOTAL	4,462,800	144	312	850	2,068,200	129,600	62	124,000	633,000	411,900	0	1,096,100
% OF TOTAL	100.0				46.3	2.9		2.8	14.2	9.2	.0	24.6
1994-1995												
PAHO - PR	3,347,900	96	240	305	1,546,900	73,800	26	54,600	498,600	305,200	0	868,800
WHO - WR	1,734,700	48	72	545	770,900	76,600	36	75,600	236,000	172,700	0	402,900
TOTAL	5,082,600	144	312	850	2,317,800	150,400	62	130,200	734,600	477,900	0	1,271,700
% OF TOTAL	100.0				45.5	3.0		2.6	14.5	9.4	.0	25.0

ANALYSIS OF THE HEALTH SITUATION

Demography

1. The twin island state of St. Christopher and Nevis with an area of 269 km had an estimated midyear population of 43,700 in 1990 which is considered to be stable, although some recent years have shown a decline in the number of inhabitants. Based on the current projections the population during 1992-1993 should remain at that level. Over the period 1980-1990, the age structure has changed with a decline in the proportion of young people less than 14 years with a marked increase in the 15-64 age groups.

Indicators of progress

2. The life expectancy at birth for both sexes in 1985 was 64.6 at birth and 67 at age 1. This has increased from 1971 when the rate at birth was 60.8 for males and 61.9 for females. It is anticipated that these rates will continue their steady increases.

3. The leading causes of overall mortality according to rank in 1989 were cerebrovascular disease, heart disease, malignant neoplasm, pneumonia, nutritional disease, diabetes mellitus, diarrhoeal diseases and hypertensive disease. Among infants, in 1989, perinatal disorders have been the leading cause of death followed by diarrhoeal diseases and congenital anomalies.

4. In the age group 1-4 years, respiratory disease is the main cause of mortality, nutritional disease has become less of a problem with approximately 25% of children suffering from mild malnutrition. Gastroenteritis still persists, but generally there has been a decline in the number of children affected from this condition.

5. Maternal mortality was recorded as 4 deaths in 1988. Notification for sexually transmitted disease is required and the cumulative number of AIDS cases reported up until 1988 was 18 with 33% in women. Death from accidents has shown a significant percentage increase in recent years. The high rate of teenage pregnancy has shown a decrease from 35% of all births in 1976 to 23% in 1986. However, there is still concern over the number of teenagers becoming pregnant annually.

Factors affecting the health status

6. The environmental situation remains critical especially as regards solid waste. As of 1989, 35% of all households have potable water piped into dwellings and another 11% pipeborne into yards. The remaining 54% of the population is served by stand pipes. The major problem with water supply relate not only to coverage but to water quality especially in rural communities. Since 1989, 83% of households have sewerage services, however, nearly 25% of them are shared. Difficulties existing in the adequate disposal or management of solid waste have contributed to the large rodent population which may give rise to the possibility of leptospirosis.

7. Traditionally, agriculture satisfied 30% of domestic food requirements, provided employment for 35% of the labor force and contributed to more than 20% of the Gross National Product (GNP). Recently, however, Agriculture has seen its share of the GNP decline from 18.7% in 1977 to 12.7% in 1985. The GDP of EC$166M and per capita GDP of $3.798 have both increased in recent times, however, with a small population the amount of financial resources available to the country specifically to the health sector is small making it extremely difficult to be self-reliant.

8. Health services are available through a network of 17 clinics, one general hospital, two cottage hospitals and a Type II Primary Care Center. Access to health services are free in Government owned facilities. However, hospital services are free in Government owned facilities. However, hospital services have suffered due to extensive damage to the general hospital by Hurricane Hugo in 1989 and a delay in the rebuilding of this hospital. There is therefore a need for improvement of services. An attempt to introduce the model district health team approach has not been successful. A problem of retention of staff exist among health workers, especially nurses.

9. The Government recognizes that the delivery of health services could be improved, therefore the issue of management capabilities should be addressed at an early date.

National health strategies

10. The health sector comprises the Ministry of Health and Women's Affairs. The Ministry of Health has a written national health policy in which there is explicit commitment to "Health for All" and the Primary Health Care Strategy. Priority areas in health outlined in the health policy are: maternal and child health; the elderly; the handicapped; occupational health and safety and coordination of health care at all levels.

11. The major strategies to achieve total coverage with effective and efficient services are directed to the strengthening of local health systems as outlined in the draft health plan which embodies definition of boundaries, community organization, health education and decision making on health issues.

12. With the thrust towards decentralization of services management at the central and local levels must be improved. The capacity to acquire and analyze information needed for effective management must be present at the local level.

13. The development of human resources is to be approached through establishing manpower planning and rationalizing the use of scarce resources.

14. With the extension of coverage, health care to vulnerable groups will be improved leading to a decrease in such areas as infant mortality and teenage pregnancy.

15. Health education will be used to inform the community about health and Government issues which affect the quantity and quality of health care so that informed decisions can be effected by the community. Specific issues that will be addressed through strategies are:

15.1 Support for the process of decentralization in which data gathering and analysis will form the bases for decision making and management of local health systems and services.

15.2 Improvement of the environment through increased coverage of quality of water in rural areas, the capacity to dispose of solid and hazardous waste and the development of an integrated approach to vector control.

15.3 Analysis of health manpower resources and development of national policies relating to categories mix and utilization and finding ways for retention of certain categories of workers.

15.4 Improvement of the physical infrastructure of secondary care facility.

15.5 Strengthening the capacity for epidemiological analysis with a focus on identification, surveillance and interventions to reduce communicable diseases, maternal mortality, low birth weights, and accidents.

15.6 Health promotion through health education and community participation aiming at changes in lifestyles that contribute to the leading causes of mortality, morbidity and disability.

15.7 Support for the process of intersectoral coordination among Government and non-Governmental Organizations to improve coverage, quality of services and appropriate use of resources.

GLOBAL STRATEGY OF COOPERATION

16. The strategies for technical cooperation are based on the "Strategic Orientations and Program priorities for the Pan American Health Organization during the Quadrennium 1991-1994", the Caribbean Cooperation in Health Initiatives, the mandates of the Directing Council and the resolutions of the Conference of Caribbean Ministers of Health.

17. The Government has identified the following as priority areas in technical cooperation with PAHO/WHO during the Biennium: Health Services Development, Environmental Sanitation, Human Resources Development, Maternal and Child Health and Communicable Diseases.

18. Strategies for providing technical cooperation during the biennium in these areas will be based on mobilization of resources through Caribbean Cooperation in Health, training, dissemination of information and development of norms, policies and plans. There will be need for promotion of research activities in the various priority areas.

19. In the decentralization process, PAHO/WHO will emphasize the strengthening of local health systems.

20. At the local level, support will be provided to the development and institutionalization of the management information system and training of health personnel.

21. In the area of human resources development of a framework for policies and plans related to manpower production to be used for determining manpower training needs, will be supported by PAHO/WHO.

22. Technical cooperation in Maternal and Child Health will be in the promotion of research activities to decrease maternal mortality, perinatal morbidity and mortality and evaluation of MCH services. Support to programs focussing on decreasing teenage pregnancy and improving adolescent health will be continued. PAHO will support the national activities for the elimination of poliomyelitis and measles.

23. Regarding communicable diseases PAHO/WHO will provide support for the development and institutionalization of strategies and plans for control to include appropriate education in prevention.

24. In the area of Environmental Health, technical cooperation will be in the form of increasing the capacity to dispose of solid and hazardous waste, promoting research activities, water purification in rural areas, and increasing public awareness.

25. PAHO will collaborate to the development of the following specific programs:

DHS: Health Services Development
CWS: Community Water Supply and Sanitation
MCH: Growth, Development and Human Reproduction

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		101,600	76.2	116,900	76.8	128,800	76.5
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		101,600	76.2	116,900	76.8	128,800	76.5
HEALTH SERVICES DEVELOPMENT	DHS	101,600	76.2	116,900	76.8	128,800	76.5
III. HEALTH SCIENCE AND TECHNOLOGY		31,700	23.8	35,300	23.2	39,500	23.5
ENVIRONMENTAL HEALTH		20,100	15.1	21,900	14.4	23,900	14.2
COMMUNITY WATER SUPPLY AND SANITATION	CWS	20,100	15.1	21,900	14.4	23,900	14.2
MATERNAL AND CHILD HEALTH		11,600	8.7	13,400	8.8	15,600	9.3
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	11,600	8.7	13,400	8.8	15,600	9.3
GRAND TOTAL		133,300	100.0	152,200	100.0	168,300	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		840	.4	0	-	0	-
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		840	.4	0	-	0	-
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	840	.4	0	-	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		197,403	99.6	231,395	100.0	165,000	100.0
FOOD AND NUTRITION		15,163	7.6	0	-	0	-
NUTRITION	NUT	15,163	7.6	0	-	0	-
MATERNAL AND CHILD HEALTH		4,815	2.4	0	-	0	-
ADOLESCENT HEALTH	ADH	4,815	2.4	0	-	0	-
COMMUNICABLE DISEASES		177,425	89.6	231,395	100.0	165,000	100.0
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	177,425	89.6	231,395	100.0	165,000	100.0
GRAND TOTAL		198,243	100.0	231,395	100.0	165,000	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	31,700	0	0	30	7,600	0	6	11,400	6,800	4,800	0	1,100
WHO - WR	101,600	0	0	45	17,100	0	26	49,400	15,000	4,800	0	15,300
TOTAL	133,300	0	0	75	24,700	0	32	60,800	21,800	9,600	0	16,400
% OF TOTAL	100.0				18.5	.0		45.6	16.4	7.2	.0	12.3
1992-1993												
PAHO - PR	35,300	0	0	25	6,700	0	4	8,000	11,300	3,200	0	6,100
WHO - WR	116,900	0	0	60	17,700	9,300	24	48,000	14,500	5,800	0	21,600
TOTAL	152,200	0	0	85	24,400	9,300	28	56,000	25,800	9,000	0	27,700
% OF TOTAL	100.0				16.0	6.1		36.8	17.0	5.9	.0	18.2
1994-1995												
PAHO - PR	39,500	0	0	25	7,100	0	4	8,400	13,200	3,800	0	7,000
WHO - WR	128,800	0	0	60	19,000	10,800	24	50,400	16,800	6,700	0	25,100
TOTAL	168,300	0	0	85	26,100	10,800	28	58,800	30,000	10,500	0	32,100
% OF TOTAL	100.0				15.5	6.4		35.0	17.8	6.2	.0	19.1

ANALYSIS OF THE HEALTH SITUATION

Demography

1. St. Lucia had a mid-year population estimated at 148,144 in 1989, and based on the current projections of an annual growth rate of 1.6%, the population during the 1992-1993 biennium should reach 155,200. Over the period 1975 to 1985, there has been an increase in the age group 15-44 and a decrease in the age group 0-5.

Indicators of health status

2. The life expectancy at birth was 70 years for males and 75 for females in 1984. This represents an increase over 1980 of 2.6 and 3.2 years, respectively.

3. The leading causes for mortality in 1984 in order of rank were heart diseases, malignant neoplasms, cerebrovascular diseases, perinatal disorders, accidents, hypertensive disease, diabetes mellitus, pneumonia, nephritis - nephrotic syndrome & nephrosis, mental disorders.

4. Infant mortality has declined to 12.7 per 1000 live births in 1988. Major causes contributing to this mortality were disorders in the perinatal period, congenital anomalies and signs - symptoms and ill defined conditions.

5. In the age group 1-4, the principal causes for mortality have been perinatal disorders, congenital anomalies, pneumonia and accidents. Deaths due to the accidents have increased dramatically in recent years. Among children less than 5 years of age, this is a major area of concern.

6. Maternal mortality rates are at a record low of .51 per 1000 live births.

Factors affecting health status

7. The environmental situation remains an area in which considerable improvement should be achieved. As of 1990, 90% of the population have access to potable water supplies but only 50% have house connections. Forty eight percent of the population have pit latrines whilst over 20% are without facilities. Less than 20% of the population can be considered to be adequately served by the solid waste disposal program. Unauthorized dumping continues to be a problem, with concomitant environmental consequences.

8. Increasing industrialization and tourist sector development are imposing additional burdens on the services and on the environment. To meet some of the water supply demands in the Castries area, a new Roseau River Valley Project is under development. An associated schistosomiasis project is also being undertaken to reduce the risk of increased disease incidence associated with the scheme.

9. Saint Lucia is still heavily dependent on agricultural exports, mainly bananas, for its economic development. GDP has grown steadily at current prices between 1977 and 1984, and was 6.8% in 1988. Major goals in the national development plan have been diversifications of the economy into tourism, which is now the second largest foreign exchange earner and industry. Government expenditure on health as a percentage of total expenditure has started to decline in the eighties but has now stabilized around 13 percent. Of the recurrent health budget 43 percent is spent on hospital services.

10. Unemployment, like elsewhere in the Caribbean, is a problem and is estimated to stand at 15% in St. Lucia.

11. There is an adequate network of health centers throughout the island that provides health services to the population. Furthermore, there are two main general hospitals and a mental hospital.

12. At present, there seems to be an adequate number of nursing personnel and professional staff. However, there should be some studies on the manpower needs for the future to ensure that suitable training programs be developed for the various categories.

National health strategies, policies and plans

13. The central authority responsible for health remains the Ministry of Health. Principal areas of managerial responsibility are hospital services, district services, drugs and medical supplies, health education, psychiatry, environmental health services, maternal and child health, and nutrition services.

14. In its policy statements, the Government has consistently elaborated on the need to improve the health care delivery system by utilizing the Primary Health Care Approach. Within this framework, several themes have been singled out as priority areas for health development. Among these are:

14.1 The development of sound management systems that are accountable, progressive, communicative, and that leads to increased productivity of the health services;

14.2 Community participation in the development of local health systems;

14.3 The continued development, recruitment, and retention of a cadre of highly trained health professionals;

14.4 The provision of a continuous supply of essential drugs and basic medical supplies that satisfies the need of the population;

14.5 The development of activities that ensure the active participation of the community in the delivery of health services as well as in activities aimed at protecting the environment;

14.6 The continuous monitoring of the effects of economic development on the environment; and finally

14.7 The provision of specific health programs for vulnerable groups such as workers, mothers and children, the elderly, and chronically ill and disabled people.

15. The major strategies proposed to achieve the intended objectives are:

15.1 Establishment of a program and policy committee for the prioritizing of health problems, formulation of policies and objectives, and monitoring of progress.

15.2 Restructuring the Ministry of Health to be more responsive to the development of district health services.

15.3 Continue the development of District Health Teams.

15.4 Continue participation in the Eastern Caribbean Drug Scheme and further improve the management aspect of the drug supply system.

15.5 Solicit active community participation in health programs or initiate activities that will encourage community involvement.

15.6 Development of expertise needed to formulate operational objectives in environmental health.

15.7 The development of an environmental health information system.

15.8 Analyzing training needs and provide training opportunities, especially in those areas where a major thrust is expected, such as management, planning, solid waste management.

GLOBAL STRATEGY OF COOPERATION

16. The PAHO/WHO technical cooperation strategy is developed around the major strategies outlined by the Government of St Lucia and related to the PAHO program categories. Emphasis will be placed on health services development based on primary health care. Following the strategic health plan that has been adopted in 1990, support will be provided for the development of detailed annual plans of action. Training in local programming and evaluation of local health systems will also be conducted. In terms of human resources development, manpower planning and personnel management will be strengthened. PAHO's role in the environmental health sector will focus on resource mobilization through the assistance in developing projects that are to be submitted for funding to donor agencies, such as CIDA and USAID. Following the Joint Country Review, the necessary adjustments in the cooperation programs will be made to ensure that program is congruent with strategies developed within the priority areas of CCH.

17. Special support will be given to priority health programs such as Maternal and Child Health, AIDS, and the Expanded Program on Immunization.

Health services development based on primary health care

18. The goal of this strategy is to consolidate the gains that have been made since introducing the concept of District Health Services and to promote the further development of local health systems. To achieve this PAHO jointly with the Government will conduct evaluations of Primary Health Care services. It will also assist in improving health information systems at the local as well as central level that will support more rational decision-making in health services planning. Utilizing the results of the evaluations and the improved performance of information systems, training will be conducted in local programming.

19. PAHO will also review the management problems of the Hospital and devise strategies not only to improve the situation but also to establish linkages with the Primary Health Care System.

20. The main strategies to improve maternal and child health services are to improve data collection and analysis of maternal deaths, establishing systems for the early detection and management of high risk pregnancies, and the development of comprehensive family life and family planning education programs. A new approach will also include the emphasis on adolescent health programs and the establishment of programs for the prevention of child abuse problems. Efforts will continue to intensify EPI programs for the elimination of poliomyelitis and measles.

Essential drug supplies

21. PAHO will continue to support the initiatives of the Government and the ECDS in improving the essential drug supply system. Improved management and the promotion of rational drug prescription and public education in the proper use of medicines is expected to increase productivity and efficiency.

Environmental sanitation

22. The main goal is to improve the operating capacity of the solid waste disposal system. PAHO will assist in continuously updating the environmental health profiles that have been prepared in the previous program cycle. Furthermore, it will actively participate in the mobilization of resources for funding the solid waste disposal projects that have been developed in the last year.

23. The effects of Schistosomiasis prevention programs will be monitored and and those activities in which there was a strong community involvement will be monitored.

24. PAHO will collaborate in the development of the following specific programs:

DHS: Health Services Development
CWS: Community Water Supply and Sanitation
MCH: Growth, Development and Human Reproduction

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		134,200	84.1	147,900	83.7	162,800	83.3
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		134,200	84.1	147,900	83.7	162,800	83.3
HEALTH SERVICES DEVELOPMENT	DHS	134,200	84.1	147,900	83.7	162,800	83.3
III. HEALTH SCIENCE AND TECHNOLOGY		25,500	15.9	28,800	16.3	32,500	16.7
ENVIRONMENTAL HEALTH		19,700	12.3	19,300	10.9	22,000	11.3
COMMUNITY WATER SUPPLY AND SANITATION	CWS	19,700	12.3	19,300	10.9	22,000	11.3
MATERNAL AND CHILD HEALTH		5,800	3.6	9,500	5.4	10,500	5.4
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	5,800	3.6	9,500	5.4	10,500	5.4
GRAND TOTAL		159,700	100.0	176,700	100.0	195,300	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		19,662	8.8	0	-	0	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		19,662	8.8	0	-	0	100.0
ESSENTIAL DRUGS AND VACCINES	EDV	19,662	8.8	0	-	0	100.0
III. HEALTH SCIENCE AND TECHNOLOGY		205,000	91.2	149,980	100.0	0	-
FOOD AND NUTRITION		26,211	11.7	0	-	0	-
NUTRITION	NUT	26,211	11.7	0	-	0	-
ENVIRONMENTAL HEALTH		19,028	8.5	0	-	0	-
COMMUNITY WATER SUPPLY AND SANITATION	CWS	19,028	8.5	0	-	0	-
MATERNAL AND CHILD HEALTH		9,781	4.4	0	-	0	-
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	9,781	4.4	0	-	0	-
COMMUNICABLE DISEASES		149,980	66.6	149,980	100.0	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	149,980	66.6	149,980	100.0	0	-
GRAND TOTAL		224,662	100.0	149,980	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL PROF. MONTHS	PERSONNEL LOCAL MONTHS	PERSONNEL CONS. DAYS	PERSONNEL AMOUNT	DUTY TRAVEL AMOUNT	FELLOWSHIPS MONTHS	FELLOWSHIPS AMOUNT	SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	19,700	0	0	0	0	0	6	11,400	4,600	3,700	0	0
WHO - WR	140,000	0	0	60	20,900	0	35	66,500	24,900	8,100	0	19,600
TOTAL	159,700	0	0	60	20,900	0	41	77,900	29,500	11,800	0	19,600
% OF TOTAL	100.0				13.1	.0		48.7	18.5	7.4	.0	12.3
1992-1993												
PAHO - PR	19,300	0	0	0	0	0	2	4,000	4,900	5,800	0	4,600
WHO - WR	157,400	0	0	75	21,700	9,300	33	66,000	26,100	10,700	0	23,600
TOTAL	176,700	0	0	75	21,700	9,300	35	70,000	31,000	16,500	0	28,200
% OF TOTAL	100.0				12.3	5.3		39.6	17.5	9.3	.0	16.0
1994-1995												
PAHO - PR	22,000	0	0	0	0	0	2	4,200	5,700	6,700	0	5,400
WHO - WR	173,300	0	0	75	23,200	10,800	33	69,300	30,200	12,400	0	27,400
TOTAL	195,300	0	0	75	23,200	10,800	35	73,500	35,900	19,100	0	32,800
% OF TOTAL	100.0				11.9	5.5		37.6	18.4	9.8	.0	16.8

ANALYSIS OF THE HEALTH SITUATION

Demography

1. Present estimates extrapolated from the 1980 census suggest that the population of St. Vincent and the Grenadines increased from 109,407 in 1985 to 114,422 in 1989. This indicates an average annual growth rate of 1.13%. If the function of migration were ignored, the average annual rate of growth increases to 1.35%.

2. Between 1980 and 1984, there was a 7.42% reduction in the under 15 years old population, a 7.56% increase in the 15-65 age group, and a 2.9% increase in the over 65 age group. The 1991 Census will provide a more accurate picture of changes in the age structure over the past ten years.

Indicators of health status

3. The life expectancy at birth was 61 years for males and 62 years for females in 1970. Corresponding figures for 1988 indicate a life expectancy of 69 years for males and 71 years for females.

4. The Crude Death Rate has remained fairly constant at between 6.5 and 6.1 per 1000 over the past five years. The leading causes of overall mortality have been diseases of the circulatory system, malignancies, endocrine and metabolic diseases, ischaemic heart disease, perinatal conditions and diseases of the digestive system, in rank order.

5. The Infant Mortality Rate fell dramatically from 60.1 per 1000 in 1980 to 24 in 1987 through a variety of strident public health initiatives. Perinatal conditions have overtaken diarrhoeal diseases as the major cause of infant mortality. However, among children 1-4 years, diarrhoeal diseases remain the major cause of morbidity and mortality. Although the prevalence of Protein Energy Malnutrition (P.E.M) declined by 50% between 1986 and 1988 due largely to the input of the WHO/UNICEF sponsored Joint Nutrition Support Program, the current situation in which 6.2% of children under 5 years of age still suffer from P.E.M. is considered unacceptably high.

6. Hypertension, diabetes and cancer have emerged as leading causes of ill health and death among the adult population. These, together with the other lifestyle related problems (of drug abuse and teenage pregnancy), reflect the need for behavior modification. At the same time, it must be noted that maternal mortality has been a very rare occurrence over the past decade, with no more than one death recorded in any one year.

7. The first definite diagnosis of AIDS was made in 1984 and, by the end of 1990, there was a cumulative total of 25 cases with 19 deaths. Overall, a total of 59 cases of HIV seropositive have been identified with a male/female ratio of 2.3:1. Most of the HIV seropositive cases have been young adults, with 75% within the 20-39 years age group. The results of a blind study among antenatals as well as the routine screening of blood donors indicate a need to study the prevalence of seropositivity within the community.

Factors affecting health status

8. The management of solid waste remains a matter of serious environmental concern. This position was corroborated by a CIDA sponsored study conducted in 1988 which identified solid waste disposal as the foremost environmental problem. At the moment, 42% of the population, mostly in the urban areas, are served by an organized refuse collection system. By the end of 1991, however, a further 15% of the population will be afforded such a service. The pit latrine is still the predominant means of sewage disposal with 61.2% of all households utilizing this method - a decline of 7.3% since 1980. At the same time, the number of households utilizing private or municipal sewerage systems has increased by an almost identical margin. About 49% of the population of St. Vincent obtain water from public standpipes, 37% (up from 23.9% in 1980) have water piped into their homes, while the rest obtain water from other private or public sources.

9. The performance of the economy in the period 1985-1989 has been encouraging. Real incomes are estimated to have risen by 5.8% per annum in real terms, or at an annual growth rate of 5.3%. Still, a large annual trade deficit has been in evidence which is offset by substantial inflows of capital from migrant workers and foreign aid. The prime movers of the economy over the period have been manufacturing, construction, agriculture, electricity and water and tourism. Present estimates on unemployment range from 20% - 40% depending on the source of information.

10. Government recurrent expenditure on medical and health services continues to compare favorably with other sectors. Only education services enjoy a greater outlay. In the financial year 1988/89, expenditure on health represented 13.5% of total recurrent expenditure, and 41.2% of all expenditure on social services.

11. Although there is a comprehensive network of facilities, including 36 clinics, a 204 bed referral hospital, 4 peripheral hospitals with a total capacity of sixty beds, a psychiatric hospital and a home for the aged poor, the availability of health care services has been reduced because of the shortage of health manpower, particularly trained nurses. In addition, about 60% of all medical officers are non-nationals.

National health strategies, policies and plans

12. For the last two years the management for the health care system and the environment have been the responsibility of the same Minister, thereby facilitating greater intersectoral collaboration.

13. The Ministry of Health and the Environment has recently enunciated its major medium term policies, targets and strategies for inclusion in the Government's National Development Plan (1991-1995).

14. The central goals of the plan will be:

14.1 Provision of comprehensive health care services at all levels with particular attention being paid to vulnerable groups such as women, children, and the aged.

14.2 Institutionalization of a dynamic health management system.

14.3 Strengthening linkages with the community, private sector, and non-governmental, regional and international agencies.

14.4 Protection and preservation of the environment working in close collaboration with all other relevant sectors.

14.5 Promotion of healthy lifestyles particularly as they relate to chronic non-communicable diseases and HIV infection and AIDS.

Strategies

15. A total of eighteen (18) key result areas have been defined for emphasis over the period of execution of the plan. These cover the entire spectrum of primary, secondary and tertiary care, while recognizing the limitations of the system in providing certain specialist care in some essential areas such as oncology and radiotherapy, nephrology and renal dialysis and neurosurgery. It is envisaged that some of these needs will be met through the establishment of regional referral centers - a development which is in the offing.

16. The strengthening of local health systems is promoted as a fundamental strategy for the achievement of sector goals since conceptually it encourages decentralization of resources, intersectoral planning, team work and sound participation. These efforts will be pursued under a Project Grant already approved by PAHO/WHO.

17. The health manpower needs will be addressed against the backdrop of the overall organizational goals and, indeed, the dictates of the national agenda. Already, some appraisal of the health sector has been done through the centrally based CIDA-sponsored Administrative Reform Program, and this will be supplemented by a health manpower study to be facilitated by PAHO/WHO. The ultimate objective is an appropriate and responsive health management system.

18. Particular emphasis will be placed on information, education and counselling of groups and sub-groups within the society as a means of changing behavior for the prevention and control of communicable and noncommunicable diseases.

19. The broad policies of the Ministry of Health and the Environment have been defined in all major program areas. These policies are summarized as follows:

19.1 The development of local health systems to emphasize the interdisciplinary team approach and community participation in all aspects of program planning, execution and evaluation.

19.2 Continue infrastructural development of Kingstown General Hospital on a phased basis, as well as improve facilities at the peripheral level.

19.3 Provide comprehensive health care to women and children to include antenatal and post-natal care, family planning services, cervical cancer screening and treatment, nutritional care, and growth monitoring.

19.4 Improve environmental sanitation by progressively extending refuse collection services to rural areas, providing low cost pit latrine units to householders, and strengthening law enforcement capabilities.

19.5 Provide health information and education at all levels of the society as a critical means of influencing lifestyles and creating behavior modification with particular reference to hypertension and diabetes, sexually transmitted diseases, nutrition, family planning/family education, and drug abuse.

19.6 Improve the quality and range of mental health services offered, and to promote community mental health as a viable approach to the prevention of mental illness and the treatment and rehabilitation of the mentally ill.

19.7 Provide services appropriate to the needs of an expanding aged population by upgrading existing facilities, promoting community based programs and establishing linkages with other social service programs and non-governmental organizations which cater to the needs of the aged.

19.8 Provide comprehensive dental health care services to children of school age; develop and promote eye health care services as a means of blindness prevention and improve cancer screening and treatment facilities.

19.9 Organize a long-term manpower development plan beginning with a manpower study to determine appropriate structure, number, mix and deployment. This will be undertaken collaboratively with the Administrative Reform Program and PAHO/WHO.

GLOBAL STRATEGY OF COOPERATION

20. The Government has identified six major priority areas in which PAHO's technical cooperation is required. These are: development of local health systems; environmental sanitation; human resource development; health promotion; maternal and child health, and chronic diseases.

21. The Technical Cooperation in the areas identified will be pursued in keeping with the spirit of the Caribbean Cooperation in Health Initiative. Projects will be developed to facilitate resource mobilization and TCC within those six areas.

22. PAHO/WHO strategies for providing technical cooperation in these priority areas will be based on improving the management capability at both the periphery and the centers, the updating and review of the public health legislation, training, resource mobilization, and the development of strategic plans.

23. In addition, improved monitoring and evaluation will be placed on commitments already received. Efforts will also be directed to the identification of other resources both nationally and internationally.

24. In the area of development of local health systems, technical cooperation provided by PAHO will be in the development of the management information system; training of health personnel at the district level and the hospital; support for the involvement of the community in planning, monitoring, and resource mobilization, and strengthening of senior management personnel in evaluation and monitoring of health programs.

25. In the areas of Environmental Health, the technical cooperation will be in the development of an environmental health information system; review and updating of environmental legislation; strengthening of the intersectoral linkages, in the areas of program development and the monitoring of environmental hazards; promotion of social participation in environmental issues, and resource mobilization to address some of the needs.

26. In the area of human resource development, the technical cooperation of the organization will be in the development of the capability to perform situation analysis; development of manpower plans; and the monitoring and evaluation of the utilization of the human resource produced. PAHO/WHO technical cooperation will also pay attention to the continuing education of health personnel for the development of skills based on the epidemiological profiles at the local level. Attention will also be given to the promotion of operations research in human resource development. Technical Cooperation will support the development of leadership capabilities at the district level to support the human resource requirements for the development of the local health system. Some of the manpower needs will be met by the provision of Fellowships.

27. In the area of health promotion, the focus of the technical cooperation will be on non-communicable diseases, particularly, hypertension, diabetes and cancer of the cervix. Emphasis will be placed on:

27.1 Developing the capabilities of health personnel and NGO's to effectively assess and apply a range of health promotion and social communication concepts and methodologies to modify individual and collective lifestyles;

27.2 Advocating and deploying these strategies and methodologies in ways which will permit the innovative application and evaluation of health promotion measures; and on

27.3 Supporting the enactment of appropriate and affordable social policies and legislation to facilitate and reinforce the adoption of patterns of behavior and styles of development which would promote health.

28. In the area of maternal and child health, the focus will be on the reduction of maternal morbidity by improving the data collection and analysis of maternal deaths and illnesses; and improving the skills of hospital personnel and those at the local level. Infant mortality will be addressed by special attention to perinatal care. Technical cooperation will support the establishment of a system for the early recognition and management of high risk pregnancies. In relation to diarrhoeal diseases, technical cooperation will support projects for greater intersectoral linkages at the local level. In addition, PAHO will cooperate to increase the coverage for related services, in particular, those required to eliminate measles and poliomyelitis.

29. In the area of chronic diseases, PAHO will work with the Ministry of Health in the development of a national register for tumors; and study the dimensions and trends in chronic diseases. The establishment of intra- and intersectoral mechanisms to plan and coordinate programs and strategies for the control of chronic diseases will also be promoted.

30. PAHO will collaborate in the development of the following specific programs:

DHS: Health Services Development
CWS: Community Water Supply and Sanitation
MCH: Growth, Development and Human Reproduction

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		117,200	76.3	133,800	76.8	147,100	76.7
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		117,200	76.3	133,800	76.8	147,100	76.7
HEALTH SERVICES DEVELOPMENT	DHS	117,200	76.3	133,800	76.8	147,100	76.7
III. HEALTH SCIENCE AND TECHNOLOGY		36,400	23.7	40,200	23.2	44,600	23.3
ENVIRONMENTAL HEALTH		23,100	15.0	24,800	14.3	26,600	13.9
COMMUNITY WATER SUPPLY AND SANITATION	CWS	23,100	15.0	24,800	14.3	26,600	13.9
MATERNAL AND CHILD HEALTH		13,300	8.7	15,400	8.9	18,000	9.4
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	13,300	8.7	15,400	8.9	18,000	9.4
GRAND TOTAL		153,600	100.0	174,000	100.0	191,700	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
III. HEALTH SCIENCE AND TECHNOLOGY		282,869	100.0	223,235	100.0	0	100.0
MATERNAL AND CHILD HEALTH		59,634	21.1	0	-	0	100.0
ADOLESCENT HEALTH	ADH	59,634	21.1	0	-	0	100.0
COMMUNICABLE DISEASES		223,235	78.9	223,235	100.0	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	223,235	78.9	223,235	100.0	0	-
GRAND TOTAL		282,869	100.0	223,235	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	130,500	0	0	45	17,100	0	30	57,000	19,500	14,200	0	22,700
WHO - WR	23,100	0	0	30	7,600	0	6	11,400	3,500	600	0	0
TOTAL	153,600	0	0	75	24,700	0	36	68,400	23,000	14,800	0	22,700
% OF TOTAL	100.0				16.1	.0		44.5	15.0	9.6	.0	14.8
1992-1993												
PAHO - PR	149,200	0	0	60	18,000	9,300	30	60,000	20,000	13,300	0	28,600
WHO - WR	24,800	0	0	30	8,000	0	6	12,000	4,100	700	0	0
TOTAL	174,000	0	0	90	26,000	9,300	36	72,000	24,100	14,000	0	28,600
% OF TOTAL	100.0				14.9	5.3		41.5	13.9	8.0	.0	16.4
1994-1995												
PAHO - PR	165,100	0	0	60	19,300	10,800	30	63,000	23,200	15,500	0	33,300
WHO - WR	26,600	0	0	30	8,500	0	6	12,600	4,700	800	0	0
TOTAL	191,700	0	0	90	27,800	10,800	36	75,600	27,900	16,300	0	33,300
% OF TOTAL	100.0				14.5	5.6		39.4	14.6	8.5	.0	17.4

ANALYSIS OF THE HEALTH SITUATION

Demography

1. Estimated mid year population for Suriname of 1988 was set at 405,000. However, given the economic crisis and the political unrest in the country, best guesses place this population now at 375,000. The single largest ethnic group is Hindustani, followed in order of size by Creole, Indonesian, Bushnegro, Chinese, Amerindian and European. Five major languages are spoken with Dutch being the official language. Approximately 50% of the population is under 20 years of age, with the sex distribution almost equal. Large-scale migration has left a disproportionate number of females in certain age groups. Almost 4.7% of the population is over 65. Close to 70% of the population live in urban areas, the overwhelming percent of these within the capital area of Paramaribo.

Indicators of health status

2. Suriname had enjoyed the reputation of being the most developed of the developing nations. In 1980 the literacy rate was 90% for men and 84.1% for women. In 1990, it is believed, the rate had dropped to 80.2 nationwide for both sexes (probably due to destruction of much physical infrastructure and emigration).

3. Crude birth rates have been dropping from high of 31 per 1000 in 1977 to a low of 22.5 in 1988. Crude mortality rates have remained constant during the same period at 7 per 1000. Infant mortality has also seen a steady decline in the same period and is now estimated at 24.6 per 1000 live births. Life expectancy at birth remains relatively low with the latest figures indicating an average of 66.8 years. Maternal death rates have remained at about 8 per 1000 live births over the last several years.

4. The 10 leading causes of death in Suriname have not changed significantly in the last 10 years. These are in order: ischemic heart diseases and hypertension; conditions arising in the perinatal period; malignant neoplasms; cerebrovascular accidents; influenza; suicide; diarrhoea; diabetes mellitus; and finally asthma and bronchitis.

5. The infant mortality rate is very high. The single greatest contributing factor is neonatal deaths caused by conditions originating in the perinatal period.

6. Among children 1-4 the leading causes of death still remain diarrhoeal disease, gastroenteritis and influenza. For example, the infant death rate for diarrhoeal diseases between 1980-1987 was 28.8 per 10,000 live births and the influenza death rate was 12.1 per 10,000 live births during the same period. Malnutrition seems to be on the increase, with growing numbers of children being hospitalized on an annual basis. In 1990 there were 123 cases recorded, of which 13 died.

7. Two of the leading causes of death among younger adults are suicide (by ingestion of agricultural poison) and accidents.

8. Cholera, plague and yellow fever have not been reported in the last 20 years. Dengue is always a constant threat with the first major epidemic recorded in 1986 (type 2). Leptospirosis has been increasing dramatically. In 1990 there was a 100% increase in reported cases over 1989 (with over 100 cases recorded in 1990 and a case fatality rate of 17%).

9. Typhoid fever epidemics are still common in the interior and epidemiological surveillance has increased in the urban areas. With regard to the EPI program, services have been severely disrupted in the interior due to political upheaval. There was a serious rubella epidemic in 1990, but only some isolated cases of the other EPI diseases (not including polio).

10. Sexually transmitted diseases, including HIV transmission, continue to pose major challenges. Malaria, another victim of the internal upheaval, was responsible for a large, though unquantifiable, number of deaths and sickness in 1990.

Factors affecting health status

11. On a yearly basis the socio-economic situation deteriorated markedly. While the economy contracted, inflation increased and hardship was felt all around. There was a real decrease in resources available to the health sector.

12. The deterioration of the foreign currency reserves situation has meant also that essential drugs, medical supplies, basic equipment and spare parts have become extremely scarce and preventive maintenance to biomedical technology, equipment and machinery has become virtually impossible.

13. The economic crisis, coupled with the political turmoil of the last several years have caused the emigration of health personnel, resulting in a general shortage of health personnel, particularly nurses, in many public health institutions. The evacuation of health personnel from the interior during the internal strife has resulted in a break in the delivery system. At the same time, during the internal hostilities a large part of the territory was cut off the coastal region thereby further limiting accessibility to health services in the interior.

14. The overall human environment suffered visible deterioration. The large numbers of persons who fled the interior to the urban areas brought new health problems. In addition, many of the regular activities involving vector control, malaria eradication, water and sanitation, were either greatly curtailed and in certain areas were halted altogether.

15. Due to the above-mentioned problems coupled with chronic shortages of transportation, the expected strengthening of many administrative subsystems, particularly the health information systems, did not materialize. It has been extremely difficult to plan and program activities and to monitor existing programs except on an ad-hoc basis.

National health strategies, policies and plans

16. The health sector of Suriname is in one sense unique. As much as 75% of the entire sector is in private hands. In the public sector, the ministry delivers its services through two major hospitals (in Paramaribo) and the Regional Health Service (RGD) responsible for primary health care in the coastal region where almost 90% of the population lives. Services are paid in the public sector by the State Health Insurance Foundation and the Ministry of Social Affairs (which covers the poor and near poor).

17. Given the continued problems of a disrupted and still declining economy, an enormous and debilitating brain drain, and chronic shortages of all kinds of basic materials, the Ministry of Health has highlighted the following priorities in its "Government Policy Declaration 1988-1993":

17.1 Complete coverage of all, irrespective of race, religion, political view or ability to pay. This will be achieved through the full decentralization of the Regional Health Service (which was formally completed on 25 November 1990), and with the full participation of the local communities through their district health committees and congresses, and the expansion of coverage by the State Health Insurance Foundation (SZF). This will be further encouraged by a small shift in reimbursement schedules by the SZF toward prevention services.

17.2 Emphasis on the preventive and educational aspects of all programs, particularly the MCH and EPI programs, food safety and nutrition, STDs/AIDS; the entire environmental health program.

17.3 Intensified control of the environment with emphasis on solid waste, water quality, housing; sanitation; vector control and food safety.

17.4 Nutrition, with special emphasis on vulnerable groups.

17.5 Full coverage for the EPI program in the entire coastal region and full cooperation with the Medical Missions in their effort to cover the interior.

17.6 Control of all sexually transmitted diseases in general through public health education, and preventive and control measures, with special emphasis on preventing the further spread of HIV infection.

17.7 Development of an emergency manpower plan in the light of the critical manpower shortage.

17.8 Restoration of the physical health infrastructure which has been destroyed by conflict in the interior of Suriname.

17.9 Capital investment in the physical health infrastructure in the urban areas to prevent further deterioration of services.

17.10 Mobilization of external resources to assist in the implementation of this 5-year health development plan.

17.11 Renewed emphasis on collaborating with neighboring countries, through TCDC.

18. The government will implement these priorities through the strengthening of local health systems, utilizing the already existing systems of intersectoral cooperation, NGO involvement and community participation.

National priority areas for technical cooperation

19. Based on the current 5 year health development plan, the Government of Suriname has sought technical cooperation from the Dutch government. Complementary areas of assistance from the Pan American Health Organization are the following priority areas:

19.1 An in-depth analysis of the Regional Health Sector with the purpose of establishing a comprehensive training program in management, epidemiology, planning and programming, health education, financial management and project development and management, as well as to strengthen the health information system.

19.2 Establishment of a more vital health education program both within the clinics and at the community level. This will involve establishing a national multisectoral Advisory Council, or Council on Health Education and district committees within each of the 10 regions.

19.3 Since nutritional status is being seriously affected by the deteriorating socio-economic conditions, cooperation will be required for continued nutritional surveillance and to mobilize resources to provide a basis level of nutrition to the populace.

19.4 Support will be required in the entire area of maternal and child health, with special emphasis on the deteriorating condition of the perinatology program, and the CDD/ARI.

19.5 Assistance will be needed in developing an integrated program of activities within the Bureau of Public Health and the Regional Health Service to implement the policy to increase the role of women in health.

19.6 Assistance is needed in the prevention and control of diabetes, hypertension, alcohol and drug abuse, focusing attention on vulnerable groups and emphasizing the importance of health lifestyles; and for the integration of mental health into the primary health care system to reduce the burden on the curative sector.

19.7 Technical cooperation in the area of environmental health is required to maintain a safe water supply system; monitor sanitation conditions; develop and strengthen the visibly deteriorating solid waste management situation; develop the food safety program; strengthen the vector control program; develop new legislative and regulatory measures; and establish norms and standards for various aspects of the overall program.

19.8 Continued support is needed to control infectious diseases with particular emphasis on STDs, HIV, malaria, dengue, leprosy, leptospirosis and zoonotic diseases.

19.9 Assistance is required for a comprehensive analysis of the health manpower situation, exploring the use of alternative types and levels of personnel for the continued support of the policy of decentralization. Assistance will also be needed to develop new curricula and training programs and in the mobilization of both local and external resources.

19.10 Technical assistance will also be required to strengthen the epidemiological surveillance systems within each region, focusing on the development on research, biostatistical and analytical skills in the epidemiology of accidents, violence, infectious diseases and services.

GLOBAL STRATEGY OF COOPERATION

20. The overall PAHO strategy will be to strengthen the public health sector of Suriname, focusing the identified priority areas: decentralization of the health services, strengthening of epidemiological analysis, maternal and child health, chronic diseases, mental health, infectious diseases, human resources development and health promotion.

21. An essential element of the global strategy will be to promote and build upon the already accepted national reality that the most effective way to deliver scarce resources is through the local community with its full participation. PAHO will work closely with the District Commissioners and act as a catalyst or facilitator in consolidating the process of intersectoral cooperation and coordination which is already in motion.

22. One way this will be done is by supporting the national strategy of establishing health congresses and use this forum to promote health concerns of vulnerable groups and women. Because of the critical need to involve two agencies, the Regional Health Service (RDG) and the Bureau of Public Health (BOG) in this role, PAHO will seek to promote better structural relationships between them by assisting in the development of norms and policies, and by providing training to health personnel to meet the increased demands of this process.

23. Another important component of the PAHO global strategy is to build on the traditional involvement of NGOs to support the efforts of the health sector. PAHO will also seek to promote TCC in those districts bordering neighboring countries in order to deal with problems resulting from easy contact between the districts and the neighboring territories.

24. The manpower shortage will be dealt with at two levels--a short-term and a medium-term basis. Analyses of needs will be conducted, including the possibility of converting some of the high number of drop-outs from medical school into alternative levels and kinds of health personnel. Special attention will be paid to the need for medical social workers, district epidemiologists, and counsellors for alcohol and drug abusers, smokers, AIDS/STD victims, mental patients, the elderly, etc. This will necessitate working closely with existing training institutions, developing plans based on feasibility studies, and developing new curricula. PAHO will also participate in actual training.

25. In assisting the government's efforts to integrate mental health services into the local health systems, special emphasis will be placed on the victims of domestic and political violence.

26. PAHO is the only UN agency in Suriname and will therefore continue to play a leading role in the evolution of the health system in Suriname.

Decentralization

27. PAHO will support the national strategy of forging the decentralization process through the conducting of regional health congress. Assistance will be

given in the analysis of the health situation, the various administrative sub-systems, the health information system, the epidemiological and health educational capacity, the managerial and administrative needs and skills, all of which will be required in preparation for the regional health congresses. PAHO will also assist in the redesign of training programs, the development of curricula and the implementation of programs to support the decentralization process. A major effort will be placed on working closely with BOG and RGD in making their sometimes varying organizations more consonant with each other. In addition, PAHO will provide some basis supplies.

Strengthening of epidemiological analysis

28. The goal is to strengthen the capacity for epidemiological analysis at the central level and to establish a corresponding capacity at the district level.

29. PAHO will assist with the development of region health profiles and the establishment of district sentinel stations to enhance the national surveillance systems. In this regard, the experience from the established systems in the EPI program will be utilized. To further strengthen the national surveillance systems, PAHO will assist in improving cooperation among the existing laboratories at the BOG and the veterinary public health laboratories; in the development of better and more standardized procedures for sending specimens to regional and reference laboratories; and in the upgrading of laboratories to do certain smears.

30. PAHO will play a substantial role in cooperating with the government in its attempt to standardize protocols for investigations and monitoring epidemics, especially for highly infectious diseases and those of national concern. In order to improve the mortality surveillance system, efforts will be directed at bringing together the various agencies involved in a more cooperative relationship.

31. Further, since resources of all kinds are scarce, an essential PAHO strategy will be to assist in establishing a multi-sectoral research council with a wide array of responsibilities. Training will be provided for the various roles to be undertaken.

32. PAHO will promote the effective management of knowledge by supporting the expansion of the monthly epidemiological bulletin with articles and studies conducted at the district level.

Maternal and child health

33. The goal of this priority area is to develop an integrated program of Maternal and Child Health Care, which comprises the six component parts, at both national and district levels.

34. To address the perinatology needs, PAHO will assist in improving the capacity for prenatal screening of pregnant women, the development of norms, protocols and standards for prenatal care, and the implementation of a effective monitoring system for high-risk pregnancy.

35. The concept of the clinics will be broadened to include more developmental monitoring, as well as continuing with the growth curve monitoring charts. This expanded activity will be done in collaboration with the RGD, Medical Society, and the MOB (Medical Development Bureau) and will include early detection of developmental problems in order to institute earlier interventions.

36. The school health program will be supported, particularly with respect to its health education component.

37. The CDD/ARR and Nutrition components of the program will be further strengthened with emphasis on breastfeeding, education, training, surveillance development of food production. Two common threads will link all efforts at strengthening the MCH program. One of these is the sustained and substantial effort to mobilize resources and the second is a renewed effort to bring more women and responsible adults into the women in health development process through a grassroots campaign to mobilize the community to share and participate.

Chronic diseases

38. The main goal in the area of chronic diseases is to improve management practices in the district of a limited number of diseases to decrease the burden on hospitals and specialists.

39. Assistance will be given in a community based health education effort to raise awareness regarding health lifestyles, diet exercise, regressive behavior, stress management, and the physician/patient relationship which must take place in clinics. A partnership approach will be fostered in the development of treatment regimens.

40. Studies will be conducted on dietary practices among various ethnic groups and on alternative methods for delivering the related services needed.

Mental health

41. The overall goal is to integrate some basic mental health services into PHC at the district level.

42. PAHO will continue to offer technical cooperation in conducting the required situation analyses, developing curricula for training. Since Suriname has no school of public health and the medical school is declining, a careful study of the capacity of the medical school as a training center will be conducted, with a view to developing the required training programs to optimize its available resources. Since manpower production is costly, PAHO will assist in the development of a project proposal to mobilize necessary resources for both short and long-term training needs.

Infectious diseases

43. The main goal of this project is to prevent and/or reduce transmission of infectious diseases.

44. This is one area in which there are clearly-defined ongoing programs, in AIDS, STDs, malaria, vector control, leprosy, etc., the strategy which will be followed will be aimed to maintaining the high level of surveillance which exists, and develop more structural mechanisms for cooperation between the various government and non-government agencies. Major efforts will be required to strengthen public health education in the various areas and in upgrading some physical facilities. PAHO will assist in preparation of project proposals aimed at mobilizing the required resources.

Human resources development

45. The main goal of this program is to strengthen the manpower planning capacity of the Ministry of Health in terms of (i) planning (ii) production and (iii) utilization of health resources. A more immediate goal, given the peculiar set of national circumstances and massive migration of trained health personnel will be to develop an interim plan which outlines immediate and priority training needs.

46. PAHO will continue to offer technical cooperation in conducting the required situation analyses, developing curricula for training programs and providing some training. Since Suriname has no school of public health and the medical school is declining, a careful study of the capacity of the medical school as training center will be conducted, with a view to developing the required training programs to optimize its available resources. Since manpower production is costly, PAHO will assist in the development of a project proposal to mobilize necessary resources for both short and long-term training needs.

Health promotion

47. The main goal is to provide information in a way that people can understand and assimilate and be motivated to change or modify regressive health behavior, either at the individual or community level.

48. PAHO will promote the establishment of a National Intersectoral Council on Health Education. A major objective of the Council is to seek funding for an already developed project proposal regarding a health media development center/capacity. PAHO will support the translation of health educational materials into the various languages and tribal dialects. PAHO will also seek to make much closer links between the National AIDS Program and the Dermatological Service of Suriname. Joint health promotion activities among training centers will be promoted, as well as the development of a collaborative effort between media personnel and health workers, whereby the media will receive training about health issues and health workers will be trained in the art of communication.

49. PAHO will collaborate in the development of the following specific programs:

MPN:	Managerial Support for National Health Development
TCC:	Technical Cooperation among Countries
HST:	Health Situation and Trend Assessment
DHS:	Health Services Development
HME:	Human Resources Education
CWS:	Community Water Supply and Sanitation
MCH:	Growth, Development and Human Reproduction
OCD:	General Communicable Disease Prevention and Control Activities

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		695,300	63.9	760,500	62.8	855,400	62.8
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		453,300	41.6	526,200	43.5	593,700	43.6
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	453,300	41.6	526,200	43.5	593,700	43.6
TECHNICAL COOPERATION AMONG COUNTRIES		0	-	23,200	1.9	26,900	2.0
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	0	-	23,200	1.9	26,900	2.0
HEALTH SITUATION AND TREND ASSESSMENT		59,400	5.5	42,400	3.5	48,000	3.5
HEALTH SITUATION AND TREND ASSESSMENT	HST	59,400	5.5	42,400	3.5	48,000	3.5
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		111,300	10.2	92,500	7.6	105,400	7.7
HEALTH SERVICES DEVELOPMENT	DHS	111,300	10.2	92,500	7.6	105,400	7.7
HUMAN RESOURCES DEVELOPMENT		71,300	6.6	76,200	6.3	81,400	6.0
HUMAN RESOURCES EDUCATION	HME	71,300	6.6	76,200	6.3	81,400	6.0
III. HEALTH SCIENCE AND TECHNOLOGY		391,900	36.1	450,000	37.2	506,200	37.2
ENVIRONMENTAL HEALTH		236,500	21.8	292,600	24.2	328,400	24.1
COMMUNITY WATER SUPPLY AND SANITATION	CWS	236,500	21.8	292,600	24.2	328,400	24.1
MATERNAL AND CHILD HEALTH		57,000	5.2	50,100	4.1	57,100	4.2
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	57,000	5.2	50,100	4.1	57,100	4.2
COMMUNICABLE DISEASES		98,400	9.1	107,300	8.9	120,700	8.9
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	98,400	9.1	107,300	8.9	120,700	8.9
GRAND TOTAL		1,087,200	100.0	1,210,500	100.0	1,361,600	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		18,800	3.1	0	-	0	100.0
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		18,800	3.1	0	-	0	100.0
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	18,800	3.1	0	-	0	100.0
III. HEALTH SCIENCE AND TECHNOLOGY		588,278	96.9	532,437	100.0	0	-
COMMUNICABLE DISEASES		588,278	96.9	532,437	100.0	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	588,278	96.9	532,437	100.0	0	-
GRAND TOTAL		607,078	100.0	532,437	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	692,900	24	24	255	396,500	13,400	65	123,500	18,300	33,200	0	108,000
WHO - WR	394,300	24	0	195	230,200	13,900	45	85,500	18,100	46,600	0	0
TOTAL	1,087,200	48	24	450	626,700	27,300	110	209,000	36,400	79,800	0	108,000
% OF TOTAL	100.0				57.8	2.5		19.2	3.3	7.3	.0	9.9
1992-1993												
PAHO - PR	788,200	24	24	110	428,500	22,800	32	64,000	71,100	32,000	0	169,800
WHO - WR	422,300	24	0	120	261,600	16,200	14	28,000	36,100	63,700	0	16,700
TOTAL	1,210,500	48	24	230	690,100	39,000	46	92,000	107,200	95,700	0	186,500
% OF TOTAL	100.0				57.0	3.2		7.6	8.9	7.9	.0	15.4
1994-1995												
PAHO - PR	887,700	24	24	110	477,400	26,400	32	67,200	82,500	37,200	0	197,000
WHO - WR	473,900	24	0	120	290,600	18,800	14	29,400	41,900	73,800	0	19,400
TOTAL	1,361,600	48	24	230	768,000	45,200	46	96,600	124,400	111,000	0	216,400
% OF TOTAL	100.0				56.4	3.3		7.1	9.1	8.2	.0	15.9

ANALYSIS OF THE HEALTH SITUATION

Demography

1. The most recent Census reported a total population of 1,234,388, a 14.32% increase over the 1980 figure. The average annual growth rate of population was 1.57 for the period 1980-87; this was well below the projected 2.07 and believed to be reflective of high out-migration as people sought relief from the economic downturn brought about by the collapse of the oil prices. According to the Central Statistical Office (CSO) figures, in the period 1960 to 1989, the population pyramid has shifted from an expansive base of 42% of the population <15 years of age to a more constrictive base with 32.5% of the population <15 years of age. Also during that period, the sex composition of the population shifted from an over all ratio of 99 to 110 males/100 females. For the decade, the population >65 years of age remained fairly static with 5.6% in 1980 to 5.7% in 1990; for the population below 15 years of age there was a slight decline from 34.2% to 32.5% for the decade. If the trend in overall growth rate of the population continues, the population should reach 1,288,104, during the biennium.

Indicators of health status

2. The life expectancy at birth has increased from 66.5 years in 1970-75 to 70.2 years in 1985-90; the latter comprising 66.9 years for males and 71.6 years for females.

3. Among infants, recent research-based reports conflict with the CSO reports of decreased infant mortality (as stated above), and have shown figures of around 26-27 deaths per 1,000 live births. Perinatal mortality accounted for more than half of the total; this latter situation being attributed to low birth-weight. Congenital anomalies, influenza, pneumonia, accidents, and diarrheal diseases making up the rest.

4. Among children 1 to 4 years, accidents have over the past decade replaced diarrheal diseases as the leading cause of death. The turnaround here has been attributed to success of the oral rehydration program. For ages 5-14, accidents continue to hold first rank of order over the period 1973 to 1987 with neoplasms, influenza/pneumonia and diarrheal diseases following (in that order.)

5. The official maternal mortality rate is 30 females per 100,000 live births. Although high, it should be noted however that only immediate obstetric conditions are captured by present reporting practices, and this figure may in fact be even higher.

6. Heart disease, cerebrovascular disease, and diabetes are known to co-exist, and together accounted for 36.9% of all deaths in 1987 compared to 44.7% in 1977. They contribute significantly to premature loss of life; 51% of deaths are due to these conditions in the age group 15-44; and 54% in the age group 45-65.

7. Malignant neoplasms have become the 2nd leading cause of death with an overall mortality rate of 86.4 per 120,000 population (74.8 in 1980); 48% of female cancer deaths and 33% of male cancer deaths occur before age 65.

8. While accidents were the 5th ranking cause of death in the nation in 1987 and accounted for 8.6% of all deaths, they rank 1st for those in the ages 1-44 years and accounted for 38.3% of all deaths in that age group. The age group 1-44 years comprised 951,841 persons or 78.5% of the total population in 1987. It should be noted that the accidental death category includes motor vehicular accidental encounters, and acts by and towards the victim; suicide, homicide and other violent deaths. From 1959-61 to the present time, the risk of accidental death for males is 3 1/2 times the risk for females.

9. Data concerning cases of AIDS using a uniform case definition, have been produced since 1983. Data for those who have tested positive for HIV were not reviewed, although the NSU estimated 132 per 100,000 population or 1,600 HIV+ persons in 1989. By December 1989, the total number of AIDS cases was 559 with the incidence rising from 17 per 100,000 population in 1983 to 12.9% per 100,000 in 1989. During the same period, the male to female rates changed from 8.0 to 2.7:1. The major mode of spread in Trinidad and Tobago is through sexual activity, homosexual, bisexual and heterosexual accounting for 437 or 77.6% of all cases. Seventy-five percent of all cases are in the 20-49 age groups.

Factors affecting health status

10. Health, which for the previous two decades had received 10-11% share of governments budget was cut to 8.7% in 1988 and 8.2% in 1989, receiving TT$481.9 and TT$450.5 million for the respective years. In 1989, however, oil prices were on the average more favorable (than in 1988) and this was reflected in the relaxing of tight fiscal measures in the 1990 budget; health was budgeted then at TT$542.3 million, or an increase of 23.6% over 1989. The sector's share in the 1991 budget climbed to TT$572.0 million--but much of this will be used to restore health workers salaries which had been cut by 10% in the 1989 Budget.

11. The tight economic situation over the decade of the eighties served to worsen problems that appear to be endemic in the delivery system. More people turned to the public health system for basic services at a time when it could ill-afford the increased numbers. Waiting times for clinic service, lab and X-ray procedures, even elective surgery grew longer. Drug shortages were common

and certain services, for example physical therapy had to be curtailed. Training programs for nurses had to be discontinued at a time when nurses represented the largest category of health manpower leaving the system. Plant and equipment failures increased as money to purchase spare parts was not available and routine maintenance was reduced.

12. Past and current governments have realized that the problems, although worsened by the economic downturn, were symptomatic of more basic problems in the sector. These included an over centralized management structure, uneven distribution of health care resources in the country (with the threat of that situation worsening with the commissioning of the Eric Williams medical Sciences Complex), insufficient financial resources to meet the requirements of a quality health service, and poor development of human resources for health. With the help of the IDB and PAHO, plans are being made for major financial and structural reform in the sector. The policies to be followed are detailed in the Government's Macro Plan.

13. Environmental health problems in Trinidad and Tobago include increased water and air pollution practices, occupational hazards, the high rate of motor vehicle accidents, and sub-standard housing.

14. In terms of vector control, efforts to eradicate the Aedes Aegypti mosquito have not been successful; the risk of Yellow Fever therefore persists. Although there have been no cases of the disease since 1979, in December 1988--January 1989 isolates of yellow fever virus were recovered from dead monkeys. Dengue Fever (of which the Aedes Aegypti is also the vector) is endemic in the population with serotypes 1, 2 and 4 being isolated. There were more than 1000 cases of dengue reported in the outbreak of 1989-1990.

15. Scabies continues to be a problem with 9,154 cases reported in 1989, the eight consecutive year of rise in the incidence of this disease. Shortages in water supply, low income, and crowding, coupled with recently reported shortages in topical scabicides in health centers, have exacerbated the situation. Gastroenteritis, although on the decrease overall, is of higher incidence in areas with water-supply problems.

16. The overall prevalence of obesity is 25%; in the age group 14-64, 60% was estimated to be in females and 19% in males. There is an association of obesity with diabetes, hypertension, and cardiovascular disease. Hospital admissions and community health services data indicate that alcoholism is a significant problem. Alcohol abuse is associated with accidents, liver disease, and hypertension. Drug abuses, specifically cocaine and marijuana, are reported on the increase; 27% of persons convicted of serious crimes in 1988 were drug abusers.

17. From the above, it is clear that throughout the biennium, the main causes of morbidity and mortality will continue to be chronic diseases related to lifestyle and environmental conditions, while prevalent and emerging infectious diseases, most notably AIDS, will remain a public health concerns. Nutrition-related disorders, accidents, substance abuse, and STDs will continue to be the principal components of lifestyle issues requiring priority attention. It is also clear that an equitable and efficient approach to combating/ameliorating these problems can only be achieved through major restructuring in the sector. National strategies policies and plans to achieve this goal follow.

National strategies, policies and plans

18. The most critical constraints affecting the health sector can be attributed to an over centralized management structure which puts pressure on an overburdened Ministry of Health; the inadequacy of financial resources of the public health sector; and the uneven distribution and quality of health resources throughout the country.

19. The Medium-term Macro Planning Framework 1989-1995 identified the priority objectives for health as affordability; equity and efficiency in health services; promotion of healthy lifestyles; personal and community responsibility; accessibility of basic health care; promotion of preventive health; and reduction of environmental health problems, in particular those related to industrial hazards.

20. Some of the national strategies proposed to achieve these objectives are:

20.1 Restructuring of the health services with emphasis on primary health care, paying particular attention to its manpower development and development of norms and policies.

20.2 Promotion of health through education and early detection, focussed primarily on chronic diseases, oral and mental health, health of youths and nutrition.

20.3 Promotion of a multi-disciplinary approach to the control of certain health problems.

20.4 Promotion of research and evaluation of environmental health problems.

20.5 Modernization and development of secondary and tertiary health care facilities.

20.6 Seeking alternative methods of financing the health sector.

21. The Ministry of Health has identified several areas around which national priority health programs will be developed, namely: Strengthening the Management of the Health Services; Maternal and Child Health; Chronic Diseases; Epidemiological Surveillance and Control; Oral and Mental Health; Environmental Health; Veterinary Public Health; Food and Drug Control; Hansen's, Sexually Transmitted Diseases and Tuberculosis.

National priority areas for technical cooperation

22. The Government has identified several areas of technical cooperation to address some of its health problems, and has applied to the IDB for technical cooperation in a health sector reform program which will focus on:

22.1 Policy Reform (including decentralization) of the public sector health institutions.

22.2 Health care financing through the establishment of a National Health Insurance System (NHIS).

22.3 The functional integration of the EWMSC with the existing Port of Spain General Hospital.

23. This program will encompass several technical areas and will provide both local and overseas training.

24. The initial activities of the project are scheduled to take approximately 3 years and is expected to result in a health sector reform loan which will be used to finance: the restructuring of the central ministry; the decentralization and strengthening of regional health and management support systems; the rationalization of the distribution and mix of manpower; and the implementation of NHIS.

25. However, this sector reform program could take as long as 10 years. Technical cooperation is also needed in the following priority areas:

25.1 Support for the strengthening of the maternal and child program, aimed at identifying causes of perinatal mortality and maternal mortality and morbidity, and contributing to the design of interventions to reduce these causes.

25.2 Development of health promotion strategies aimed at modification in lifestyles that contribute to the leading causes of mortality and morbidity, particularly hypertension, diabetes, cancer of the cervix, sexually transmitted diseases, including AIDS, and accidents.

25.3 Strengthening of the epidemiological surveillance system aiming at improving data collection, analysis and design of interventions, to deal with the common health problems identified at county level.

25.4 Continued strengthening of the management of the local health systems at district and county levels.

25.5 Improvement in the environment, aiming at improving the distribution, storage and utilization of potable water, promoting methodologies for safe disposal of liquid and solid waste and the control of environmental hazards.

25.6 Strengthening the capacity of personnel at central level for policy formulation, planning and the assumption of a normative, rather than an executive role.

25.7 Strengthening the capacity of training institutions to produce appropriately trained health personnel.

GLOBAL STRATEGY OF COOPERATION

26. The Government has already initiated action in relation to technical cooperation through the IDB for its major health sector reform program, the commissioning of its teaching and tertiary care institutions, and the financing of health care.

27. PAHO/WHO will continue its support to the Ministry of Health in those areas where the Ministry is deficient in its technical expertise in relation to counterparting the IDB funded consultants, the development of the health system infrastructure, and national priority health programs. PAHO/WHO strategies for providing technical cooperation will be based largely on training, development of norms and policies, direct technical assistance, and information dissemination, ensuring that there is complementary, rather than duplication of efforts.

28. Technical cooperation among countries will continue to be promoted, particularly in the areas of development of research projects and implementation of joint action in relation to CCH.

29. In the area of restructuring of the health services, attention will be given to the strengthening of the managerial capacity at the periphery, and the institutionalization of the planning and programming process. Social participatory strategies will be encouraged, particularly in relation to the mobilization of the resources of the community and NGOs in support of priority health programs. PAHO will continue to support the development of programs that focus on women, health, and development.

30. To facilitate and support planning activities at the local level, emphasis will be placed on assisting the Ministry in reviewing, organizing, and institutionalizing the planning process at the central level, and programming and supporting nationals in their counterparting function in the IDB funded activities.

31. Good epidemiological data are essential to good planning, and PAHO/WHO will continue to provide support in the continuing development of a surveillance system within the context of a decentralized system of management.

32. In the area of human resource development, the main goals will be the strengthening of the capacity of the Ministry of Health in manpower planning, utilization and management, and the strengthening of the capacity of training institutions to produce appropriately trained personnel. The priority health programs on which PAHO/WHO will focus its attention are, Environmental Health, Maternal and Child Health, and Chronic Diseases.

33. In the environmental sector, technical cooperation efforts will focus on strengthening the capacity of WASA to provide services; improving the environmental standards in the rural areas; the development of mechanisms to coordinate intersectoral activities impinging on environmental health; and the sensitization of the community, industrialists and political directorate to the benefits of environmental protection.

34. The focus in maternal and child health will be to address those priority areas which contribute to the continuing unacceptably high morbidity and mortality among this group, and to support the alleviation of socially related problems among young children and adolescents.

35. In the area of chronic diseases, the main focus will be on health promotion and early detection. Particular attention will be paid to diabetes, hypertension, oral health, and accidental injuries.

Health services development

36. The goal is to complement the restructuring activities being undertaken through IDB technical cooperation, leading to the efficient and effective operation of the local health system. This will be done through the development of norms, policies and plans, information dissemination, training and resource mobilization. Norms, plans and policies will be developed particularly in relation to the institutionalization of the planning and management processes. Information dissemination will be used as a tool in the mobilization of resources, aimed at increasing community, intersectoral and NGO involvement in the solution of health problems, and in the promotion of health. Training will be focussed on those areas not included in the IDB project, but which are important to the strengthening of the technical and management skills at the periphery.

Health policy analysis and development

37. Training and direct technical assistance will be the main strategies used in strengthening the capacity of the Ministry of Health to counterpart and absorb the technological transfer consequence on the massive inflow of expertise during the sector reform program. Direct technical assistance will be given in reviewing and developing norms and procedures for the planning process at central level, while training will be aimed at improving the analytical skills of senior technical and administrative personnel.

Health situation assessment

38. The goal is to strengthen the capacity of health personnel at both peripheral and central levels to undertake epidemiological analyses in the determination of priority health problems, and the identification of possible solutions.

39. The main focus will be on training and the development of norms and policies. Training will be aimed at developing the skills of the staff leading to the formation of a Central Information Coordinating Unit, and preparing non-medical epidemiological surveillance staff, particularly for use at the periphery. Norms and procedures will be prepared for the continued development of the health information system, and the periodic analysis of the health situation at country and national levels.

Health manpower development

40. The main focus will be on strengthening the capacity of the Ministry of Health in the area of manpower planning, policy development and utilization, and giving support to institutions responsible for the preparation of health personnel. Training, development of policies, norms and plans, and resources mobilization will be the strategies for achieving this. Training will be aimed at improving the ability of staff at central and peripheral levels to match human resources with task requirements. Norms, policies, and plans will be developed for management of human resources, and resources will be mobilized to support training institutions in staff and curriculum development, and in the delivery of training programs.

Environmental health

41. Technical cooperation will be aimed at improving the water supply and sanitation sectors and controlling environmental hazards. The focus of the cooperation will be training, development of policies, norms and standards, information dissemination, and resource mobilization. Direct technical cooperation and information dissemination will be utilized to strengthen the management of the water and sanitation sector. Information dissemination will also be aimed at sensitizing industry and creating public awareness of environmental health issues, and alternative methods of sanitary disposal.

Training will be provided to improve human resource management and administration and update technical knowledge. Norms, policies and plans will be developed in relation to human resource management, and water control standards. Community resources will be mobilized to promote low cost appropriate technologies for rural sanitation.

42. All available resources will be utilized in strengthening insect vector control and surveillance within the context of the subregional Vector Borne Diseases Project.

43. In the area of the control of environmental hazards, the focus will be on the development and implementation of national environmental policy, environmental legislation, and standards and promotion of public awareness. Resources will be mobilized for the establishment of national environmental and chemical information systems, and for the development of a public education program. Direct technical cooperation, information dissemination and training will be used for institutional strengthening.

Maternal and child health

44. Information dissemination, training and resource mobilization will be the main strategies employed to improve the technical skills of health personnel, improve maternal and infant morbidity and mortality surveillance, and promote behavioral change among parents and adolescents.

45. Training will be utilized to upgrade key personnel on utilization of surveillance methodologies, and development of intervention programs. Information dissemination will be aimed at gaining public support for drug abuse, STDs, and teenage pregnancy prevention programs. Adolescents will be particularly targeted in this effort. Resources of the University professional groups and NGOs will be mobilized to support these interventions.

46. PAHO will collaborate in the development of the following specific programs:

MPN: Managerial Support for National Health Development
TCC: Technical Cooperation among Countries
HST: Health Situation and Trend Assessment
HDP: Health Policy Analysis and Development
DHS: Health Services Development
HME: Health Manpower Education
CWS: Community Water Supply and Sanitation
CEH: Control of Environmental Health Hazards
MCH: Growth, Development and Human Reproduction

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		1,490,000	86.8	1,551,800	80.5	1,726,400	80.3
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		584,100	34.0	680,600	35.3	778,600	36.2
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	584,100	34.0	680,600	35.3	778,600	36.2
TECHNICAL COOPERATION AMONG COUNTRIES		51,200	3.0	59,400	3.1	68,900	3.2
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	51,200	3.0	59,400	3.1	68,900	3.2
HEALTH SITUATION AND TREND ASSESSMENT		42,600	2.5	46,300	2.4	24,300	1.1
HEALTH SITUATION AND TREND ASSESSMENT	HST	42,600	2.5	46,300	2.4	24,300	1.1
HEALTH POLICY DEVELOPMENT		242,400	14.1	245,400	12.7	277,300	12.9
HEALTH POLICY ANALYSIS AND DEVELOPMENT	HDP	242,400	14.1	245,400	12.7	277,300	12.9
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		530,200	30.9	485,900	25.2	538,300	25.1
HEALTH SERVICES DEVELOPMENT	DHS	530,200	30.9	485,900	25.2	538,300	25.1
HUMAN RESOURCES DEVELOPMENT		39,500	2.3	34,200	1.8	39,000	1.8
HUMAN RESOURCES EDUCATION	HME	39,500	2.3	34,200	1.8	39,000	1.8
III. HEALTH SCIENCE AND TECHNOLOGY		225,400	13.2	375,500	19.5	422,100	19.7
ENVIRONMENTAL HEALTH		194,800	11.4	319,200	16.6	358,200	16.7
COMMUNITY WATER SUPPLY AND SANITATION	CWS	194,800	11.4	267,400	13.9	300,200	14.0
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	0	-	51,800	2.7	58,000	2.7
MATERNAL AND CHILD HEALTH		30,600	1.8	56,300	2.9	63,900	3.0
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	30,600	1.8	56,300	2.9	63,900	3.0
GRAND TOTAL		1,715,400	100.0	1,927,300	100.0	2,148,500	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		144,098	23.5	0	-	0	100.0
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		6,341	1.0	0	-	0	100.0
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	6,341	1.0	0	-	0	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		14,476	2.4	0	-	0	-
HEALTH SERVICES DEVELOPMENT	DHS	14,476	2.4	0	-	0	-
HUMAN RESOURCES DEVELOPMENT		123,281	20.1	0	-	0	-
HUMAN RESOURCES EDUCATION	HME	123,281	20.1	0	-	0	-
III. HEALTH SCIENCE AND TECHNOLOGY		469,550	76.5	276,470	100.0	0	-
ENVIRONMENTAL HEALTH		123,032	20.0	0	-	0	-
COMMUNITY WATER SUPPLY AND SANITATION	CWS	123,032	20.0	0	-	0	-
MATERNAL AND CHILD HEALTH		3,788	.6	0	-	0	-
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	3,788	.6	0	-	0	-
COMMUNICABLE DISEASES		342,730	55.9	276,470	100.0	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	342,730	55.9	276,470	100.0	0	-
GRAND TOTAL		613,648	100.0	276,470	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	556,100	48	0	110	361,100	17,500	0	0	48,000	5,700	45,800	78,000
WHO - WR	1,159,300	48	120	175	620,000	6,800	113	214,700	66,600	17,600	0	233,600
TOTAL	1,715,400	96	120	285	981,100	24,300	113	214,700	114,600	23,300	45,800	311,600
% OF TOTAL	100.0				57.1	1.4		12.5	6.7	1.4	2.7	18.2
1992-1993												
PAHO - PR	673,000	48	0	110	447,200	21,500	14	28,000	34,900	11,100	0	130,300
WHO - WR	1,254,300	48	120	235	690,900	11,000	88	176,000	74,300	61,800	0	240,300
TOTAL	1,927,300	96	120	345	1,138,100	32,500	102	204,000	109,200	72,900	0	370,600
% OF TOTAL	100.0				59.0	1.7		10.6	5.7	3.8	.0	19.2
1994-1995												
PAHO - PR	760,300	48	0	110	501,500	25,000	14	29,400	40,400	12,800	0	151,200
WHO - WR	1,388,200	48	120	140	753,900	12,700	88	184,800	86,200	71,700	0	278,900
TOTAL	2,148,500	96	120	250	1,255,400	37,700	102	214,200	126,600	84,500	0	430,100
% OF TOTAL	100.0				58.4	1.8		10.0	5.9	3.9	.0	20.0

ANALYSIS OF THE HEALTH SITUATION

1. Significant gains have been made in the health of citizens of the United States of America during the decade of the 1980s. Over the ten year period from 1977 to 1987, infant mortality decreased by 28% and death rates for young children aged one through fourteen declined by 21%, for adolescents and young adults by 13% and for adults aged 25 to 64 by 21%. For adults aged 65 and older, the number of days of restricted activity was reduced by 17%.

2. Although infant mortality decreased to 9.9 deaths per 1000 live births in 1988, this rate is still considerably higher than that reported by most other industrialized countries. Furthermore, significant disparities continue to exist between minority and majority populations. Disorders relating to low birth weight, sudden infant death syndrome, respiratory distress syndrome and congenital anomalies cause more than half of these infant deaths, the majority in the neonatal period. By the beginning of 1990, more than 2000 babies had been born with HIV infection and reported rates of cocaine addicted babies were as high as 20 percent in some urban hospitals.

3. The health profile of children is no longer dominated by the threat of significant infectious diseases. Diseases such as polio, diphtheria, scarlet fever, pneumonia, and whooping cough have been eliminated--or virtually so. The leading cause of death in childhood, unintentional injuries, accounts for more deaths than any other cause, yet is largely preventable. Primarily because of the use of car seats and seatbelts, deaths from motor vehicle accidents have decreased by 40 percent among children aged one to four and 20 percent among those aged 5 to 14. Mental retardation, learning disorders, emotional and behavioral problems, and vision and speech impairments are more prevalent among children living in poverty than among other, more affluent, groups. Early use of tobacco, alcohol and other addictive substances; poor dietary and exercise habits; lead poisoning; and violence toward children still pose significant health risks. In fact, the dominant preventable health problems of adolescents and young adults are injuries and violence that kill or disable and lifestyle patterns that may adversely affect health many years in the future.

4. For individuals between the ages of 25 and 64, death rates from motor vehicle accidents, coronary heart disease and stroke have decreased by 30, 40 and 50 percent respectively since 1970. Various types of cancer, dominated by lung cancer, colorectal cancer, and breast cancer, have now become the leading cause of death. For this age group, improved health can be achieved by overcoming risk factors associated with improper diet, lack of exercise, smoking, excessive alcohol consumption, and sedentary lifestyles. In addition to overcoming these behavioral factors, early diagnosis through appropriate screening programs can have a positive impact on mortality rates.

5. The major causes of death among people aged 65 years and older are heart disease, cancer, stroke, chronic obstructive pulmonary disease, pneumonia, and influenza. Chronic problems such as dementia, arthritis, osteoporosis, incontinence and visual and hearing impairments have a significant impact on daily living. Even so, people who reach age 65 can expect to live, on average, another 16 years, of which 12 are likely to be healthy.

6. Even with these notable advances, gaps still exist between the health status of the total population and population groups such as those with low incomes, those who are members of some racial and ethnic minority groups and those with disabilities.

7. In 1960, 5 percent of the Gross National Product was spent on medical services. By the end of 1990, it is estimated that it will have reached nearly 12 percent. When added to lost economic productivity due to illness or early death, the total costs of illness would be far higher (an estimated 18% of GNP in 1980). The ability to pay for sophisticated technology to diagnose and treat many illnesses is now beginning to surpass available resources, making the prevention of disease and the promotion of health and economic imperative.

Strategies and national health plans

8. Building on the agenda adopted 10 years ago in Promoting Health/Preventing Disease: Objectives for the Nation, the Public Health Service, within the Department of Health and Human Services, published Healthy People 2000 in September 1990. This blueprint commits the country to achieving three broad goals--to increase the span of healthy life, to reduce health disparities and to achieve access to preventive services for all Americans. Three broad approaches are set forth to achieve these goals--health promotion, health protection and preventive services. As a common theme, the importance of shared responsibility is underscored. That is, responsibility for achieving the Healthy People 2000 objectives is shared by families and individuals, who must commit themselves to changing their behavior; by government, which must use its power to make the social and physical environment a healthier place; by health professionals, who must work to prevent, not just to treat, diseases and conditions that result in disability and premature death; and by communities, which must be supportive of the efforts of individuals and groups to promote health.

9. The objectives for health promotion focus on physical activity and fitness, nutrition, tobacco, alcohol and other drugs, family planning, mental health and mental disorders, violent and abusive behavior, and educational and community-based programs. Those for health protection focus on unintentional injuries, occupational safety and health, environmental health, food and drug safety and oral health. Preventive services objectives are categorized by maternal and infant health, heart disease and stroke, cancer, diabetes and chronic disability conditions, HIV infection, sexually transmitted diseases, immunization and infectious diseases and clinical preventive services. Objectives, over 300 in total, are also summarized and presented separately for children, adolescents and young adults, adults and older adults.

10. Examples of the objectives that have been established for the year 2000 include reduction of infant mortality to no more than 7 deaths per 1000 live births, reduction of maternal mortality to no more than 3.3 deaths per 100,000 live births (a 50% rate reduction from 1987), reduction of cigarette smoking to a prevalence of no more than 15 percent among people aged 20 and older (baseline 29 percent in 1987), reduction of coronary heart disease deaths to no more than 100 per 100,000 people, confining the prevalence of HIV infection to no more than 800 per 100,000, and increasing immunization levels to 90% of children under age 2.

11. Thus Healthy People 2000 sets forth a national agenda for change by setting measurable objectives, which, when achieved, will signify a substantial improvement in the health and well-being of the people of the United States. (Source: Healthy People 2000, published by the U.S. Department of Health and Human Services).

GLOBAL STRATEGY OF COOPERATION

12. The global strategy for technical cooperation with the United States of America focuses on two themes. The first is the provision of fellowships for United States health professionals to receive advanced training and experience in settings outside the country. The second is to use the considerable expertise available in the United States to support health development in other countries of the Americas, with particular emphasis on disease prevention and health promotion. Efforts will be concentrated on communicable disease control, chronic disease control, food safety, drug abuse control, environmental health and equipment maintenance. Likewise, experts from Latin America, the Caribbean and other regions will participate with national health authorities in consultations regarding achievement of the national health agenda.

13. PAHO will collaborate in the development of the following specific programs:

DHS: Health Services Development
HME: Health Manpower Education

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		247,500	71.2	373,700	100.0	402,900	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		135,400	39.0	255,700	68.4	279,000	69.2
HEALTH SERVICES DEVELOPMENT	DHS	135,400	39.0	255,700	68.4	279,000	69.2
HUMAN RESOURCES DEVELOPMENT		112,100	32.2	118,000	31.6	123,900	30.8
HUMAN RESOURCES EDUCATION	HME	112,100	32.2	118,000	31.6	123,900	30.8
III. HEALTH SCIENCE AND TECHNOLOGY		100,100	28.8	0	-	0	-
HEALTH PROMOTION		44,600	12.8	0	-	0	-
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	44,600	12.8	0	-	0	-
VETERINARY PUBLIC HEALTH		55,500	16.0	0	-	0	-
FOOD SAFETY	FOS	55,500	16.0	0	-	0	-
GRAND TOTAL		347,600	100.0	373,700	100.0	402,900	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	147,900	0	0	405	102,400	0	0	0	0	45,500	0	0
WHO - WR	199,700	0	0	255	64,500	0	59	112,100	23,100	0	0	0
TOTAL	347,600	0	0	660	166,900	0	59	112,100	23,100	45,500	0	0
% OF TOTAL	100.0				48.1	.0		32.2	6.6	13.1	.0	.0
1992-1993												
PAHO - PR	160,900	0	0	405	108,100	0	0	0	0	52,800	0	0
WHO - WR	212,800	0	0	255	68,100	0	59	118,000	26,700	0	0	0
TOTAL	373,700	0	0	660	176,200	0	59	118,000	26,700	52,800	0	0
% OF TOTAL	100.0				47.2	.0		31.6	7.1	14.1	.0	.0
1994-1995												
PAHO - PR	175,800	0	0	405	114,600	0	0	0	0	61,200	0	0
WHO - WR	227,100	0	0	255	72,200	0	59	123,900	31,000	0	0	0
TOTAL	402,900	0	0	660	186,800	0	59	123,900	31,000	61,200	0	0
% OF TOTAL	100.0				46.3	.0		30.8	7.7	15.2	.0	.0

ANALYSIS OF THE HEALTH SITUATION

1. Uruguay is the first Latin American country to achieve a post-transitional demographic and epidemiological situation. The current population (approximately 3,100,000 inhabitants) is growing by 0.7% annually, and its age structure will vary less than during the transition. Thus, if between 1950 and 1990 children under the age of 15 went from 32% to 22% of the total, and adults over 65 from 8% to 12%, it is estimated that by the year 2000 the former group will have reached 24% and the latter 13%.

2. Today's life expectancy of 72 years is expected to reach 73 years by the year 2000. As such, the mortality structure already reflects the end of the transition, with low percentages for infectious causes and increasingly higher ones for cardiovascular diseases and malignant neoplasms. With respect to morbidity, the growing impact of habits and behaviors can be seen in opposition to the decrease in factors found in the natural environment. In the current situation, eating habits that favor red meat--which is highly available in the country--become risk factors, as does the perpetuation of unhygienic practices in the disposal of viscera in cattle slaughterhouses.

3. Rising awareness of the epidemiological situation has led the government to decide upon a reorientation of health policy and a restructuring--only recently initiated--of the health service system for 1990-1995. The authorities have prioritized the promotion of healthy life styles and behavior modification, without overlooking areas with a longer tradition in which considerable gains can still be made (maternal and child health, for example).

4. The Ministry of Public Health has decided to change its central focus (until now, the administration of its own services, which cover the population with the fewest resources, around 25% of the total) to health promotion and the coordination and monitoring of all private and public services (including monitoring of the quality of care). The Ministry's own services constitute the sphere of operations of the Government Health Services Administration (ASSE), a branch of the Ministry within which it is attempted to conduct a solid decentralization process as well as to make managerial changes aimed at participatory administration of the services. The restructuring of services entails modifying the quantity and quality of the uneven supply of human resources, for which reason these resources become a crucial theme in health policy, both in terms of what is done to their size and structure, as well as in terms of systems of work and payment. The priority health problems have been identified--including those which emerge with greater weight in the new epidemiological situation--so that they can become favored courses of action for social communication and for the public and private health services.

GLOBAL STRATEGY OF COOPERATION

5. In accordance with the Strategic Orientations, and based on the results of the Meeting for Joint Evaluation of Technical Cooperation held in August 1990, technical cooperation in 1992 and 1993 should accompany the reorganization of the sector which was initiated in 1990, as a result of the growing awareness of the post-transitional demographic and epidemiological situation. The change in the role of the Ministry of Public Health will progressively be translated into modifications of its structure, and it is anticipated that there will be development of the units in charge of health promotion and use of social communication as well as coordination and monitoring. Within ASSE, support for the process of managerial decentralization and strengthening will make it possible to fulfill other strategic orientations and program priorities.

6. Another area whose development should be supported, in accordance with the Program Priorities, is the one which will support the formalization and execution of monitoring the 12 priority programs defined by the Ministry, which largely coincide with those identified by the Organization.

7. Support for human resources development is one of the Program Priorities which will be translated into support for one of the essential aspects of the reorganization which has been undertaken.

8. Certain priorities which are politically foreordained by the government are oral health care and control of hydatid disease, which must be maintained and eventually strengthened as the targets of technical cooperation. As a necessary complement to fulfillment of the Strategic Orientation on the administration of knowledge, and one which will be implemented in support of the exchange and generation of important information and knowledge, a project on Dissemination of Scientific and Technical Information will begin in 1991, starting with the establishment of an Information and Documentation Center. During the biennium, it is expected to consolidate its development.

9. PAHO will collaborate in the development of the following specific programs:

MPN:	Managerial Support for National Health Development
TCC:	Technical Cooperation among Countries
DHS:	Health Services Development
HME:	Health Manpower Education
HBD:	Scientific and Technical Information Dissemination
CWS:	Community Water Supply and Sanitation
NCD:	Health Promotion and Prevention and Control of Noncommunicable Diseases

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		1,017,800	86.0	861,900	67.2	968,300	67.4
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		361,700	30.6	463,800	36.2	522,500	36.4
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	361,700	30.6	463,800	36.2	522,500	36.4
TECHNICAL COOPERATION AMONG COUNTRIES		37,700	3.2	43,700	3.4	50,700	3.5
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	37,700	3.2	43,700	3.4	50,700	3.5
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		573,700	48.4	212,900	16.6	233,900	16.3
HEALTH SERVICES DEVELOPMENT	DHS	573,700	48.4	212,900	16.6	233,900	16.3
HUMAN RESOURCES DEVELOPMENT		44,700	3.8	83,500	6.5	93,900	6.5
HUMAN RESOURCES EDUCATION	HME	44,700	3.8	83,500	6.5	93,900	6.5
HEALTH INFORMATION SUPPORT		0	-	58,000	4.5	67,300	4.7
SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION	HBD	0	-	58,000	4.5	67,300	4.7
III. HEALTH SCIENCE AND TECHNOLOGY		164,700	14.0	419,800	32.8	469,800	32.6
ENVIRONMENTAL HEALTH		68,100	5.8	60,000	4.7	65,000	4.5
COMMUNITY WATER SUPPLY AND SANITATION	CWS	68,100	5.8	60,000	4.7	65,000	4.5
HEALTH PROMOTION		96,600	8.2	359,800	28.1	404,800	28.1
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	96,600	8.2	359,800	28.1	404,800	28.1
GRAND TOTAL		1,182,500	100.0	1,281,700	100.0	1,438,100	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		5,650	.9	0	-	0	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		5,650	.9	0	-	0	100.0
REHABILITATION	RHB	5,650	.9	0	-	0	100.0
III. HEALTH SCIENCE AND TECHNOLOGY		601,800	99.1	395,500	100.0	0	-
MATERNAL AND CHILD HEALTH		76,423	12.6	0	-	0	-
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	76,423	12.6	0	-	0	-
COMMUNICABLE DISEASES		525,377	86.5	395,500	100.0	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	525,377	86.5	395,500	100.0	0	-
GRAND TOTAL		607,450	100.0	395,500	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL PROF. MONTHS	PERSONNEL LOCAL MONTHS	PERSONNEL CONS. DAYS	PERSONNEL AMOUNT	DUTY TRAVEL AMOUNT	FELLOWSHIPS MONTHS	FELLOWSHIPS AMOUNT	SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	930,500	48	48	705	597,600	5,700	40	76,000	72,200	12,600	0	166,400
WHO - WR	252,000	24	0	220	218,900	2,300	12	22,800	5,700	2,300	0	0
TOTAL	1,182,500	72	48	925	816,500	8,000	52	98,800	77,900	14,900	0	166,400
% OF TOTAL	100.0				68.9	.7		8.4	6.6	1.3	.0	14.1
1992-1993												
PAHO - PR	1,151,500	48	48	490	648,400	11,600	31	62,000	94,400	41,300	0	293,800
WHO - WR	130,200	0	0	210	56,000	2,700	9	18,000	6,500	5,200	0	41,800
TOTAL	1,281,700	48	48	700	704,400	14,300	40	80,000	100,900	46,500	0	335,600
% OF TOTAL	100.0				55.0	1.1		6.2	7.9	3.6	.0	26.2
1994-1995												
PAHO - PR	1,294,500	48	48	490	717,500	13,500	31	65,100	109,600	47,900	0	340,900
WHO - WR	143,600	0	0	210	59,500	3,100	9	18,900	7,500	6,100	0	48,500
TOTAL	1,438,100	48	48	700	777,000	16,600	40	84,000	117,100	54,000	0	389,400
% OF TOTAL	100.0				54.0	1.2		5.8	8.1	3.8	.0	27.1

ANALYSIS OF THE HEALTH SITUATION

1. According to preliminary figures from the October 1990 census, the Venezuelan population is estimated at 18,106,265 inhabitants, residing in 4,154,154 dwellings. According to official estimates dating from before the census, 43.6% of the population is under the age of 15 years, 43.5% are from 15 to 24 years of age, and 12.9% are 45 years of age or above. The population is thus predominantly young, and even has a higher proportion of children under the age of 15 than Latin America as a whole.

2. In December 1989, the first election of governors and mayors in the country's political history took place, all of which has made it possible to initiate a process of decentralization, since the governors have been granted the right to take part in the investment of 130 billion bolivars provided under the social investment plan. Also of importance is the health sector's decision to participate as an element of strategic national development, integrating health into the solution of other socioeconomic problems, in addition to those closely related to disease.

3. Different factors have prevented greater achievements in the health area, as summarized by the low coverage of the services, especially at the primary and secondary levels, which is due principally to deterioration of the infrastructure as well as a lack of the necessary equipment. During 1990, the national priorities underwent some changes in comparison to previous years. Cardiovascular problems, cancer, accidents, and cerebrovascular diseases retain their importance as the principal causes of death, but there has also been a resurgence of infectious diseases. Since we had the dengue epidemic, there has been an upswing in malaria, enteritis and other diarrheal diseases, and, due to the dramatic increase in critical poverty, the available levels of energy and nutrients have fallen, leading to the appearance of a growing number of cases of kwashiorkor at an early age.

4. During 1990, the hospital crisis deepened, and in many cases was related to the global crisis affecting the health sector. However, it is considered that this situation is the result not only of the sector's budgetary deficit, but also of a deficiency if not a complete lack of management in resource administration, due to a health policy which has subordinated primary health care activities to other interests. Hospital overcrowding is due, among other things, to the diversity of services that are provided in these health establishments, with outpatient consultations that should be covered by an effective primary level. There is also sectoral dearticulation, as represented by the large number of institutions that provide health services, and which have differences in structural organization, administrative systems, coverage, production, and resources, etc.

National health plans and strategies

5. Health is recognized as being the biological, psychological, and social well-being of individuals and population groups. Health policies are oriented toward providing accessible health services to the entire population, with efficiency, efficacy, and equity, and on a timely and comprehensive basis. The focus is placed on the fundamental strategy of primary health care, through the strengthening of local health systems, with emphasis on the development of health plans based on the local epidemiological profile and community participation in the definition of the policies, strategies, execution, and evaluation of health programs. Emphasis is also placed on social development activities, through self-management in the establishment of micro-enterprises.

6. The Organic Law of the National Health System is in the process of being implemented, but it has proved to be difficult to integrate the various health-providing sectors. For this reason, a restructuring of the Ministry of Health and Social Welfare has been initiated, so that it can be organized institutionally through new internal regulations, as a step toward making the National Health System a reality, in accordance with the above law.

7. The low value placed on preventive activity, poor environmental sanitation, the lack of adequate education and culture for comprehensive health, and deterioration of the physical plant and equipment of the health centers are all evidence of the system's need for reform. This situation has been aggravated by the economic crisis which today has become critical. These factors, coupled with the high levels of poverty and the rising cost of private health services and drugs, highlight the need for the preservation of health to be the sector's most important objective, and for a risk approach to be used, since the mortality rate detected in the poorest strata is 4 times the rate registered in the strata which are more amply provided with resources.

8. In order to check this situation, the national government has emphasized the strengthening of local health systems, through the execution of specific programs on vulnerable populations and utilization of the primary health care strategy. This process is taking place within 6 health districts in 6 different states and at the level of the state of Monagas, through the administration of a self-managed census, which has also made it possible to organize the community by setting up hospital social councils and health social committees which will serve as the bases for organizing the National Health System with the requisite social involvement.

9. With the goal of softening the impact of the economic crisis on marginal populations, the government has prepared a series of social investment programs, such as the children's foundation, the expanded program on maternal and child health, support of the popular economy, the social network, day-care homes, unemployment insurance, pregnancy care insurance, the basic food basket, schoolvouchers, transportation vouchers, milk vouchers, the program on tools and uniforms, the program for comprehensive housing subsidies, the program on housing policy, transportation subsidies, subsidies for investment in vehicles for transportation workers, and nutritional protection for pregnant women, schoolchildren, and adults through public kitchens. In conclusion, a large number of social investment initiatives are taking place today. The Ministry

of Social Development has been established as a basic part of the Ministry of the Family, along with the office of the Ministry of State for Women's Affairs. Restructuring of the Venezuelan Social Security Institute has been initiated through a process of decentralization, with regard to the resources used for procurement.

10. Based on the national priorities identified for 1990, the government has decided to request technical cooperation in the following priority areas:

10.1 Support for the process of decentralization and strengthening of the 239 autonomous municipalities (future local health systems), integrating the health services (Ministry of Health and Social Welfare, Venezuelan Social Security Institute [IVSS], IPASME, private organizations, etc.).

10.2 Analysis of the health sector through matching priority local problems with local policies, and including them in the formulation of national and regional policies.

10.3 Strengthening of the capacity for epidemiological assessment of risks and harm at the local level, from the perspective of social illness and health, in order to carry out local interventions in vulnerable populations, using a risk criterion and placing emphasis on social participation (particularly participation by women), based on local surveillance systems, as well as local interventions in social development.

10.4 Improvement of the environment through the updating of drinking water supply and sewerage. Formulation of national policies on air pollution and use of appropriate technologies to solve environmental problems at the local level, including the problem of solid waste disposal.

10.5 Optimization of resource utilization in the local health systems, reconciling the epidemiological profile with the use of the available infrastructure.

10.6 Analysis of the work force at all levels.

11. Development of the program for eradication of foot-and- mouth disease, control of paralytic rabies, and strengthening of infrastructure and technological research and development in animal health.

12. Promotion of technical cooperation with Colombia, Guyana, the Caribbean countries, and the Andean Pact countries.

GLOBAL STRATEGY OF COOPERATION

13. The PAHO/WHO strategies for the provision of technical cooperation in these areas will be based principally on resource mobilization, social communication, training, the formulation of standards, policies, and plans, and the integration of programs at the local level.

14. The program priorities will focus on the following processes: Integration of the health service system in order to establish the National Health System, in accordance with the Organic Law of the National Health System. Development and strengthening of local health systems, with the autonomous municipality identified as the basic unit of the health infrastructure. This will be strengthened with the goal of obtaining local decision-making capacity with full social participation, in the programming as well as the execution and evaluation of specific program priorities, based on the local epidemiological profile and with emphasis on the primary health care strategy. There will be strengthening of the leadership in the Ministry of Health and Social Welfare for sectoral administration with promotion of decentralization of services which makes it possible to consolidate local health systems, promote excellence in the services, and reorganize and strengthen simplified medicine and family health promoters. There will also be development of the capacity for analyzing the financial sector, through studies on evaluation of health expenditures and human resources development as well as on applied research that is in harmony with the findings of local, state, and national information systems. This research should optimize the use of the resources for execution of the programs defined as priorities by the different levels of activity.

15. In the area of sanitation, the goal is to achieve community satisfaction at the local level, measuring the coverage of drinking water and sewerage services as well as the use of appropriate technologies to solve environmental problems at the local level.

16. In the area of social health, the risk approach needs to be emphasized for the decision to establish micro-enterprises in communities with a higher level of development and social investment in the least protected populations.

17. Venezuela and the countries of the subregion have a wealth of potential when it comes to human, scientific, and technological resources, and these need to be identified so that they can be mobilized, through the mechanism of TCAC, together with the use of epidemiology for political decision-making in health--jointly when border situations are involved--thus integrating the country with its neighboring countries and the Caribbean area and promoting Andean Cooperation in Health.

18. PAHO will collaborate in the development of the following specific programs:

MPN: Managerial Support for National Health Development
TCC: Technical Cooperation among Countries
HST: Health Situation and Trend Assessment
DHS: Health Services Development
ORH: Oral Health
HME: Health Manpower Education
RPD: Research Promotion and Development
NUT: Nutrition
CEH: Control of Environmental Health Hazards
MCH: Growth, Development and Human Reproduction
ZNS: Zoonoses

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		2,307,600	79.3	2,811,100	80.6	3,219,500	80.7
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		620,700	21.3	796,900	22.9	923,000	23.2
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	620,700	21.3	796,900	22.9	923,000	23.2
TECHNICAL COOPERATION AMONG COUNTRIES		83,900	2.9	97,300	2.8	112,900	2.8
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	83,900	2.9	97,300	2.8	112,900	2.8
HEALTH SITUATION AND TREND ASSESSMENT		259,000	8.9	442,000	12.7	503,600	12.6
HEALTH SITUATION AND TREND ASSESSMENT	HST	259,000	8.9	442,000	12.7	503,600	12.6
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		838,400	28.9	915,200	26.1	1,043,500	26.1
HEALTH SERVICES DEVELOPMENT	DHS	777,200	26.8	841,500	24.0	959,900	24.0
ORAL HEALTH	ORH	61,200	2.1	73,700	2.1	83,600	2.1
HUMAN RESOURCES DEVELOPMENT		419,800	14.4	479,900	13.8	545,500	13.7
HUMAN RESOURCES EDUCATION	HME	419,800	14.4	479,900	13.8	545,500	13.7
RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT		85,800	2.9	79,800	2.3	91,000	2.3
RESEARCH PROMOTION AND DEVELOPMENT	RPD	85,800	2.9	79,800	2.3	91,000	2.3
III. HEALTH SCIENCE AND TECHNOLOGY		602,100	20.7	675,000	19.4	766,400	19.3
FOOD AND NUTRITION		66,900	2.3	69,400	2.0	80,200	2.0
NUTRITION	NUT	66,900	2.3	69,400	2.0	80,200	2.0
ENVIRONMENTAL HEALTH		133,900	4.6	157,800	4.5	179,400	4.5
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	133,900	4.6	157,800	4.5	179,400	4.5

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
MATERNAL AND CHILD HEALTH		164,100	5.6	169,100	4.9	189,800	4.8
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	164,100	5.6	169,100	4.9	189,800	4.8
VETERINARY PUBLIC HEALTH		237,200	8.2	278,700	8.0	317,000	8.0
ZOONOSES	ZNS	237,200	8.2	278,700	8.0	317,000	8.0
GRAND TOTAL		2,909,700	100.0	3,486,100	100.0	3,985,900	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		94,920	8.4	0	-	0	100.0
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		94,920	8.4	0	-	0	100.0
ESSENTIAL DRUGS AND VACCINES	EDV	94,920	8.4	0	-	0	100.0
III. HEALTH SCIENCE AND TECHNOLOGY		1,030,186	91.6	395,500	100.0	0	-
COMMUNICABLE DISEASES		478,116	42.5	395,500	100.0	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	435,815	38.7	395,500	100.0	0	-
MALARIA	MAL	42,301	3.8	0	-	0	-
VETERINARY PUBLIC HEALTH		552,070	49.1	0	-	0	-
FOOT-AND-MOUTH DISEASE	FMD	552,070	49.1	0	-	0	-
GRAND TOTAL		1,125,106	100.0	395,500	100.0	0	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	1,808,700	48	168	945	860,400	45,300	168	319,200	134,700	48,100	0	401,000
WHO - WR	1,101,000	72	72	685	699,100	21,700	109	207,100	59,600	23,900	15,600	74,000
TOTAL	2,909,700	120	240	1630	1,559,500	67,000	277	526,300	194,300	72,000	15,600	475,000
% OF TOTAL	100.0				53.6	2.3		18.1	6.7	2.5	.5	16.3
1992-1993												
PAHO - PR	2,308,800	48	168	330	833,100	89,600	68	136,000	377,700	133,100	15,800	723,500
WHO - WR	1,177,300	72	72	340	758,800	42,700	42	84,000	122,500	77,900	0	91,400
TOTAL	3,486,100	120	240	670	1,591,900	132,300	110	220,000	500,200	211,000	15,800	814,900
% OF TOTAL	100.0				45.6	3.8		6.3	14.3	6.1	.5	23.4
1994-1995												
PAHO - PR	2,650,600	48	168	330	953,400	103,900	68	142,800	438,200	154,400	18,300	839,600
WHO - WR	1,335,300	72	72	340	859,000	49,400	42	88,200	142,200	90,500	0	106,000
TOTAL	3,985,900	120	240	670	1,812,400	153,300	110	231,000	580,400	244,900	18,300	945,600
% OF TOTAL	100.0				45.5	3.8		5.8	14.6	6.1	.5	23.7

CARIBBEAN PROGRAM
COORDINATION (CPC)

CARIBBEAN PROGRAM
COORDINATION (CPC)

GLOBAL STRATEGY OF COOPERATION

1. The strategy will emphasize the further development of the office of Caribbean Program Coordination to enable it to carry out its functions of coordination of the use of PAHO resources assigned to the Caribbean and to provide direct support to the Technical Cooperation activities carried out in Barbados, the Eastern Caribbean, the French Antilles and French Guiana. Continued efforts will be undertaken to promote efficiency and increase productivity. It will be necessary to increase the support staff and provision will be made for two additional secretaries in the office to accommodate the anticipated increased workload due to the increase of programmatic activity and the development and execution of extrabudgetary funds.

2. Linkages with the CARICOM Secretariat and subregional institutions such as the University of the West Indies will be strengthened so as to facilitate the smooth functioning of the joint Secretariat of the Caribbean Cooperation in Health Initiative, now entering the implementation phase while still fostering technical cooperation between the countries of the Caribbean.

3. The Joint Evaluation Reviews will be used to continue to orient the country programs within the framework of CCH based on the Strategic Orientations and Program Priorities for 1991-1994.

4. The management of knowledge will be emphasized. Appropriate research will be actively promoted; the documentation center will be further developed to become a main repository of information on health and health conditions of the Caribbean. Dissemination of information will be stressed and linkages established with the mass media.

5. PAHO will also seek to create entry points into the political systems of the Caribbean so as to ensure health and development issues are fully considered in the development process of the Caribbean.

6. Close attention will be paid to Women, Health and Development issues as part of the coordination function.

7. PAHO will collaborate in the development of the following specific programs:

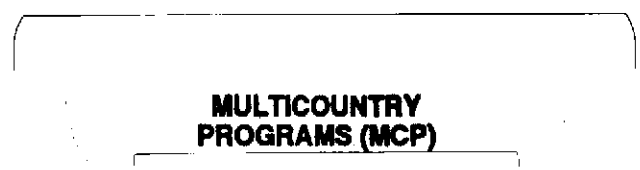
MPN: Managerial Support for National Health Development
TCC: Technical Cooperation among Countries
HDP: Health Policy Analysis and Development

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		1,803,500	100.0	1,755,700	100.0	2,002,100	100.0
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		1,611,400	89.3	1,707,900	97.3	1,946,600	97.2
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	1,611,400	89.3	1,707,900	97.3	1,946,600	97.2
TECHNICAL COOPERATION AMONG COUNTRIES		150,900	8.4	0	-	0	-
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	150,900	8.4	0	-	0	-
HEALTH POLICY DEVELOPMENT		41,200	2.3	47,800	2.7	55,500	2.8
HEALTH POLICY ANALYSIS AND DEVELOPMENT	HDP	41,200	2.3	47,800	2.7	55,500	2.8
GRAND TOTAL		1,803,500	100.0	1,755,700	100.0	2,002,100	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	960,000	48	120	0	692,800	28,100	0	0	0	34,400	41,200	163,500
WHO - WR	843,500	24	72	0	411,300	20,000	0	0	0	0	0	412,200
TOTAL	1,803,500	72	192	0	1,104,100	48,100	0	0	0	34,400	41,200	575,700
% OF TOTAL	100.0				61.2	2.7		.0	.0	1.9	2.3	31.9
1992-1993												
PAHO - PR	901,400	48	144	0	772,700	34,800	0	0	3,900	34,800	47,800	7,400
WHO - WR	854,300	24	72	0	392,500	23,200	0	0	0	0	0	438,600
TOTAL	1,755,700	72	216	0	1,165,200	58,000	0	0	3,900	34,800	47,800	446,000
% OF TOTAL	100.0				66.4	3.3		.0	.2	2.0	2.7	25.4
1994-1995												
PAHO - PR	1,021,600	48	144	0	872,100	40,400	0	0	4,600	40,400	55,500	8,600
WHO - WR	980,500	24	72	0	444,800	26,900	0	0	0	0	0	508,800
TOTAL	2,002,100	72	216	0	1,316,900	67,300	0	0	4,600	40,400	55,500	517,400
% OF TOTAL	100.0				65.8	3.4		.0	.2	2.0	2.8	25.8


MULTICOUNTRY
PROGRAMS (MCP)

MULTICOUNTRY PROGRAMS (MCP)

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
I. DIRECTION, COORDINATION AND MANAGEMENT		1,446,700	5.7	1,501,600	5.5	1,741,200	5.6
GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT		1,446,700	5.7	1,501,600	5.5	1,741,200	5.6
GENERAL PROGRAM DEVELOPMENT	GPD	1,235,000	4.9	1,306,000	4.8	1,515,100	4.9
EXTERNAL COORD. FOR HEALTH AND SOCIAL DEVELOPMENT	COR	211,700	.8	195,600	.7	226,100	.7
II. HEALTH SYSTEM INFRASTRUCTURE		14,326,000	56.7	15,165,200	55.4	17,312,100	55.4
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		1,126,400	4.5	1,247,000	4.5	1,426,600	4.5
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	956,500	3.8	1,019,500	3.7	1,167,200	3.7
ADMINISTRATIVE ANALYSIS	AAN	169,900	.7	227,500	.8	259,400	.8
TECHNICAL COOPERATION AMONG COUNTRIES		274,800	1.1	273,900	1.0	317,800	1.0
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	274,800	1.1	273,900	1.0	317,800	1.0
HEALTH SITUATION AND TREND ASSESSMENT		1,339,100	5.3	1,353,600	5.0	1,535,300	4.9
HEALTH SITUATION AND TREND ASSESSMENT	HST	1,339,100	5.3	1,353,600	5.0	1,535,300	4.9
HEALTH POLICY DEVELOPMENT		1,979,100	7.8	2,233,400	8.1	2,551,100	8.1
HEALTH POLICY ANALYSIS AND DEVELOPMENT	HDP	1,492,300	5.9	1,349,500	4.9	1,542,000	4.9
HEALTH ECONOMICS AND FINANCING	HDE	374,300	1.5	496,900	1.8	570,900	1.8
HEALTH LEGISLATION	HLE	112,500	.4	193,300	.7	215,800	.7
WOMEN, HEALTH AND DEVELOPMENT	WHD	0	-	193,700	.7	222,400	.7
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		4,031,800	16.0	3,809,500	13.9	4,347,100	14.0
HEALTH SERVICES DEVELOPMENT	DHS	2,530,000	10.0	2,416,800	8.8	2,758,300	8.9
ESSENTIAL DRUGS AND VACCINES	EDV	292,000	1.2	197,600	.7	223,900	.7
ORAL HEALTH	ORH	383,700	1.5	296,500	1.1	338,000	1.1
DISASTER PREPAREDNESS	DPP	173,300	.7	233,100	.9	268,400	.9
CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY	CLR	296,400	1.2	335,900	1.2	381,800	1.2
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	230,500	.9	215,800	.8	246,900	.8
REHABILITATION	RHB	125,900	.5	113,800	.4	129,800	.4
HUMAN RESOURCES DEVELOPMENT		3,289,700	13.0	3,677,700	13.5	4,182,400	13.4
COORDINATION & SUPPORT OF HUMAN RESOURCES DEVELOP.	HMC	2,131,700	8.4	2,240,300	8.2	2,530,200	8.1
HUMAN RESOURCES ADMINISTRATION	HMA	394,200	1.6	534,500	2.0	613,300	2.0
HUMAN RESOURCES EDUCATION	HME	763,800	3.0	902,900	3.3	1,038,900	3.3

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT		2,285,100	9.0	2,570,100	9.4	2,951,800	9.5
RESEARCH PROMOTION AND DEVELOPMENT	RPD	2,053,400	8.1	2,143,300	7.8	2,464,800	7.9
HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT	HDT	231,700	.9	264,000	1.0	301,400	1.0
RESEARCH AND DEVELOPMENT IN THE FIELD OF VACCINES	RDV	0	-	162,800	.6	185,600	.6
III. HEALTH SCIENCE AND TECHNOLOGY		9,473,400	37.6	10,665,200	39.1	12,112,600	39.0
FOOD AND NUTRITION		703,600	2.8	703,700	2.5	800,100	2.5
FOOD	FOD	105,300	.4	121,000	.4	139,100	.4
NUTRITION	NUT	598,300	2.4	582,700	2.1	661,000	2.1
ENVIRONMENTAL HEALTH		718,500	2.8	877,100	3.2	1,000,700	3.2
COMMUNITY WATER SUPPLY AND SANITATION	CWS	368,000	1.5	314,700	1.2	359,200	1.2
SOLID WASTES AND HOUSING HYGIENE	RUD	87,900	.3	81,200	.3	91,200	.3
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	60,400	.2	282,600	1.0	323,300	1.0
WORKERS' HEALTH	OCH	202,200	.8	198,600	.7	227,000	.7
MATERNAL AND CHILD HEALTH		1,502,800	5.9	1,598,100	5.8	1,817,300	5.8
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	506,400	2.0	431,400	1.6	494,100	1.6
ADOLESCENT HEALTH	ADH	32,700	.1	63,700	.2	70,800	.2
ACUTE RESPIRATORY INFECTIONS	ARI	147,300	.6	184,600	.7	210,400	.7
IMMUNIZATION	EPI	710,900	2.8	797,600	2.9	903,700	2.9
DIARRHEAL DISEASES	CDD	105,500	.4	120,800	.4	138,300	.4
COMMUNICABLE DISEASES		3,962,800	15.8	4,358,200	16.1	4,942,800	16.1
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	202,100	.8	316,000	1.2	362,000	1.2
TROPICAL DISEASE RESEARCH	TDR	23,600	.1	44,400	.2	49,300	.2
TUBERCULOSIS	TUB	116,400	.5	157,700	.6	178,100	.6
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	920,400	1.3	271,300	1.0	307,900	1.0
VECTOR-BORNE DISEASES	VBC	2,772,200	10.9	2,540,900	9.3	2,880,000	9.4
MALARIA	MAL	292,500	1.2	615,100	2.3	698,900	2.2
PARASITIC DISEASES	PDP	0	-	90,300	.3	102,500	.3
LEPROSY	LEP	192,000	.8	274,600	1.0	311,200	1.0
SEXUALLY TRANSMITTED DISEASES	VDT	43,600	.2	47,900	.2	52,900	.2
HEALTH PROMOTION		943,200	3.7	1,167,400	4.3	1,323,100	4.2
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	434,400	1.7	561,500	2.1	634,000	2.0
TOBACCO OR HEALTH	TOH	50,800	.2	57,700	.2	65,800	.2
PREV/TREAT. OF MENTAL AND NEUROLOGICAL DISORDERS	MND	126,000	.5	152,400	.6	172,900	.6
ACCIDENT PREVENTION	APR	44,600	.2	50,300	.2	56,900	.2
HEALTH OF THE ELDERLY	HEE	154,300	.6	164,500	.6	186,700	.6
PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE	ADA	77,000	.3	117,300	.4	134,100	.4
OCULAR HEALTH	PBD	56,100	.2	63,700	.2	72,700	.2

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
VETERINARY PUBLIC HEALTH		1,642,500	6.6	1,960,700	7.2	2,228,600	7.2
FOOD SAFETY	FOS	274,200	1.1	161,100	.6	180,400	.6
FOOT-AND-MOUTH DISEASE	FMD	517,900	2.1	471,200	1.7	536,200	1.7
ZOONOSES	ZNS	850,400	3.4	1,328,400	4.9	1,512,000	4.9
GRAND TOTAL		25,246,100	100.0	27,332,000	100.0	31,165,900	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
I. DIRECTION, COORDINATION AND MANAGEMENT		379,693	.6	245,000	.5	245,000	1.4
GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT		379,693	.6	245,000	.5	245,000	1.4
GENERAL PROGRAM DEVELOPMENT	GPD	103,098	.2	0	-	0	-
EXTERNAL COORD. FOR HEALTH AND SOCIAL DEVELOPMENT	COR	276,595	.4	245,000	.5	245,000	1.4
II. HEALTH SYSTEM INFRASTRUCTURE		20,757,937	32.3	15,175,690	31.9	1,443,516	8.2
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		299,426	.5	0	-	0	-
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	129,267	.2	0	-	0	-
ADMINISTRATIVE ANALYSIS	AAN	170,159	.3	0	-	0	-
TECHNICAL COOPERATION AMONG COUNTRIES		2,901,969	4.5	1,215,530	2.6	0	-
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	2,901,969	4.5	1,215,530	2.6	0	-
HEALTH POLICY DEVELOPMENT		0	-	1,100,000	2.3	0	-
WOMEN, HEALTH AND DEVELOPMENT	WHD	0	-	1,100,000	2.3	0	-
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		15,095,625	23.5	10,588,204	22.2	952,000	5.4
HEALTH SERVICES DEVELOPMENT	DHS	6,814,997	10.6	6,161,400	12.9	0	-
ESSENTIAL DRUGS AND VACCINES	EDV	2,470,503	3.9	920,000	1.9	0	-
ORAL HEALTH	ORH	6,698	.*	0	-	0	-
DISASTER PREPAREDNESS	DPP	5,778,012	9.0	3,506,804	7.4	952,000	5.4
CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY	CLR	6,160	.*	0	-	0	-
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	19,255	.*	0	-	0	-
HUMAN RESOURCES DEVELOPMENT		2,460,917	3.8	2,271,956	4.8	491,516	2.8
COORDINATION & SUPPORT OF HUMAN RESOURCES DEVELOP.	HMC	648,377	1.0	459,416	1.0	491,516	2.8
HUMAN RESOURCES EDUCATION	HME	1,812,540	2.8	1,812,540	3.8	0	-

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
III. HEALTH SCIENCE AND TECHNOLOGY		42,956,978	67.1	32,158,390	67.6	15,887,160	90.4
FOOD AND NUTRITION		248,226	.4	0	-	0	-
NUTRITION	NUT	248,226	.4	0	-	0	-
ENVIRONMENTAL HEALTH		2,028,225	3.1	2,600,000	5.5	0	-
COMMUNITY WATER SUPPLY AND SANITATION	CWS	987,033	1.5	600,000	1.3	0	-
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	1,041,192	1.6	2,000,000	4.2	0	-
MATERNAL AND CHILD HEALTH		24,966,975	39.3	15,964,365	33.4	15,262,160	86.8
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	3,793,358	5.9	2,511,400	5.3	2,354,700	13.4
ADOLESCENT HEALTH	ADH	45,200	.1	0	-	0	-
ACUTE RESPIRATORY INFECTIONS	ARI	789,913	1.2	991,600	2.1	1,004,800	5.7
IMMUNIZATION	EPI	17,950,833	28.4	10,833,265	22.6	10,219,960	58.1
DIARRHEAL DISEASES	CDD	2,387,671	3.7	1,628,100	3.4	1,682,700	9.6
COMMUNICABLE DISEASES		11,039,819	17.1	11,879,070	25.0	0	-
TROPICAL DISEASE RESEARCH	TDR	5,000	.*	0	-	0	-
TUBERCULOSIS	TUB	94,886	.1	33,456	.1	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	9,210,111	14.4	7,491,050	15.7	0	-
VECTOR-BORNE DISEASES	VBC	19,744	.*	0	-	0	-
MALARIA	MAL	1,615,766	2.5	4,354,564	9.2	0	-
LEPROSY	LEP	64,312	.1	0	-	0	-
SEXUALLY TRANSMITTED DISEASES	VDT	30,000	.*	0	-	0	-
HEALTH PROMOTION		953,704	1.4	0	-	0	-
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	39,815	.1	0	-	0	-
TOBACCO OR HEALTH	TOH	222,054	.3	0	-	0	-
PREV/TREAT. OF MENTAL AND NEUROLOGICAL DISORDERS	MND	74,409	.1	0	-	0	-
CANCER	CAN	79,961	.1	0	-	0	-
HEALTH OF THE ELDERLY	HEE	335,391	.5	0	-	0	-
PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE	ADA	122,535	.2	0	-	0	-
OCULAR HEALTH	PBD	79,539	.1	0	-	0	-
VETERINARY PUBLIC HEALTH		3,720,029	5.8	1,714,955	3.7	625,000	3.6
FOOD SAFETY	FOS	3,114	.*	0	-	0	-
FOOT-AND-MOUTH DISEASE	FMD	2,445,185	3.8	975,651	2.1	0	-
ZOONOSES	ZNS	1,271,730	2.0	739,304	1.6	625,000	3.6
GRAND TOTAL		64,094,608	100.0	47,579,080	100.0	17,575,676	100.0

* LESS THAN .05 PER CENT

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	15,413,100	288	144	7695	4,496,900	2,065,900	0	0	3,197,100	579,900	1,845,300	3,228,000
WHO - WR	9,833,000	744	120	3320	6,117,800	1,120,000	0	0	1,379,700	480,000	171,200	564,300
TOTAL	25,246,100	1032	264	11015	10,614,700	3,185,900	0	0	4,576,800	1,059,900	2,016,500	3,792,300
% OF TOTAL	100.0				42.1	12.6		.0	18.1	4.2	8.0	15.0
1992-1993												
PAHO - PR	18,801,900	216	144	8270	4,827,500	2,974,300	0	0	4,171,800	981,900	2,006,800	3,839,600
WHO - WR	8,530,100	552	96	2535	5,519,400	983,600	0	0	1,101,600	300,000	45,700	579,800
TOTAL	27,332,000	768	240	10805	10,346,900	3,957,900	0	0	5,273,400	1,281,900	2,052,500	4,419,400
% OF TOTAL	100.0				37.8	14.5		.0	19.3	4.7	7.5	16.2
1994-1995												
PAHO - PR	21,492,700	216	144	8270	5,315,000	3,450,500	0	0	4,840,100	1,139,400	2,328,000	4,419,700
WHO - WR	9,673,200	552	96	2535	6,180,500	1,141,000	0	0	1,278,100	348,100	53,100	672,400
TOTAL	31,165,900	768	240	10805	11,495,500	4,591,500	0	0	6,118,200	1,487,500	2,381,100	5,092,100
% OF TOTAL	100.0				37.0	14.7		.0	19.6	4.8	7.6	16.3

REGIONAL DIRECTOR'S
DEVELOPMENT PROGRAM

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
I. DIRECTION, COORDINATION AND MANAGEMENT		3,350,000	100.0	3,725,200	100.0	4,142,500	100.0
GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT		3,350,000	100.0	3,725,200	100.0	4,142,500	100.0
REGIONAL DIRECTOR'S DEVELOPMENT PROGRAM	DGP	3,350,000	100.0	3,725,200	100.0	4,142,500	100.0
GRAND TOTAL		3,350,000	100.0	3,725,200	100.0	4,142,500	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	3,194,000	0	0	0	0	0	0	0	0	0	0	3,194,000
WHO - WR	156,000	0	0	0	0	0	0	0	0	0	0	156,000
TOTAL	3,350,000	0	0	0	0	0	0	0	0	0	0	3,350,000
% OF TOTAL	100.0				.0	.0		.0	.0	.0	.0	100.0
1992-1993												
PAHO - PR	3,569,200	0	0	0	0	0	0	0	0	0	0	3,569,200
WHO - WR	156,000	0	0	0	0	0	0	0	0	0	0	156,000
TOTAL	3,725,200	0	0	0	0	0	0	0	0	0	0	3,725,200
% OF TOTAL	100.0				.0	.0		.0	.0	.0	.0	100.0
1994-1995												
PAHO - PR	3,969,000	0	0	0	0	0	0	0	0	0	0	3,969,000
WHO - WR	173,500	0	0	0	0	0	0	0	0	0	0	173,500
TOTAL	4,142,500	0	0	0	0	0	0	0	0	0	0	4,142,500
% OF TOTAL	100.0				.0	.0		.0	.0	.0	.0	100.0

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
I. DIRECTION, COORDINATION AND MANAGEMENT		5,582,900	14.6	5,861,600	12.7	6,509,300	12.8
GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT		5,582,900	14.6	5,861,600	12.7	6,509,300	12.8
INFORMATICS MANAGEMENT	ISS	5,582,900	14.6	5,861,600	12.7	6,509,300	12.8
II. HEALTH SYSTEM INFRASTRUCTURE		22,282,600	59.9	28,699,100	63.0	31,807,100	62.9
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		700,000	1.9	4,226,600	9.3	4,549,300	9.0
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	700,000	1.9	3,650,000	8.0	3,900,000	7.7
ADMINISTRATIVE ANALYSIS	AAN	0	-	576,600	1.3	649,300	1.3
HEALTH SITUATION AND TREND ASSESSMENT		2,497,200	6.7	2,889,500	6.3	3,250,800	6.4
HEALTH SITUATION AND TREND ASSESSMENT	HST	2,497,200	6.7	2,889,500	6.3	3,250,800	6.4
HEALTH POLICY DEVELOPMENT		1,588,300	4.3	2,591,300	5.7	2,915,300	5.8
HEALTH POLICY ANALYSIS AND DEVELOPMENT	HDP	1,187,400	3.2	1,428,900	3.1	1,608,500	3.2
HEALTH ECONOMICS AND FINANCING	HDE	400,900	1.1	495,700	1.1	558,200	1.1
HEALTH LEGISLATION	HLE	0	-	270,900	.6	305,200	.6
WOMEN, HEALTH AND DEVELOPMENT	WHD	0	-	395,800	.9	443,400	.9
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		3,955,100	10.7	4,560,700	10.0	5,129,000	10.1
HEALTH SERVICES DEVELOPMENT	DHS	2,095,500	5.6	2,449,800	5.4	2,753,000	5.4
ESSENTIAL DRUGS AND VACCINES	EDV	506,300	1.4	472,700	1.0	532,800	1.1
ORAL HEALTH	ORH	247,800	.7	270,900	.6	305,200	.6
DISASTER PREPAREDNESS	DPP	274,300	.7	334,300	.7	375,600	.7
CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY	CLR	430,300	1.2	537,300	1.2	604,200	1.2
HEALTH EDUCATION AND COMMUNITY PARTICIPATION	HED	218,400	.6	270,900	.6	305,200	.6
REHABILITATION	RHB	182,500	.5	224,800	.5	253,000	.5
HUMAN RESOURCES DEVELOPMENT		3,386,500	9.1	3,947,600	8.7	4,290,700	8.5
COORDINATION & SUPPORT OF HUMAN RESOURCES DEVELOP.	HMC	2,080,100	5.6	2,355,500	5.2	2,649,500	5.2
HUMAN RESOURCES ADMINISTRATION	HMA	658,900	1.8	614,600	1.4	541,600	1.1
HUMAN RESOURCES EDUCATION	HME	647,500	1.7	977,500	2.1	1,099,600	2.2

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
HEALTH INFORMATION SUPPORT		8,777,700	23.5	9,016,000	19.8	10,022,600	19.8
OFFICIAL AND TECHNICAL PUBLICATIONS	HBP	4,251,100	11.4	4,692,000	10.3	5,262,700	10.4
PUBLIC INFORMATION	HBF	1,547,300	4.1	1,763,300	3.9	1,880,600	3.7
LANGUAGE SERVICES	HBL	1,855,000	5.0	1,606,000	3.5	1,808,900	3.6
SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION	HBD	1,124,300	3.0	954,700	2.1	1,070,400	2.1
RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT		1,377,800	3.7	1,467,400	3.2	1,649,400	3.3
RESEARCH PROMOTION AND DEVELOPMENT	RPD	976,900	2.6	1,017,800	2.2	1,143,400	2.3
HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT	HDT	400,900	1.1	224,800	.5	253,000	.5
RESEARCH AND DEVELOPMENT IN THE FIELD OF VACCINES	RDV	0	-	224,800	.5	253,000	.5
III. HEALTH SCIENCE AND TECHNOLOGY		9,419,300	25.5	10,952,800	24.3	12,197,500	24.3
FOOD AND NUTRITION		688,300	1.9	808,200	1.7	909,400	1.8
FOOD	FOD	182,500	.5	196,200	.4	221,500	.4
NUTRITION	NUT	505,800	1.4	612,000	1.3	687,900	1.4
ENVIRONMENTAL HEALTH		2,274,500	6.1	2,501,800	5.5	2,814,200	5.6
COMMUNITY WATER SUPPLY AND SANITATION	CWS	1,720,500	4.6	1,257,000	2.8	1,413,300	2.8
SOLID WASTES AND HOUSING HYGIENE	RUD	153,100	.4	196,200	.4	221,500	.4
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	153,100	.4	749,100	1.6	842,700	1.7
WORKERS' HEALTH	OCH	247,800	.7	299,500	.7	336,700	.7
MATERNAL AND CHILD HEALTH		2,016,900	5.4	2,415,900	5.4	2,593,300	5.2
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	967,600	2.6	1,084,900	2.4	1,094,600	2.2
ACUTE RESPIRATORY INFECTIONS	ARI	163,100	.4	224,800	.5	253,000	.5
IMMUNIZATION	EPI	572,900	1.5	719,000	1.6	810,800	1.6
DIARRHEAL DISEASES	CDD	323,300	.9	387,200	.9	434,900	.9
COMMUNICABLE DISEASES		1,942,900	5.3	2,011,600	4.5	2,261,500	4.5
GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL	OCD	247,800	.7	299,500	.7	336,700	.7
TROPICAL DISEASE RESEARCH	TDR	247,800	.7	74,700	.2	83,700	.2
TUBERCULOSIS	TUB	218,400	.6	270,900	.6	305,200	.6
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	75,500	.2	87,700	.2	98,200	.2
MALARIA	MAL	1,088,100	2.9	917,700	2.0	1,032,000	2.0
PARASITIC DISEASES	PDP	0	-	286,400	.6	322,000	.6
LEPROSY	LEP	65,300	.2	74,700	.2	83,700	.2

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
HEALTH PROMOTION		1,590,000	4.3	2,136,200	4.8	2,404,500	4.8
HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS.	NCD	836,400	2.2	1,224,700	2.7	1,379,900	2.7
PREV/TREAT. OF MENTAL AND NEUROLOGICAL DISORDERS	MND	258,000	.7	312,500	.7	351,200	.7
HEALTH OF THE ELDERLY	HEE	247,800	.7	299,500	.7	336,700	.7
PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE	ADA	247,800	.7	299,500	.7	336,700	.7
VETERINARY PUBLIC HEALTH		906,700	2.5	1,079,100	2.4	1,214,600	2.4
FOOD SAFETY	FOS	247,800	.7	299,500	.7	336,700	.7
ZOONOSES	ZNS	658,900	1.8	779,600	1.7	877,900	1.7
GRAND TOTAL		37,284,800	100.0	45,513,500	100.0	50,513,900	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

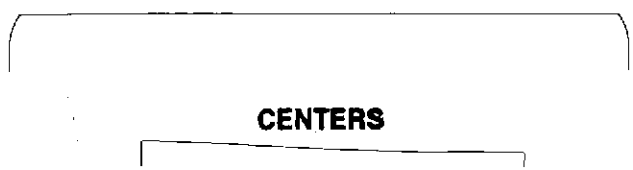
PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
I. DIRECTION, COORDINATION AND MANAGEMENT		210,065	2.6	260,000	3.1	288,000	4.9
GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT		210,065	2.6	260,000	3.1	288,000	4.9
INFORMATICS MANAGEMENT	ISS	210,065	2.6	260,000	3.1	288,000	4.9
II. HEALTH SYSTEM INFRASTRUCTURE		3,091,785	38.1	3,491,550	42.1	2,885,500	49.1
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		0	-	286,200	3.4	322,000	5.5
ADMINISTRATIVE ANALYSIS	AAN	0	-	286,200	3.4	322,000	5.5
TECHNICAL COOPERATION AMONG COUNTRIES		188,580	2.3	87,420	1.1	0	-
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	188,580	2.3	87,420	1.1	0	-
HEALTH SERVICES BASED ON PRIMARY HEALTH CARE		887,163	10.9	927,430	11.2	138,000	2.3
HEALTH SERVICES DEVELOPMENT	DHS	101,233	1.2	124,000	1.5	138,000	2.3
DISASTER PREPAREDNESS	DPP	785,930	9.7	803,430	9.7	0	-
HUMAN RESOURCES DEVELOPMENT		867,400	10.7	1,046,000	12.6	1,173,100	20.0
COORDINATION & SUPPORT OF HUMAN RESOURCES DEVELOP.	HMC	867,400	10.7	1,046,000	12.6	1,173,100	20.0
HEALTH INFORMATION SUPPORT		1,127,642	13.9	1,084,500	13.1	1,184,400	20.1
OFFICIAL AND TECHNICAL PUBLICATIONS	HBP	428,168	5.3	429,000	5.2	466,000	7.9
PUBLIC INFORMATION	HBF	673,575	8.3	655,500	7.9	718,400	12.2
LANGUAGE SERVICES	HBL	16,037	.2	0	-	0	-
SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION	HBD	9,862	.1	0	-	0	-
RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT		21,000	.3	60,000	.7	68,000	1.2
HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT	HDT	21,000	.3	60,000	.7	68,000	1.2

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
III. HEALTH SCIENCE AND TECHNOLOGY		4,798,911	59.3	4,562,507	54.8	2,709,580	46.0
FOOD AND NUTRITION		56,400	.7	56,500	.7	62,800	1.1
FOOD	FOD	56,400	.7	56,500	.7	62,800	1.1
ENVIRONMENTAL HEALTH		149,955	1.9	170,000	2.0	185,000	3.1
COMMUNITY WATER SUPPLY AND SANITATION	CWS	149,955	1.9	170,000	2.0	185,000	3.1
MATERNAL AND CHILD HEALTH		1,845,850	22.8	2,106,240	25.3	2,326,980	39.5
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	921,798	11.4	993,400	11.9	1,105,100	18.8
ACUTE RESPIRATORY INFECTIONS	ARI	74,500	.9	81,100	1.0	90,200	1.5
IMMUNIZATION	EPI	447,624	5.5	554,880	6.7	590,410	10.0
DIARRHEAL DISEASES	CDD	401,928	5.0	476,860	5.7	541,270	9.2
COMMUNICABLE DISEASES		2,414,293	29.8	1,946,886	23.4	69,300	1.2
TROPICAL DISEASE RESEARCH	TDR	259,800	3.2	0	-	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	2,154,493	26.6	1,946,886	23.4	69,300	1.2
HEALTH PROMOTION		224,435	2.8	222,140	2.7	0	-
HEALTH OF THE ELDERLY	HEE	86,575	1.1	0	-	0	-
OCULAR HEALTH	PBD	137,860	1.7	222,140	2.7	0	-
VETERINARY PUBLIC HEALTH		107,978	1.3	60,741	.7	65,500	1.1
ZOONOSES	ZNS	107,978	1.3	60,741	.7	65,500	1.1
GRAND TOTAL		8,100,761	100.0	8,314,057	100.0	5,883,080	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	24,120,000	2382	2160	0	21,854,300	262,300	0	0	67,500	1,571,300	0	364,600
WHO - WR	13,164,800	1176	1128	30	11,409,900	13,700	0	0	19,200	472,900	0	1,249,100
TOTAL	37,284,800	3558	3288	30	33,264,200	276,000	0	0	86,700	2,044,200	0	1,613,700
% OF TOTAL	100.0				89.3	.7		.0	.2	5.5	.0	4.3
1992-1993												
PAHO - PR	29,654,900	2087	2016	0	26,499,800	243,700	0	0	85,200	1,883,400	0	942,800
WHO - WR	15,858,600	1200	1104	30	14,872,200	2,200	0	0	16,000	228,200	0	740,000
TOTAL	45,513,500	3287	3120	30	41,372,000	245,900	0	0	101,200	2,111,600	0	1,682,800
% OF TOTAL	100.0				91.0	.5		.0	.2	4.6	.0	3.7
1994-1995												
PAHO - PR	32,755,300	2040	2016	0	29,248,200	271,000	0	0	94,600	2,093,400	0	1,048,100
WHO - WR	17,758,600	1200	1104	30	16,661,800	2,500	0	0	17,800	253,800	0	822,700
TOTAL	50,513,900	3240	3120	30	45,910,000	273,500	0	0	112,400	2,347,200	0	1,870,800
% OF TOTAL	100.0				91.0	.5		.0	.2	4.6	.0	3.7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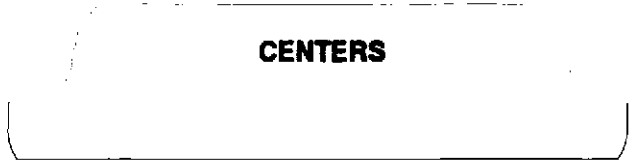
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PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		1,712,900	7.8	2,248,300	9.0	2,542,200	9.0
HEALTH SITUATION AND TREND ASSESSMENT		983,800	4.5	1,219,200	4.9	1,381,400	4.9
HEALTH SITUATION AND TREND ASSESSMENT	HST	983,800	4.5	1,219,200	4.9	1,381,400	4.9
HEALTH INFORMATION SUPPORT		729,100	3.3	1,029,100	4.1	1,160,800	4.1
SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION	HBD	729,100	3.3	1,029,100	4.1	1,160,800	4.1
III. HEALTH SCIENCE AND TECHNOLOGY		20,376,200	92.2	22,832,400	91.0	25,638,000	91.0
FOOD AND NUTRITION		4,536,300	20.6	5,148,300	20.5	5,576,400	19.8
FOOD	FOD	1,451,900	6.6	948,600	3.8	908,400	3.2
NUTRITION	NUT	3,084,400	14.0	4,199,700	16.7	4,668,000	16.6
ENVIRONMENTAL HEALTH		3,638,400	16.5	4,433,800	17.6	5,019,400	17.8
COMMUNITY WATER SUPPLY AND SANITATION	CWS	1,544,200	7.0	1,655,100	6.6	1,863,800	6.6
SOLID WASTES AND HOUSING HYGIENE	RUD	202,300	.9	259,800	1.0	293,600	1.0
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	1,891,900	8.6	2,518,900	10.0	2,861,800	10.2
MATERNAL AND CHILD HEALTH		1,262,500	5.7	1,526,000	6.1	1,741,200	6.2
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	1,262,500	5.7	1,526,000	6.1	1,741,200	6.2
VETERINARY PUBLIC HEALTH		10,939,000	49.4	11,724,300	46.8	13,301,000	47.2
FOOD SAFETY	FOS	198,700	.9	58,600	.2	68,100	.2
FOOT-AND-MOUTH DISEASE	FMD	7,247,000	32.7	8,114,900	32.4	9,184,100	32.6
ZOONOSES	ZNS	3,493,300	15.8	3,550,800	14.2	4,048,800	14.4
GRAND TOTAL		22,089,100	100.0	25,080,700	100.0	28,180,200	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
II. HEALTH SYSTEM INFRASTRUCTURE		6,558,638	16.5	5,250,687	14.5	4,345,000	13.2
HEALTH SITUATION AND TREND ASSESSMENT		4,489,462	11.3	3,067,624	8.5	2,045,000	6.2
HEALTH SITUATION AND TREND ASSESSMENT	HST	4,489,462	11.3	3,067,624	8.5	2,045,000	6.2
HEALTH INFORMATION SUPPORT		2,069,176	5.2	2,183,063	6.0	2,300,000	7.0
SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION	HBD	2,069,176	5.2	2,183,063	6.0	2,300,000	7.0
III. HEALTH SCIENCE AND TECHNOLOGY		33,043,970	83.5	30,992,230	85.5	28,583,500	86.8
FOOD AND NUTRITION		14,564,401	36.9	14,891,700	41.1	14,954,600	45.5
NUTRITION	NUT	14,564,401	36.9	14,891,700	41.1	14,954,600	45.5
ENVIRONMENTAL HEALTH		1,975,470	5.0	1,310,127	3.6	1,166,800	3.5
COMMUNITY WATER SUPPLY AND SANITATION	CWS	1,015,843	2.6	588,784	1.6	597,200	1.8
SOLID WASTES AND HOUSING HYGIENE	RUD	33,537	.1	0	-	0	-
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	926,090	2.3	721,343	2.0	569,600	1.7
MATERNAL AND CHILD HEALTH		2,236,755	5.6	1,534,830	4.2	0	-
GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION	MCH	2,236,755	5.6	1,534,830	4.2	0	-
COMMUNICABLE DISEASES		3,095,222	7.8	2,125,823	5.9	0	-
ACQUIRED IMMUNODEFICIENCY SYNDROME	HIV	3,095,222	7.8	2,125,823	5.9	0	-
VETERINARY PUBLIC HEALTH		11,172,122	28.2	11,129,750	30.7	12,462,100	37.8
FOOT-AND-MOUTH DISEASE	FMD	7,301,600	18.4	7,190,000	19.8	7,975,000	24.2
ZOONOSES	ZNS	3,870,522	9.8	3,939,750	10.9	4,487,100	13.6
GRAND TOTAL		39,602,608	100.0	36,242,917	100.0	32,928,500	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	19,267,200	1340	5256	680	14,632,700	860,100	82	155,800	270,200	558,700	0	2,789,700
WHO - WR	2,821,900	264	144	175	2,051,800	128,000	0	0	4,500	104,300	0	533,300
TOTAL	22,089,100	1604	5400	855	16,684,500	988,100	82	155,800	274,700	663,000	0	3,323,000
% OF TOTAL	100.0				75.6	4.5		.7	1.2	3.0	.0	15.0
1992-1993												
PAHO - PR	21,761,800	1217	4680	620	16,515,400	895,100	112	224,000	329,100	823,400	0	2,974,800
WHO - WR	3,318,900	216	144	285	2,336,300	136,300	0	0	55,300	121,000	0	670,000
TOTAL	25,080,700	1433	4824	905	18,851,700	1,031,400	112	224,000	384,400	944,400	0	3,644,800
% OF TOTAL	100.0				75.2	4.1		.9	1.5	3.8	.0	14.5
1994-1995												
PAHO - PR	24,396,800	1176	4680	620	18,333,600	1,038,600	112	235,200	382,100	955,500	0	3,451,800
WHO - WR	3,783,400	216	144	285	2,643,300	158,300	0	0	64,100	140,300	0	777,400
TOTAL	28,180,200	1392	4824	905	20,976,900	1,196,900	112	235,200	446,200	1,095,800	0	4,229,200
% OF TOTAL	100.0				74.5	4.2		.8	1.6	3.9	.0	15.0

TECHNICAL AND
ADMINISTRATIVE DIRECTION

TECHNICAL AND
ADMINISTRATIVE DIRECTION

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
I. DIRECTION, COORDINATION AND MANAGEMENT		7,856,700	25.6	7,755,800	22.2	8,423,000	21.7
GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT		7,856,700	25.6	7,755,800	22.2	8,423,000	21.7
EXECUTIVE MANAGEMENT	EXM	2,764,000	9.0	3,241,600	9.3	3,608,700	9.3
GENERAL PROGRAM DEVELOPMENT	GPD	4,454,300	14.5	3,467,400	9.9	3,636,300	9.4
EXTERNAL COORD. FOR HEALTH AND SOCIAL DEVELOPMENT	COR	638,400	2.1	1,046,800	3.0	1,178,000	3.0
II. HEALTH SYSTEM INFRASTRUCTURE		935,100	3.0	2,225,200	6.3	2,489,700	6.4
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		935,100	3.0	2,225,200	6.3	2,489,700	6.4
MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT	MPN	0	-	1,829,400	5.2	2,046,300	5.3
ADMINISTRATIVE ANALYSIS	AAN	935,100	3.0	395,800	1.1	443,400	1.1
IV. PROGRAM SUPPORT		21,990,000	71.4	24,905,300	71.5	27,872,900	71.9
ADMINISTRATION		21,990,000	71.4	24,905,300	71.5	27,872,900	71.9
BUDGET AND FINANCE	BFI	6,736,500	21.9	7,649,400	21.9	8,602,800	22.2
GENERAL SERVICES & HEADQUARTERS OPERATING EXPENSES	PGS	11,061,000	35.9	12,408,900	35.7	13,826,100	35.7
PERSONNEL	PER	2,796,800	9.1	3,313,400	9.5	3,722,100	9.6
PROCUREMENT	SUP	1,395,700	4.5	1,533,600	4.4	1,721,900	4.4
GRAND TOTAL		30,781,800	100.0	34,886,300	100.0	38,785,600	100.0

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
I. DIRECTION, COORDINATION AND MANAGEMENT		351,421	5.5	283,700	4.2	310,600	5.2
GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT		351,421	5.5	283,700	4.2	310,600	5.2
EXECUTIVE MANAGEMENT	EXM	52,226	.8	0	-	0	-
GENERAL PROGRAM DEVELOPMENT	GPD	144,727	2.3	64,100	.9	71,300	1.2
EXTERNAL COORD. FOR HEALTH AND SOCIAL DEVELOPMENT	COR	154,468	2.4	219,600	3.3	239,300	4.0
II. HEALTH SYSTEM INFRASTRUCTURE		91,800	1.4	0	-	0	-
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT		91,800	1.4	0	-	0	-
ADMINISTRATIVE ANALYSIS	AAN	91,800	1.4	0	-	0	-
IV. PROGRAM SUPPORT		5,893,007	93.1	6,466,400	95.8	5,682,400	94.8
ADMINISTRATION		5,893,007	93.1	6,466,400	95.8	5,682,400	94.8
BUDGET AND FINANCE	BFI	1,623,058	25.6	1,830,500	27.1	2,006,800	33.5
GENERAL SERVICES & HEADQUARTERS OPERATING EXPENSES	PGS	3,532,261	55.8	3,543,900	52.6	2,468,300	41.2
PERSONNEL	PER	231,588	3.7	259,000	3.8	294,600	4.9
PROCUREMENT	SUP	506,100	8.0	833,000	12.3	912,700	15.2
GRAND TOTAL		6,336,228	100.0	6,750,100	100.0	5,993,000	100.0

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	23,463,800	1478	2650	1515	17,521,700	551,800	0	0	12,300	54,300	0	5,323,700
WHO - WR	7,318,000	288	648	0	4,129,200	141,300	0	0	0	37,900	0	3,009,600
TOTAL	30,781,800	1766	3298	1515	21,650,900	693,100	0	0	12,300	92,200	0	8,333,300
% OF TOTAL	100.0				70.3	2.3		.0	.0	.3	.0	27.1
1992-1993												
PAHO - PR	26,599,600	1411	2520	1410	20,006,200	575,500	0	0	15,000	61,100	0	5,941,800
WHO - WR	8,286,700	315	600	0	4,755,000	177,000	0	0	0	39,500	0	3,315,200
TOTAL	34,886,300	1726	3120	1410	24,761,200	752,500	0	0	15,000	100,600	0	9,257,000
% OF TOTAL	100.0				71.0	2.2		.0	.0	.3	.0	26.5
1994-1995												
PAHO - PR	29,556,400	1392	2520	1410	22,226,900	639,700	0	0	16,700	68,000	0	6,605,100
WHO - WR	9,229,200	312	600	0	5,302,600	196,700	0	0	0	43,900	0	3,686,000
TOTAL	38,785,600	1704	3120	1410	27,529,500	836,400	0	0	16,700	111,900	0	10,291,100
% OF TOTAL	100.0				71.0	2.2		.0	.0	.3	.0	26.5

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
I. DIRECTION, COORDINATION AND MANAGEMENT		2,205,300	100.0	2,536,500	100.0	2,832,700	100.0
GOVERNING BODIES		2,205,300	100.0	2,536,500	100.0	2,832,700	100.0
GOVERNING BODIES	GOB	2,205,300	100.0	2,536,500	100.0	2,832,700	100.0
GRAND TOTAL		2,205,300	100.0	2,536,500	100.0	2,832,700	100.0

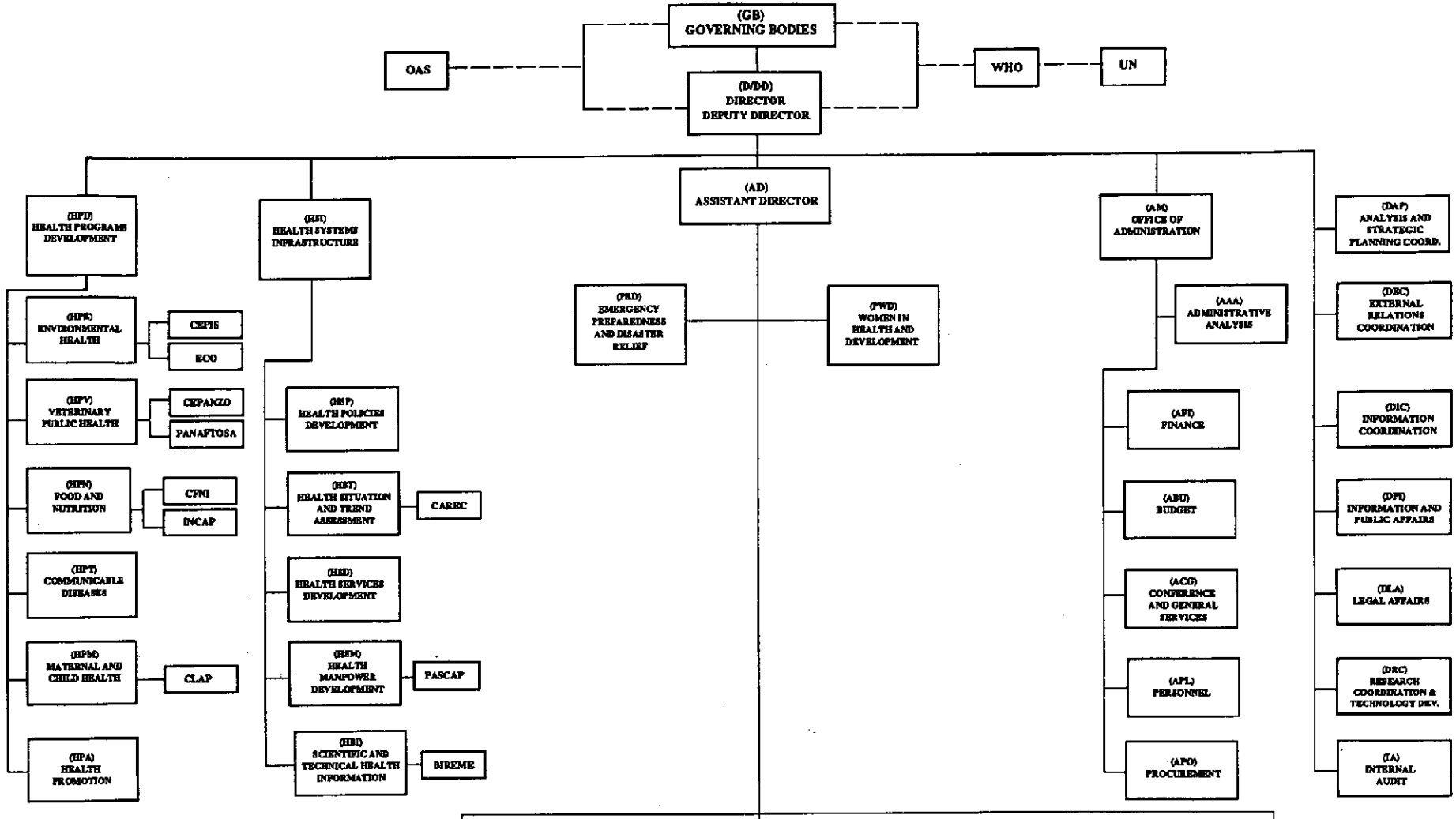
ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

SOURCE OF FUNDS	TOTAL AMOUNT	PERSONNEL				DUTY TRAVEL	FELLOWSHIPS		SEMINARS AND COURSES	SUPPLIES AND EQUIPMENT	GRANTS	OTHER
		PROF. MONTHS	LOCAL MONTHS	CONS. DAYS	AMOUNT	AMOUNT	MONTHS	AMOUNT				
	$				$	$		$	$	$	$	$
1990-1991												
PAHO - PR	1,881,200	72	96	0	710,800	0	0	0	0	0	0	1,170,400
WHO - WR	324,100	0	0	0	0	0	0	0	0	0	0	324,100
TOTAL	2,205,300	72	96	0	710,800	0	0	0	0	0	0	1,494,500
% OF TOTAL	100.0				32.2	.0		.0	.0	.0	.0	67.8
1992-1993												
PAHO - PR	2,176,100	72	96	0	874,600	0	0	0	0	0	0	1,301,500
WHO - WR	360,400	0	0	0	0	0	0	0	0	0	0	360,400
TOTAL	2,536,500	72	96	0	874,600	0	0	0	0	0	0	1,661,900
% OF TOTAL	100.0				34.5	.0		.0	.0	.0	.0	65.5
1994-1995												
PAHO - PR	2,432,100	72	96	0	985,600	0	0	0	0	0	0	1,446,500
WHO - WR	400,600	0	0	0	0	0	0	0	0	0	0	400,600
TOTAL	2,832,700	72	96	0	985,600	0	0	0	0	0	0	1,847,100
% OF TOTAL	100.0				34.8	.0		.0	.0	.0	.0	65.2

IV. PAHO ORGANIZATIONAL STRUCTURE

IV. PAHO ORGANIZATIONAL STRUCTURE

PAHO ORGANIZATIONAL CHART



BIREME LATIN AMERICAN AND CARIBBEAN CENTER FOR HEALTH SCIENCES INFORMATION
CAREC CARIBBEAN EPIDEMIOLOGY CENTER
CEPANZO PAN AMERICAN ZOONOSES CENTER
CEPIS PAN AMERICAN CENTER FOR SANITARY ENGINEERING AND ENVIRONMENTAL SCIENCES
CFNI CARIBBEAN FOOD AND NUTRITION INSTITUTE
CLAP LATIN AMERICAN CENTER FOR PERINATOLOGY AND HUMAN DEVELOPMENT
ECO PAN AMERICAN CENTER FOR HUMAN ECOLOGY AND HEALTH
INCAP INSTITUTE OF NUTRITION OF CENTRAL AMERICA AND PANAMA
PANAFTOSA PAN AMERICAN FOOT-AND-MOUTH DISEASE CENTER
PASCAP PROGRAM FOR HEALTH TRAINING FOR CENTRAL AMERICA AND PANAMA

OFFICE RESPONSIBLE FOR ACTIVITIES IN:

1/ TURKS AND CAICOS ISLANDS
2/ BERMUDA, CAYMAN ISLANDS
3/ NETHERLANDS ANTILLES

* OFFICE RESPONSIBLE FOR ACTIVITIES IN :

ANTIGUA AND BARBUDA
BARBADOS
DOMINICA
GRENADA
ST. KITTS Y NEVIS
SAINT LUCIA
ST. VINCENT & THE GRENADINES
BRITISH TERRITORIES:
ANGUILLA, BRITISH VIRGIN ISLANDS, MONTSERRAT
FRENCH DEPARTMENTS IN THE AMERICAS:
GUADELOUPE, MARTINIQUE, ST. MARTIN AND ST. BARTHOLOMEW; AND FRENCH GUIANA

PAHO ORGANIZATIONAL STRUCTURE - DESCRIPTION

GOVERNING BODIES (GB)

Included in this section are the cost estimates for the meetings of the Pan American Sanitary Conference, the Directing Council, the Executive Committee and the WHO Regional Committee. The cost estimates assume that the meetings will be held in Washington, D.C. Estimated costs for the services of the External Auditor, who is engaged by and reports directly to the Governing Bodies, are also included in this section.

OFFICE OF THE DIRECTOR/DEPUTY DIRECTOR (D/DD)

The Director's Office provides overall policy guidance to the Bureau and direct supervision to the offices of Analysis and Strategic Planning Coordination, External Relations Coordination, Information Coordination, Information and Public Affairs, Legal Affairs, and Research Coordination. The office includes the Director, the Deputy Director, and related supporting staff. n addition, funds to support Internal Audit activities are included in this office.

Analysis and Strategic Planning Coordination (DAP)

The Office of Analysis and Strategic Planning Coordination is part of the Office of the Director and is responsible for assisting the Office in analyzing, developing, implementing, and monitoring fulfillment of the policies of the Organization and ensuring that they are sensitive to changes in political, economic, and social conditions in the Region in order to guarantee greater efficiency and effectiveness in PAHO's technical cooperation, taking due account of the intersectoral dimension of health in improving health conditions in the Region. Fulfillment of this fundamental function of coordinating the development of policies is based on the technical contributions of the regional programs and the recommendations of the Country Representative Offices of PAHO/WHO in the countries.

The Office acts as Secretariat of the Subcommittee of Planning and Programming of the Executive Committee of PAHO and of the General Advisory Committee of the Office of the Director. In that function it coordinates follow-up of policies laid down by the Governing Bodies and implements decisions taken by the Office of the Director in accordance with resolutions of the Governing Bodies and the urgent needs for technical cooperation in the Region. It also acts as Secretariat of the General Advisory Committee to the Director.

The Office is responsible for the methodological development and coordination of the implementation and evaluation of short, medium and long-term planning and programing (AMPES). It also coordinates application of such methodology in technical cooperation operational programming. In this area it collaborates with the development of PAHO's basic production units in the countries.

This Office is also responsible of coordinating the Special Initiative of Central America and for supporting other special initiatives of the Organization.

External Relations Coordination (DEC)

The principal function of the Office of External Relations Coordination is to serve as a focal point for coordinating cooperation activities between PAHO and other bilateral and multilateral international agencies and organizations, international and regional development banks, and nongovernmental agencies, geared to mobilizing the technical and financial resources that the countries require for their health programs and to promoting interinstitutional actions in support of the strategies for attaining the goal of health for all by the year 2000. In addition, it collaborates with the Governments in the establishment of mechanisms that will facilitate the formulation of needs for external financial cooperation in health in a form that will be acceptable to the financing agencies. It also serves as a WHO focal point for the promotion of technical cooperation among countries (TCC) in the health field.

Information Coordination (DIC)

The functions of the Office of Information Coordination are: (a) develop, recommend, and implement policies in the areas of information systems and processing; (b) provide analytical and computational services for administrative and technical programs, including feasibility studies, systems analysis, program development and maintenance; (c) provide advisory services on the selection of computing hardware and software to the Organization; and (d) encourage the use of computing technology to improve the productivity of technical and administrative personnel.

Information and Public Affairs (DPI)

The Office of Information and Public Affairs disseminates information on PAHO's goals and activities, and on health conditions in Member Countries to the press and to a wide range of public and professional audiences. It produces nontechnical publications, maintains a photo archive, and coordinates all video production, visual aids, photography, visual instructional material and video teleconferencing activities for the Organization.

Legal Affairs (DLA)

The Office of Legal Affairs is responsible for rendering legal advice and counsel to the Director and other PAHO officials and to PAHO Governing Bodies regarding application to PAHO of international law and national laws, as well as on questions involving PAHO constitutional, procedural and administrative provisions. This Office represents the Organization in disputes and negotiations involving legal issues, including contractual, personnel, extrabudgetary and legislative matters. The Office also prepares or assists in the preparation of contracts, treaties, agreements, resolutions and other documents which have legal implications for the Organization.

Research Coordination and Technological Development (DRC)

The Office of Research Coordination and Technological Development assists the Office of the Director in the development and continuos review of PAHO's research policies, and ensures that these policies and their implications are known throughout the Organization. It maintains an effective coordinating mechanism for research in PAHO and establishes a mechanism for supporting the technical offices in promoting research and technological development in specific areas. It strengthens research and technology development capability in the Region by promoting institutional development, the exchange of research findings and the supply of information to researchers and institutions. It serves as the Secretariat to the Regional Advisory Committee on Medical Research and its subcommittees, and coordinates the administration of a PAHO program of research grants. The Office also promotes the development and implementation of national health research and technology development policies and interacts with the appropriate international agencies to facilitate this process.

OFFICE OF THE ASSISTANT DIRECTOR (AD)

The Office of the Assistant Director is responsible for supporting the technical and administrative units of the Regional Office, the Country Offices, and the United States of America-Mexico Border Field Office in the fulfillment of the policies and resolutions adopted by the Governing Bodies and the decisions of the Director of the Organization. It coordinates and supports the programming, execution and evaluation of technical cooperation with the Countries; operational relations with WHO/Geneva and the other Regional Offices; Emergency Preparedness and Disaster Relief; and the Program on Women in Health and Development.

Emergency Preparedness and Disaster Relief (PED)

The objective of the Office of Emergency Preparedness and Disaster Relief is to improve the countries' ability to prepare for emergencies and to strengthen the participation of the health sector in preparatory planning for disaster cases. To this end, it promotes the establishment of suitable programs that will serve as a focal point in the ministries of health of the countries; carries out manpower training activities; prepares guidelines, manuals and teaching materials; supports operations and epidemiological research in emergency situations; compiles, selects and distributes informative and technical material; and cooperates with various international agencies and institutions that provide assistance to the health sector in giving aid to countries that are victims of an emergency situation.

Women in Health and Development (PWD)

The Office of Women in Health and Development has as its objective to promote, support and monitor fulfillment of the mandates of the Governing Bodies of PAHO/WHO and the Regional Five-Year Plan of Action on Women in Health and Development approved by them. It serves as a focal point for all information and initiatives that the countries and the Organization undertake in regard to this Plan, and it coordinates activities with other interested agencies in this field.

OFFICE OF ADMINISTRATION (AM)

The Office of Administration is responsible for providing administrative support to all of the Field and Headquarters activities of the Organization, including the supervision and the formulation of policy for the functions and operations of Administrative Analysis, Budget, Finance and Accounts, Conference and General Services, Personnel, and Procurement.

Administrative Analysis (AAA)

The Office of Administrative Analysis is responsible for the development of administrative systems for the central and country administration of the Organization. It is also responsible for issuing directives and procedures, as well as management advisory services and assistance, and delegations of authority.

Finance and Accounts (AFI)

The Office of Finance and Accounts is responsible for financial management and accounting policies, rules and procedures; controlling, disbursing and reporting on funds of the Organization; health insurance program; banking and investments; field office financial administration; pension and income taxes; and grant administration.

Budget (ABU)

The Office of Budget is responsible for establishing and maintaining budgetary policies and procedures in order to provide a basic budgetary infrastructure for the implementation of the program activities in accordance with the mandates of the Governing Bodies as implemented by the Director. The Office supports the planning, development, and preparation of the biennial program budget and annual operating program budget documents. It controls and analyzes the monetary position of the biennial program budget and annual operating program budget by monitoring the funding situation and degree of utilization of financial resources.

Conference and General Services (ACG)

The Office of Conference and General Services is responsible for conference arrangements and records; language services; building management; administrative supplies and equipment; communications and mail; transportation; inventory records; and word processing services.

Personnel (APL)

The Office of Personnel is responsible for personnel recruitment and assignment; post classification and salary systems; performance appraisal system; staff entitlements; staff rules and personnel policies/procedures; and personnel records and files. It is also responsible for the implementation of staff development and training policies, as well as for the consolidation of training needs of the various units in the Organization, and for the implementation and/or coordination of these activities in a systematic and programmatic manner.

Procurement (APO)

The Procurement Office is responsible for the procurement and shipment of supplies and equipment for operating programs, and purchases for Member Countries and on behalf of WHO.

HEALTH SYSTEMS INFRASTRUCTURE (HSI)

This area of the Organization's technical cooperation includes the following units:

Health Policy Development (HSP)

The Unit of Health Policy Development is responsible for cooperation with the countries in the fields of analysis, formulation, implementation, and evaluation of national health policies in the context of efforts to attain the goal of health for all by the year 2000 and in the area of the relation between health and political, economic, and social development. For this purpose it has adopted a multidisciplinary approach that requires its articulation with other programs and coordination of the Secretariat. The principal areas of competence of the program are accordingly related to national socioeconomic development processes and their ties to health, including intersectoral relations, analysis of the political process and of the formulation of health policies in the countries, sectoral planning in the context of development, general aspects of the economics and financing of the health sector, institutional organization and general legislation in the health sector, and the development of technological policies in the field of health.

Health Situation and Trend Assessment (HST)

The Unit of Epidemiology has as its principal objectives to promote the development and use of epidemiology in the countries; to conduct epidemiological surveillance of the diseases of international importance; and to analyze the health situation, its profiles and trends in the countries of the Americas. In

order to fulfill these objectives, the Unit carries its technical cooperation through: epidemiological analysis of health problems undertaken jointly with national groups and allied units of the Organization; direct delivery of assistance for the progressive improvement of the national services of epidemiology; promotion of and participation in epidemiological research of importance; strengthening of programs for training in epidemiology; collection, analysis and dissemination of information on diseases of international importance; organization of alerts and delivery of prompt assistance in situations of epidemiological emergency, and coordinated epidemiological support for program areas and services where such is warranted. In carrying out these activities, the Epidemiology Unit does its work using epidemiologists located at Headquarters, in the countries and at CAREC, as well as through analysis and epidemiological dissemination systems. The Unit is responsible for the health situation evaluation and trend assessment in the Region; the preparation of country profiles; the coordination of PAHO's technical information system; and the strengthening of national information health systems. This Unit also coordinates the institutional efforts in the prevention and control of sexually transmitted diseases and of AIDS.

Health Services Development (HSD)

The main objective of the Unit of Health Services Development is to support the actions being carried out in the countries for the extension of health service coverage to the entire population within the framework of objectives, goals and strategies that the countries have jointly adopted in order to attain Health for All by the Year 2000.

Priority fields of areas of action include: the coordination of interprogrammatic activities aimed at strengthening and developing local health systems; the delivery of services to the rural and urban populations, especially the traditionally neglected groups; and the adaptation of resources to the needs of services delivery within an organizational approach, according to levels of complexity.

For carrying out the activities proposed, the Unit has technical resources in the following disciplines: health education, organization and community participation; primary care; organization and administration of medical care, including nursing and medical records; oral health care; programming, development and maintenance of health establishments; radiodiagnostic and radiation therapy services, including radiation protection; essential drugs; and production and quality control of biologicals and reactives.

Health Manpower Development (HSM)

The Unit of Health Manpower Development cooperates with the countries of the Region in the development of their manpower, ensuring not only that the number and kind of personnel are adequate, but also that this manpower is socially responsible and technically, scientifically and administratively competent, in accordance with their level of performance. This competence is to be based on the needs of the services and on the relation to existing health problems. In this regard, the Unit promotes the development of new educational methods and the dissemination of those already known so that knowledge can be managed in terms of the planning process; the training and utilization of human resources; and the collection, analysis and dissemination of scientific and technical information on health.

The areas of interaction are reflected in two large groups of activities: those related to administration of the health manpower development process, and those related to the education of personnel as such. The first group involves the formulation of policies for human resources development, the strengthening of national research capability in this field, the development of information on the structure and characteristics of health manpower in the countries, the promotion of occupational structure studies, and the development of continuing education, closely tied to supervision. The second group includes health manpower education, institutional and program development, training in public health and in health administration, educational and technological development, scientific and technical information, and direct training through fellowships.

The Unit is related to other technical units of the Organization, especially in the support it provides for the development of specific human resources in the countries, through joint programming and through relations with centers for training and manpower utilization.

For supporting development of the educational process, the Unit has, in addition to its technical staff at Headquarters, intercountry programs and the Expanded Program of Textbooks and Instruction Materials (PALTEX).

Scientific and Technical Health Information (HBI)

The objective of the Scientific and Technical Health Information Unit is to provide technical cooperation to the Member States in order to ensure the availability and accessibility of scientific and technical health information that is relevant, valid, and timely and that supports the development of health programs.

For this purpose, it coordinates production of the official publications of the Organization; it organizes PAHO's technical documentation and information; it maintains the Latin American Center on Health Sciences Information (BIREME); it provides technical supervision of the Documentation Centers of the Representatives in the Countries and of the Centers; and it provides cooperation for the development of national capabilities with respect to information, documentation, and health publications.

HEALTH PROGRAMS DEVELOPMENT (HPD)

This area of the Organization's technical cooperation includes the following Units:

Environmental Health (HPE)

The Unit of Environmental Health provides technical cooperation to the Member Countries in the prevention and control of environmental conditions and factors that have adverse effects on human health--and specifically in the strengthening and extension of drinking water and sanitation services so as to reach the objectives and goals of the International Drinking Water Supply and Sanitation Decade and of Health for All by the Year 2000; in the identification and evaluation of problems caused by solid wastes, and in the strengthening of the administration of these wastes; in the development and improvement of housing sanitation in less privileged urban and rural areas; and in the diagnosis, evaluation, prevention and control of the factors of environmental pollution and other risks to human health.

The Unit's scope of action includes activities specifically devoted to workers' health, concentrated on the identification and control of occupational hazards in the workplace.

In order to concentrate available resources so as to have efficient and effective technical cooperation with the Member Countries, the Unit develops five components: drinking water supply and disposal of excreta; management of solid wastes; housing sanitation; evaluation and control of environmental pollution; and promotion and strengthening of the institutional capacity of the countries to administer and operate their environmental health services. The first four correspond to specific program areas which aim at attaining the objectives of the program, supported by the fifth component, which will develop the institutional, human and financial resources necessary for the implementation of these program areas.

Veterinary Public Health (HPV)

The Unit of Veterinary Public Health includes the application of theoretical and practical knowledge as well as veterinary medical resources, towards the protection and improvement of human health. Its general aims are to cooperate with the Member Countries in the: (a) reduction of human suffering and death from the principal zoonoses; (b) amelioration of human hunger and malnutrition, by contributing to the increased supply of food animal protein, through improved animal health and prevention of economic losses from foot-and-mouth disease and zoonoses; (c) prevention of human injury and illness and reduction of economic losses, by protecting and assuring the safety of food supplies; and (d) promotion of overall human health and well-being through the use of appropriate veterinary public health methods.

The elements of its program include: zoonoses, foot-and-mouth disease, food safety, laboratory animal medicine, veterinary public health education and training, veterinary medical contributions to environmental quality, and veterinary public health in direct support of human health services.

The Unit also coordinates the activities of CEPANZO in Argentina and PANAFTOSA in Brazil. The program's activities of technical cooperation have been oriented to meet the needs of the Member Countries in attaining self-sufficiency through the use of appropriate technology and active community participation, in effectively utilizing their intersectorial resources, and in mutually sharing technical cooperation with each other.

Food and Nutrition (HPN)

The Unit of Food and Nutrition's goal is to support countries in the development, adaptation and use of appropriate methods for the promotion of food scarcity and of proper nutrition and for the reduction and prevention of nutritional deficiencies, through both the health services and intersectoral approaches.

The Unit also coordinates the activities of CFNI in Jamaica and INCAP in Guatemala.

Communicable Diseases (HPT)

The Unit of Communicable Diseases develops the following lines of action: (a) to provide technical cooperation for the development of national programs for the prevention and control of communicable diseases, where these represent a public health problem; (b) to strengthen the technical capability of program personnel; and (c) to promote research activities aimed at resolving the problems that interfere with progress.

The Unit deals with the following priority diseases: malaria, dengue/urban yellow fever, American trypanosomiasis, schistosomiasis, leprosy, leishmaniasis, and onchocerciasis, other filariases, tuberculosis, and hepatitis. In view of the fact that several diseases are transmitted by insects, the program emphasizes the biology and control of vectors.

Maternal and Child Health (HPM)

The Unit of Maternal and Child Health comprises the following components: mother health, child health, school age and adolescent health, family planning, growth and development, immunizations, diarrhea, and acute respiratory infections. It also coordinates the activities of CLAP in Uruguay.

These components comprise the majority of the interventions needed to improve the health of mothers and children and, therefore, its programs are basically important to primary health care.

Main areas of action of the Unit are related to the support of country programs, the monitoring of the health situation and trends in maternal and child health, the promotion of integrated health policies, strengthening of human resources for maternal and child health programs, development of health education and health promotion technologies, support and coordination of applied research on health of mothers and children, and dissemination and wide distribution of technical information.

Health Promotion (HPA)

The Unit of Health Promotion is oriented toward collaboration with the Member Countries in setting their own policies and health programs, based on adequate information about the magnitude of the population problems.

Its intervention is focused upon the control of risk factors present throughout the life of the individual, through the promotion of activities integrated in the health services at all levels of care, with emphasis on changed lifestyles and the primary health care strategy.

Consequently, important areas of activity are found in the Unit in the areas of chronic noncommunicable diseases, cancer, mental health, health of the elderly, prevention of blindness, and accident prevention and rehabilitation.

Bearing in mind the priority problems in the adult population, the Unit promotes activities on disease prevention, the promotion of health and the quality of life. These activities, which include advisory services, information, research and training, are coordinated with those of other units in the Organization for the efficient integration of cooperation activities.

PROGRAM BUDGET BY ORGANIZATIONAL STRUCTURE - PAHO AND WHO REGULAR

		1990-1991		1992-1993		1994-1995	
		AMOUNT	PCT.	AMOUNT	PCT.	AMOUNT	PCT.
	GOVERNING BODIES	2,205,300	1.1	2,536,500	1.1	2,832,700	1.1
	DIRECTOR/DEPUTY DIRECTOR	15,903,900	8.2	17,802,500	7.9	19,827,400	7.9
D/DD	OFFICE OF THE DIRECTOR/DEPUTY DIRECTOR	1,255,900	0.6	1,468,400	0.7	1,631,600	0.6
DAP	ANALYSIS AND STRATEGIC PLANNING COORDINATION	1,940,500	1.0	2,161,000	1.0	2,383,800	0.9
DEC	EXTERNAL RELATIONS COORDINATION	850,100	0.4	1,242,400	0.6	1,404,100	0.6
DIC	INFORMATION COORDINATION	5,582,900	3.0	5,861,600	2.4	6,509,300	2.7
DPI	INFORMATION AND PUBLIC AFFAIRS	1,547,300	0.8	1,763,300	0.8	1,880,600	0.7
DLA	LEGAL AFFAIRS	664,300	0.3	795,500	0.4	887,100	0.4
DRC	RESEARCH COORDINATION AND TECHNOLOGICAL DEVELOPMENT	3,662,900	1.9	4,037,500	1.8	4,601,200	1.8
IA	INTERNAL AUDIT	400,000	0.2	472,800	0.2	529,700	0.2
	ASSISTANT DIRECTOR	3,830,300	2.0	4,401,700	2.0	4,978,700	2.0
AD	OFFICE OF THE ASSISTANT DIRECTOR	1,643,400	1.0	1,939,200	0.8	2,173,700	0.8
PED	EMERGENCY PREPAREDNESS AND DISASTER RELIEF COORDINATION	447,600	0.2	567,400	0.3	644,000	0.3
PWD	WOMEN IN HEALTH AND DEVELOPMENT	477,000	0.2	589,500	0.3	665,800	0.3
FEP	FIELD OFFICE: US/MEXICO BORDER	1,262,300	0.6	1,305,600	0.6	1,495,200	0.6
	ADMINISTRATION	26,921,100	13.8	29,881,800	13.3	33,512,600	13.3
AM	OFFICE OF ADMINISTRATION	454,800	0.2	517,100	0.2	573,900	0.2
AAA	ADMINISTRATIVE ANALYSIS	1,105,000	0.6	1,199,900	0.5	1,352,100	0.5
ABU	BUDGET	983,900	0.5	1,246,200	0.6	1,405,300	0.6
ACG	CONFERENCE AND GENERAL SERVICES	12,905,000	6.7	14,002,700	6.2	15,621,400	6.2
AFI	FINANCE	5,752,600	2.9	6,403,200	2.9	7,197,500	2.9
APL	PERSONNEL	4,324,100	2.2	4,979,100	2.2	5,640,500	2.2
APO	PROCUREMENT	1,395,700	0.7	1,533,600	0.7	1,721,900	0.7

PROGRAM BUDGET BY ORGANIZATIONAL STRUCTURE - EXTRABUDGETARY FUNDS (CONT.)

		1990-1991		1992-1993		1994-1995	
		AMOUNT	PCT.	AMOUNT	PCT.	AMOUNT	PCT.
	HEALTH PROGRAMS DEVELOPMENT	65,082,852	33.6	56,149,368	40.6	47,110,940	65.6
HPD	DIRECTION	20,427	*	-	-	-	-
HPE	ENVIRONMENTAL HEALTH	4,153,650	2.1	4,080,127	2.9	1,351,800	1.9
HPV	VETERINARY PUBLIC HEALTH	15,000,129	7.7	12,905,446	9.3	13,152,600	18.3
HPN	FOOD AND NUTRITION	14,869,027	7.7	14,948,200	10.8	15,017,400	20.9
HPT	COMMUNICABLE DISEASES	2,059,508	1.1	4,388,020	3.2	-	-
HPM	MATERNAL AND CHILD HEALTH	28,069,677	14.5	19,605,435	14.1	17,589,140	24.5
HPA	HEALTH PROMOTION	910,434	0.5	222,140	0.2	-	-
	COUNTRIES	75,787,127	39.1	39,614,485	28.6	9,402,682	13.1
	TOTAL	193,921,332	100.0	138,500,639	100.0	71,782,938	100.0

* LESS THAN .05 PER CENT

PROGRAM BUDGET BY ORGANIZATIONAL STRUCTURE - EXTRABUDGETARY FUNDS

		1990-1991		1992-1993		1994-1995	
		AMOUNT	PCT.	AMOUNT	PCT.	AMOUNT	PCT.
	DIRECTOR/DEPUTY DIRECTOR	4,478,043	2.3	2,687,800	1.9	1,630,000	2.3
DAP	ANALYSIS AND STRATEGIC PLANNING COORDINATION	1,034,233	0.5	864,100	0.6	71,300	0.1
DEC	EXTERNAL RELATIONS COORDINATION	2,528,517	1.4	848,200	0.6	484,300	0.7
DIC	INFORMATION COORDINATION	210,065	0.1	260,000	0.2	288,000	0.4
DPI	INFORMATION AND PUBLIC AFFAIRS	673,575	0.3	655,500	0.5	718,400	1.0
DLA	LEGAL AFFAIRS	10,653	*	-	-	-	-
DRC	RESEARCH COORDINATION AND TECHNOLOGICAL DEVELOPMENT	21,000	*	60,000	*	68,000	0.1
	ASSISTANT DIRECTOR	8,235,155	4.2	5,529,584	4.0	952,000	1.3
AD	OFFICE OF THE ASSISTANT DIRECTOR	186,260	0.1	119,350	0.1	-	-
PED	EMERGENCY PREPAREDNESS AND DISASTER RELIEF COORDINATION	6,563,942	3.3	4,310,234	3.1	952,000	1.3
PWD	WOMEN IN HEALTH AND DEVELOPMENT	398,783	0.2	1,100,000	0.8	-	-
FEP	FIELD OFFICE: US/MEXICO BORDER	1,086,170	0.6	-	-	-	-
	ADMINISTRATION	6,480,281	3.3	6,752,600	4.9	6,004,400	8.4
AM	OFFICE OF ADMINISTRATION	309,278	0.2	-	-	-	-
AAA	ADMINISTRATIVE ANALYSIS	261,959	0.1	286,200	0.2	322,000	0.4
ABU	BUDGET	301,842	0.2	375,500	0.3	408,000	0.6
ACG	CONFERENCE AND GENERAL SERVICES	3,548,298	1.7	3,543,900	2.5	2,468,300	3.5
AFI	FINANCE	1,321,216	0.7	1,455,000	1.1	1,598,800	2.2
APL	PERSONNEL	231,588	0.1	259,000	0.2	294,600	0.4
APO	PROCUREMENT	506,100	0.3	833,000	0.6	912,700	1.3
	HEALTH SERVICES INFRASTRUCTURE	33,857,874	17.5	27,766,802	20.0	6,682,916	9.3
HSI	DIRECTION	23,000	*	-	-	-	-
HST	HEALTH SITUATION AND TREND ASSESSMENT	18,979,288	9.8	14,631,383	10.5	2,114,300	2.9
HSD	HEALTH SERVICES DEVELOPMENT	9,020,063	4.7	7,205,400	5.2	138,000	0.2
HSM	HEALTH MANPOWER DEVELOPMENT	3,328,317	1.7	3,317,956	2.4	1,664,616	2.3
HBI	SCIENTIFIC AND TECHNOLOGICAL HEALTH INFORMATION	2,507,206	1.3	2,612,063	1.9	2,766,000	3.9

PROGRAM BUDGET BY ORGANIZATIONAL STRUCTURE - PAHO AND WHO REGULAR (CONT.)

		1990-1991		1992-1993		1994-1995	
		AMOUNT	PCT.	AMOUNT	PCT.	AMOUNT	PCT.
	HEALTH SERVICES INFRASTRUCTURE	29,015,000	14.9	32,657,600	14.6	36,524,500	14.5
HSI	DIRECTION	532,100	0.3	594,100	0.3	464,200	0.2
HST	HEALTH SITUATION AND TREND ASSESSMENT	8,715,600	4.5	9,982,800	4.4	11,288,100	4.4
HSD	HEALTH SERVICES DEVELOPMENT	7,021,000	3.6	7,802,800	3.5	8,832,100	3.5
HSM	HEALTH MANPOWER DEVELOPMENT	6,641,800	3.4	7,602,100	3.4	8,446,200	3.4
HBI	SCIENTIFIC AND TECHNOLOGICAL HEALTH INFORMATION	6,104,500	3.1	6,675,800	3.0	7,493,900	3.0
	HEALTH PROGRAMS DEVELOPMENT	39,031,500	20.0	44,418,900	19.8	49,902,400	19.8
HPD	DIRECTION	320,800	0.2	516,700	0.2	575,400	0.2
HPE	ENVIRONMENTAL HEALTH	6,631,400	3.4	7,812,700	3.5	8,834,300	3.5
HPV	VETERINARY PUBLIC HEALTH	13,488,200	6.9	14,764,100	6.5	16,744,200	6.7
HPN	FOOD AND NUTRITION	5,928,200	3.0	6,660,200	3.0	7,285,900	2.9
HPT	COMMUNICABLE DISEASES	5,347,500	2.7	5,821,600	2.6	6,583,200	2.6
HPM	MATERNAL AND CHILD HEALTH	4,782,200	2.5	5,540,000	2.5	6,151,800	2.4
HPA	HEALTH PROMOTION	2,533,200	1.3	3,303,600	1.5	3,727,600	1.5
	COUNTRIES	72,289,400	37.0	83,237,100	37.2	94,202,100	37.5
	CARIBBEAN PROGRAM COORDINATION	1,803,500	0.9	1,755,700	0.8	2,002,100	0.8
	REGIONAL DIRECTOR'S DEVELOPMENT PROGRAM	3,350,000	1.7	3,725,200	1.7	4,142,500	1.6
	CONTRIBUTION TO RETIREES' HEALTH INSURANCE	700,000	0.4	3,650,000	1.6	3,900,000	1.5
	TOTAL	195,050,000	100.0	224,067,000	100.0	251,825,000	100.0

ANNEX

ANNEX

PROGRAM BUDGET - PAHO REGULAR FUNDS
(WHO CLASSIFIED LIST OF PROGRAMS)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
I. DIRECTION, COORDINATION AND MANAGEMENT		17,332,700	13.4	18,477,600	12.0	20,417,300	11.8
GOVERNING BODIES		1,881,200	1.4	2,176,100	1.4	2,432,100	1.4
REGIONAL COMMITTEES	RCO	1,881,200	1.4	2,176,100	1.4	2,432,100	1.4
WHO'S GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT		15,451,500	12.0	16,301,500	10.6	17,985,200	10.4
EXECUTIVE MANAGEMENT	EXM	2,448,400	1.9	2,902,600	1.9	3,234,900	1.9
DIR.-GENERAL'S/REG. DIRECTORS' DEVELOPMENT PROGRAM	DGP	3,194,000	2.5	3,569,200	2.3	3,969,000	2.3
GENERAL PROGRAM DEVELOPMENT	GPD	3,227,100	2.5	2,201,900	1.4	2,296,300	1.3
EXTERNAL COORDINATION FOR HEALTH & SOCIAL DEVELOP.	COR	850,100	.7	1,242,400	.8	1,404,100	.8
HEALTH-FOR-ALL STRATEGY COORDINATION	HSC	1,008,700	.8	1,244,900	.8	1,364,100	.8
INFORMATICS MANAGEMENT	ISS	4,723,200	3.6	5,140,500	3.4	5,696,800	3.3
II. HEALTH SYSTEM INFRASTRUCTURE		48,481,900	37.5	61,170,100	40.3	69,018,000	40.6
HEALTH SYSTEM DEVELOPMENT		27,119,200	21.1	37,350,500	24.7	42,375,400	25.0
HEALTH SITUATION AND TREND ASSESSMENT	HST	4,281,900	3.3	4,381,700	2.9	4,962,800	2.9
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT	MPN	22,724,800	17.7	32,504,600	21.5	36,891,600	21.8
HEALTH LEGISLATION	HLE	112,500	.1	464,200	.3	521,000	.3
HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE		12,507,900	9.6	13,184,000	8.6	14,865,300	8.7
HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE	PHC	12,507,900	9.6	13,184,000	8.6	14,865,300	8.7
DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH		7,304,300	5.6	8,997,200	5.9	10,034,900	5.9
DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH	HRH	7,304,300	5.6	8,997,200	5.9	10,034,900	5.9
PUBLIC INFORMATION AND EDUCATION FOR HEALTH		1,550,500	1.2	1,638,400	1.1	1,742,400	1.0
PUBLIC INFORMATION AND EDUCATION FOR HEALTH	IEH	1,550,500	1.2	1,638,400	1.1	1,742,400	1.0

PROGRAM BUDGET - PAHO REGULAR FUNDS (CONT.)
(WHO CLASSIFIED LIST OF PROGRAMS)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
III. HEALTH SCIENCE AND TECHNOLOGY		23,869,900	18.2	26,736,000	17.5	29,777,900	17.4
RESEARCH PROMOTION AND DEVELOPMENT		3,036,600	2.3	3,427,500	2.2	3,912,400	2.3
RESEARCH PROMOTION AND DEVELOPMENT	RPD	3,036,600	2.3	3,427,500	2.2	3,912,400	2.3
GENERAL HEALTH PROTECTION AND PROMOTION		5,401,200	4.2	6,000,900	3.9	6,527,600	3.8
NUTRITION	NUT	4,779,800	3.7	5,462,200	3.6	5,914,300	3.5
ORAL HEALTH	ORH	493,200	.4	430,700	.3	490,600	.3
ACCIDENT PREVENTION	APR	60,200	.*	50,300	.*	56,900	.*
TOBACCO OR HEALTH	TOH	68,000	.1	57,700	.*	65,800	.*
HEALTH OF SPECIFIC POPULATION GROUPS		4,350,100	3.3	5,792,100	3.7	6,351,700	3.6
MATERNAL AND CHILD HEALTH	MCH	3,809,200	2.9	5,201,500	3.4	5,683,800	3.3
ADOLESCENT HEALTH	ADH	101,400	.1	63,700	.*	70,800	.*
WORKERS' HEALTH	OCH	439,500	.3	526,900	.3	597,100	.3
PROTECTION AND PROMOTION OF MENTAL HEALTH		111,400	.1	117,300	.1	134,100	.1
PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE	ADA	111,400	.1	117,300	.1	134,100	.1
PROMOTION OF ENVIRONMENTAL HEALTH		9,193,200	7.0	9,947,600	6.6	11,212,300	6.6
COMMUNITY WATER SUPPLY AND SANITATION	CWS	6,694,800	5.1	5,985,800	3.9	6,743,500	3.9
ENVIRONMENTAL HEALTH IN RURAL & URBAN DEVELOPMENT	RUD	314,800	.2	277,400	.2	312,700	.2
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	1,685,000	1.3	3,132,400	2.1	3,535,300	2.1
FOOD SAFETY	FOS	498,600	.4	552,000	.4	620,800	.4
DIAGNOSTIC, THERAPEUTIC, REHABILITATIVE TECHNOLOGY		1,777,400	1.3	1,450,600	1.0	1,639,800	1.0
CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY	CLR	558,300	.4	560,700	.4	634,800	.4
ESSENTIAL DRUGS AND VACCINES	EDV	691,000	.5	445,500	.3	503,700	.3
REHABILITATION	RHB	528,100	.4	444,400	.3	501,300	.3

PROGRAM BUDGET - PAHO REGULAR FUNDS (CONT.)
(WHO CLASSIFIED LIST OF PROGRAMS)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
IV. DISEASE PREVENTION AND CONTROL		19,257,900	14.7	22,735,000	14.8	25,811,500	14.9
DISEASE PREVENTION AND CONTROL		19,257,900	14.7	22,735,000	14.8	25,811,500	14.9
IMMUNIZATION	EPI	141,800	.1	156,800	.1	180,000	.1
DISEASE VECTOR CONTROL	VBC	0	-	331,100	.2	384,300	.2
MALARIA	MAL	957,400	.7	880,400	.6	992,400	.6
PARASITIC DISEASES	PDP	0	-	90,300	.1	102,500	.1
TROPICAL DISEASE RESEARCH	TDR	23,600	.*	119,100	.1	133,000	.1
DIARRHEAL DISEASES	CDD	65,300	.1	74,700	.*	83,700	.*
ACUTE RESPIRATORY INFECTIONS	ARI	147,300	.1	184,600	.1	210,400	.1
TUBERCULOSIS	TUB	422,100	.3	196,200	.1	221,500	.1
ZOONOSES	VPH	12,270,400	9.4	13,624,900	8.9	15,458,600	9.0
AIDS	GPA	359,400	.3	359,000	.2	406,100	.2
OTHER COMMUNICABLE DISEASE PREVENTION AND CONTROL	OCD	2,491,500	1.9	2,998,900	2.0	3,427,100	2.0
CANCER	CAN	0	-	57,000	.*	65,100	.*
OTHER NONCOMMUNIC. DISEASE PREVENTION AND CONTROL	NCD	2,379,100	1.8	3,662,000	2.4	4,146,800	2.4
V. PROGRAM SUPPORT		21,080,600	16.2	23,457,300	15.4	26,291,300	15.3
HEALTH INFORMATION SUPPORT		5,008,100	3.9	5,449,600	3.6	6,130,200	3.6
HEALTH INFORMATION SUPPORT	HBI	5,008,100	3.9	5,449,600	3.6	6,130,200	3.6
SUPPORT SERVICES		16,072,500	12.3	18,007,700	11.8	20,161,100	11.7
PERSONNEL	PER	1,974,000	1.5	2,260,000	1.5	2,537,400	1.5
GENERAL ADMINISTRATION AND SERVICES	GAD	7,655,300	5.9	8,636,700	5.7	9,627,900	5.6
BUDGET AND FINANCE	BFI	5,371,700	4.1	5,976,500	3.9	6,721,200	3.9
EQUIPMENT AND SUPPLIES FOR MEMBER STATES	SUP	1,071,500	.8	1,134,500	.7	1,274,600	.7
GRAND TOTAL		130,023,000	100.0	152,576,000	100.0	171,316,000	100.0

* LESS THAN .05 PER CENT

PROGRAM BUDGET - WHO REGULAR FUNDS
(WHO CLASSIFIED LIST OF PROGRAMS)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
I. DIRECTION, COORDINATION AND MANAGEMENT		3,108,900	4.7	2,903,100	4.1	3,231,400	4.0
GOVERNING BODIES		324,100	.5	360,400	.5	400,600	.5
REGIONAL COMMITTEES	RCO	324,100	.5	360,400	.5	400,600	.5
WHO'S GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT		2,784,800	4.2	2,542,700	3.6	2,830,800	3.5
EXECUTIVE MANAGEMENT	EXM	315,600	.5	339,000	.5	373,800	.5
DIR.-GENERAL'S/REG. DIRECTORS' DEVELOPMENT PROGRAM	DGP	156,000	.2	156,000	.2	173,500	.2
GENERAL PROGRAM DEVELOPMENT	GPD	659,100	1.0	574,600	.8	661,700	.8
HEALTH-FOR-ALL STRATEGY COORDINATION	HSC	794,400	1.2	752,000	1.1	809,300	1.0
INFORMATICS MANAGEMENT	ISS	859,700	1.3	721,100	1.0	812,500	1.0
II. HEALTH SYSTEM INFRASTRUCTURE		27,877,700	42.8	30,686,100	43.0	34,503,800	43.0
HEALTH SYSTEM DEVELOPMENT		11,138,100	17.2	12,405,200	17.4	14,027,600	17.4
HEALTH SITUATION AND TREND ASSESSMENT	HST	4,851,600	7.5	6,200,200	8.7	6,991,000	8.7
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT	MPN	6,286,500	9.7	6,205,000	8.7	7,036,600	8.7
HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE		11,906,300	18.2	13,232,100	18.6	14,796,600	18.6
HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE	PHC	11,906,300	18.2	13,232,100	18.6	14,796,600	18.6
DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH		4,118,400	6.3	4,311,200	6.0	4,845,800	6.0
DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH	HRH	4,118,400	6.3	4,311,200	6.0	4,845,800	6.0
PUBLIC INFORMATION AND EDUCATION FOR HEALTH		714,900	1.1	737,600	1.0	833,800	1.0
PUBLIC INFORMATION AND EDUCATION FOR HEALTH	IEH	714,900	1.1	737,600	1.0	833,800	1.0
III. HEALTH SCIENCE AND TECHNOLOGY		12,844,600	19.8	14,880,500	20.8	16,831,000	20.9
RESEARCH PROMOTION AND DEVELOPMENT		434,900	.7	443,000	.6	504,600	.6
RESEARCH PROMOTION AND DEVELOPMENT	RPD	434,900	.7	443,000	.6	504,600	.6

PROGRAM BUDGET - WHO REGULAR FUNDS (CONT.)
(WHO CLASSIFIED LIST OF PROGRAMS)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
GENERAL HEALTH PROTECTION AND PROMOTION		1,966,900	3.0	2,183,400	3.1	2,489,500	3.1
NUTRITION	NUT	1,757,300	2.7	1,903,400	2.7	2,172,500	2.7
ORAL HEALTH	ORH	209,600	.3	280,000	.4	317,000	.4
HEALTH OF SPECIFIC POPULATION GROUPS		2,168,000	3.3	2,719,500	3.7	3,072,400	3.8
MATERNAL AND CHILD HEALTH	MCH	1,669,300	2.6	2,220,900	3.1	2,509,300	3.1
WORKERS' HEALTH	OCH	96,600	.1	34,600	.*	39,700	.*
HEALTH OF THE ELDERLY	HEE	402,100	.6	464,000	.6	523,400	.7
PROTECTION AND PROMOTION OF MENTAL HEALTH		631,800	1.0	764,400	1.1	860,800	1.1
PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE	ADA	247,800	.4	299,500	.4	336,700	.4
PREV./TREAT. OF MENTAL AND NEUROLOGICAL DISORDERS	MND	384,000	.6	464,900	.7	524,100	.7
PROMOTION OF ENVIRONMENTAL HEALTH		6,418,300	9.9	7,599,000	10.7	8,584,600	10.7
COMMUNITY WATER SUPPLY AND SANITATION	CWS	4,390,100	6.8	4,475,400	6.3	5,040,900	6.3
ENVIRONMENTAL HEALTH IN RURAL & URBAN DEVELOPMENT	RUD	202,300	.3	259,800	.4	293,800	.4
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	899,300	1.4	1,939,600	2.7	2,208,100	2.7
FOOD SAFETY	FOS	926,600	1.4	924,200	1.3	1,041,800	1.3
DIAGNOSTIC, THERAPEUTIC, REHABILITATIVE TECHNOLOGY		1,224,700	1.9	1,171,200	1.6	1,319,100	1.6
CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY	CLR	314,300	.5	312,500	.4	351,200	.4
ESSENTIAL DRUGS AND VACCINES	EDV	910,400	1.4	858,700	1.2	967,900	1.2
IV. DISEASE PREVENTION AND CONTROL		12,019,400	18.6	12,895,100	17.9	14,602,500	18.0
DISEASE PREVENTION AND CONTROL		12,019,400	18.6	12,895,100	17.9	14,602,500	18.0
IMMUNIZATION	EPI	1,312,500	2.0	1,516,600	2.1	1,714,500	2.1
DISEASE VECTOR CONTROL	VBC	3,229,900	5.0	2,668,200	3.7	3,016,400	3.7
MALARIA	MAL	1,055,200	1.6	952,100	1.3	1,080,000	1.3
PARASITIC DISEASES	PDP	0	-	286,400	.4	322,000	.4
TROPICAL DISEASE RESEARCH	TDR	247,800	.4	0	-	0	-
DIARRHEAL DISEASES	CDD	386,500	.6	433,300	.6	489,500	.6
ACUTE RESPIRATORY INFECTIONS	ARI	153,100	.2	224,800	.3	253,000	.3
TUBERCULOSIS	TUB	181,700	.3	232,400	.3	261,800	.3
LEPROSY	LEP	257,300	.4	349,300	.5	394,900	.5
ZOONOSES	VPH	2,024,300	3.1	1,881,000	2.6	2,128,500	2.6
SEXUALLY TRANSMITTED DISEASES	VDT	43,600	.1	47,900	.1	52,900	.1
AIDS	GPA	51,100	.1	15,700	.*	17,300	.*
OTHER COMMUNICABLE DISEASE PREVENTION AND CONTROL	OCD	2,310,000	3.6	3,011,000	4.2	3,430,200	4.3
BLINDNESS AND DEAFNESS	PBD	56,100	.1	63,700	.1	72,700	.1
OTHER NONCOMMUNIC. DISEASE PREVENTION AND CONTROL	NCD	710,300	1.1	1,212,700	1.7	1,368,800	1.7

PROGRAM BUDGET - WHO REGULAR FUNDS (CONT.)
(WHO CLASSIFIED LIST OF PROGRAMS)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
V. PROGRAM SUPPORT		9,176,400	14.1	10,126,200	14.2	11,340,300	14.1
HEALTH INFORMATION SUPPORT		3,258,900	5.0	3,228,600	4.5	3,628,500	4.5
HEALTH INFORMATION SUPPORT	HBI	3,258,900	5.0	3,228,600	4.5	3,628,500	4.5
SUPPORT SERVICES		5,917,500	9.1	6,897,600	9.7	7,711,800	9.6
PERSONNEL	PER	822,800	1.3	1,053,400	1.5	1,184,700	1.5
GENERAL ADMINISTRATION AND SERVICES	GAD	3,405,700	5.2	3,772,200	5.3	4,198,200	5.2
BUDGET AND FINANCE	BFI	1,364,800	2.1	1,672,900	2.3	1,881,600	2.3
EQUIPMENT AND SUPPLIES FOR MEMBER STATES	SUP	324,200	.5	399,100	.6	447,300	.6
GRAND TOTAL		65,027,000	100.0	71,491,000	100.0	80,509,000	100.0

* LESS THAN .05 PER CENT

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS
(WHO CLASSIFIED LIST OF PROGRAMS)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
I. DIRECTION, COORDINATION AND MANAGEMENT		20,441,600	10.4	21,380,700	9.5	23,648,700	9.4
GOVERNING BODIES		2,205,300	1.1	2,536,500	1.1	2,832,700	1.1
REGIONAL COMMITTEES	RCO	2,205,300	1.1	2,536,500	1.1	2,832,700	1.1
WHO'S GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT		18,236,300	9.3	18,844,200	8.4	20,816,000	8.3
EXECUTIVE MANAGEMENT	EXM	2,764,000	1.4	3,241,600	1.4	3,608,700	1.4
DIR.-GENERAL'S/REG. DIRECTORS' DEVELOPMENT PROGRAM	DGP	3,350,000	1.7	3,725,200	1.7	4,142,500	1.6
GENERAL PROGRAM DEVELOPMENT	GPD	3,886,200	2.0	2,776,500	1.2	2,958,000	1.2
EXTERNAL COORDINATION FOR HEALTH & SOCIAL DEVELOP.	COR	850,100	.4	1,242,400	.6	1,404,100	.6
HEALTH-FOR-ALL STRATEGY COORDINATION	HSC	1,803,100	.9	1,996,900	.9	2,193,400	.9
INFORMATICS MANAGEMENT	ISS	5,582,900	2.9	5,861,600	2.6	6,509,300	2.6
II. HEALTH SYSTEM INFRASTRUCTURE		76,359,600	39.3	91,856,200	41.0	103,521,800	40.8
HEALTH SYSTEM DEVELOPMENT		38,257,300	19.7	49,755,700	22.2	56,403,000	22.1
HEALTH SITUATION AND TREND ASSESSMENT	HST	9,133,500	4.7	10,581,900	4.7	11,953,800	4.7
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT	MPN	29,011,300	14.9	38,709,600	17.3	43,928,200	17.2
HEALTH LEGISLATION	HLE	112,500	.1	464,200	.2	521,000	.2
HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE		24,414,200	12.5	26,416,100	11.8	29,661,900	11.8
HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE	PHC	24,414,200	12.5	26,416,100	11.8	29,661,900	11.8
DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH		11,422,700	5.9	13,308,400	5.9	14,880,700	5.9
DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH	HRH	11,422,700	5.9	13,308,400	5.9	14,880,700	5.9
PUBLIC INFORMATION AND EDUCATION FOR HEALTH		2,265,400	1.2	2,376,000	1.1	2,576,200	1.0
PUBLIC INFORMATION AND EDUCATION FOR HEALTH	IEH	2,265,400	1.2	2,376,000	1.1	2,576,200	1.0

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)
(WHO CLASSIFIED LIST OF PROGRAMS)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
III. HEALTH SCIENCE AND TECHNOLOGY		36,714,500	18.9	41,616,500	18.6	46,608,900	18.6
RESEARCH PROMOTION AND DEVELOPMENT		3,471,500	1.8	3,870,500	1.7	4,417,000	1.8
RESEARCH PROMOTION AND DEVELOPMENT	RPD	3,471,500	1.8	3,870,500	1.7	4,417,000	1.8
GENERAL HEALTH PROTECTION AND PROMOTION		7,368,100	3.8	8,184,300	3.6	9,017,100	3.5
NUTRITION	NUT	6,537,100	3.4	7,365,600	3.3	8,086,800	3.2
ORAL HEALTH	ORH	702,800	.4	710,700	.3	807,600	.3
ACCIDENT PREVENTION	APR	60,200	.*	50,300	.*	56,900	.*
TOBACCO OR HEALTH	TOH	68,000	.*	57,700	.*	65,800	.*
HEALTH OF SPECIFIC POPULATION GROUPS		6,518,100	3.4	8,511,600	3.8	9,424,100	3.6
MATERNAL AND CHILD HEALTH	MCH	5,478,500	2.8	7,422,400	3.3	8,193,100	3.3
ADOLESCENT HEALTH	ADH	101,400	.1	63,700	.*	70,800	.*
WORKERS' HEALTH	OCH	536,100	.3	561,500	.3	636,800	.3
HEALTH OF THE ELDERLY	HEE	402,100	.2	464,000	.2	523,400	.2
PROTECTION AND PROMOTION OF MENTAL HEALTH		743,200	.4	881,700	.4	994,900	.4
PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE	ADA	359,200	.2	416,800	.2	470,800	.2
PREV./TREAT. OF MENTAL AND NEUROLOGICAL DISORDERS	MND	384,000	.2	464,900	.2	524,100	.2
PROMOTION OF ENVIRONMENTAL HEALTH		15,611,500	8.0	17,546,600	7.9	19,796,900	7.9
COMMUNITY WATER SUPPLY AND SANITATION	CWS	11,084,900	5.7	10,461,200	4.7	11,784,400	4.7
ENVIRONMENTAL HEALTH IN RURAL & URBAN DEVELOPMENT	RUD	517,100	.3	537,200	.2	606,500	.2
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	2,584,300	1.3	6,072,000	2.3	5,743,400	2.3
FOOD SAFETY	FOS	1,425,200	.7	1,476,200	.7	1,662,600	.7
DIAGNOSTIC, THERAPEUTIC, REHABILITATIVE TECHNOLOGY		3,002,100	1.5	2,621,800	1.2	2,958,900	1.2
CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY	CLR	872,600	.4	873,200	.4	986,000	.4
ESSENTIAL DRUGS AND VACCINES	EDV	1,601,400	.8	1,304,200	.6	1,471,600	.6
REHABILITATION	RHB	528,100	.3	444,400	.2	501,300	.2

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)
(WHO CLASSIFIED LIST OF PROGRAMS)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
IV. DISEASE PREVENTION AND CONTROL		31,277,300	15.9	35,630,100	15.9	40,414,000	16.2
DISEASE PREVENTION AND CONTROL		31,277,300	15.9	35,630,100	15.9	40,414,000	16.2
IMMUNIZATION	EPI	1,454,300	.7	1,673,400	.7	1,894,500	.8
DISEASE VECTOR CONTROL	VBC	3,229,900	1.7	2,999,300	1.3	3,400,700	1.4
MALARIA	MAL	2,012,600	1.0	1,832,500	.8	2,072,400	.8
PARASITIC DISEASES	PDP	0	-	376,700	.2	424,500	.2
TROPICAL DISEASE RESEARCH	TDR	271,400	.1	119,100	.1	133,000	.1
DIARRHEAL DISEASES	CDD	451,800	.2	508,000	.2	573,200	.2
ACUTE RESPIRATORY INFECTIONS	ARI	300,400	.2	409,400	.2	463,400	.2
TUBERCULOSIS	TUB	603,800	.3	428,600	.2	483,300	.2
LEPROSY	LEP	257,300	.1	349,300	.2	394,900	.2
ZOONOSES	VPH	14,294,700	7.3	15,505,900	6.9	17,587,100	7.0
SEXUALLY TRANSMITTED DISEASES	VDT	43,600	.*	47,900	.*	52,900	.*
AIDS	GPA	410,500	.2	374,700	.2	423,400	.2
OTHER COMMUNICABLE DISEASE PREVENTION AND CONTROL	OCD	4,801,500	2.5	6,009,900	2.7	6,857,300	2.7
BLINDNESS AND DEAFNESS	PBD	56,100	.*	63,700	.*	72,700	.*
CANCER	CAN	0	-	57,000	.*	65,100	.*
OTHER NONCOMMUNIC. DISEASE PREVENTION AND CONTROL	NCD	3,089,400	1.6	4,874,700	2.2	5,515,600	2.2
V. PROGRAM SUPPORT		30,257,000	15.5	33,583,500	15.0	37,631,600	15.0
HEALTH INFORMATION SUPPORT		8,267,000	4.2	8,678,200	3.9	9,758,700	3.9
HEALTH INFORMATION SUPPORT	HBI	8,267,000	4.2	8,678,200	3.9	9,758,700	3.9
SUPPORT SERVICES		21,990,000	11.3	24,905,300	11.1	27,872,900	11.1
PERSONNEL	PER	2,796,800	1.4	3,313,400	1.5	3,722,100	1.5
GENERAL ADMINISTRATION AND SERVICES	GAD	11,061,000	5.7	12,408,900	5.5	13,826,100	5.6
BUDGET AND FINANCE	BFI	6,736,500	3.5	7,649,400	3.4	8,602,800	3.4
EQUIPMENT AND SUPPLIES FOR MEMBER STATES	SUP	1,395,700	.7	1,533,600	.7	1,721,900	.7
GRAND TOTAL		195,050,000	100.0	224,067,000	100.0	251,825,000	100.0

* LESS THAN .05 PER CENT

PROGRAM BUDGET - EXTRABUDGETARY FUNDS
(WHO CLASSIFIED LIST OF PROGRAMS)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
I. DIRECTION, COORDINATION AND MANAGEMENT		941,179	.5	788,700	.5	843,600	1.2
WHO'S GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT		941,179	.5	788,700	.5	843,600	1.2
EXECUTIVE MANAGEMENT	EXM	52,226	.*	0	-	0	-
GENERAL PROGRAM DEVELOPMENT	GPD	141,125	.1	0	-	0	-
EXTERNAL COORDINATION FOR HEALTH & SOCIAL DEVELOP.	COR	431,063	.2	464,600	.3	484,300	.7
HEALTH-FOR-ALL STRATEGY COORDINATION	HSC	106,700	.1	64,100	.*	71,300	.1
INFORMATICS MANAGEMENT	ISS	210,065	.1	260,000	.2	288,000	.4
II. HEALTH SYSTEM INFRASTRUCTURE		46,618,349	24.2	26,172,947	18.9	6,533,916	9.0
HEALTH SYSTEM DEVELOPMENT		9,594,074	4.9	5,651,837	4.1	3,060,900	4.2
HEALTH SITUATION AND TREND ASSESSMENT	HST	4,678,451	2.4	3,067,624	2.2	2,045,000	2.8
MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT	MPN	4,915,623	2.5	2,584,213	1.9	1,015,900	1.4
HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE		32,107,166	16.8	16,547,654	11.9	1,090,000	1.5
HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE	PHC	32,107,166	16.8	16,547,654	11.9	1,090,000	1.5
DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH		4,089,584	2.1	3,317,956	2.4	1,664,616	2.3
DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH	HRH	4,089,584	2.1	3,317,956	2.4	1,664,616	2.3
PUBLIC INFORMATION AND EDUCATION FOR HEALTH		827,525	.4	655,500	.5	718,400	1.0
PUBLIC INFORMATION AND EDUCATION FOR HEALTH	IEH	827,525	.4	655,500	.5	718,400	1.0
III. HEALTH SCIENCE AND TECHNOLOGY		57,774,282	29.7	43,960,480	31.8	28,265,782	39.5
RESEARCH PROMOTION AND DEVELOPMENT		30,610	.*	0	-	0	-
RESEARCH PROMOTION AND DEVELOPMENT	RPD	30,610	.*	0	-	0	-
GENERAL HEALTH PROTECTION AND PROMOTION		17,376,898	9.0	15,019,200	10.9	15,017,400	21.1
NUTRITION	NUT	16,611,907	8.6	14,948,200	10.8	15,017,400	21.1
ORAL HEALTH	ORH	542,937	.3	71,000	.1	0	-
TOBACCO OR HEALTH	TOH	222,054	.1	0	-	0	-

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)
(WHO CLASSIFIED LIST OF PROGRAMS)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
HEALTH OF SPECIFIC POPULATION GROUPS		24,215,999	12.4	19,785,572	14.3	11,856,182	16.5
MATERNAL AND CHILD HEALTH	MCH	23,228,767	12.0	19,622,659	14.2	11,791,600	16.4
ADOLESCENT HEALTH	ADH	480,761	.2	145,945	.1	64,582	.1
WORKERS' HEALTH	OCH	84,505	.*	16,968	.*	0	-
HEALTH OF THE ELDERLY	HEE	421,966	.2	0	-	0	-
PROTECTION AND PROMOTION OF MENTAL HEALTH		574,560	.3	0	-	0	-
PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE	ADA	500,151	.3	0	-	0	-
PREV./TREAT. OF MENTAL AND NEUROLOGICAL DISORDERS	MND	74,409	.*	0	-	0	-
PROMOTION OF ENVIRONMENTAL HEALTH		8,715,265	4.5	5,164,664	3.7	1,392,200	1.9
COMMUNITY WATER SUPPLY AND SANITATION	CWS	6,180,335	3.2	1,443,321	1.0	822,600	1.1
ENVIRONMENTAL HEALTH IN RURAL & URBAN DEVELOPMENT	RUD	33,537	.*	0	-	0	-
CONTROL OF ENVIRONMENTAL HEALTH HAZARDS	CEH	2,498,279	1.3	3,721,343	2.7	569,600	.8
FOOD SAFETY	FOS	3,114	.*	0	-	0	-
DIAGNOSTIC, THERAPEUTIC, REHABILITATIVE TECHNOLOGY		6,860,950	3.5	3,991,044	2.9	0	-
CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY	CLR	10,052	.*	0	-	0	-
ESSENTIAL DRUGS AND VACCINES	EDV	5,300,294	2.7	2,061,044	1.5	0	-
REHABILITATION	RHB	1,550,604	.8	1,930,000	1.4	0	-
IV. DISEASE PREVENTION AND CONTROL		80,163,672	41.3	58,500,049	42.2	27,691,240	38.5
DISEASE PREVENTION AND CONTROL		80,163,672	41.3	58,500,049	42.2	27,691,240	38.5
IMMUNIZATION	EPI	19,549,262	10.1	11,527,265	8.3	10,810,370	15.1
DISEASE VECTOR CONTROL	VBC	419,744	.2	940,000	.7	0	-
MALARIA	MAL	5,882,430	3.0	6,204,564	4.5	100,000	.1
PARASITIC DISEASES	PDP	262,908	.1	75,000	.1	75,000	.1
TROPICAL DISEASE RESEARCH	TDR	264,800	.1	0	-	0	-
DIARRHEAL DISEASES	CDD	3,263,234	1.7	2,105,686	1.5	2,223,970	3.1
ACUTE RESPIRATORY INFECTIONS	ARI	1,281,992	.7	1,219,700	.9	1,095,000	1.5
TUBERCULOSIS	TUB	100,238	.1	33,456	.*	0	-
LEPROSY	LEP	64,312	.*	0	-	0	-
ZOONOSES	VPH	15,714,385	8.1	12,905,446	9.3	13,152,600	18.3
SEXUALLY TRANSMITTED DISEASES	VDT	119,044	.1	4,256	.*	0	-
AIDS	GPA	30,095,451	15.5	23,262,536	16.7	234,300	.3
OTHER COMMUNICABLE DISEASE PREVENTION AND CONTROL	OCD	2,152,330	1.1	0	-	0	-
BLINDNESS AND DEAFNESS	PBD	310,706	.2	222,140	.2	0	-
CANCER	CAN	617,461	.3	0	-	0	-
OTHER NONCOMMUNIC. DISEASE PREVENTION AND CONTROL	NCD	65,375	.*	0	-	0	-

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)
(WHO CLASSIFIED LIST OF PROGRAMS)

PROGRAM CLASSIFICATION		1990-1991 AMOUNT	1990-1991 % OF TOTAL	1992-1993 AMOUNT	1992-1993 % OF TOTAL	1994-1995 AMOUNT	1994-1995 % OF TOTAL
V. PROGRAM SUPPORT		8,423,850	4.3	9,078,463	6.6	8,448,400	11.8
HEALTH INFORMATION SUPPORT		2,530,843	1.3	2,612,063	1.9	2,766,000	3.9
HEALTH INFORMATION SUPPORT	HBI	2,530,843	1.3	2,612,063	1.9	2,766,000	3.9
SUPPORT SERVICES		5,893,007	3.0	6,466,400	4.7	5,682,400	7.9
PERSONNEL	PER	231,588	.1	259,000	.2	294,600	.4
GENERAL ADMINISTRATION AND SERVICES	GAD	3,532,261	1.8	3,543,900	2.6	2,468,300	3.4
BUDGET AND FINANCE	BFI	1,623,058	.8	1,830,500	1.3	2,006,800	2.8
EQUIPMENT AND SUPPLIES FOR MEMBER STATES	SUP	506,100	.3	833,000	.6	912,700	1.3
GRAND TOTAL		193,921,332	100.0	138,500,639	100.0	71,782,938	100.0

* LESS THAN .05 PER CENT