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THIRD EVALUATION OF THE IMPLEMENTATION OF THE STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000

In 1977, the Member States of the World Health Organization (WHO) unanimously adopted the Global Strategy for Health for All by the Year 2000 (Resolution WHA30.43) and, subsequently, the Plan of Action for its implementation. The World Health Assembly also proposed that the respective reports be analyzed every two years by the regional committees, the Executive Board, and the World Health Assembly and that, every six years, an evaluation be performed to determine the effectiveness and impact of the national, regional, and global strategy. The process was initiated in 1983 with a first monitoring report.

To facilitate monitoring of the progress and implementation of the national strategies for health for all and the preparation of the national reports, in 1982 WHO designed a common framework, which has subsequently been modified to reflect the comments and suggestions of the Member States and Regional Offices. This is the third version (CFE3).

The purpose of the third evaluation— the last before the year 2000— was to permit the Member States to evaluate progress in meeting the goal of health for all and applying the primary health care strategy, with a view to identifying the areas that require priority action and the elements that hinder or facilitate this progress. The present report was based on the results of 33 national reports received at Headquarters up to 25 July 1997 and other complementary sources. The reporting countries represented more than 90% of the population of the Region of the Americas. All the national reports were sent to WHO and are also available at PAHO Headquarters.

The consolidated report is organized according to the eight sections presented in the Common Framework, and the results obtained at the national and regional level will be analyzed by

the WHO Executive Board and the World Health Assembly in 1998. The delegations to the XL Directing Council of PAHO are invited to analyze and approve the present report during the discussion of the topic to contribute to the analysis that will be conducted at the global level in 1998.

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EXECUTIVE SUMMARY

The purpose of the third evaluation of the health for all strategy (HFA)— the last before the year 2000— was to permit the Member States to evaluate progress in meeting the goal of health for all and applying the primary health care strategy in order to identify the areas that require priority action and the elements that hinder or facilitate this progress. The main conclusions drawn from the 33 country reports received at PAHO Headquarters and complemented with other information sources, are the following:

- By mid-decade, nearly all the countries of the Region had moved toward democratic and participatory models of government. However, serious problems of governance persist. This shift has led to the need to redefine the relationship between government and civil society through the speedy adoption of political and organizational reforms known as State reform. Despite the countries' efforts to improve the contribution of national health policy, there still are serious constraints to achieving better results.
- There are currently more poor people in the Latin American and Caribbean subregion than in the early 1980s, with the greatest concentration in urban areas.
- Demographic trends in the Region have not changed. The decline in fertility and the aging and urbanization of the population have persisted and even intensified, as have the inequities and inequalities of the socioeconomic and demographic situation in the countries.
- Despite the progress in expanding coverage, there are serious problems related to water quality and water supply, as well as solid waste disposal. There is interest in moving toward sustainable development, a

concern shared by the population, governments, and nongovernmental organizations.

- The financial constraints in the social sectors over the past decade have increasingly revealed the serious limitations of institutions in terms of resource management, a situation that has worsened due to the rising costs in the services. Infrastructure development is one component that requires strengthening within the health sector reform processes. Another is improving the mechanisms to ensure the supply of essential drugs and other supplies.
- Since the second evaluation there have been significant changes in the formulation and implementation of national and health sector policy. Decentralization, social participation, and inter- and intrasectoral coordination are part of the strategies that have been promoted and that in some places have yielded positive results.
- A good number of countries have taken significant steps toward the creation or strengthening of health promotion and health education units in their ministries of health.
- The countries have accorded high priority to the care of children under five and women. Action has been geared toward improving coverage. However, the population's need for access persists due owing to a variety of constraints. There is a growing trend toward the delivery of integrated health services to priority population groups.
- Immunization rates in the Region are high. The last case of poliomyelitis occurred in 1991. Other important gains have been made toward the elimination of measles and neonatal tetanus.
- The need for financing and other resources has been considered a constraint to expanding and maintaining health programs. In many countries decentralization to

the local level and greater community involvement could contribute to the sustainability of the activities.

- Great progress has been made toward achieving a steady increase in life expectancy at birth, linked to the decrease in infant mortality and communicable diseases. At the same time, however, there has been an increase in chronic diseases and disabilities. The importance of diseases such as tuberculosis, dengue, and malaria has persisted or even grown in the Region. Although some indicators have improved, large gaps still persist between countries and between and within communities or social groups, a fact that should be considered when establishing policies to approach or achieve the objectives of the goal.
- The vision of HFA represents a desired future state that we will approach by renewing commitment to the goal and by implementing suitable strategies and concrete actions. This vision may be summarized as a shared understanding of health in which the energies of the Hemisphere respond ethically to the challenges that arise for the achievement of sustainable human development with dignity and equity in the future of the Americas. This vision is based on a value system guided by equity, solidarity, and sustainability.

■

Introduction

In 1977, the Member States of the World Health Organization (WHO) unanimously adopted the Global Strategy for Health for All by the Year 2000 (Resolution WHA30.43) and, subsequently, the Plan of Action for its implementation. They also agreed to monitor progress in the implementation of their national strategies and to evaluate, at regular intervals, their effectiveness in improving the health status of the population. The World Health Assembly proposed that the respective reports be analyzed every two years by the regional committees, the Executive Board, and the World Health Assembly and that every six years an evaluation be performed to determine the effectiveness and

impact of the strategy on national, regional, and global plans. The process was initiated in 1983 with a first monitoring report.

To facilitate the presentation of systematic reports and summarization of information at the regional and global levels, a common framework was developed by WHO in 1982 to assist Member States in the collection, analysis, and use of the information needed to monitor progress in the implementation of the national strategies for health for all. The common framework was subsequently expanded, revised, and improved for the first evaluation (1985), the second monitoring (1988), the second evaluation (1991), and the third monitoring (1994).

The primary purpose of the third evaluation— the last before the year 2000— was to permit the Member States to evaluate progress in meeting the goal of health for all and applying the primary health care strategy, with a view to identifying the areas that require priority action and the elements that hinder or facilitate this progress. The present version of the framework (CFE3) was designed to assist the governments and to encourage and support an analytical rather than a merely descriptive review. The indicators were revised to ensure that they would be useful for making decisions at the country level. The common framework would also facilitate regional and global comparisons and analyses.

This common framework was sent to the countries, and the PAHO/WHO Representatives were asked to provide the necessary support and collaboration to permit each country to measure progress, identify problems, and use the results to improve their health plans.

Reports were received from the following countries and territories: Argentina, Barbados, Belize, Bermuda, Bolivia, Brazil, British Virgin Islands, Cayman Islands, Canada, Costa Rica, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Montserrat, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, Saint Kitts and Nevis, Saint Lucia, Trinidad and Tobago, United States of America, Uruguay, and

Venezuela. Once received in Washington, the country reports were photocopied and sent to WHO in Geneva.

The preparation of the regional summary presented a number of challenges. Although most of the reports reached PAHO Headquarters by the established deadline, a number were considerably delayed and some never arrived. While the 33 countries from which reports were received represent over 90% of the population of the Region, the fact that the content of the reports varied considerably in its breadth and depth made it difficult to draw valid regional conclusions about the status of achieving health for all by the year 2000 based on these reports alone.

Since each report was prepared primarily to meet the needs of the country, variations existed in the dates of the information covered and in other items. A regional evaluation, however, would be more useful if data were comparable among countries and over time. Accordingly, in addition to the reports received from these 33 countries, information from the PAHO Technical Information System, from previous reports from the countries to PAHO, from PAHO technical programs, and from other sources (ECLAC, IDB, Office of Statistics of the United Nations, UNDP, UNESCO, UNICEF, World Bank) were used to supplement the data provided in the country reports. In most instances, where a data item in the country report differed from that available from other sources, the information in the country report was used.

The quality of the reports varied greatly. Some reports were quite detailed and provided the information requested in the framework. The reports from a few countries were incomplete and contained more of a description of activities than an analysis of the status of the Health for All strategy in the country. The framework requested that data regarding specific diseases be reported in two or more sections. Countries handled this in various ways: some respected the framework; others put all the information in one section (with or without a cross-reference); and some repeated selected portions of the data. Indicators were occasionally presented as absolute numbers rather than the requested rates, and at times it was not entirely clear

whether the indicator reflected a national experience, that of the governmental health sector, or only that of the ministry of health.

Given the above, it was recognized that this regional summary could not be the sum of the information provided in the country reports. Accordingly, this report reflects the best information available— in some instances, that available in the specific programs in the Regional Office. The individual country reports are available for review at both PAHO and WHO Headquarters to answer specific questions.

The consolidated report is organized according to the sections presented in the common framework. Section 8 contains a regional summary of the status of the basic indicators used to evaluate Health for All by the year 2000. All data tables are included in the Annex.

Given the completeness and timeliness of the report of the third monitoring, *Health for All and Primary Health Care in the Region of the Americas, Monitoring Report on the Strategies, 1994*, the document is being provided to the delegates as a separate reference.

Section 1. Trends in Policy Development

At mid-decade, the Region of the Americas finds itself in a situation marked by the consolidation of Hemisphere's democracies, modernization of the public sector, and economic recovery after the profound crisis of the 1990s.

The signing of the Peace Accords at Chapultepec Palace by the government and guerrilla forces of El Salvador in 1992, the installation of new governments born of free and democratic elections, the peaceful transfer of power by the will of the people in countries with a long authoritarian tradition, and political power sharing with pluralistic forces in societies where political hegemony had traditionally been exercised by a single party are among the most outstanding events that bear witness to the growing progress in democratic pluralism during the interval between the second evaluation of the strategy for health for all by the year 2000 and the present one.

The intensification of these trends does not in any way imply that countries with long-standing or newly installed democratic governments are not facing or have not faced a crisis in governance during the period in question.

Within the context of this political situation, it is important to consider the analyses of the Economic Commission for Latin America (ECLAC) regarding the evidence of dissatisfaction and discontent among various population groups— a situation that the Commission attributes both to society's unequal distribution of the costs and benefits associated with economic restructuring and to the absence of explicit institutional mechanisms that nourish credibility that there is a desire to equitably distribute the fruits of future growth. The Commission considers this latter aspect the more important of the two, noting that the second half of the 1990s may bring additional popular dissatisfaction.

At the same time, asserting that the adjustment process has still not yielded the effects anticipated by the vast majority of the population and in some cases has even

exacerbated existing social problems, reducing the income of the population and markedly increasing unemployment, the Inter-American Development Bank (IDB) characterizes the situation as one of growing weariness among many social groups.

From the countries' response, it can be reported that changes in policy-making took place in the Region that are perceived to have influenced the strategy for health for all by the year 2000. At least five countries considered the following elements influential: the incorporation of definitions stating that securing well-being for majority of the nation's population is the key challenge in any sustainable development process; those designed to promote social participation and the intersectoral approach; others related to State reform, with emphasis on decentralization; and still others linked to tax and trade reforms.

A second group of countries considered the changes associated with privatization, educational reform, and policies on women, the environment, social security, regional integration, the exchange rate, and judicial reform to be influential factors. Some of the structural reforms carried out in Latin American and Caribbean countries, such as social security and labor reforms, were barely mentioned or not considered at all.

The countries indicated that some of the measures adopted to ensure that policies in areas other than health have a positive impact on health and the health situation are increased social expenditure, expanded educational and social security coverage, the work of the social cabinets, and the implementation of compensatory programs for disadvantaged groups.

The measures related to increased social expenditure and compensatory programs for disadvantaged groups are worth examining. With regard to social expenditure, during the period evaluated real spending on social services for the period 1994-1995 was 22% higher than the figure at the close of the 1980s. By 1995 spending on education had risen to more than 4% of GDP, while spending for 1990-1992 in this area was around 3.5%. In 1995, real per capita expenditure

on education was 18% higher than in 1992. Another sector that benefited from the increase in social expenditures was social security, which was able to modify retirement and pension rules, amortize liabilities accumulated by the system, and expand service coverage.

Regarding implementation of compensatory programs, the reality is that in at least three countries of the Region such programs are of a permanent nature and form part of medium- and long-term social policy, although they were conceived as mechanisms to cushion the social impact of adjustment policies.

The countries' efforts to enhance the contribution of structural, macroeconomic, and sectoral policies to the Health for All strategy have been hindered by several factors, the most important of which, judging by the frequency with which they are mentioned in the reports of the national authorities, are:

- (a) The limited institutional structure of State agencies and the organizations of civil society.
- (b) The excessive centralization of decision-making and available resources. Concentration of decision-making at the highest level of the executive branch has considerably limited the development of the decentralized levels of the State, including the municipal authority.
- (c) The weakness of the basic intersectoral coordination mechanisms. This is responsible for the lack of integration in defining and executing strategies for action and identifying mechanisms for financing and prioritizing investments and activities targeting disadvantaged population group. This has contributed to a duplication of efforts and has diminished the synergy of the activities required for implementing the Health for All strategy.
- (d) The absence of intersectoral coordination between the public and private sector.

- (e) Little integrated development of the primary health care strategy and poor implementation of its components.
- (f) The absence of mechanisms to monitor and assess the impact of macroeconomic structural and sectoral policies, including among these latter the impact of health on the proposed goals of the strategies for Health for All. The deficiencies of the national information systems are considered the most significant obstacle to the development of these mechanisms.

Another limitation should be considered, given the purposes included in this section, and that is the problems of governance that are affecting the political system. The countries noting this problem are equally distributed among those that have recently taken the path of democratic transition and those that have been consolidating their political systems for over a decade.

These problems manifest themselves in different ways, from a lack of understanding and resistance to change due to inertia, frequent changes of ministers of health, popular protests, and the increased abstentionism of the most recent elections in the countries.

Conclusions

By the middle of this decade, nearly all the countries of the Region had moved toward democratic, participatory models of government. However, serious problems of governance persist. This shift has led to the need to redefine the relationship between government and civil society through the speedy adoption of political and organizational reforms known as State reform. Despite the countries' efforts to improve the contribution of national policy-making in health, there are still serious constraints to achieving better results.

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Section 2. Trends in Socioeconomic Development

2.1 Economic Trends

Although real GDP growth rates for Latin America and the Caribbean in the 1990s clearly indicate an economic recovery in the countries of the subregion, both the Economic Commission for Latin America and the Caribbean (ECLAC), and the Inter-American Development Bank (IDB) characterize this growth as "moderate" or "not entirely satisfactory." While a clear improvement over the stagnation of the 1980s, the 3% average growth for the period 1990-1996 has still not caught up to the levels reached by these economies in the decades preceding the 1980s.

The behavior of this growth reveals differences among the countries, ranging from Guyana with an annual average variation in GDP of +8.1% for the period 1991-1996 to Cuba with -4.8%—variability that denotes the unstable growth of these economies.

In 14 countries of the subregion, the GDP for 1996, weighted by population and expressed in 1990 dollars, was lower than that of 1980. The cumulative variation in these countries is significantly above -20% in Haiti, Nicaragua, Suriname, and Venezuela; in four countries it is virtually the same as in 1980; in three, the growth ranges from 10% to 20%; and only in two is it over 30%.

As for economic indicators other than GDP, there is a growth in real demand in the subregion, both in consumption and investment, as well as exports. In the case of investment, the 1990s have witnessed the recovery of this component of demand, although investment rates are still below the levels attained prior to the crisis of the 1980s.

In the case of social investment, this recovery, which began in 1989, has reached levels in the 1990s that put real spending at 22% higher than the social expenditure of the

subregion at the end of the 1980s. The behavior of social spending on health has been different, for, while like all social expenditure it began to grow in 1989, the trend was reversed in 1991 and 1992, and the figure fell to 1981 levels. In 1993 it began to rise again, putting social expenditure in health in 1995 (in terms of real per capita expenditure) at more than 22% above the figure to which the downturn of 1992 had brought it.

2.1.1 Public Finance

Central government expenditures as a share of GNP rose for most countries in the Region between 1990 and 1994 (Table 1). In Bolivia, El Salvador, Paraguay, and Peru, central government expenditure as a share of GNP rose over 35%. Seven countries showed a decrease in the share of government spending: Brazil, Colombia, Mexico, Venezuela, and Panama experienced a slight decrease, while in Chile and Guatemala, government spending as a share of GNP fell by over 20%.

The percentage of total government expenditure going to social services has also been increasing, albeit modestly, for the majority of countries. Even in countries where central government spending decreased as a share of GNP, the share of public spending in the social sectors tended to rise. Only in Guatemala was a relatively large decrease in the share of government spending in GNP accompanied by a significant decrease in social spending as a share of public expenditure. In general, social sector spending from 1990 to 1994 has been mildly favored and protected relative to other public functions.

Very little detailed public sector data is available for 1995 and 1996. This period, which included the Mexican peso crisis and its effects in other countries in Latin America, is likely to show a significant, if temporary, change in public expenditure in countries such as Argentina, Brazil, and Mexico. The impact of this on public expenditures in social services remains to be seen.

2.1.2 The Evolution of Poverty and Income Distribution in the Countries of Latin America and the Caribbean

Although the magnitude of poverty in Latin America decreased from 41% to 39% of total households between 1990 and 1994, this reduction was not enough to offset the 5% increase of the 1980s. In absolute terms, the number of people below the poverty line in Latin America grew from 197 million in 1990 to 209 million in 1994, with 65% of this population concentrated in urban areas, although the proportion of poor in the total rural population remained greater than in the cities.

A look at the degree and variations of urban poverty in the Latin American countries for which information for comparative purposes is available reveals that the magnitude of this poverty ranges from countries such as Argentina and Uruguay, where less than 15% of all households are under the poverty line, to Bolivia, El Salvador, Guatemala, Haiti, Honduras, and Nicaragua, where the figure is over 50%. In between are Brazil, Colombia, Ecuador, Mexico, and Peru, with figures ranging from 31% to 50%. Brazil, Chile, Panama, and Uruguay have less poverty than in 1980, while Argentina, Honduras, Mexico, Nicaragua, and Venezuela have more. Colombia, Costa Rica, and Peru remain at similar levels (Table 2).

In the Caribbean, poverty has increased in the 1980s and 1990s. Estimates put 38% of the population at below the poverty line, with rates in the countries ranging from 12% to 42%.

In terms of poverty, Latin America and the Caribbean are poorer now than they were at the beginning of the 1980s.

There are even cases of countries where poverty is still greater than in 1980, despite the growth in GDP per capita in percentage terms and the decline in poverty during the period 1990-1994.

Income distribution is responsible for the evolution of the relative poverty in Latin America and the Caribbean. In Latin America, the income share of the poorest 40% of

households was larger in 1994 than in 1986 in Brazil, Chile, and Uruguay; it was smaller in Mexico, Panama, and, the metropolitan area of Greater Buenos Aires in Argentina; and it was the same in Colombia, Costa Rica, Paraguay (metropolitan area of Asunción), and Venezuela.

The income share of the wealthiest 10% of households was larger in 1994 than in 1986 in Chile, Mexico, Panama, Paraguay (metropolitan area of Asunción), and Venezuela; it was the same in Argentina (metropolitan area of Greater Buenos Aires) and Costa Rica, and was smaller in Brazil, Colombia, and Uruguay. This decile includes more than 40% of the total urban income in Brazil, Chile, and Colombia; 37% in Guatemala, Honduras, Nicaragua, and Panama; nearly 35% in Argentina, Bolivia, Mexico, and Paraguay; 31% in Venezuela; 27.5% in Costa Rica, and 25.4% in Uruguay.

Because it depends fundamentally on wages, the income share of households is closely linked not only to unemployment, but to the worker's place in the job market.

The profile of workers in households with incomes below the poverty line shows that they do not work only in sectors characterized by low productivity (understood as enterprises with up to five employees, activities engaged in by nonprofessional and unskilled self-employed individuals, and domestic service), but in the formal sector as well. In 1994 in 7 out of 12 countries studied by ECLAC, the percentage of wage earners in the private sector, excluding the employees of microenterprises and belonging to this category, was between 30% and 50%; in three countries it ranged from 10% to 20%; and only in two was it between 5% and 6%.

Concerning unemployment and job creation, the average annual rate of urban unemployment in Latin America and the Caribbean rose from 6.6% in 1994 to 7.8% in 1995, the largest increase since 1983. Significant within this context is the impact of unemployment on women and young people. According to ECLAC estimates, unemployment is from 10% to 20% higher than the average rate for women and 50% higher for young people. It is necessary to know the effects of changes in the age distribution of the population

on the size of the work force, as well as the composition and nature of the job market.

2.2 Demographic Trends

Within the context of the sweeping social and economic changes in the Region since the 1960s, major transformations have taken place in the demographic dynamic, and its trends—mortality, fertility, birth rate, population growth—have followed a downward trajectory. Population growth has significantly slowed, and changes have occurred in the composition, age structure, distribution, and geographic mobility of the population, changes that are directly related to changes in the supply of human resources and the demand for goods and services.

By mid-decade in the 1990s, the population of the Americas reached 774 million (from 331 million in 1950), nearly 13% of the current world population, with estimates indicating that it will reach 1,062 million by the year 2025. In terms of population, Latin America's relative weight in the Hemisphere has increased over time: in 1950 it accounted for 48.7% of the population; in 1995, 61.3%; and, according to current projections, by 2025 it will have 65.1% of the Region's population. The population of North America, in contrast, has fallen from 50.1% in 1950 to 37.7% in 1995, with estimates putting it at 33.9% by 2025 (Table 3).

The countries of the Region are shifting from a scenario of low demographic growth accompanied by high mortality and fertility rates to another, also characterized by low demographic growth, but now with low mortality and fertility rates. In this extended process known as "demographic transition," two intermediate points can be identified: in the first, demographic growth increases as a result of the decline in mortality; in the second, that growth subsides, due to the subsequent decline in fertility. The Region— and Latin America in particular— is currently experiencing a rapid decline in fertility, although there is vast differences between and within countries and, potentially, a wide margin for reduction.

Since the second evaluation of the strategy for HFA/2000 (1991), using the classification developed by CELADE to indicate the stages of demographic transition, the countries have been grouped as follows:

Group I, incipient transition (high birth rate; high mortality; moderate natural growth, on the order of 2.5%): Bolivia and Haiti are still in this category.

Group II, moderate transition (high birth rate; moderate mortality; high natural growth of around 3.0%): Peru has moved out of this category; El Salvador, Guatemala, Honduras, Nicaragua, and Paraguay remain.

Group III, full transition (moderate birth rate; moderate or low mortality; moderate natural growth of around 2.0%): Chile moved out of this category; Peru moved in; Brazil, Colombia, Costa Rica, Dominican Republic, Ecuador, Guyana, Mexico, Panama, Suriname, Trinidad and Tobago, and Venezuela remain.

Group IV, advanced transition (moderate or low birth and mortality rates; low natural growth on the order of 1.0%): Chile moved into this group; Argentina, Bahamas, Barbados, Canada, Cuba, Guadeloupe, Jamaica, Martinique, Puerto Rico, United States, and Uruguay remain.

The demographic transition process makes it possible to detect significant changes in the age distribution of regional populations; the aging of the population is especially visible. The proportion of the population under 15 years of age in the Americas has fallen from 34% in 1950 to 29% in 1995, with projections pointing to a figure of 22% by the year 2025. As in the world population, the 65-and-over age group grew in both percentage terms— from 6% to 12%— and in volume, more than tripling between 1950 and 1995. It is important to point out, however, that these regional trends are strongly influenced by the demographic patterns observed in North America more than that of Latin America and the Caribbean.

Contrary to expectations, demographic trends in the Region did not change course in response to the serious

crisis of the 1980s. The decline in fertility has continued and even intensified in the countries, as have the inequities, both socioeconomic and demographic. Moreover, the gaps may be widening due to the effects of other demographic phenomena in the Region in recent years, such as accentuated urbanization (due to intense rural-urban migration), rapid urban growth, and growing urban-urban internal migration. The identification and analysis of these inequalities can undoubtedly help to determine the need for health services and redefine priorities in health care, making it possible to meet the targets set for the application of the strategy for health for all (Table 3).

2.3 Social Trends

2.3.1 Education

According to the available country reports for this third evaluation, the educational situation in the Region in the past six years has been marked by steady progress in raising the educational level of the population (although the pace has been less rapid than in previous evaluation exercises). It is worth noting that in four decades the Hemisphere has succeeded in reducing its illiteracy rates by 36%, an important aspect of which has been a reduction in the literacy gap between the sexes. However, not only is there great heterogeneity between countries, but large differences within them. Furthermore, in this evaluation period the negative impact of the 1980s' crisis on educational development in the Region is clear. Indeed, while national efforts have succeeded in significantly raising enrollment rates in the basically public educational system, especially at the primary level, completion rates are low; even more marked is the school drop-out rate among women. This contrast—high enrollment and low completion rates—is also present in different degrees in the secondary and higher education systems.

However, despite the progress of recent decades, the average educational level is currently lower than it should be, given the Region's degree of socioeconomic development.

In fact, as recently noted by the IDB, based on per capita income, while 82% of boys and girls in the Region should have completed the fourth grade, the actual figure does not exceed 66%. The social gap is evident: the percentage of students who do not complete this educational level is almost double the figure it should be for the level of income in Latin America. Similarly, the Region's work force should have at least 7.0 years of formal schooling; however, the actual level is 5.2 years, a fact that reflects the limited coverage and rates of completion in secondary education. The observable gaps in educational development in the Region today may stem from inadequate mobilization of public sector resources to meet the growing demands generated by population growth and the urbanization process and/or from the inefficiency of the educational systems of the Region.

2.3.2 *Employment*

During the present decade, a phenomenon noted at the time of the third monitoring of the strategy for HFA/2000 in 1990 has become evident in the Region: the *third-worldization* of the work force in Latin America, a process that explains the apparent contradiction in the social indicators. It is clear that, during this same period, a substantive increase in the number of jobs has not occurred.

Hence, the supply of jobs generated by economic growth in the Region thus far in the decade has not increased. The growth of the informal sector of the regional economy with the recession of the 1980s— the so-called *third-worldization*— is precisely what is responsible for these employment trends. Beyond these, the "growth without employment" observed in the Region in these years suggests that the higher production in most of the countries has been due more to technological development than to an increase in new employment-generating investment in the branches of economic activity where this growth has occurred.

2.3.3 *Women's Role*

In education, literacy among women has grown faster than among men, significantly reducing the historical gap in this profile. However, while enrollment rates in primary, secondary, and higher education institutions are similar for both sexes, the rates of completion are lower for women.

In employment, there has been a slow but steady increase in women's participation in the work force, related, among other things, to a major expansion in the educational system in the Region and a significant decline in fertility.

2.4 Food Supply and Nutritional Status

A number of countries (17) presented information on the nutritional status of children, but for most of them the data did not reflect the national situation.

Some countries achieved improvements in this area through the application of strategies such as breast-feeding, proper weaning practices, appropriate feeding during acute episodes of disease, immunization programs, and programs for the control of diarrheal and respiratory diseases. However, in many of the countries that have significantly reduced the levels of malnutrition, large differentials in terms of geographical location and population strata can be observed that the summarized measurements do not reveal. The establishment of operational nutritional surveillance systems facilitates the collection of disaggregated data that can be used both to identify depressed areas and target interventions.

Low birthweight, in addition to posing a risk factor for the newborn, may also indicate that the pregnant woman received inadequate nutrition. As observed in Table 4, of the 19 countries with information for the second and third evaluations, six of them indicated no change, 10 reported an improvement in the situation, and nine a slight deterioration.

With regard to micronutrient deficiencies such as iron, iodine, and vitamin A, the information is usually inadequate

and corresponds only to some countries or areas within a country. In addition, the concentration of these deficiencies in certain geographical areas and population groups is more accentuated than are general nutritional problems.

2.5 Lifestyles

In their reports on the third evaluation of the implementation of the strategy for health for all, most of the countries of the Region report an increase in the relative importance of lifestyles and environmental factors as determinants of health and living conditions in recent years, although they recognize that the data and information are lacking that would make it possible to characterize the situation and monitor its trends. The exceptions are Canada and the United States, which have very detailed goals, plans, programs, and interventions for promoting healthy lifestyles among their inhabitants.

The increase in the relative importance of lifestyle in the health of the population since the second evaluation of HFA/2000 is attributed by the countries to the changing epidemiological profile of their peoples, which together with demographic changes, reveal a rise in chronic diseases, especially in urban populations and environments.

In general, the following trends can be observed in the Region, to one degree or another:

- With the increasing opening of the market, processed foods have become more available, as have transnational fast-food franchises, which are becoming increasingly popular. In contrast, the availability of fresh fruit and vegetables has not kept pace. Although the specific impact of these changes on nutritional status has not been reported, it is assumed that the proportion of energy intake from fats is increasing, a phenomenon also associated with inadequate levels of physical activity in many countries in the Region.

- Another recent trend reported by many countries is a greater openness about topics related to sex and sexual health, largely mediated by national efforts to combat sexually transmitted diseases and HIV/AIDS, and to promote reproductive health and family planning.
- A growing number of countries report that the use of tobacco, alcohol, and psychoactive substances is a matter of concern in their national health plans, and that work is under way to determine the magnitude and extension of the problem and to draft legislative initiatives for its control. However, to date only a few countries— such as Canada and the United States— have incorporated specific plans for the prevention and control of these problems into their primary health care platform. A similar situation is reported with respect to the growing problem of violence, intentional and unintentional, especially urban and family violence.

2.6 Conclusions

Although the 3% average GDP growth rate for the period 1990-1996 represents a real improvement over the stagnation of the 1980s, GDP has still not attained the levels achieved by the economies in the decades leading up to that period.

There are more poor people in Latin America and the Caribbean than at the beginning of the 1980s, with the largest concentration of this population located in urban areas.

Demographic trends in the Region have not altered their course; the decline in fertility and the aging and urbanization of the population have persisted and even intensified, together with the socioeconomic and demographic inequities and inequalities within the countries.

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Section 3. Health and Environment

Concern about environmental problems has increased in the countries of the Americas, as it has in other regions of the world.

3.1 *General Protection of the Environment*

Since the 1992 United Nations Conference on Environment and Development (UNCED-92), held in Rio de Janeiro, increasing attention has been paid to seeking ways to implement the Declaration of Principles and Agenda 21, which were agreed to at the Conference. A number of regional and subregional meetings have been held to address the topic of health and the environment.

In 1995, the Pan American Conference on Health and Environment in Sustainable Human Development was convened by PAHO. This Conference was designed to develop an understanding of the full scope and magnitude of the issues of health and environment, as well as social issues in general, including their mutual interaction and their contribution to sustainable human development. The centerpiece of the Conference was the "Pan American Charter on Health and Environment in Sustainable Development," a Hemisphere-wide declaration expressing the shared determination to move forward within the framework of equity, solidarity, social justice, and environmental preservation. In support of this initiative, a regional plan of action was drafted that takes into account new trends in planning and serves as a strategic guide for implementing the Pan American Charter as it is adapted to each country's national reality (1).

Three Central American Conferences on Ecology and Health (Conferencias Centroamericanas sobre Ecología y Salud - ECOSA I, II, III) have been held. While it is still too early to measure the impact that these Conferences have had on the health of the population, they have already had a number of positive outcomes. Achievement of the proper

relationship between health and the environment requires multisectoral action. At the country level, preparation of the country reports to these Conferences offered the opportunity to bring together representatives from government agencies, nongovernmental organizations, and the community at large— a first step to creating plans of action and clarifying roles.

Several countries have enacted laws on the environment, and some have created organizational structures to deal with sustainable development and the environment. Some countries have required environmental impact studies as part of new projects. Some, in an effort to reduce atmospheric pollution, especially in urban areas, have banned the use of lead in gasoline and are requiring emission control devices in automobiles. Some countries prohibit smoking in public buildings and in public transport, or have begun on a more limited basis by banning smoking within the ministry of health.

A number of countries are beginning or increasing steps to monitor air quality.

The cholera epidemic aroused increased concern about food safety and intensified food inspection efforts and the training of food handlers. A few countries have introduced food hygiene standards and licensing to ensure that products will satisfy the demands of the export market. These and other actions taken to combat the cholera epidemic, such as household disinfection of water, have led to a reduction in morbidity and mortality from diarrheal diseases in a number of countries.

The lack of proper solid waste disposal is a major cause of concern in most countries because of the problems it presents in vector control and atmospheric pollution.

The countries of the Region identified a number of constraints, some which were common to many. There is a lack of resources to implement all the necessary actions. There are not enough human resources, and many lack the necessary training. The many organizations involved in environmental health management often have overlapping

mandates and statutes that result in conflict and a duplication of responsibility. There is a failure to apply sanctions for noncompliance with environmental laws and regulations.

Overcoming these constraints requires, among other things, development and adherence to a plan of action, improvement in organizational structure and interinstitutional coordination, strengthening of programs at the local level, and the creation of education and training programs

3.2 *Water Supply and Sanitation*

Table 5 shows water supply and sanitation coverage at the time of the second evaluation (1988) and in 1995. The 1995 coverage for the total population with access to water supply through house connections and other acceptable means, such as public faucets at a reasonable distance, was 73%. The data indicate that the development of water supply services in Latin America and the Caribbean has been much slower than expected and has even declined as several countries have revised their level of coverage downward. More consideration has been given to factors such as the reliability of services and distances as countries have begun to look more closely at their water supply infrastructure (2).

In the field of sanitation, by 1995 the total coverage of wastewater and excreta disposal facilities had increased to 69%. The urban services remained constant at 80%; however, rural services were extended to approximately 40% of the population (2).

One of the most critical sanitary problems in Latin America remains the lack of sewage treatment. Untreated and inadequately treated sewage contaminates surface and ground water. Previous estimates put the level of sewage that received treatment at 10% or less. The 1995 survey indicated that the percent of sewage collected that receives treatment is just above 10% (2). Waterways and coastal areas are polluted by industrial waste, agricultural fertilizers, and pesticides in addition to human waste.

As a result of the cholera epidemic, countries have increased investment in water supply and sanitation. Some countries have placed emphasis on improving the situation of rural populations.

Decentralization and community participation have contributed to projects arising from the perceived needs of the community. This has required the preparation of technical standards and the training of community workers to meet these new responsibilities.

The five most serious constraints identified by the countries, in order of priority were: the lack of government policy for the sector; funding constraints; the inappropriateness of the institutional framework; the inadequacy of the cost recovery systems; and the obsolescence of existing legislation. Other constraints were the lack of trained professionals and technicians, logistics, and the lack of community involvement (2).

These constraints are serious, and the question of resources is an especially difficult one to resolve. Instituting effective policies for charging for services to ensure sustainability has been mentioned by some countries as one approach to follow.

3.3 Conclusions

There has been environmental degradation, which in some countries has its roots in poverty. Serious problems exist in the quality of the water supply, basic sanitation, and solid waste disposal. There is, however, interest in achieving sustainable development, a concern that is shared by the population, government institutions, and nongovernmental organizations.

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Section 4. Resources for Health

4.1 *Human Resources for Health*

The data collected in the countries of the Region indicate the persistence of the trend toward professional medical specialization noted in the previous evaluations. The principal characteristics are related to the steady rise in the number of physicians in the Region, with the ratio in most of the countries exceeding 10 physicians per 10,000 population. Among dentists, extreme values are observed, from 0.1 per 10,000 to 12.0 per 10,000 population. The health work force continues to be largely female and concentrated in nursing. The distribution of nurses in the countries ranges from 1 to 77 per 10,000 population (Table 6).

Decentralization of the health services has not led to the expected redistribution of the human resources concentrated in urban areas. Moreover, the institutions responsible for training human resources have neglected education in public health, health policy, and health management. Reduced employment in health and the changes in financing resulting from State reform have influenced policies related to the development of new human resources for health in most of the countries of the Region.

Countries usually have a variety of institutions that, working in isolation, make decisions about training and education needs, as well as the job market for human resources for health. There are no national mechanisms, or only weak ones, for coordinating interinstitutional efforts to guarantee the accessibility and appropriate distribution of service providers. Fourteen of the reports received note that mechanisms have not been established at the national level to determine whether human resources for health are meeting the countries' demands in terms of current institutional needs, guaranteed access, and the appropriate distribution of service providers to meet the needs of the population.

While most of the countries have information on recent graduates from their public institutions responsible for the training of health workers, other aspects, such as education, training, distribution, and performance in the private sector, are unknown. There is a marked trend in the sector toward overspecialization and private practice, where the delivery of services is based on purchasing power and demand.

Another element that has affected human resources development is the high degree of management turnover due to changes in government and direction, the lack of a personnel policy to facilitate this development, and appropriate incentives not only to keep personnel on board, but keep them motivated as well.

Analysis by category of the composition of the personnel structure in the ministries of health in one of the reports indicates that, at the present time, roughly half of employees are assigned to ministry functions, approximately three in 10 workers are assigned to offices dealing with curative aspects of health, and less than one in 10 to prevention. For every physician there are five people performing administrative work.

At the same time there are no signs that the geographical and social distribution of health workers has improved since the Second Evaluation of the Implementation of the Strategy for HFA/2000. Health workers remain highly concentrated in the cities, to the detriment of rural areas and urban peripheries. Virtually all countries reporting note this situation and consider its reversal critical. For example, 80% of physicians in Guatemala are located in the metropolitan area, where the ratio is approximately 28 per 10,000 population. The situation with respect to nursing is similar, which leaves a deficit in the country's response capability. Ecuador cites the persistence of an inadequate distribution of these resources among regions and between urban and rural areas, noting the greatest deficit in mountain areas. It is important to underscore that 92.4% of health workers are located in urban areas. The job market in the health sector is facing serious problems. Out of

every 1,000 entering dental students, only 326 ultimately graduated and 50 found permanent jobs.

In the English-speaking Caribbean, the negative growth of professional nurses persists. These countries have a special situation related to the foreign health workers in their work force.

The appearance of new actors in the health sector job market (banks, NGOs, other agencies) has meant significant changes in the mechanisms and processes involved in the regulation of health care and the health professions. Conditions in recent years were not conducive to strengthening human resources planning on the part of the ministries of health. In a political context in which the mandates of the health authorities are relatively short and the maturation time for decisions with respect to human resources is relatively long, structural action needed for solving the health problem is often postponed or considered unviable. Many initiatives have materialized in the form of official commissions to review health resources. However, in most cases these commissions have not led to actions that contribute to the achievement of the expected results, since they depend on the political situation and the interest and will of the responsible authorities to convene them.

Important areas of health sector reform are the improvement of working conditions and wages, the decentralization of resources, better quality training, and improved performance of human resources. Despite this, however, the most important constraint is the failure to develop a model of human resources needs in health in coordination with the institutions that train resources; this affects the distribution of human resources for health and the quality of care, leading to a lack of professional opportunities in the public sector. One of the most important factors in recent times that has limited the expansion of human resources has been cutbacks in spending by the public sector, precipitated by the downturn in the economy.

4.2 Financial Resources for Health

In 1994 the countries of Latin America and the Caribbean spent around US\$ 118 billion on health, or about \$250 per capita. National health expenditure (NHE) in the Region in 1994 represented 7.5% of the gross domestic product (GDP).

There are vast differences among the countries of the Region with respect to the absolute and relative levels of national health expenditure. The level of spending ranges from less than \$30 in Haiti and Honduras to more than \$800 in Argentina and Bahamas. NHE as a percentage of GDP ranges from less than 4% in Guatemala, Haiti, and Trinidad and Tobago to over 8% in Argentina, Belize, Canada, Costa Rica, Nicaragua, the United States, and Uruguay.

From 1980 to 1994 health expenditure in the Region soared. NHE as a percentage of GDP rose from 5.8% in 1980 to 7.5% in 1994. Health expenditure per inhabitant increased from \$200 in 1980 to \$250 in 1994— this, even though the average per capita income in the Region in 1994 was similar to that of the early 1980s (\$3,400 in constant 1994 dollars).

Despite a significant recovery of economic growth and public spending, per capita public health expenditure in 1994 was similar to that of 1980: about \$110.

Private health expenditure, expenditures for health goods and services, and contributions to private health insurance and prepaid health plans remain the principal component of national spending on health— about 56% of the total health expenditure of the Region (Tables 7 and 8).

4.3 Physical Infrastructure

In contrast to the 1970s, infrastructure development policy in the past 15 years has stagnated and is currently one of the components with the greatest need for state policy support. There is generally no policy for the

development of physical infrastructure, which includes facilities and equipment, as an integral part of health policy. This means that equipment and facilities are not procured through an evaluation of the health needs of the population because of an absence of selection procedures and procurement strategies.

Health facilities planning does not represent a systematic, multidisciplinary, sequential process beginning with the evaluation of needs and concluding with the space design for specific functions and activities. It has been estimated that in 1990, all public and private institutions in Guatemala achieved coverage of approximately 54% of that country's population. However, the health centers and health posts located in populations of over 1,000 inhabitants had a ratio of 1 center for every 10,000 population. It is significant that the population is generally very scattered, residing in approximately 18,000 communities of less than 500 inhabitants each.

In the majority of the countries, technical services are not an integral part of the health care system nor are maintenance plans for hospital equipment. Equipment is usually serviced at central headquarters, as the need arises, and not according to a preventive maintenance program; the same holds true for the maintenance of physical plants. There is no knowledge in the Americas of the percentage of functioning equipment. Most of the time, when equipment is not utilized it is because it is inappropriate, there is a lack of specialized personnel who know how to use it, or often, because of minor faults and a lack of spare parts.

Moreover, there are no selection criteria for choosing equipment for the different types of facilities. The selection and local procurement process is subject more to the current availability of financial resources than to an analyses of the technological options and the operating and maintenance costs involved.

A considerable number of the ministries of health lack a sufficient budget for repairing and maintaining infrastructure and equipment, with the average budget

allotment for "Buildings, additions, and improvements" ranging from 1.9% to 2.5% of the total general expenditure of the ministry of health, in contrast to the international standards of 7% to 10%. This area has been strengthened in some countries through international assistance. Another element to consider is the high turnover among engineering and maintenance staff and the absence of a sustained human resources development policy in this area— a situation that has favored outsourcing to the private sector.

One of the more important changes in physical infrastructure that has had a positive impact on the health of the population is the expansion and improvement of the network of outpatient facilities. Efforts have been made to carry out planned activities in different programs and, although there has been no systematized planning of health facilities, there has been greater distribution in many countries, with geographical coverage that attempts to meet the demand for access to health services. With regard to infrastructure, the condition of the physical infrastructure and equipment of facilities is unknown in the countries of the Region. Some countries have conducted inventories that have given them a better sense of the dimensions of the problem— a situation that, in terms of the degree of utilization of the equipment, can be characterized as follows: well-utilized, 93.4%; underutilized, 6.2%; overutilized, 0.4%. There are even countries with 60% of units nonfunctional .

Some countries have set up a classification system to define the levels of potential risk to the health of the population, based on quality and safety criteria. However, greater organization is still needed for their execution. One country report indicates that during a census of 393 health care facilities (57.8% of the total), it was found that only 0.8% of the facilities evaluated had some method for treating hazardous solid waste.

4.4 *Essential Drugs and Other Supplies*

One of the eight essential elements of the Declaration of Alma-Ata in 1978 was the provision of essential drugs,

whose use should change the way the services are operated and the way drugs are used. Although several countries have instituted changes, they are a long way from the levels they expected to reach. Despite this, since free market principles are a component of the health sector reform processes in many countries, drug legislation and regulation have constituted a national priority— their objective being to create and/or update the legal framework to improve the supply and rational use of drugs. Even in countries that do not have an explicitly defined national drug policy, this aspect is always part of the political agenda. Governments in most of the countries recognize that there are problems of access and equity with respect to essential drugs and are making efforts to improve availability and access.

The pharmaceutical market in Latin America has been estimated at \$18.1 billion, with Argentina, Brazil, and Mexico accounting for 77%. However, these are not the countries with the greatest consumption per capita. Consumption ranges from less than \$5 per capita in some countries to over \$100 in others. The private sector constitutes 78% of the total pharmaceutical market. In each regional bloc (Southern Common Market, Central America, and Andean Area), the appropriate regulatory authorities of the member countries meet periodically to harmonize drug regulation practices.

Three major problems have been identified with respect to public policies on essential drugs: the annual budget is low in terms of the need for coverage; the supply is ineffective; and while a distribution system exists, it does not function properly in practice.

Few Latin American countries have a national drug commission to support policy design and implementation and search for solutions to the problems presented. These commissions often have no control over the actions that they recommend or the capacity to manage them, so that, in most cases, they are a mere formality.

The main constraints to improving access to essential drugs are poorly implemented drug policies; poor information and education of the human resources in the health sector

concerning the prescription, dispensing, and rational use of drugs, and limited budgets for procurement. The most controversial aspects of the discussions on new legislation revolve around generic programs for essential drugs, the prescription of generic drugs, the use of nontraditional sales outlets for drugs, the criteria for classifying prescription drugs and drugs for self-medication, and the requirements for establishing pharmacies.

Some characteristics of the drug supply system in the Region are:

- (a) the existence of national drug regulation agencies responsible for licensing for the pharmaceutical market (many countries have drawn up lists of essential drugs that are limited to institutions under the ministries of health);
- (b) some countries continue to centralize purchasing to take advantage of economies of scale for public institutions (Bolivia, Ecuador, and Honduras); others, with advanced decentralization processes, have decentralized their budgets and financial resources to the local level (hospitals, health centers);
- (c) as part of the efforts to move toward greater equity in access to essential drugs, some countries have developed a distribution network that includes new sales outlets, in addition to the traditional health centers and pharmacies (here, the community's participation has been important);
- (d) there have been budget cutbacks in the social sectors, with the corresponding budget cutbacks for pharmacies; as a result, many countries have adopted different sources of financing, where patient responsibility for assuming costs has increased.

Traditional medicine is practiced throughout the Region. There is widespread use of medicinal plants, which have not been included in the national drug formularies.

Some of the measures envisaged for developing this area to renew the strategy for HFA/2000 are: approval of proposed general regulations on drugs and pharmacies; development and strengthening of drug supply and inspection systems; and development of the areas of analysis and quality control for pharmaceuticals. Other measures are geared toward monitoring quality at the local level, ongoing dissemination of adequate medications at the local and community levels, and upgrading of the infrastructure of local storerooms.

Some countries have no medical criteria or guidelines for justifying transfusions of whole blood and blood products. In recent years, the appearance of AIDS on the scene has increased social pressures to ensure the absolute safety of the products transfused. This has resulted new and greater burdens in terms of the logistics, management, and organization of transfusion services. Donor selection continues to be a key factor, hence the need for serological screening of all donors. Only 5 of the 33 countries that sent the information reported 100% control of donated blood and blood products. The status of serological screening coverage for HIV, hepatitis B and C, syphilis, and *T. cruzi* in donors in different Latin American countries in 1995 is described in Table 9. In the case of the Dominican Republic, approximately 33,000 units of blood are collected a year from the public and private sector. Of these, 22% are from volunteer donors, 47% from family members, and 31% from paid donors. It is estimated that some 95% to 98% of donations are screened for HIV.

4.5 *International Partnership for Health*

In the Region of the Americas, the amount of international assistance received for health as a percentage of total public health expenditure ranged from 0% (United States) to 15.3% (Haiti) in 1996.

The new health plans based on the reforms are having a major impact on health sector financing, efficiency in the use of available resources, and the proper management and development of human resources. Furthermore, international

agencies have increased their work with institutions other than the ministries of health—NGOs, for example. In addition, the governments have emphasized the need for strengthening ties with new or nontraditional collaborators in health, such as the Inter-American Development Bank and the World Bank, through the health sector reform projects.

The orientation of international cooperation agencies usually depends on their area of interest, which sometimes conflicts with existing health needs in the countries. There is a trend toward the vertical implementation of projects. This is compounded by other factors, such as the temporary nature of the donors' interests and the public sector's difficulty in ensuring the sustainability of the projects.

As part of the measures promoted, the ministries of health have created international cooperation offices to coordinate external cooperation; central and peripheral structures have been strengthened to increase the countries' analytical and response capability with respect to offers of financing from the international donors; and community participation in the projects has been promoted.

It is important to point out one particular aspect of international cooperation: immunization and vaccination campaigns. The world's most important producers of vaccines, Canada and the United States, are located in the Region of the Americas. There are also other vaccine-producing countries, although their output is smaller.

Some of the constraints are: (a) the low level of execution of the external resources and their small share of the health sector budget; (b) the excessive bureaucracy required for bringing planned programs to fruition; (c) the limited number of human resources assigned and trained in project development and program execution; (d) a nonexistent or incomplete information system on the execution of international cooperation programs, projects, and resources; and (e) the downward trend in international cooperation, marked by a significant reduction in the amount of resources for cooperation.

4.6 Conclusions

The planning and reorganization of health resources have not been adequate to the needs stemming from the policies and strategies for HFA/2000 and primary health care. The financial constraints of the social sectors in the past decade have made manifest the increasingly serious limitations of the institutions with regard to the management of their resources. This has become even more evident in light of the rising cost of services. Infrastructure development policy is one of the components that needs to be strengthened within the health sector reform processes, as are the mechanisms for the supply of essential drugs and other inputs.

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Section 5. Development of the Health System

5.1 *Health Policies and Strategies*

Since the Second Evaluation, important changes have taken place in the formulation and implementation of national policies that for three decades have been marked by: (a) centralized decision-making in the ministries of health; (b) financial rigidity and inflexibility of in the regulation of public health sector personnel; and (c) lack of organizational capacity.

The main strategies for executing national policies have been deconcentration- decentralization, social participation, intersectoral and intrasectoral coordination, and the growing private sector participation.

The health sector reform programs have spurred the administrative decentralization of the ministries of health, since this activity is the principal purpose of the reforms and the key element for improving primary health care.

The new health policies generally consider the following areas fundamental: the strengthening of primary health care; administrative decentralization and decentralization of the responsibility of the different management levels; the prioritization of community participation; and the development of opportunities for multisectoral and intrasectoral coordination.

The positive development of health policies includes a greater understanding of the determinants of health and recognition or raising consciousness that gender is a health determinant, in addition to the initiative that some countries are preparing on indigenous populations.

In contrast, the fiscal reduction of health expenditure and the growing phenomenon of privatization of the health services are elements that have not fostered the health policy development in the majority of the countries. Other

constraints are the failure to upgrade managerial capabilities in health system institutions, excessive centralization of decision-making and available resources, insufficient sector financing, the absence of basic mechanisms for intersectoral coordination, lack of intrasectoral coordination between the public and private sector, enormous difficulties related to access by the population to health services at the local level, limited application of the primary health care strategy in some countries, the poor quality of hospital services, an inadequate supply of drugs and other supplies, and underutilization of the resources allocated to the supply of essential drugs and irrational use thereof.

The subregional integration processes have grown increasingly stronger in aspects beyond economics and trade, addressing mutual problems between neighboring countries, strengthening technical cooperation projects and some specific areas (the registry and joint marketing of drugs; biologicals; rehabilitation; and information systems), in addition to a number of bilateral subregional projects and agreements.

Dissemination of the health policies has been very limited, in part because the mechanisms for dissemination and dialogue among the various levels are not in place in some cases or have not been sufficiently developed. The last component of this is the lack of continuity from one government administration to the next, marked by the adoption of short-term measures without proposals or guarantees of a strategy for sustainable development; the sluggish progress of administrative decentralization, which hinders the application of reforms in government institutions; the failure to consolidate a national information system; and poor managerial capacity.

With regard to strengthening the strategy for HFA/2000, several countries stated that while they do not have a specific plan of action, the goals and strategies are reflected in the health plans of their ministries.

5.2 *Intersectoral Cooperation*

Except for a few countries, there have no significant changes with respect to strengthening ties between the ministries of health and other government ministries. The usual mechanisms are interministerial committees set up to deal with social matters. Some countries reported that these mechanisms to support achievement of the goal of HFA/2000 have not been evaluated to date.

The consensus has been that efforts have not been as consistent as desired for achieving the maximum effect. One shortcoming has been the absence of functional mechanisms to promote and guide the process in an organized manner. There is a need to develop new strategies to remedy this situation. Because it strengthens local entities, decentralization promoted through the reform process is one of the best mechanisms for ensuring more effective intersectoral cooperation.

Canada is one of the few countries that recognizes and has reinforced the intersectoral approach, establishing several initiatives and programs for effective and appropriate intersectoral cooperation, among them a national strategy to reduce tobacco use (TDRS); Phase II of the Canadian Drug Strategy (CDS), a strategy on health and environment, the Family Violence Initiative (FVI), the Healthy Communities Project (HCP), and a child development initiative (CDI), although it also recognizes that, in practice, intersectoral cooperation is difficult to carry out.

Similarly, in the United States the "Healthy People 2000" initiative has served as a bridge for collaborating with other federal agencies. This initiative has worked with the Environmental Protection Agency, the Department of Education, the National Transportation Administration, and other government agencies to pool efforts on common objectives. This initiative is a joint effort between the federal and state governments. Several states have developed an identical organizational structure with 22 priority areas, while others have adopted their own

structures. So far, 44 states have publicized their objectives for the year 2000.

Several countries mentioned joint work with the ministries of education to incorporate health education and health promotion topics into the programs of study.

The countries recognize that health is more than just health care and that the health of the population is determined by a variety of factors that include, but are not limited to, income, biological and genetic make-up, social support network, child development, education, health services, employment and working conditions, gender, physical environment, culture, and personal health practices, but they also recognize that many of these health determinants health are beyond the scope of the health sector. Thus, intersectoral collaboration and broad public support are essential for successful implementation of the health strategies. In practice, however, there is not much evidence that this principle is being applied. Even in countries where this type of effort has been made, community involvement is occurring without the support of formal policies.

5.3 *Organization of the Health System*

One important element of current health policy in the majority of the countries of the Region is connected with the processes of State reform. The prevailing phenomenon of State reform and the decentralization of national life have made it imperative redefine institutional roles in the health sector—especially that of the ministries of health and the exercise of their steering role in the sectoral reform processes. Overcoming the vast inequities in health and well-being in the Region remains the principal objective of the steering role in health.

Two groups of countries are involved: those that have advanced in an overall project of reform (Argentina, Canada, Chile, Colombia, Costa Rica, Mexico, and the United States) and those that have taken steps in response to adjustment programs and will be developing overall reforms (Belize,

Bolivia, Brazil, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Nicaragua, Panama, Peru, Uruguay, and Venezuela).

In the context of rapidly growing needs and diminished resources, most of the countries of the Americas are attempting to remodel their State structures by putting systems in place that guarantee lower public spending and higher efficiency in the use of the available financial resources.

In this context it is clear that the public health services have not succeeded in achieving a degree of harmonious, equitable, quality, and efficient development that will enable them to assimilate the effects of the crisis. The picture painted of the health sector at the regional level is that it is incapable of providing total and comprehensive coverage for all citizens. Disadvantaged groups with out access to basic health services are found in virtually all the countries, and the prevailing discourse speaks of a significant social deficit marked by limited access for the majority of the population.

The health sector is also presented as a disjointed entity comprised of many institutions working in isolation, with a socioeconomically stratified clientele. These conditions make for a duplication of efforts and gaps in services, mainly in rural areas and the periurban populations of the large cities.

In practice, health care management has basically been centralized, but the trend toward ceding greater decision-making power to the local levels is growing daily. This does not include financial decentralization 100% of the time. Among the principal functions that need to be strengthened by the ministries of health are the development of national strategies and policies, the distribution of resources, and research and development for the introduction of new technology, legislation, and regulations.

Introducing changes in the organizational structure of the health sector implies new challenges, some of them geared toward the implementation and impact of the reform

processes. One factor that has limited project development and execution, as well as the development of the steering role and the policy-making and regulatory capacity has been the high managerial turnover stemming from changes in government and direction, which in several countries translates into emergency programs that hinder the construction of a stable financial and management model.

With the exception of some programs, the monitoring and evaluation of national plans and strategies are not systematic or conducted with a view to making pertinent changes. Moreover, the mechanisms for the dissemination of information and decision-making are in place but are not always effective.

The health sector in most of the countries consists of a public and private sector and is characterized by a serious lack of articulation and coordination among the various institutions that serve the health sector and the subsectors. There is also a lack of consistency among policies and strategies in the planning of health services and programs. Although officially, priority has been given to PHC in some countries, in practice about 80% of the budget of health institutions goes to hospitals and curative medicine.

The lack of an adequate information system affects the timeliness and reliability of the data, with reports indicating that some information systems on health services have not been updated in over 20 years. This problem hinders the definition of a health policy grounded in the identification of the sector's priority problems and needs.

Concerning health legislation, in the vast majority of the countries the law does not respond to either the dynamic required by the reform processes or health needs. Hence, it is imperative to review and update current legislation and regulations.

Decentralization has become one health sector tool for achieving strategic goals such as improving the health conditions of the population, increasing access to services

and the quality of care, overcoming inefficiencies, and improving the cost-benefit ratio of activities.

There are powerful reasons for changing the health system, among them the demographic and epidemiological changes under way and the deficiencies in coverage and equity. With respect to the health services, at the beginning of 1995 some 7 to 10 million people still lacked health care.

The decentralization process has varied among the countries of the Region. Thus, activities in Mexico focused on changes in the services covering the uninsured population. To strengthen the health services of the states, the health care model modified, a basic package of services was defined, the use of essential drugs was rationalized, and a master plan for infrastructure was drawn up. In this country, decentralization has taken the work schedules and social coverage of workers into account and has involved an exhaustive review of the legal aspects of health.

In Chile, since 1990 sector policy has been geared to separating financing from service delivery, strengthening the regulatory role of the ministry of health, modifying the health care model, decentralizing health programs, adapting payment modalities, targeting expenditure to the population living in extreme poverty, and modernizing human resources management. In this reform perspective, the strategic elements of Chile's decentralization process are strengthening the regulatory capacity of the ministry of health, reorganizing the services to separate functions, strengthening the right of the people to choose services, reorienting payment modalities, and bolstering managerial capacity at the local level.

In 1993 Bolivia began a structural reform of the State in order to shift from a centralized State to a new structure based on popular participation within the context of a new national development model. One of the key elements of this change is decentralization and the strengthening of municipal entities. There are three key elements in the proposed State reform: popular participation, the integrated nature of the development, and a new power

relationship between the political and the economic sphere. Within this framework, popular participation is the heart of the change, and decentralization becomes a national policy that people feel they have a stake in.

State decentralization in Colombia began in 1986 with the mayoral elections. It was consolidated in 1991 with the adoption of the new Constitution, in which the right to health and social security was enshrined, as was the mandate to transfer resources and authority to the municipios. Significant among the advances in this area have been the injection of health issues into the national debate, greater community participation, increased resources for indigenous populations, articulation with the decentralization of education and sanitation, and increased coverage through greater access to social security.

In the remaining countries where decentralization is under way, it has been emphasized that national sectoral reform processes are introducing changes in the various health sector agencies with a view to increasing the equity and efficiency of their benefits together with management efficiency. These changes are occurring within a context influenced by macroeconomic adjustments, a redefinition of the State's role, and a pluralistic democratic strengthening of society, combined with demographic and epidemiological changes that demand changes in health and social policies and strategies.

Each country has decided what, when, and where to decentralize, based on its particular situation and the transformation goals pursued by its national reform process. However, there are still problems that must be solved, such as the absence of political unity, heavy resistance to the process in several countries, lack of the necessary technical assistance; and lack of systematic information on some experiences and innovative modalities.

5.4 *Managerial Process*

During the period analyzed, two major initiatives have been launched to support health sector management: health sector adjustment projects and health sector reform.

Health system efficiency and effectiveness are closely related to the quality of management. The resources available for health are inadequate and have forced health authorities to develop management styles that can guarantee optimal utilization of resources to achieve the maximum impact on the health of the population. As mentioned, this approach requires the intervention of the various management levels and other measures that accompany this process, among them intersectoral cooperation, a health information system, and research on health technology.

The reform processes are being driven by the following specific goals: better quality care, efficient practice, equitable access, rational allocation of resources, and improved information systems.

The excessive bureaucracy of the ministries has been one of the main constraints to improving health management. The establishment and implementation of plans and programs has been another chronic problem in most of the countries. There is also a real need for research in the health services to learn about the cost of services, the health care generally covered by the private sector, the pharmaceutical and insurance industry, and government subsidies to private health care providers.

Some of the constraints to the countries' efforts to upgrade health system management are a resistance to change, lack of experience in managing the health services in a professional manner, and the need to improve training to permit human resources to assume new roles and responsibilities in the deconcentration process currently under way.

5.5 Health Information System

Health information systems in the countries of the Region generally consist of a series of disarticulated

subsystems that do not reflect the total health experience of the country. Most are limited to reporting systems with relatively little use made of surveys or other data gathering techniques. The lack of timeliness and completeness of the data, coupled with a lack of analytical capabilities, limits the usefulness of the information system to support decision-making.

Increasing use is being made of computers, but manual processing of data, especially at the local level, still exists in some countries. Several countries reported that data were being transmitted electronically to the central level and that the computer was being used for electronic mail and for access to the Internet. An increasing number of countries, among them Brazil, Canada, Chile, Colombia, Costa Rica, and the United States, are placing their health data on a World Wide Web site, making it possible for users to access the information from any location.

Computerization, especially of the surveillance system, has made it possible to detect outbreaks of disease more rapidly and to increase the timeliness of reports and feedback. Two countries observed that computerization had led to management assigning greater priority to information. In a few instances, however, the computer system did not live up to expectations. This was attributed to a lack of technical follow-up, insufficient staff, and poor computer maintenance.

Many countries reported distributing educational diskettes to staff on a variety of topics. No mention was made of bibliographic services in describing health information systems, but the topic was included in the discussion of health research.

In terms of actions needed to improve the efficiency of information support to the managerial process, several countries indicated the need to implement a computerized system or to expand and strengthen the existing system. The training of staff at all levels is also required, especially in the use and analysis of the information. With decentralization, health services are being offered in a number of new programs and settings, such as healthy schools

or healthy markets, and these pose a series of information challenges.

5.6 Community Action

While all the countries have expressed a commitment to community involvement, there are wide variations in how the concept is applied. In the larger countries, decentralization and democratization have provided an impetus to community participation, and local health committees have been created to provide a forum for participation and often for the joint management of a health unit. In some countries community participation has evolved into social participation, which implies the involvement of all other social services in the community.

To help ensure effective joint participation in the planning and monitoring of health services at the local level, countries have devoted efforts to capacity building, providing training to both health workers and community leaders. A few countries have incorporated training on working with communities in academic programs for technical and professional health workers.

Nevertheless, the lack of training in community participation was often cited as a constraint. In several of the smaller countries, there is little community involvement on a steady basis. Communities can be mobilized to collaborate on specific projects such as vector control but are not involved in the planning and implementation of health services. These countries, however, often have NGOs that foster community involvement.

5.7 Emergency Preparedness

The countries of the Region are subject to a variety of natural disasters such as hurricanes, earthquakes, volcanic eruptions, floods, and droughts. Deforestation and the construction of housing in unstable areas means that heavy rainfall can cause landslides, leading to losses in lives

and property. Technological disasters are a matter of increasing concern in a number of countries.

Almost all countries have national emergency management committees, many of which have been in place for a number of years, and their plans have concentrated on activities in the aftermath of a disaster. Several countries now report that they are giving greater emphasis to disaster prevention and mitigation. While some training in disaster prevention and mitigation is being provided, more is needed to obtain community involvement in the action to take before and during a disaster.

In 1991, PAHO designed the Supply Management Project (SUMA), a tool specifically developed to help bring order and efficiency to the inventory, sorting, and distribution of emergency supplies in the aftermath of a disaster. Since then several countries have trained personnel in the use of this system.

Another area of activity has been the development of disaster plans for hospitals and other health institutions, providing training in their use and testing the plan and the adequacy of the training in simulation exercises. The simulations have been useful and have generated interest in the community. Countries that have not been able to conduct this type of exercise due to a lack of resources identified this as a constraint.

5.8 *Health Research and Technology*

While many countries in Latin America and the Caribbean carry out research activities, in most instances it is guided by the availability of funding and by personal or institutional interests rather than the needs of health programs. Moreover, even when available, research findings are often not incorporated into the decision-making process.

In recent years, however, countries have been establishing units within the ministry of health or committees to address health research needs and to develop a national health research policy.

Several countries reported that technology is acquired without prior research prior and with no evaluation of its results.

The dissemination of research findings and communication among investigators is a problem. Steps to increase the availability of scientific information through electronic means— CD-ROM or the Internet— are being introduced in a few countries; however, this remains an important constraint in some countries.

The lack of trained investigators is another constraint. PAHO and Canada's International Development Research Center (IDRC) have set up a program offering public health research training grants. The initiative endeavors to train leaders in public health research by offering grantees an opportunity to obtain advanced training in this field, as well as the possibility of receiving additional funding for the implementation of a research project. Given its focus on applied research and on the strengthening of research institutions as well as individuals, the initiative seeks to enhance the decision-making process of the Region's countries and, in so doing, improve the populations' health.

5.9 Conclusions

Since the second evaluation there have been important changes in the formulation and implementation of national and health sector policies. Decentralization, social participation, and inter- and intrasectoral coordination are strategies that are being implemented and have in some instances already produced favorable results.

These changes have been accompanied by a reduction in health expenditure, which has stressed the need for improved management. Health information systems and research should guide decision-makers but all too often are not doing so because of limitations in the information system and the types of research being performed, as well as a lack of analytical skills to make use of these tools.

Effective implementation of these strategies and tools requires new knowledge, attitudes, and practices on the part of all participants in the process. Training has been provided, but more remains to be done.

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Section 6. Health Services

6.1 *Health Education and Promotion*

The Ottawa Charter (1986), the Declaration of Santa Fe de Bogotá (1992), the Caribbean Charter (1993), and Resolution CD37.R14 of the Directing Council (1993) all urge the strengthening of health promotion. The latter also emphasizes the need to promote "healthy cities."

As a step toward meeting their commitments to implement health promotion programs, countries have either created or strengthened health education and promotion units within the ministry of health. Improved intersectoral coordination has resulted in the incorporation of health education and promotion topics in school curricula and in literacy programs. However, some other countries reported that interinstitutional and intersectoral coordination still need improvement.

In some countries health promotion/education staff have been decentralized to the local level in order to strengthen grassroots participation at the municipio and community level, with positive results noted in knowledge, attitudes, and practices. However, the lack of resources, both financial and of trained workers, especially at the local level, has been an obstacle to full implementation.

6.2 *Maternal and Child Health/Family Planning*

Since the second evaluation, several countries have reformulated their maternal and child health programs into reproductive health programs or integrated programs on women's health. A number of countries have established committees or plans of action to reduce maternal mortality.

Increasing attention is being paid to adolescent health, particularly in the area of sex education, with a view to preventing sexually transmitted diseases and teen pregnancy.

Of the 20 countries for which data are available for the second and third evaluations (Table 10), 16 show that the percentage of women attended by trained personnel during pregnancy was either 100% or had increased since the previous evaluation. Progress toward increasing the percentage of deliveries attended by trained personnel has not been as great (17 of 25), but nine countries had coverage rates of 98% or higher for both periods. Many countries are unable to provide information on the percentage of infants cared for by trained personnel. Eleven of the 16 countries reporting the percentage of women of childbearing age who use family planning show increased rates.

The lack of resources, especially human resources, is a constraint to improving maternal and child health services.

Some countries also mentioned the need not only to improve interinstitutional and intersectoral coordination but also to strengthen integration within the ministry's maternal and child health department.

6.3 *Immunization*

As can be seen in Table 11, immunization coverage among children under 1 year of age improved between 1989 and 1995. Eleven countries reported the percentage of children under 1 who were fully immunized: Barbados (1996, 93%), Costa Rica (1996, 84%), Dominican Republic (1994/95, over 80%), Grenada (1995, 77%), Guyana (1995, 83%), Honduras (1996, 91%), Mexico (1995, 95.6%), Montserrat (1995, 100%), Saint Kitts and Nevis (1995, 99%), Saint Lucia (1995, over 90%), and Uruguay (1996, 90%). The summary of the status of indicators found in Section 8 shows the degree to which the countries in the Region have reached the goal of 100% coverage.

The last case of poliomyelitis in the Region was notified in August 1991 in Peru. Since polio is still present in other regions of the world, it is critical that surveillance of acute flaccid paralysis continue at a high level. Some of the surveillance indicators for poliomyelitis have deteriorated in some countries.

One of the indicators requested by the common framework is the percentage of women immunized with tetanus toxoid during pregnancy. This indicator does not take into account pregnant women who are adequately immunized, and only a few countries reported it. The strategy recommended by PAHO for achieving the goal of no more than 1 case of neonatal tetanus per 1,000 live births is the vaccination of women of child-bearing age with at least two doses of tetanus toxoid vaccine in the areas at risk for the disease and proper investigation of cases that are still occurring to allow corrective measures to be taken. For 1994, 98% of all districts in the high-incidence countries either reported zero cases of neonatal tetanus or presented a rate of less than 1 case per 1,000 live births.

As a result of mass vaccination campaigns that began in 1992 in the most densely populated countries of the Region, the number of measles cases notified dropped from 100,741 to 6,489. Many countries in the Region have had two or more years free of measles.

Four countries include measles, mumps, and rubella vaccine among their basic immunizations. Three countries administer hepatitis B vaccine to high-risk health workers, and one country has begun administering it to newborns. Three countries mentioned that influenza vaccine is provided to senior citizens.

Difficult geographic access, cultural barriers, and financial and administrative constraints to the acquisition of vaccines are the major constraints reported.

6.4 *Prevention and Control of Locally Endemic Diseases* ***see also Section 7)***

Malaria morbidity rates have risen in the Region, with the 1995 rate for the total population of the Americas at 165.6 per 100,000 and 515.3 per 100,000 for the population inhabiting areas at ecological risk for malaria transmission. There has been an increase in diagnostic efficiency as a result of focusing surveillance on areas at

the highest risk. In recent years there has been an integration of case finding, diagnosis, and immediate treatment into the local health services and steady improvement in the availability of treatment for diagnosed cases. Vector control activities have continued to be applied by the countries, but control programs are facing drastic cutbacks in funding (1).

Dengue and dengue hemorrhagic fever have increased tremendously in the Region over the past several years. A regional network of 49 dengue laboratories has been established, and training for clinical case diagnosis and case management has been conducted (2). A number of countries reported success in stimulating communities to eliminate mosquito-breeding sites.

Tuberculosis remains a major public health threat in the Region, with an estimated 400,000 cases and 60,000 to 75,000 deaths each year. The World Health Assembly has adopted two targets for tuberculosis control for the year 2000: cure of 85% of all detected pulmonary smear-positive (infectious) cases and detection of 70% of new smear-positive cases. The global strategy for the control of the disease is based on the provision of directly-observed treatment, short-course (DOTS). Some countries in the Region detect more than 70% of new smear-positive cases, and a few have surpassed the cure rate target (3).

It is estimated that the number of persons living with acquired immunodeficiency syndrome (AIDS) in the Americas ranges from 500,000 to 600,000 cases, and the number of HIV-infected men, women, and children probably stands at about 2.5 million (4). The countries' efforts are directed toward educational programs to prevent contracting HIV infection and to testing blood prior to transfusion. While most countries in the Region cannot afford to provide AZT therapy to all HIV-positive patients, several have made the drug available to HIV-positive pregnant women to prevent prenatal and perinatal transmission.

At the time of the second evaluation, cholera had absent from the Western Hemisphere for 90 years. In January 1991 a cholera epidemic broke out in Peru and has since extended across Central and South America, affecting every

country but Uruguay. Because cholera is underreported and case definitions differ from country to country, cholera surveillance figures represent only a small fraction of the actual number of people infected. From 1991 to 1995, Latin American countries reported more than 1 million cases of cholera, including more than 11,000 deaths. In 1995, total reports of cholera cases declined, continuing a trend that had been observed each year since 1991. The overall cholera case-fatality rate in Latin America has consistently held at 1% or lower since 1991. These data indicate that cholera case management continues to be effective in most of Latin America. Despite the prevention and control measures instituted, cholera is likely to persist in many countries in endemic seasonal patterns, unless major improvements in water distribution, sewage treatment systems, hygiene education, and food safety are achieved and sustained (5).

Leishmaniasis, Chagas disease, rabies, and leprosy are among the other endemic diseases reported in the Region.

6.5 Treatment of Common Diseases and Injuries

Diarrhea and acute respiratory infections are the most common diseases affecting children under the age of 5. A number of countries have adopted case management treatment protocols for these two diseases, and some have reported a reduction in case incidence. A few countries mentioned moving to the strategy of providing integrated care to children under 5 years of age.

In countries with aging populations, chronic noncommunicable diseases are important causes of morbidity. Among adults, diabetes mellitus and hypertension are the diseases most frequently cited, and some countries have adopted treatment protocols and established special clinics to treat patients with these two problems. Cervical cancer is the leading cancer site among Latin American and Caribbean women. A number of countries, notably in the Caribbean, are establishing cervical cancer control programs to promote early detection and treatment of this condition.

One country cited drowning as a frequent accident and suggested the need to provide training in resuscitation techniques to reduce the number of deaths. Although this was the only specific mention of injuries, a number of countries mentioned concern about violence (and the aggressive behavior that leads to it) and its consequences in terms of personal aggression and homicide, domestic violence, and motor vehicle accidents.

6.6 Conclusions

In the interval since the Second Evaluation, the need to strengthen health promotion has been stressed at subregional meetings, and a number of countries have taken steps to create or strengthen health promotion/health education units within the ministry of health.

Countries assign high priority to the care of women and children under 5 years of age. Progress has been made in improving coverage, but lack of access due to physical or cultural reasons is still a source of concern in some countries. There is an increasing trend toward providing integrated care to selected population groups.

Immunization rates in the Region are high. The last case of poliomyelitis in the Region occurred in 1991. Good progress has been made in eliminating measles and neonatal tetanus. The danger now is that these successes will lead to complacency and the assigning of lower priority to the immunization program.

The lack of financial and other resources is seen as a constraint to expanding or even maintaining health programs. Several countries have high expectations that decentralization and increased community involvement at the grassroots level will provide the funds needed to sustain activities. However, as one country has pointed out, negotiation is needed to obtain resources in the presence of competing demands, and many health workers do not yet have the necessary skills in this area.

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Section 7. Trends in Health Status

7.1 Life Expectancy

In the interval between the second and third evaluation all the countries, with the exception of Haiti, achieved a life expectancy at birth (LEB) of 60 years or more. Out of 48 countries and other political units with available estimates, 35 have met the regional target of 70 years, and there is a bloc of countries that, if they continue along the same path, could achieve it by the end of the century. The gradual reduction in infant mortality and changing epidemiological patterns are responsible for the general increase in LEB. Analyzing this indicator by sex, the difference in the three subregions tends to increase in favor of women: 5.7 years in Latin America, 5.2 in the Caribbean, and 6.6 in North America (Table 12).

7.2 Mortality

Infant mortality rate for the period is estimated at 47 per 1,000 live births, marking an eight-point decline over the previous period. However, despite this steady decline, large differences persist among the countries of the Region and certain populations within each country. Thus, Costa Rica, Cuba, and Chile, for example, have rates approaching those of the developed countries, while Haiti and Bolivia have rates exceeding 65 per 1,000 live births. Of the 33 countries reviewed for this report, approximately one-third have no possibility of meeting the target for the year 2000 (less than 30 deaths in children under 1 year of age per 1,000 live births).

A 50% reduction in maternal mortality is one of the targets of HFA/2000. Of the 28 countries with available information for comparing the data from the third evaluation with that of 1980, 14 experienced a reduction in maternal mortality and 14 an increase. From the second to the third evaluations, of the 32 countries with information, maternal

mortality increased in 20 and decreased in 12 (Table 5). These increases reflect the work of the maternal mortality committees, the surveillance of maternal deaths, and the efforts to improve the quality of reporting in death certificates. It should be recalled that in countries with small populations, a single maternal death can significantly modify the rate.

The decline in mortality from diarrheal diseases in children under 5 since the 1960s continues. Even so, diarrheal diseases remain a significant health problem in a considerable number of countries of the Region. The cholera epidemic that struck most of the Region had a paradoxical effect: the tremendous mobilization of resources and dissemination of information yielded preventive measures that succeeded in reducing morbidity and mortality from other diarrheal diseases. Nevertheless, a number of Central American countries report increased mortality from diarrheal diseases since the last evaluation.

Mortality from acute respiratory infections (ARI) has varied among the countries. From 1985 and 1994 mortality from this cause has fallen by as much as 50% in some countries, while in others, such as Nicaragua and Belize, it has risen above that percentage. In Haiti, one in four deaths in children under 5 is due to ARI. The gap between the developed countries of the Region and the developing countries is especially marked with regard to mortality from this group of diseases, and the trends point to an increase in this gap. Two factors may influence and explain this situation: the barriers to access to the health services and the poor quality of care in many of the countries.

Mortality from malaria persists at low levels, continuing the downward trend of recent years. The same holds true for deaths from measles, which fell drastically due to the low incidence of this disease at present.

In 1995, some 60,000 to 75,000 people died of tuberculosis in the Region, with significant differences between countries. Some, such as Ecuador, exceeded 10 deaths per 100,000 population. There is no clear trend in mortality from this disease in the Region.

The epidemiological transition has been characterized by a progressive increase in the burden of chronic diseases.

Thus, the predominance of cardiovascular disease and the rising trend in mortality from this cause are present throughout the Region. One exception is the most developed countries, such as Canada, where a slight decline has already been observed in the main causes of death, particularly cardiovascular disease. The control of hypertension, lower fat consumption, and a decline in smoking explain this changing trend. The wide range of rates among the countries is due to deficiencies in the systems for recording deaths. Cancer is the second largest cause of death in the Region. Mortality from cancer is likely to follow the increase in life expectancy.

In the majority of the countries, mortality from traffic accidents has increased with the number of automobiles— a phenomenon that is often not accompanied by improvements in road networks or appropriate legislation. Canada constitutes an exception, since legislative and health education measures have reduced mortality from this cause since the second evaluation (Table 13).

7.3 Morbidity

Some 32% of the population of the Americas lives in areas with ecological conditions favorable to malaria transmission. In recent years the epidemiological stratification of malaria has been accompanied by the incorporation of case-finding, diagnosis, and treatment in the local health services. The diagnostic efficiency of the health services is 16.9%, with more than 3 million slides examined, while the efficiency of active surveillance remains low (less than the 3%), accompanied by high operational costs. In the 21 countries with active malaria programs, 1,302,791 positive slides were diagnosed in 1995 versus 1,230,671 in 1991, although, based on the consumption of antimalarial drugs, it is estimated that the real number

of cases is between 4.5 and 9.3 million a year. In fact, the countries of the Andean Area and Central America observed an increase in cases during the evaluation period.

Widespread use of multidrug therapy for the treatment of leprosy patients has led to a dramatic reduction in the problem in the Region. At the end of the five-year period most of the countries had rates below 1 per 10,000 population and have accordingly eliminated it as a public health problem, although in the interior of some countries there are population groups in which the prevalence exceeds the figure cited.

Pulmonary tuberculosis is a re-emerging disease in the Region in both the developing and the developed countries. Factors that especially affect society's most disadvantaged groups, such as the economic crisis, migration, AIDS, and the problem of providing proper treatment for diagnosed patients, with the resulting emergence of resistant strains, have led to a deceleration in the reduction of the incidence of the disease, if not an increase of the number of cases.

The mass introduction of immunization against measles through the vaccination programs has drastically decreased the incidence and mortality from this disease. As a result, between 1993 and 1994 the countries of the English-speaking Caribbean had no confirmed measles cases. The goal of elimination in this decade appears attainable if efforts are centered on improving vaccination coverage and the monitoring system in some countries. Neonatal tetanus is declining in countries that still report cases. The last confirmed case of poliomyelitis in the Region was reported in 1991.

There is limited data on the prevalence of anemia and vitamin A deficiency in women and children under 5. Some surveys conducted in Costa Rica and Guatemala illustrate the range of the prevalence of these nutritional disorders, which remain a serious public health problem.

The incidence of AIDS per million population in 1995 was 58.5; in the Caribbean, it was 247.1 and in North America, 215.4. HIV is transmitted in the subregions

through homosexual and bisexual contact (Andean Area, Brazil, Southern Cone, and Mexico), as well as heterosexual contact (Central American Isthmus and the Caribbean). Transmission by intravenous drug use is frequent in the Southern Cone and Brazil, with 29.1% and 26%, respectively.

The number of new cases of AIDS diagnosed since the second evaluation increased slightly in Latin America and decreased in North America. Especially troubling it is the situation in Haiti, with a 10% prevalence of HIV carriers in urban centers and 5% in rural areas. Epidemiological surveillance, health education, and access by the population to prevention measures should be priority areas of action.

Dengue remains endemic in most of the Region. Toward the end of the evaluation period serious epidemics occurred in Brazil, Venezuela, Central America, and the Caribbean. In 1990 nine countries diagnosed cases of the disease, while by 1995 the number had risen to 25. In the 1970s 10 cases of dengue hemorrhagic fever were reported; in the 1980s the number had risen 13,235, and in the period 1990-96 the figure was 28,434. The increase in vector densities, the circulation of several serotypes, urbanization, migration, and the ineffectiveness of programs to combat the disease are responsible for this situation. Since the case-fatality rate for dengue hemorrhagic fever is not negligible (1.4%), steps must be taken to control the vector and educate the population (Table 14).

7.4 Disability

Information for assessing the real disability situation in the Region is scarce, although the economic problems and the logical increase in this problem as a result of the epidemiological transition suggest that we are facing one of the main challenges of the coming years. This is what many countries have understood, and the proof of their concern is the proliferation of laws and agencies devoted to addressing the problem of disability. In the past five years, of the countries analyzed, Bolivia, Ecuador, El Salvador, Jamaica, Paraguay, Saint Lucia, Uruguay, and Venezuela have developed standards and institutions with this objective. Information systems and policies to integrate and care for the disabled

should be created or strengthened, while decisive action should be taken in the field of prevention.

7.5 Conclusions

The steady increase in life expectancy at birth, linked with lower infant mortality and mortality from communicable diseases, has led to an increase in the burden of chronic diseases and disabilities. However, despite the achievements in the area of vaccine-preventable diseases, the burden of diseases such as tuberculosis, dengue, or malaria has remained constant or increased in the Region. Although the gaps in some indicators have diminished, large gaps still persist among countries and between communities or social groups within them, a fact that should be taken into account when setting policies to approach or meet the objectives of the goal.

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Section 8. Outlook for the Future

The Governing Bodies of PAHO, after reflecting on the renewal of the goal of health for all and the primary health care strategy in the context of the global changes affecting the health of the populations and the health services systems, reviewed the document *Renewal of the Call for Health for All* and reaffirmed its importance. The summary below consists of excerpts from this document.

8.1 General Assessment and Strategic Issues

The countries of the Region assumed their commitment to the goal of HFA at the World Health Assembly in 1977 and subscribed to this goal at the historic meeting in Alma-Ata in 1978. The primary health care strategy (PHC) was seen as the vehicle for attaining HFA, and each country proceeded to translate these commitments into the terms of its particular socioeconomic and health situation, while at the same time recognizing certain minimum targets that all countries must achieve. In the Americas, the establishment of HFA/2000 and the implementation of the PHC strategy were embodied in the regional strategy of HFA/2000 in 1980 and the Plan of Action in 1981. These documents facilitated the setting of targets, operational priorities, and baselines against which progress toward Health for All in the future.

This review of progress in the principal strategies aimed at achieving the goal of HFA revealed that the development of national policies and strategies has not included the participation of other sectors and actors, and that the definition and organization of priorities has often been based on interests that run counter to the attainment of HFA and the implementation of PHC. Moreover, the organization of the national systems has not been based on primary health care, and management of the services has frequently been plagued by bottlenecks in the collection, analysis, and utilization of information for the definition of priorities, plans, and policies. Participation, while it has increased and has served to open up opportunities, has

sometimes been utilitarian or has petered out once specific projects were completed. While the importance of equity has been preserved in the rhetoric, it has not translated into improvements in the distribution of resources, and the hospital has continued to be at the center of the health services system.

One of the main problems standing in the way of implementation of PHC has been the shortage of resources following the crisis of the 1980s, which forced the countries to adopt economic adjustment program and fiscal austerity programs, leading in turn to steady and rapid deterioration of the health infrastructure and reduced operating capacity in the public health services. This chain of event, coupled with the relative lack of competitiveness in the health sector, impaired the services' ability to respond at a time when the decentralization processes were too embryonic to support changes at the local level. Other obstacles were insufficient political commitment at decision-making levels due to the frequent turnover of authorities at the ministries, a shortage of inputs, inadequate supervision, neglect of the sociocultural aspects of health, little information being provided to the communities, weak technological development, limited support from the medical profession, and opposition from certain sectors. The mobilization of resource for HFA has also been affected by the slowness of internal negotiations and definition of national priorities, insufficient knowledge about opportunities for cooperation and the resource mobilization process, and limited national experience in project design and management. At the same time, the broad terms in which the goal and the strategy are expressed have given rise to interpretations that have failed to give adequate consideration to questions related to sustainability and financial feasibility.

It was also a time when democratic governments were being strengthened, and this process opened up opportunities for the participation of citizens in the national endeavor. The nongovernmental sector assumed a growing role in implementation of the PHC strategy, sometimes with significantly more resources than were being handled by the national governments. In mid-1980s the countries of the

Region were promoting the processes of decentralization and local health system development. During that same time, the health promotion strategy was placing more emphasis on social action and development with equity and envisaging the formulation and execution of policies to promote the health of individuals and the environment, strengthen alliances, and networks for social support, and increase the people's control over their own development.

The improvements in general morbidity and mortality and the increases in life expectancy were not attributable exclusively to the implementation of PHC and HFA but chiefly to the political will of many governments to move forward in this area. These approaches were nevertheless essential to the achievement of some improvements in health status, in the coverage, organization, and management of health services, in the improvement of surveillance systems, and in the dissemination of a more comprehensive view of health. Poliomyelitis has been eliminated and the incidence of other diseases preventable by vaccination has been reduced; life-spans have increased; and in many cases conventional indicators have improved despite cutbacks in national budgets. Still, the conception of PHC, both in its comprehensive and its specifically targeted sense, has not been internalized or incorporated into the operations of the health services systems.

This can be observed in the indicators summarizing the regional experience found at the end of this section. Although the third evaluation includes 72 indicators, only the 25 representing the world commitment to the goal of HFA have been included in this summary. Others can be found in the tables in the Annex. These indicators should be interpreted with caution, since the information furnished by the countries is not always comparable. For example, a number of countries, sometimes without explicitly mentioning it, considered nursing children to be boys and girls under 1 year of age; others included children under 5; and still others apparently considered only the newborn. The indicators reflect achievements as well as the areas needing improvement, among them the quality of the information.

8.2 Vision of the Future

The vision of HFA represents a desired future state that we will approach by renewing commitment to the goal and by implementing suitable strategies and concrete actions. This vision may be summarized as a shared understanding of health in which the Hemisphere's energies respond ethically to the challenges that arise for the achievement of sustainable human development with dignity and equity in the future of the Americas. This vision is based on a value system guided by equity, solidarity, and sustainability.

8.2.1 Objectives

The objectives listed below are general in nature; they will vary in importance depending on national realities and their priority in national political agendas:

- to ensure access by the entire population to high-quality health education and health information, essential drugs, nutrition, water supply, and sanitation, as well as cost-effective and quality health services;
- to reduce the negative impact of socioeconomic, political, and ecological conditions on the health of the most vulnerable groups;
- to seek to develop populations that are physically, psychologically, and socially healthy and violence-free, in a process characterized by dignity and respect for cultural diversity, which takes gender-based aspects into account in the planning of interventions;
- to eradicate, eliminate, reduce, and control the main diseases, injury, and conditions that adversely affect health, especially emerging or re-emerging diseases;
- to promote and facilitate access by all people to healthy environments and living conditions through the promotion of healthy lifestyles and the reorganization

of health and environmental services and regulatory mechanisms;

- to ensure the availability of the knowledge and technology needed for their application in recovering and achieving gains in health.

8.2.2 Policy Orientations

The following is a summary of the policy orientations for national processes to achieve HFA:

- Effective social participation and the development of skills aimed at increasing the options available to individuals and the control they exercise over those options is the essence of the goal of HFA.
- It is necessary to develop to its proper dimension a health practice that is aimed at individuals, diseases, and cure— an initiative that has been promoted but has not yet been attained under the PHC strategy.
- There must be intensified connections between the health of the population, the environment, and sustainable human development.
- The essential components of the ties and close collaboration between the actors and sectors that are concerned with, or have influence on, the attainment of HFA are society in general through community organizations; the political decision-making levels; governmental and nongovernmental organizations; the private sector, including the technological and pharmaceutical industries; and insurance companies. Steps should be taken to strengthen the capacity of these groups to enable them to participate actively in health advocacy, promotion, and protection.
- The renewal of HFA implies the harmonization of social policies, including health policies related to the promotion of socioeconomic development— specifically macroeconomic policies--and among these, especially

policies that have to do with fiscal adjustment and reduction of the fiscal deficit.

- Mechanisms for general cooperation between countries and/or regions, while recognizing the differences between them, should promote the expression of and response to local needs in health development.
- It is necessary to identify, enlist, and make accessible the various moral, political, scientific, cultural, economic, and organizational capabilities and resources for health development that exist in each of the different societies.
- There should be capacity in the communities and the decentralized levels of health (states, municipios, cantons, departments) to maintain or achieve a high quality of service in which the use of existing resources is maximized.
- Leadership ensures the future success of institutions and the sector by bringing together and expressing a set of values, a mission, and a vision of where they are headed.

8.3 *Proposed Strategies*

The strategic and programmatic orientations of PAHO for the period 1995-1998 refer to: health promotion and protection, disease prevention and control, environmental protection and development, health in human development, and health systems and services development. These represent a point of departure for processes aimed at reshaping or identifying new strategies of action geared toward renewing the goal of HFA in the Americas.

With the new millennium approaching, the Member States should renew their commitment to the goal of HFA and its health strategies within the context of the social, economic, political, environmental, and technological trends that are affecting the health of the populations, the environment, and the health services, giving priority to the

adoption of policies to resolve their health problems in a sustainable manner and steadily improve the quality of life of their peoples.

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