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REPORT ON THE MONITORING OF THE REGIONAL STRATEGIES OF HEALTH FOR ALL BY THE YEAR 2000

Upon adopting the Global Strategy of Health for All by the Year 2000, the Member States of WHO agreed to monitor the advances made in the implementation of their national strategies and to evaluate, at regular intervals, the impact in terms of improvement in the state of health of the population. In 1986 the Thirty-ninth World Health Assembly (Resolution WHA39.7) decided that reports on monitoring should be prepared every three years, instead of every two years, while the evaluations of effectiveness would continue to be done once every six years, beginning in 1985.

To guide them in the preparation of their national reports on monitoring, the countries received a copy of the document "Monitoring of the Strategies of Health for All by the Year 2000. Common Framework: Monitoring (CFM)," prepared by WHO with a view to facilitating the collection and analysis of the necessary information. The present report is based on the results presented in the 28 national reports received at Headquarters as of 12 September 1988. The reporting countries represent almost 100% of the population of Latin America and the Caribbean and two thirds of the population of the Region of the Americas. All the national reports will be submitted to WHO.

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The results obtained at the national and Regional level will be analyzed by the Executive Board of WHO and the World Health Assembly in 1989. The delegates to the XXXIII Meeting of the Directing Council of PAHO are invited to analyze the present report with a view to discussing the item during the Meeting, and with the intent of contributing to the analysis to be carried out on a worldwide basis in 1989.

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1. INTRODUCTION

The Member States of WHO unanimously adopted the Global Strategy of Health for All by the Year 2000 (Resolution WHA30.43, 1977) and, subsequently, the Plan of Action for its implementation. In addition, they agreed to monitor the progress of the implementation of their national strategies and to evaluate the effect, in terms of improvement, on the population's state of health at regular intervals. The World Health Assembly proposed that the corresponding reports be analyzed every two years by the regional committees, the Executive Board, and the World Health Assembly, and that the efficiency and the effect of the Strategy in the national, regional, and global plans be evaluated every six years. The process began in 1983 with the first report on monitoring, followed in 1985 by the first report evaluating the effectiveness of the implementation of the national strategies. The Thirty-ninth World Health Assembly (Resolution WHA39.7, 1986) decided to set the frequency of the reports on monitoring at every three years, instead of every two; the frequency of the reports on the effectiveness of the Strategy's implementation was left at once every six years, beginning in 1985.

In order to streamline the presentation of systematic reports and the summary information at the regional and world levels, a common frame of reference was adopted. In 1982 WHO prepared a Common Framework and Format (CFF) to facilitate the collection and analysis of the information needed for monitoring progress in the implementation of the national strategies and for reporting on said progress to the regional committees, the Executive Board, and the World Health Assembly.[1] Subsequently, an expanded CFF was prepared in order to include reports evaluating the effectiveness of the implementation of the strategies.[2] The Common Framework-Monitoring (CFM)[3] that was utilized in the present monitoring activity is the result of modifications made to the CFF on the basis of observations and suggestions of the Member States and the regional offices.

Based on the experience acquired in the evaluation carried out in this Region during 1984-1985, it was decided to distribute the CFM to the countries to serve as orientation for the preparation of the national reports. In addition, the PAHO/WHO Country Representatives were encouraged to give their full support and collaboration so that each country could measure the progress made, identify any difficulties and obstacles encountered, and, finally, utilize the results of the analysis to enhance their health plans.

A total of 28 countries and territories had submitted their national reports: Argentina, Bahamas, Bolivia, Brazil, Canada, Cayman Islands, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Trinidad and Tobago, Turks and Caicos Islands,

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1 Document DGO/82.1
2 Document DGO/84.1
3 Document DGO/86.1

Uruguay, and Venezuela. These represent almost 100% of the population of Latin America and the Caribbean and two thirds of the population of the Region of the Americas. The analyses of the specific indicators took into account not only the national reports received but also data from supplementary sources (World Bank, IDB, UNESCO, CEPAL, Bank of the Caribbean, AID, United Nations Statistical Office, IMF) as well as information from technical areas in PAHO (Environmental Health, Maternal and Child Health, EPI, Health Services Development) and previous reports from the PAHO Member Countries. The use of supplementary sources made it possible to present information on all the countries of the Region, though not for all the indicators, and this information is contained in the tables presented in the Annex. It also permitted the inclusion data that were more consistent and sometimes more current that what had been submitted by the countries themselves. To the extent possible, an effort was made to show the values for the data for different time periods, so that the the evolution of the indicators could be appreciated, and hence the socioeconomic and health development of the countries of the Region.

The consolidated regional report covers the following topics: socioeconomic situation, monitoring process and mechanisms, national health policies and strategies, health systems development, international action, availability of primary health care, and the health situation.

2. SOCIOECONOMIC SITUATION

After showing a moderate annual growth rate of 3.8% on the average during the three-year period 1984-1986, the gross domestic product (GDP) in Latin America and the Caribbean grew at a slower rate in 1987, being just over 2%. As a result, per capita income remained more or less the same as in 1986. With a few exceptions (Brazil, Colombia, Panama), the countries' per capita GDP in 1987 was lower than in 1980.

This economic crisis has been the causal factor in rising unemployment, higher inflation, and the gradual worsening in the supply of goods and services, especially those provided by the public sector. With very few exceptions, there is a gradual decrease in the amounts earmarked for health in the budgets prepared by the central governments.

The main obstacle continues to be the unprecedented external debt of the governments of Latin America and the Caribbean, which exceeded the limits of the economy in the period 1980-1987. Overall, the international financial and economic climate was not favorable: the gradual falling trend in interest rates over the last several years came to a halt in late 1986. As a consequence and according to available information, the payments made in 1987 appear higher than those made in 1986. The total disbursed for the external debt rose from US$242 billion in 1980 to $374 billion in 1984 and $395 billion in 1986.

In 1987 inflation skyrocketed in Argentina, Brazil, and Mexico at rates that exceeded 100 per cent. The presence of the informal sector in urban

centers is becoming ever stronger; and considering that it is not covered by the health services provided by social security and that it exists in a context of annual urban growth that exceeds 3%, this sector is overloading the demand for services. If to this urban situation we add the fiscal sector's adjustment policy, the possibilities of allocating or reorienting resources to the rural and farm population become even more limited. It is not suprising then that the attempts to reallocate resources from the central levels to the peripheral and postponed levels have met with difficulties or have even been reversed, as in the case of Peru, or that serious problems have arisen in the establishment of local health teams, both in the supply of human resources and in providing them with the minimal inputs and equipment for their activities.

From the foregoing and given the current economic and labor context, it can be deduced that the possibility of preventing further deterioration and achieving the goals of HFA/2000 will require considerable effort not only in the form of enhancing the efficiency and administration of available resources, but also by adopting new policies and strategies for the mobilization and orientation of nontraditional and nonpublic resources in an attempt to close the health gap.

3. MONITORING PROCESS AND MECHANISMS

The responses from the 28 countries and territories described the efforts under way to promote the monitoring of HFA/2000 at the various levels of the sector. The levels of progress vary, since some of the countries have been able to define and implement such a process (Bahamas, Brazil, Canada, Cayman Islands, Chile, Costa Rica, Cuba, Guyana, Haiti, Honduras, Nicaragua, Panama, and Venezuela), while the rest have begun but have not been able to fully implement it, with the result that achievements have been partial. For example, some have not been able to integrate the process into the social security system or they have encountered serious problems impeding the implementation of a monitoring process.

With regard to the availability of data for world and regional indicators, the situation varies.

The data on coverage range from timely information on vaccinations for the six diseases of the EPI to isolated and incomplete data on coverage of primary health care (PHC) and tetanus toxoid immunization for pregnant women, or data that do not have adequate continuity, coverage, or breakdown (except for Cuba), e.g. data on care for pregnant women (prenatal and delivery) and nursing infants. The information on water supply and sanitation coverage is sufficient to monitor the progress made, although there are problems regarding consistency, continuity, and accuracy. Despite the fact that no uniform classification exists for the term "population with easy access," in most cases it is defined as the population living within 200 meters of a public standpipe.

Few countries have reliable information on the percentage of spending that is used for PHC, and many provided figures without clarifying what they represented. Furthermore, it is difficult to obtain continuous figures on the percentage of the GDP used for health, and available data are taken from sporadic, specific studies. The underregistration of births and deaths and the fact that birthweight is not recorded on most birth registration forms make it difficult to acquire this information as well as information on infant mortality for all the countries. Data on infant mortality and life expectancy are taken from population censuses and the accompanying demographic studies. The weight-to-age indicator for children is only obtained through special surveys, except in Chile and Cuba where it has been integrated into the regular programs.

With regard to quantitative socioeconomic indicators, different methods are used when obtaining and using literacy rates and the per capita gross national product (GNP). Literacy rates are basically available only from the population censuses, which means they lack continuity. The per capita GNP is available each year, but there are problems concerning the data that is included in the country reports: they correspond to different years; different presentations (US$ vs. other currencies, current vs. constant prices, GNP, GDP, factor costs, etc.). All the countries normally report GNP figures that are much lower than those that appear in other publications, thereby making it difficult to compare them. For this reason, the annexed tables include data from other sources.

A variety of obstacles have arisen in the implementation of a monitoring process. They can be grouped into three broad categories:

Resources: Lack of qualified human resources to carry out the processes, as well as insufficient infrastructure and financial support.

Data: Underregistration of births and deaths; incomplete registration of services provided; multiplicity of sources; untimeliness of data; data not processed at the local level; lack of conceptual uniformity.

Management: Limited utilization of data generated; institutional atomization and lack of coordination (sectoral and intersectoral); low priority assigned to PHC; emphasis on political and economic factors in decision-making.

The principal measures that are being taken in the countries to strengthen the monitoring process are: decentralization and the use of the information locally; training; development of information systems, especially in informatics; broader coverage of data, especially regarding vital statistics and services; use of data for monitoring and supervision in priority programs.

The progress made in the Region in terms of the acquisition of data is unquestionable. However, it is also necessary to point out that the lack of comprehensiveness, timeliness, and comparability of the data continues to be an important impediment in the monitoring of HFA/2000.

4. NATIONAL HEALTH POLICIES AND STRATEGIES

With regard to the formulation of national health policies and strategies that are consistent with HFA/2000 and PHC, the countries have maintained and strengthened the commitment described in the previous report on evaluation. Several of the countries have revised their national health policies and strategies (Bahamas, Bolivia, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, and Venezuela) since 1985.

The forms of support given to this strategy reach far beyond statements by the top levels of administration or integration into the health plans. Mexico, for instance, has strengthened its support through the country's constitution and health legislation; in Guatemala, a presidential decree has manifested the priority of drugs and maternal and child health; Brazil has included the strategy in the draft of the country's new constitution; Honduras has organized a National Health Congress; Peru has seen the functional integration of this strategy with social security and the preparation of a National Health Congress; Venezuela has passed an organic law for its National Health System; and Argentina has given parliamentary approval to a law on National Social Security. Canada, a country that provides coverage for the entire population, has made a major move in its health policy action by reorienting its health initiatives toward the development of new programs for promotion and prevention.

Since all the national health policies and strategies are consistent with the global strategy, special note is taken of the recent efforts in the area of decentralization (through different modalities) and the development of local health systems in view of the emphasis and priority assigned to them by the countries.

The obstacles standing in the way of implementation of the national health policies and strategies are varied and many of them are predictable, such as limited personnel (in quantity and quality); the effects of centralized and bureaucratic administration and management; the use of health policy by political parties; the lack of education and health awareness of the population; the instability of leaders (of the institutions and the community). In some countries there is the added factor of social instability (El Salvador, Nicaragua, and Peru). The main impediment, which up to now has not been predictable owing to its prolonged presence, is the economic crisis that has hit the countries and that does not appear to have any solution in the short term. Not only is it aggravating unemployment and the size of the marginal population, but as a result of the reduction or stagnation of the per capita GNP, the increase in the burden of the external debt, and the fiscal adjustment policies adopted, the crisis is having an effect on the levels of resources available both for social security and for health care for neglected groups. In other words, there are fewer resources available to meet a greater potential demand.

Aware of this, the countries have adopted an approach to the development of national health policies and strategies that is directed toward

achieving greater efficiency in the use of their resources through the decentralization and restructuring of their health systems through: reforms in the administrative, logistical, and managerial systems; the mobilization of resources, especially at the local level; coordination with sectoral or extrasectoral institutions; and providing guidance to nongovernmental organizations. This explains the emphasis being placed on social participation, since it is a suitable instrument for better utilization of resources at the local level.

Integration of the national health policies and strategies into overall development policies is a key requirement. However, it appears to be going through a critical period. Several of the reporting countries had nothing to say in this regard, which may indicate a possible lack of integration. Most of the other countries stated that the national health policies and strategies are considered in the development plans and that various mechanisms (plans, cabinet, committees, etc.) have been set up to coordinate the overall policies. Except for Canada and Cuba, they all reported a lack of perspective for the medium and long terms, since they have not been able to establish long-term strategies for the development of health and the socioeconomic situation as a whole. Without real integration and coordination, it will be difficult to maintain the rate of improvement in health observed over the last 30 years.

5. HEALTH SYSTEMS DEVELOPMENT

A. Organization of the Health System Based on the Strategy of Primary Care

All the countries (or rather, the Ministries of Health) have adopted the strategy of PHC as the central axis for the development of the health system. However, the acceptance and understanding of this strategy by the different levels and institutions that make up the health sector has been only partial in most of the responding countries. Some of the most frequently mentioned obstacles that have prevented full acceptance are:

- the predominantly curative approach of the health services and of many professional groups;

- the insufficiency of the physical and financial resources allocated for health promotion and protection and for the formation of basic health teams at the primary care level;

- the resistance of professional groups and institutions in the sector to fully adopt the strategy of PHC and the lack of interest, knowledge, motivation, and commitment of health personnel with respect to the development of this strategy;

- the tendency to narrowly interpret PHC as a single program or a set of vertical programs whose components are developed separately and in different stages;

- the multiplicity of institutions that are involved in the health sector in many countries, which makes it difficult to have intrasectoral coordination and to establish a uniform operational and conceptual approach to the strategy of PHC;

- the insufficient development of community participation as a component of the strategy of PHC in most of the countries.

All the countries reported that measures have been adopted to strengthen their health systems based on the strategy of PHC. In most of them, this process has been oriented toward strengthening the local level of the services system and introducing local programming schemes along with mechanisms for intrasectoral and intersectoral coordination at the local and regional levels. A common trend in many of the countries is the search for administrative schemes based on the decentralization and deconcentration of management mechanisms and the regionalization of health services--for example, the case of Nicaragua, with its territorial health systems. Several countries have formulated care models based on the coordination and more rational utilization of existing institutional resources at the local and regional levels. Also, the countries of Latin America and the Caribbean have undertaken major efforts in the formation and training of human resources to perform functions at the primary care level, as well as to introduce the concept of PHC in the formation of health professionals.

Many countries have established geographical, social, and operational criteria for identifying the underserved population groups at greatest risk in order to direct available resources toward them in a selective fashion with a view to improving equity in the delivery of services--for example, the program for the eradication of poverty in Colombia.

The programs most directly linked to the components of PHC, such as child survival, water supply and basic sanitation, control of diseases preventable by vaccination, control of vector-borne diseases, the supply of basic drugs, and health education, have received priority both in the allocation of national resources and in the efforts of the international community that collaborates with the developing countries of the Region. In some countries, health legislation has been modified or revised with an eye to formalizing or institutionalizing new mechanisms for intersectoral and intrasectoral coordination; the occupational profiles of health workers have been reformulated; and technical and administrative standards have been adopted for the decentralization of management and the strengthening of local health systems.

Better coordination among the institutions of the sector is a common goal in almost all the countries. However, with few exceptions, the reports indicated that this process was still at an early stage, particularly coordination between the services of the social security institutes and those of the Ministries of Health. Brazil, Costa Rica, Mexico, Panama, Peru, and Venezuela reported some significant advances since 1985, ranging from the formulation of a legal framework for the coordination/integration of services

up to the formation of common administrative and technical standards for the institutions and the implementation of integrated models of multi-institutional services in pilot regions. The countries mentioned the following factors as hindrances to intrasectoral coordination: resistance and inertia of the institutional bureaucracies, normative and operational discrepancies between institutions, differences in administrative and financial management, the lack of adequate legal standards, and the multiplicity of institutions involved.

The countries reported that their systems of patient referral and back-referral in most cases do not function appropriately and effectively. This is due in part to the fact that the capacity of response has not been adapted to the different levels of referral. Some, like Chile and Mexico, have succeeded in setting up schemes for the referral of patients with specific problems (high maternal and child risk, AIDS, auxiliary services, diagnoses, emergencies). In most of the countries, the incipient schemes for decentralization and the development of local health systems envisage this aspect as a fundamental point to be promoted in the near future.

B. Intersectoral Collaboration

The reporting countries mentioned that practically all the national sectors that participate in the overall process of development either directly or indirectly affect the population's state of health. Some of the most directly related sectors are: agriculture; education; social welfare; protection and improvement of the environment, including water supply, basic sanitation, and environmental pollution control; housing and human settlements; labor; and the population and family planning programs. In some countries, the Armed Forces and Public Safety sectors have provided logistical support for national health campaigns and mobilization programs.

A key role is played by the sector made up of the institutions that regulate public spending and national finances, the Ministries of Finance and the Central Banks, since it regulates the level of resources available for the performance of public health and other basic services. For the period under analysis, most of the Latin American and Caribbean countries have responded to the economic crisis by establishing economic adjustment or reactivation policies that are characterized by a marked reduction in public spending on the so-called nonproductive activities, such as health and education. This policy has led to a reduction, or in the best of cases to stagnation, in the resources available for the development and operation of health services, while producing a negative impact on the access of the great majority of the population to the necessary inputs for meeting their most basic needs (food, employment, housing, etc.). The health consequences of these policies that are aimed at containing costs and reducing the quality of life in broad sectors of the Region have not yet been fully examined, but available information shows that their impact has already been felt in the health of the most vulnerable groups and will continue to be manifested for quite some time.

The countries have established various institutional mechanisms to ensure that the goals and activities of the various sectors of development are coherent with the general development policy as well as mutually supportive. In some countries (Brazil, Costa Rica, Honduras), the ministers of the social sector are grouped in a Cabinet or Council for Social Development for the formulation, promulgation, and evaluation of coordinated policies and programs. In others, the Secretariat or Ministry of Planning is responsible for promoting such coordination. None of the countries reported having a procedure for the systematic monitoring and analysis of the health repercussions of large development projects. However, many countries are concerned with this issue, and the environmental impact reports that the international lending and some bilateral agencies require include evaluations of the impact on health.

Some countries have tested instruments for intersectoral coordination at the local and regional levels, e.g. Guatemala has established Urban and Rural Development Councils with multi-institutional and community participation. Similar agencies at the municipal, canton, or district level have been set up in Bolivia, Brazil, Costa Rica, Guyana, Mexico, and Paraguay. In other countries, ad hoc mechanisms for interinstitutional coordination have been successful for individual activities or projects, such as campaigns for vaccination, child survival, water and sanitation, etc. There are particularly well advanced multisectoral projects being carried out in Canada in the areas of tobacco use, drugs, environmental health, and cities, in keeping with that country's priorities for promotion and prevention.

The difficulties and obstacles standing in the way of achieving an optimum level of intersectoral collaboration in health development are:

- lack of consensus on priorities and even on the political and ideological framework of the various institutions and sectors in the countries, due in part to the fact that the national development plans tend to be not very specific with regard to sectoral goals and activities;

- scarce financial resources for undertaking joint intersectoral actions;

- weak or lack of technical and administrative mechanisms for local, multisectoral, and participatory programming of activities at the local level;

- persistence of centralized or concentrated managerial and administrative models in the decision-making process that limit local autonomy in multisectoral actions;

- the low priority and the limited negotiating power of the health sector compared with the other sectors in the countries;

- lack of trained human resources with experience in intersectoral work, especially middle-level management;

- lack of political will at the top decision-making levels to establish effective mechanisms for intersectoral coordination.

In several countries, as part of the effort to develop local health systems under a decentralized scheme, proposals have been made to encourage and facilitate the establishment of operational mechanisms for joint programming and coordination between sectors at the local level. Other measures include the formulation of constitutional mandates for intersectoral coordination and the formal participation of health sector authorities in the administration of other health-related institutions (water and sanitation, social welfare, nutrition, etc.). Finally, several countries indicated the need and desirability of promoting the dissemination of the concepts of PHC and HFA/2000 among other sectors and groups of national life in order to foster greater receptivity and acceptance of this component of the strategy.

C. Community Participation

The diversity of social and political models in the developing countries of the Region of the Americas is manifested by the different levels and forms of community participation in health and development. The period since 1985 has been characterized by the consolidation and extension of the democratization process in the Hemisphere. In this period, new constitutional systems were inaugurated in Brazil and Guatemala, and changes were made, as the result of elections, in the governments of several other countries of Central and South America and the Caribbean. The level and nature of community participation in health should be analyzed in the context of these general political processes, especially in those countries that have recently emerged from situations in which democratic participation in national political life was very limited.

All the reporting countries stated that their official policy included the need to support and promote community participation as an essential component of the strategy of PHC. In practice, however, the implementation of this policy is limited in most cases to community involvement in isolated aspects of specific activities at the local level, mainly in the form of health collaborators or volunteers or through the contribution of labor and funds for the construction of small local infrastructure works. Some of the countries, such as Bolivia, have established mechanisms for the participation of organizations that are representative of the communities in the formulation, implementation, and evaluation of policies and programs at the national level. In others (Colombia, Costa Rica, Dominican Republic, Honduras, Nicaragua, Peru, and Venezuela), the Ministries of Health have set up programs, offices, or departments that are responsible for the promotion, coordination, and standardization of community participation in health programs. In Venezuela "hospital member boards" have been formed with the participation of the community.

According to the reports, all the countries have some type of community voluntary personnel, especially in rural areas, to collaborate in specific programs, e.g. vector control or diarrheal disease control, as well as trained lay or traditional midwives. Other countries have community agents who are trained and regularly supervised by the health services and who carry out broader actions of basic health promotion and care (Bolivia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Paraguay, Peru). Some countries have carried out mass programs to mobilize the population, for immunization in particular, which have involved organized community groups (social welfare groups, community groups, churches, etc.) in programming and execution at the local level, and in some cases (Bolivia, for example) this participation has been expanded to the national level through the establishment of the People's Health Council.

All the countries acknowledge and support the contribution of nongovernmental organizations (NGOs) to the development of PHC. In some countries, their role is basically to support health education and promotion activities, while in others they supply primary-level services to a large sector of the population that is not covered by the state system. Thus in Canada, health units at all levels rely heavily on the services provided by volunteer agencies, especially in the area of promotion. In Bolivia, Honduras, and Guatemala, agreements have been reached between the Government and the principal NGOs that offer services in the health field with a view to improving coordination in the programming and execution of activities.

The reporting countries identified the main obstacles that have prevented community participation in the strategy of PHC. They included:

- the inappropriate attitudes, behavior, and knowledge of health workers with regard to the promotion, supervision, and acceptance of community participation in the programs, and the lack of human resources trained in community promotion;

- the high mobility of community representatives and volunteers, which makes it impossible to have stable development and ongoing training of community resources;

- the frustration generated by the limited capacity of the health services to respond in a timely and relevant manner to the community's needs;

- the limited knowledge of health and the low educational level of the population, as well as their apathy--resulting from the inability to satisfy their basic needs--which limits their interest and capacity to participate in the programming and evaluation of actions;

- the difficulties in establishing contact between the communities and the health services because of geographical inaccessibility, lack of means of communication, linguistic and cultural differences, etc.

- the situation of internal armed conflict that prevails in some countries of the Region;

- the existence of a paternalistic approach, both in the field and among the high-level authorities, that does not distinguish between participation and manipulation of the community, together with the trend of politicizing the mechanisms for community participation;

- the lack of materials needed for effectively promoting participation (vehicles, educational materials, etc.);

- bureaucratic rigidity and the persistence of centralized schemes of management and administration of the health services that hinder their ability to respond in a timely fashion to the demands of the participatory process.

The countries proposed some specific measures that they plan to adopt in the short and medium terms to overcome these deficiencies. Several will increase their use of the mass media for disseminating basic knowledge of health and promoting individual awareness of the responsibility to protect one's own health as well as that of the family. In addition, programs for health education and training of leaders at the community level will be strengthened in almost all the countries. Several countries propose to improve the awareness and attitudes of health personnel vis-à-vis the promotion of community participation. In the countries that will promote the development of local health systems and administrative decentralization, mechanisms will be tested for achieving community participation in the process of local programming and in other aspects of service management.

D. Management Processes and Mechanisms

Over the last three years, the management of health services has shown some common features in most of the countries that have had to introduce broad measures aimed at fiscal austerity and the rationalization of spending. Administrative reforms have been implemented with a view to increasing the efficiency of the public sector, and some countries are testing schemes for the partial or total transfer to the private sector of some services that were traditionally handled by the State, as in the case of Chile, through the partial privatization of Social Security. Even in the countries that have been able to avoid this privatization of the health services, there is considerable pressure on the health sector to exercise greater control and reap greater results from the limited resources available for its operation.

As a result, the reformulation and revision of health services administration and management received top priority during this period. This process has led in Uruguay, for example, to the separation of care delivery in the Ministry of Public Health, with the creation of a new institution for the management of services.

Furthermore, the democratization of national political life, which has been occurring in many countries of Latin America, is also characterized by a trend toward the deconcentration and decentralization of the administrative functions of the State. Several countries have attempted to strengthen regional, state, departmental, municipal, and other levels as a means of increasing the State's adaptation and capacity of response to the demands of the population.

The health sector as well has come under this process. Thus in Chile there is a trend toward municipalization, and in Colombia a major restructuring--political, administrative, and fiscal--is under way. Most of the countries have taken up the task of establishing, strengthening, and reinforcing the local health systems as the principal instrument for achieving the goal of HFA/2000. Based on this process of developing the local health systems, the countries propose to establish the following mechanisms with a view to increasing the efficiency and operating capacity of the services:

- effective coordination, or even integration, of the services offered by various institutions outside and within the sector at the local and regional levels;

- the implementation of comprehensive and participatory processes for the local programming of health activities that will facilitate the equitable, efficient, and effective utilization of available resources for addressing the most urgent priority health problems of the community;

- development of the technical and administrative capacity of middle-management staff at the regional and local levels as a prerequisite for the gradual decentralization of the management of the services;

- the design and establishment of information, monitoring, and evaluation systems geared to supporting the effective administration and management of the health systems.

Since 1985, several countries have reviewed and modified the institutional, organic, and functional framework of the sector with a view to opening the way for new schemes of management. The normative, regulatory, and control functions of the central level of the Ministries of Health have been strengthened, rather than increasing the executive functions and responsibilities of the peripheral levels of a given institution or of others that play a role in the delivery of services: social security, municipal and provincial governments, etc. (Brazil, Mexico). Other countries have defined more clearly the responsibilities and spheres of action of the different institutions that make up the sector as a step toward greater coordination and possibly intrasectoral integration (Costa Rica, Panama, and Venezuela).

Some countries have formulated and implemented legal instruments and standards for decentralized management not only of the health sector but of

other public services as well (Colombia, Guatemala, Mexico, Peru). Also, many Ministries of Health in the Region have modified their technical, policy-making, and administrative structures to make them consonant with the goal of decentralizing and facilitating the administration and management of priority programs (Bolivia, Dominican Republic, Ecuador, Guatemala, Honduras, Peru).

Many obstacles have affected the adoption of these managerial measures, including:

- lack of available economic resources for the development of administrative decentralization, e.g. wage standardization;

- lack of sufficiently trained managers at the peripheral levels;

- the multiplicity of and the lack of effective coordination and control between projects financed by external sources, which contributes to a dispersion of the efforts of the technical and administrative staff at the central and peripheral levels;

- the lack of consistency between the policies, strategies, and operational plans of the different institutions in the sector, as well as the introduction of party-oriented political criteria in the distribution of resources to the institutions and peripheral levels;

- the lack of a sufficient base of reliable information for monitoring, evaluating, and supporting the administration and management of the sector;

- the lack of cost systems that would make it possible to ensure more equitable and effective distribution of available resources.

In order to overcome these obstacles, the countries have assigned priority to promoting and deepening, at the institutional level, the development of the functions of planning, programming and evaluation, managerial training, upgrading of information systems, organization of budget allocations, and financial and accounting control.

E. Health Manpower

Of the countries reporting, only four (Cuba, Haiti, Mexico, and Trinidad and Tobago) stated that they have a health manpower plan for meeting the needs of the strategy of PHC. Eight countries are in the process of preparing or studying the formulation of such plans. Less than one-half of the countries feel that they have made progress since 1985 in improving equity in the distribution of human resources. The main reasons cited for this situation are the economic crisis, limited financial resources, and the unwillingness of health personnel to be stationed in less developed areas.

Several countries have instituted or strengthened programs for the training of professional and middle-level health staff using the approach of teaching-service integration in order to bring medical, nursing, and middle-level technical students into contact, from the very beginning of their training, with the concepts and practice of PHC in primary level services within an extramural community context. Many countries reported having recently revised the curricula of their professional training programs with a view to incorporating more public health elements as well as the strategy of PHC. Since 1985, five have established programs or schools for the training of specialists in public health and health services admininistration. Some have placed special emphasis on the training of teaching staff. All the countries have broad continuing education programs for health personnel in specific aspects of the strategy of PHC. Several countries have set up interinstitutional commissions on health manpower for the purpose of improving coordination and planning in this field.

Most of the countries reported that the main obstacles limiting the availability of human resources for PHC stem from the current financial and economic crisis. The remuneration of this staff in most of the countries is not enough to overcome their unwillingness to be stationed in rural areas of low accessibility. The lack of supplies, infrastructure, and basic equipment in the underserved areas causes frustration that leads to health workers leaving the services. In Nicaragua, these reasons, coupled with current conditions in the country, have led to a sizable exodus of health personnel. The lack of clear national policies and of a plan for training human resources in health, with the resulting lack of coordination and inefficiency in the utilization of the resources available for this purpose, have contributed to a deterioration of the situation in several countries.

In order to counteract this trend, the countries propose to formulate national policies and plans for human resources, to strengthen programs for the ongoing training of health personnel at all levels, to develop an information base and the technical capability necessary for the planning and monitoring of human resources, to institute effective measures to motivate health personnel located in less favored areas, and to improve the mechanisms of coordination between the health services and the institutions that train human resources.

F. Research and Technology

Only 13 of the reporting countries have a national policy for the selection and use of health technology, even though in some cases it may only be official policy or in the early stages of implementation. Since 1985, Costa Rica and Mexico have been reviewing and making an inventory of their technologies; priority lists of necessary technologies were drawn up to serve as guidelines for the regulatory institutions of each sector to establish specific directives. The coordination of the selection and use of health technology is generally weak in most of the countries. In some, this task is assigned to national commissions, academies, or ministries of science and technology or to specific interinstitutional groups, but almost all the

reporting countries agreed that this function is not properly performed in the health field. Peru set up a Sectoral Office for the Coordination of Research and Development of Technology in 1985 but this initiative has since been discontinued.

With regard to the identification and formulation of national research policies centered on priority health problems, ten countries have explicit guidelines in this area and seven are still in the stage of preparation and tentative formulation. The orientations respond to the priorities as derived from the epidemiological profiles and the level of development of the health services: basic and applied clinical and epidemiological research; infectious, contagious, and parasitic diseases with the highest prevalence; food and nutrition; human reproduction; alcoholism and drug addiction; traffic accidents; and prevalent chronic diseases. Also, several countries have set guidelines for identifying the priorities of applied research in health services and associated technologies, such as the production of drugs, natural medicine, and epidemiology applied to the planning, administration, and training of human resources.

In the field of health research, the functions of coordination, promotion, and dissemination of results are carried out through inter-institutional national health institutes or national research commissions in nine countries. The others do not have any formal mechanisms for these activities. The countries mentioned several factors that impede the effective preparation and implementation of research and health technology policies, among them, again, the lack of financial resources for investing in research on priority areas, the lack of trained research and support staff, the weakness of the mechanisms for inter-institutional coordination to ensure the rational utilization of the resources applied to research, and the limited political will to promote research as an instrument of development.

In order to solve these problems, the countries propose to establish or strengthen the agencies that regulate science and technology in health with a view to coordinating, promoting, and disseminating the efforts being made in this field, as well as assigning financial resources specifically for research in the budgets of the sectoral institutions. Several countries will undertake efforts to sensitize the political authorities and public opinion regarding the need to envisage the development of science and technology as an essential component of the overall and the sectoral process of development.

G. Utilization and Mobilization of Resources

Of the reporting countries and territories, only six stated that they have a basic plan for the mobilization and use of material and financial resources in support of the national strategy of HFA/2000 (Brazil, Cayman Islands, Chile, Cuba, Mexico, Turks and Caicos Islands). Panama and Trinidad and Tobago have begun work on the preparation of such a plan.

Ten countries have made some kind of reassignment of resources toward postponed areas and groups in the implementation of their national policies

for the decentralization and deconcentration of services. Ten countries reported having increased their installed physical capacity and strengthened the infrastructure and equipment of the service delivery units in underserved areas. Twelve countries increased the level of internal resources assigned to the development of PHC, be it in the number of health staff positions and operating expenses for inputs and logistics, or in funds for investments in infrastructure.

The obstacles most commonly cited with regard to the mobilization of resources were: the fiscal crisis, excessive external indebtedness, internal inflation, increases in the price of basic inputs on the international market, etc. All the countries have implemented measures aimed at increasing efficiency in the utilization and performance of available resources through the establishment of systems for expenditures, production, and costs, the streamlining of administrative procedures, the development of information systems with a managerial approach, and others as described in the previous chapters. Several countries have attempted to mobilize more resources from state, municipal, and provincial agencies to support the process of decentralization and the strengthening of the local health systems.

Only 14 of the 28 countries and territories gave information on the proportion of the GNP (GDP in some cases) used for health; the remaining data from other reports submitted to PAHO. Almost all these data come without any specification as to what they cover, making it difficult to arrive at any real assessments and comparisons between countries. The proportion of national expenditures used for primary health care is even more difficult to specify, since some countries only reported on spending for specific programs aimed at extending coverage without including, for example, ambulatory services, health education, and environmental improvement. This situation reflects the countries' lack of information on the production, costs, and expenditures of services by level of care, without which it is practically impossible to objectively monitor the efficiency and equity of the distribution and allocation of available resources. Since there are only a few countries that reported data, it has been decided to leave this column blank in the Annex.

6. INTERNATIONAL ACTION

A. International Transfer of Resources

Eleven countries felt that they had carried out a systematic analysis of the international cooperation needs of their national HFA/2000 strategies. The Central American countries, with support from PAHO/WHO, have drawn up a Plan of Health Priorities for Central America and Panama since 1985, in which they jointly systematize their requirements for external financial cooperation in six priority areas along with a joint portfolio of national and subregional projects. Under this initiative, the Central American countries have mobilized a total of US$390 million from external sources since 1985 for the development of health in the subregion. A similar effort has been initiated by the Member Countries of CARICOM (English-speaking Caribbean countries).

The priority areas to receive external support as identified by all the countries include all the components of the strategy of PHC (water and basic sanitation, immunization and child survival, maternal health and family planning, communicable diseases control, food and nutrition, essential drugs and development of the pharmaceutical industry, chronic diseases control), as well as projects aimed at increasing the operating capacity of the health services by expanding their installed physical capacity and infrastructure, providing maintenance for facilities and equipment, training human resources, developing biotechnology, and strengthening the managerial system.

B. Cooperation Among Countries

Since 1985 almost all the reporting countries have established cooperation agreements to promote joint health actions in border areas, especially vector-borne disease control, immunization, and epidemiological surveillance. Also, bilateral or multilateral agreements have been instituted between several countries for the exchange of knowledge and experiences, joint research, and manpower training in specific fields of common interest, such as biotechnology (Brazil, Cuba, Mexico), the production and quality control of drugs (Argentina, Brazil, Central America, Mexico), nutrition education, and the prevention and rehabilitation of drug addiction (English-speaking Caribbean). Cuba also provides technical cooperation in health, under a bilateral framework, to thirty developing countries in Latin America, Asia, and Africa.

The most significant mechanisms of TCDC that have been developed since 1985 are the PAHO/WHO-supported subregional cooperation initiatives. The Plan of Health Priorities for Central America and Panama was initiated in 1984. Since then, it has served as a vehicle not only for the mobilization of external resources but also for strengthening ties of technical cooperation among the countries of the subregion in areas of mutual interest and priority, such as malaria control, food and nutrition, manpower training, child survival, essential drugs, and other areas. The process of approximation and collaboration among the Central American countries has developed rapidly, despite the situation of conflict and instability that characterized the subregion during the period, and this makes the development achieved even more remarkable. There have already been several annual meetings of health authorities in this subregion (REMSCAP), and similar initiatives have begun in the English-speaking Caribbean. Efforts have continued toward the strengthening of Andean cooperation in health: under the Hipólito Unanue Agreement, the XIV Meeting of Ministers (REMSAA) was held in Bogotá, Colombia, this year, and there have been numerous technical meetings stemming from commitments made in these ministerial-level meetings.

C. International Technical Cooperation (WHO)

PAHO/WHO cooperation with the countries of the Region is considered useful for the development of the various components of the strategy of PHC, since all of them have received support in the form of international and national technical advisory services, manpower training locally and abroad,

the dissemination of scientific and technical information, the strengthening of national capacities to coordinate international cooperation in health and to mobilize additional external resources, the promotion of applied research in the countries' priority problems, and the contribution of financial resources for specific key activities.

Most of the countries expressed that the PAHO/WHO Programming and Evaluation System (AMPES) is a useful instrument for the joint programming of activities. Several countries indicated that the subregional cooperation initiatives also helped to improve the utilization of resources from PAHO/WHO technical cooperation. The obstacles preventing the optimum utilization of the available resources, as pointed out by the countries, included the difficulties encountered by the national programs in clearly defining their technical cooperation requirements, as well as the frequent turnover of technical staff members in managerial positions: this leads to changes in the priorities of cooperation and an inadequate understanding of the role of the Organization as an agency for technical cooperation and funding. Also, several countries indicated that coordination among the international agencies that provide cooperation in health is inadequate in many cases.

In this regard, the reporting countries receive technical cooperation from other United Nations agencies, such as UNICEF, UNDP, UNFPA, WFP, FAO, and others. At the bilateral level, collaboration is provided by USAID (USA), JICA (Japan), GTZ (Federal Republic of Germany), Italy, France, Spain, the European Economic Community (EEC), and others. In several countries, the Inter-American Development Bank (IDB) and the World Bank are also important sources of financial and technical resources.

In most of the countries the overall coordination of international cooperation is the responsibility of the Secretariat or Ministry of Planning. Few countries indicated that they have established offices or units within their Ministries of Health that are effectively coordinating all international cooperation in the area of health.

7. AVAILABILITY OF PRIMARY CARE

The quantification of "PHC coverage" is conceptually and methodologically complicated. The countries usually give qualitative responses by stating that the availability and accessibility of services has improved, although they are not able to express this improvement quantitatively or periodically.

In the report evaluating the strategies, 19 countries had data on health services coverage; this figure has since risen to 26. Of these, 15 countries do not have up-to-date data; there is new information for seven countries (Canada, Cayman Islands, Cuba, Ecuador, Haiti, Honduras, Trinidad and Tobago); and for four countries the figures have been updated (Costa Rica, Guyana, Mexico, Suriname). Except for Suriname, these last four countries showed higher figures than previously--especially Mexico, which reported that PHC coverage rose from 51% in 1980 to 91% in 1987.

The essential elements of PHC continue to show, overall, a positive trend. The available information from 26 countries in Latin America and the Caribbean indicates that the population with drinking water services through household connections or easy access (within 200 meters of a public standpipe) rose from 68% of the total population in 1980 to 73% in 1985, with increases in the urban area of 83% to 86% and of 40% to 45% in the rural area. Slower growth was observed in the coverage of sanitation services: from 42% to 45% overall, with increases of 59% to 60% in the urban area, and from 11% to 15% in the rural area. Taking into account that the urban population grew at an average annual rate of 3.4% in this period while the rate for the rural population was 0.07%, it can be inferred that most of the increase was concentrated in the urban area, in which, for example, the population with water supply through household connections or easy access grew by 40 million, representing more than 85% of the total increase with respect to the population having these services in 1980.

For the diseases of the EPI, the favorable trend observed in immunization coverage during the period 1978-1983 improved further in 1983-1987. Thus, in Latin America and the Caribbean, the percentage of under one-year old children immunized against polio rose from 75% to 80%. (Of the 39 countries that had information for 1987, 28 had a level of coverage greater than 70%; in 1983, only 21 had attained this level.) (It should be pointed out that in 1985 the countries of the Region of the Americas adopted the goal of eradicating the wild poliovirus by 1990.) DPT vaccination coverage of children under one rose from 43% to 58% in 1987, measles vaccination coverage rose from 47% to 56%, and BCG coverage fell from 74% to 71% (mainly as a result of the drop in Brazil, which fell from almost total coverage (98.9%) to 68.4%).

With regard to the immunization of pregnant women with tetanus toxoid, it is not possible to make a comparison over time in view of the recent establishment of this indicator and the lack of information.

As concerns prenatal care, new data were provided by Haiti, Honduras, Mexico, Dominican Republic. All the countries for which comparative information is available (Canada, Cayman Islands, Costa Rica, Ecuador, El Salvador, Jamaica, Nicaragua, Panama, Peru, Suriname, Trinidad and Tobago, Venezuela) showed levels that were higher than those of three years ago.

With regard to care at delivery by trained personnel, the number of reporting countries has risen. Of these, 28 had levels greater than 70%, seven were between 40% and 70%, and two were less than 40% (Haiti and Paraguay). Usually the percentage of deliveries attended by trained personnel is nearly equal to or greater than the percentage of pregnant women who receive prenatal care, but Colombia, Ecuador, Nicaragua, and Paraguay have delivery care levels that are clearly lower than those for prenatal care.

The percentage of postnatal care was, for the most part, between the levels of prenatal and delivery care, except in Bolivia, where it is greater than the percentage of care for infants, the Dominican Republic, Peru, and Venezuela, where the level is lower.

Generally speaking, none of these indicators of service coverage, which appear in the Annex, are comparable between countries, since they are calculated using different methods.

8. HEALTH SITUATION

According to the latest UN report on population estimates and projections, Latin America (including the Caribbean) has the second highest rate of natural growth in the world, in spite of a moderate but continuous decline in mortality and a rapid drop in the birth rate over the last two decades. The annual population growth around 1987 is estimated at 2.3%, and it is foreseen that this rate will continue to drop. With few exceptions, the populations of the countries of Latin America and the Caribbean have a large component of young people.

Urbanization has been a very significant demographic phenomenon in Latin America in recent decades. According to projections, 76% of the total population will be living in urban areas by the end of this century. The Governments of the Region are already feeling the pressure to respond to the basic needs of urban residents, whose total will increase from 200 million in 1975 to 420 million by the year 2000.

The general trends in health indicators in the Region as a whole and in the individual countries continued to improve as regards mortality rates, although perhaps more slowly than in the 1970s. The UN estimates of overall demographic figures for Latin America and the Caribbean in recent years are as follows:

	1970-75	1980-85	1985-90
Crude death rate (per 1,000 population)	9.7	8.2	7.6
Life expectancy at birth (years)	60.7	64.2	65.7
Infant mortality (per 1,000 live births)	80.0	62.0	56.0
Total fertility rate (15-49 years)	5.0	4.1	3.7
Average annual growth rate (%)	2.53	2.30	2.19

All the countries showed a favorable trend, although in some it was stronger than in others--and there are still some large disparities between countries (and, logically, within the countries). It is thus that, in the 25 Latin American and Caribbean countries for which estimates and projections on

this indicator are available (prepared by the United Nations), infant mortality for 1985-1990 is greater than 50 (world indicator) in 10 of them, and in two of them it exceeds 100 (Bolivia and Haiti). According to these same estimates, infant mortality in 15 countries is greater than 30 (the regional goal).

Also, the official figures for infant mortality around 1986, as reported by the countries to PAHO, are all less than 50, with the exception of the Dominican Republic, Guatemala, Honduras, Nicaragua, and Peru. This illustrates the situation of the vital statistics registries, which suffer from serious problems of coverage and quality in most of the countries.

Of the 37 countries for which there are estimates of life expectancy at birth are available, only two (Bolivia and Haiti) had life expectancies lower than 60 years (world indicator), and in 16 it was lower than 70 (regional indicator) for the five-year period 1985-1990.

With respect to low birthweight, several countries reported that in over 10% of the births the infant weighed less than 2,500 grams (world indicator). The figures of many other countries may not be reliable in view of the low coverage of delivery care and the fact that information usually is reported only for births at hospitals, which produces a considerable bias in the figures.

The seriousness of the state of children's health can be seen in the weight-age indicator, which reflects nutritional status. Despite the fact that the data are not comparable among themselves because they refer to different years, ages, and methods, the small number of countries reporting figures greater than 90% is very significant. However, it is likely that many of the data (probably all the data before 1982-1983) are based on the Gómez classification, which tends to overestimate malnutrition.

The official figures for maternal mortality also decreased during the period 1979-1985, with very few exceptions. However, several countries had levels greater than 10, with a maximum of 48 in Bolivia. Many studies have indicated that this rate is underestimated, probably in most of the countries, owing to problems of quality and coverage of medical certification of the cause of death, among others.

It is difficult to measure, especially in terms of mortality, the impact of the economic crisis on the health situation of the population. Recent data on poverty are incomplete, although information from various countries confirms the general impression that social conditions are deteriorating in many developing countries. A recent study found that the number of persons who live below the poverty level increased, at least up to 1983-1984, in Brazil, Chile, Jamaica, and Peru. Also, there has been pronounced and extensive deterioration in the trend toward better levels of child health and nutrition. It is important to emphasize that, as the crisis continues and becomes deeper, it will endanger the significant progress made in recent decades, especially in the reduction of infant and child mortality.

A clear indicator of this situation are the problems being faced in recent years by several countries of the Region in their efforts to reduce infant mortality (Argentina, Brazil, Colombia, Costa Rica, Panama, Uruguay, Venezuela).

9. CONCLUSIONS

Over the last seven years the countries of Latin America and the Caribbean have been experiencing the most severe economic crisis since the 1930s. As a consequence, there has been an alarming increase in unemployment and internal inflation, accompanied by a gradual worsening in the supply of goods and services, especially in the public sector. The greatest obstacle to development continues to be the Latin American debt crisis: today, Latin America and the Caribbean are net exporters of capital toward the industrialized countries. During 1987 more than US$28 billion was transferred out of the Region, and during the last five years Latin America has sent abroad $130 billion to pay the accumulated external debt.

Consequently, the countries have adopted economic adjustment or reactivation policies that are characterized by a marked reduction in public spending on the so-called "nonproductive activities," such as health and education. The implementation of these measures has led to stagnation or a reduction in the resources available for the development and operation of health services. This has been felt in the form of limited capital investments in basic sanitation and in the replacement, maintenance, and preservation of equipment and physical plants. The impact has also been felt in the ability to maintain an adequate level of current expenditures; this has impeded the normal operation of programs that focus on prevalent problems and has limited administrative development and the training of personnel in the sector.

In addition, the economic crisis has been detrimental to the well-being of vast sectors of the population. At present nearly one third of the population lives below the level of absolute poverty. Moreover, this poverty is distributed unequally within each country, thereby contributing to even greater disparities in the Region. In terms of coverage, of the 423 million inhabitants of Latin America and the Caribbean, some 130 million currently do not have permanent access to basic health services. In addition, the estimates for population growth indicate that during the period 1986-2000 the population will grow by some 160 million people, a population for whom it is necessary to ensure adequate health care. This is the most important challenge to the countries' health systems. It means that the services, which so far have generally not been able to serve the entire population with equity, effectiveness, and efficiency, should be reorganized and reoriented not only to continue operating but also to bridge the current gap and respond to the health care needs of the new population.

Some countries have already implemented a process for monitoring and follow-up of the strategy of PHC and HFA/2000, but in most of them work has

just begun in this area: data for world indicators are not always available. For example, the information on EPI coverage is timely and complete in almost all the countries, a reflection of the regional effort to promote this program and eradicate the wild poliovirus. Also, the information on water and basic sanitation coverage is available on most countries, although there are still problems of consistency, continuity, and accuracy. On the other hand, the information on nutritional status, low birthweight, basic health care, maternal and child health services, health spending, and local care is reliable in only a few countries.

The obstacles standing in the way of implementation of the process of monitoring and evaluation in the countries are grouped into three broad categories:

- those attributable to the lack of human resources and infrastructure for adequately collecting and analyzing the information;

- the poor quality of available data, considering the levels of underregistration, the multiplicity of sources, untimely delivery, and deficiencies in processing;

- the limited linkage between the management process and the information system in decision-making in the health system.

The national health policies and strategies of all the countries of the Region are coherent and consistent, at the level of official policy, with the strategy of PHC and HFA/2000. The adaptation of these policies and strategies has been limited by constraints in the financial, material, and human resources and, in some countries, by political and social instability. Health development in the Region is directed to achieving greater efficiency in the use of available resources by restructuring the health systems, a process that includes decentralization, the strengthening of local health systems, administrative reform, the mobilization of local resources, and interinstitutional and intersectoral coordination. However, many countries of Latin America and the Caribbean lack solid, long-term comprehensive strategies for the development of health and of the socioeconomic situation as a whole, and this may make it difficult to maintain the rate of improvement observed over the last thirty years.

Better coordination between the institutions that make up the health sector in the different countries is a common goal to almost all of them. However, with few exceptions, this is reported as a very incipient process, particularly with regard to coordination between the services provided by the social security institutes and those provided by the Ministries of Health.

The reporting countries all mentioned that practically all the national sectors that participate in the overall process of development either directly or indirectly affect the state of the population. Various institutional mechanisms have been established to ensure that the goals and activities of the various sectors of development are coherent with the general development

policy and mutually support each other. In several countries of the Region, the effort to develop local health systems under a decentralized managerial and administrative scheme is aimed in part at encouraging and facilitating the establishment of operational mechanisms for joint programming and coordination between sectors at the local level. Other measures that seek to improve this aspect of the strategy of PHC include the formulation of constitutional mandates for intersectoral coordination and the formal participation of health sector authorities in the administration of other health-related institutions.

All the countries of the Region stated, as part of their official policy, the need to support and promote community participation as an essential component of the strategy of PHC. Most of the time, the community is involved in isolated aspects of the execution of activities at the local level, mainly in the form of health collaborators or volunteers or through the contribution of labor and funds for the construction of small local infrastructure works. Some of the countries have established mechanisms for the participation of organizations that are representative of the communities in the formulation, execution, and evaluation of policies and programs at the national level. In others, the Ministries of Health have established programs, offices, or departments that are responsible for the promotion, coordination, and standardization of community participation in health programs.

Since 1985 several countries have reviewed and modified the institutional, organic, and functional framework of the sector with a view to opening the way for new schemes of management. The normative, regulatory, and control functions of the central level of the Ministries of Health have been strengthened, rather than increasing the executive functions and responsibilities of the peripheral levels of a given institution or of others that play a role in the delivery of services. Other countries have defined more clearly the responsibilities and spheres of action of the different institutions that make up the sector as a step toward greater coordination and possibly intrasectoral integration.

Some countries have formulated and implemented legal instruments and standards for the decentralized management of the health sector and other public services. Also, many Ministries of Health in the Region have modified their technical, policy making, and administrative structures to make them consonant with the goal of decentralizing and facilitating the administration and management of priority programs.

Of the countries reporting, few have a health manpower plan for meeting the needs of the strategy of PHC, and less than one-half of the countries felt that progress had been made since 1985 in improving the equity of the distribution of human resources. The principal reasons cited for this situation were the economic crisis, limited financial resources, and the resistance of health personnel to be stationed in less developed areas. Several countries have instituted or strengthened training programs for professional and middle-level health staff using the approach of teaching-service integration. Many countries reported having recently revised

the curricula of professional training programs with a view to incorporating more public health elements and the strategy of PHC. All the countries have broad continuing education programs for health personnel in specific aspects of the strategy of PHC. Several of them have created interinstitutional commissions on health manpower for the purpose of improving coordination and planning in this area.

Only a few countries report that they have a national policy for the selection and use of health technology, even though in some cases it may only be official policy or in the early stages of implementation. The coordination of the selection and use of health technology is generally weak in most of the countries. With regard to the identification and formulation of national policies for health research, ten countries have explicit guidelines in this area, and seven are still in the stage of preparation and tentative formulation. The orientations respond to the priorities as derived from the epidemiological profiles and the level of development of the health services. The countries mentioned several factors that impede the effective preparation and implementation of research and health technology policies: the lack of financial resources, the lack of sufficient research and support staff, the weakness of the mechanisms for inter-institutional coordination, and the limited political will to promote research as an instrument of development.

Ten countries have made some kind of reassignment of resources toward postponed areas and groups in the implementation of their national policies for the decentralization and deconcentration of services. Ten countries reported having increased their installed physical capacity and strengthened the infrastructure and equipment of the service delivery units in underserved areas. Twelve countries increased the level of internal resources assigned to the development of PHC, be it in the number of health staff positions and operating expenses for inputs and logistics, or in funds for investments in infrastructure. In the other countries, the economic crisis has impeded the allocation of any additional internal resources. Several countries are attempting to mobilize more resources from state, municipal, and provincial agencies to support the process of decentralization and the strengthening of the local health systems.

Eleven countries felt that they had made a systematic analysis of the international cooperation needs of their national HFA/2000 strategies. The Central American countries, with support from PAHO/WHO, have drawn up the Plan of Health Priorities for Central America and Panama (PPS/CAP) since 1985, in which they have succeeded in mobilizing a total of US$390 million from external sources for the development of health in the subregion. A similar effort has been initiated by the Member Countries of CARICOM (English-speaking Caribbean countries).

Since 1985 almost all the countries of the Region have established cooperation agreements to promote joint health actions in border areas or have become party to bilateral or multilateral agreements between several countries for the exchange of knowledge and experiences, joint research, and manpower training in specific fields of common interest.

The trends observed in the Region with regard to the coverage of the strategy of PHC and the health situation showed the following relevant features:

- water and sanitation: moderate increase in coverage, with rates being higher in the urban areas;

- EPI diseases: increased coverage of polio, DPT, and measles vaccinations, exceeding 90% in many countries;

- prenatal care, care during delivery, and postnatal care: it is not possible to draw any conclusions based on the information available, which is isolated and incomplete for most of the countries, although it is clear that in most of them coverage is far from satisfactory.

- PHC coverage: there is insufficient information on this indicator to determine any regional trend;

- mortality, natality, life expectancy: improvements have been made, although at lower levels than in previous periods;

- nutrition and low birthweight: although only very few countries have regular nutrition surveillance systems, isolated data from surveys and special studies in most of the countries revealed the persistence of high levels of undernutrition among children and low birthweight in the Region.

In summary, during the coming years it will be necessary to focus on the establishment and strengthening of mechanisms for monitoring and following up the strategy of PHC and HFA/2000 in the Region of the Americas, as well as improving the availability, coverage, and quality of information. The current emphasis on the development of managerial and administrative schemes that are conducive to greater equity and efficiency in the utilization of resources will need to consider, in turn, the need to design and operationalize an information base for this purpose. Although progress has been made, the Region still has a long way to go in this field.

Annex

ANNEXES

TABLE No. 1. SELECTED HEALTH INDICATOR

COUNTRY OR TERRITORY	% NEWBORNS WITH BIRTH WEIGHT LESS THAN 2500g		% CHILDREN WITH APPROPRIATE WEIGHT		INFANT MORTALITY ESTIMATES		OFF. INF. MORTALITY	LIFE EXPECTANCY AT BIRTH (YEARS)				MATERNAL MORTALITY RATE (PER 10,000 LIVE BIRTHS)	
	YEAR	VALUE	YEAR	VALUE	80-85	85-90	CIRCA 85	80 - 85		85 - 90		CIRCA 79	CIRCA 85
								M	F	M	F		
ANGUILLA	1984	3.8	1975	56.9	28		18.6	62.2	76.9	...	...	...	...
ANTIGUA & BARBUDA	1982	8.2	...	...	18		11.5	68.6	71.9	...	...	7.5	17.0
ARGENTINA	1985-7	5-12	...	...	36	32	26.0	66.4	73.1	67.3	74.0	7.8	5.8
BAHAMAS	1986	8	1986	96.5	24		26.1	69.2		...	...	3.7	1.8
BARBADOS	...	...	1978	60.5	14	11	17.3	70.0	75.4	70.7	76.4	7.0	6.9
BELIZE	...	...	1984	71.8	23		26.3	71.2		...	...	5.4	4.9
BERMUDA	1984	6.8	...	...	15		...	73.0		...	...	...	...
BOLIVIA	1987	6	1981	55	124	110	...	48.5	53.0	50.8	55.4	...	48.0
BRAZIL	1987	8	1980	48.5	71	63	...	60.9	66.0	62.3	67.6	...	...
CANADA	1986	5.6	...	...	9	8	7.9	72.3	79.3	72.8	80.1	0.7	0.4
CAYMAN ISLANDS	1987	7	1987	97	24		2.8	74.5		...	...	...	...
CHILE	1987	7.2	1987	92.1	23	20	19.5	66.7	72.9	67.6	73.9	7.3	5.0
COLOMBIA	1987	17.3	1977-80	48.3	50	46	41.7	61.4	66.0	62.6	67.2	16.0	...
COSTA RICA	1985	6.6	1982	65.8	20	18	17.8	70.5	75.7	71.1	76.4	4.2	4.0
CUBA	1984	7.9	...	...	17	15	13.6	71.8	75.2	72.2	75.8	5.3	3.6
DOMINICA	1983	10.5	1978	49.5	16		21.6	68.0	74.0	...	...	13.1	5.8
DOMINICAN REPUBLIC	1984	15	1985	58.6	75	65	56.2	60.7	64.6	62.7	66.7	8.0	9.4
ECUADOR	...	...	...	42.8	70	63	40.5	62.3	66.4	63.4	67.6	15.9	15.1
EL SALVADOR	1987	8.2	...	85.3(U) 78.5(R)	70	59	34.4	62.6	67.1	64.9	69.3	6.9	6.8
FRENCH GUIANA, GUADELOUPE & MARTI.	...	...	...	...	...		...	...	...	...	...	...	...
GRENADA	...	...	1978	60.3	21		13.8	64.0	67.0	...	...	11.9	14.2
GUATEMALA	1980	10	1988	46.7	70	59	56.8	56.8	61.3	59.7	64.4	15.0	7.6
GUYANA	1986	12	1985	75	36	30	49.0	65.8	70.8	67.3	72.5	3.5	11.2
HAITI	1986	15	1987	58	128	117	...	51.2	54.4	53.1	56.4	...	23.0
HONDURAS	1981	9.2	1987	62	82	69	62.4a/	58.2	61.7	60.9	64.5	8.2	5.0
JAMAICA	1987	12	1987	75.8	21	18	9.2	70.3	75.7	71.0	76.7	...	...
MEXICO	1984	15	...	...	53	47	...	63.5	68.1	64.9	69.6	10.0	9.1
MONTSERRAT	1978	7.8	...	...	18	...	12.1	...	...	...	...	...	...
NETHERLANDS ANTILLES	...	...	...	...	16		...	72.8		...	...	2.5	...
NICARAGUA	1985-6	8.3	1986	50.0	76	62	63.2	58.7	61.0	62.0	64.6	8.5	4.7
PANAMA	1985	8	1985	83.3	26	23	19.4	69.2	72.9	70.1	74.1	7.0	6.2
PARAGUAY	1986	8	1982	68	45	42	40.1a,b/	62.8	67.5	63.7	68.5	43.8	28.3
PERU	1982	9	1984	86.4	99	88	88.2	56.8	60.5	59.5	63.4	7.0	8.9
SAINT LUCIA	1985	9.7	1980	76.9	23	...	23.0	68	73	...	...	10.7	...
ST. CHRISTOPHER/NEVIS	1983	9.4	1980	67.6	43	...	27.8	67.6	72.1	...	...	8.3	9.0
ST. VINCENT & THE GRENADINES	1982	10	1983	61.9	33	...	23.0	68.5		...	...	8.8	10.3
SURINAME	1987	12.8	1986	83-90	36	30	35.0	65.5	70.6	67.0	72.3	5.7	6.0
TRINIDAD & TOBAGO	1987	13	1978	50.7	24	20	12.6	66.2	71.3	67.6	72.9	6.7	5.4
TURKS Y CAICOS ISLANDS	1986	2	1985	93	24		...	...	...	...	...	...	...
UNITED STATES	...	...	...	...	11	10	10.6	70.6	78.1	71.3	78.8	1.0	0.8
URUGUAY	1985	7.9	...	...	30	27	23.8	67.1	73.7	67.8	74.4	4.9	2.6
VENEZUELA	1987	9.8	1974	51.1	39	36	25.8	66.0	72.1	66.7	72.8	5.9	6.1
VIRGIN ISLANDS (UK)	...	...	...	...	41	...	16.2	70.0		...	...	...	...

... Data not available. a/ Survey data. b/ Area of information. (R) Rural. (U) Urban.

See sources and notes at the end of the tables.

TABLE No. 2. HEALTH SERVICES COVERAGE

COUNTRY OR TERRITORY	POPULATION COVERED BY HEALTH SERVICES (%)	PREGNANT WOMEN ATTENDED (%)			INFANTS ATTENDED (%)
	1983 - 1987	INMUNIZ WITH TET-TOX 1985 - 87	DURING PREGNANCY 1983 - 87	DURING DELIVERY 1983 - 87	1983 - 87
ANGUILLA	...	...	80	100	97
ANTIGUA & BARBUDA	100	...	...	86	100
ARGENTINA	...	...	...	92	...
BAHAMAS	100	68	100	100	...
BARBADOS	100	...	98	98	78
BELIZE	75	...	81	83	90
BERMUDA	...	...	90	90	90
BOLIVIA	...	3	17	17	30
BRAZIL	...	62	75	73	...
CAYMAN ISLANDS	100	...	98	100	100
CANADA	99	...	100	100	100
CHILE	95	...	91	98	90
COLOMBIA	87	6	65	51	...
COSTA RICA	97	20	91	97	91
CUBA	100	87.5	100	99	...
DOMINICA	100	...	96	96	93
DOMINICAN REPUBLIC	...	25	60	65	32
ECUADOR	80	12	71	44	75
EL SALVADOR	...	...	69	66	45
GRENADA	...	...	...	81	68
GUATEMALA	60	12	...	51	...
GUYANA	96	47	95	93	98
HAITI	45	31	41	40	33
HONDURAS	62	46	65	90	72
JAMAICA	...	...	76	79	70
MEXICO	91	42	60	87	...
MONTSERRAT	100	...	100	96	95
NETHERLANDS ANTILLES	...	...	...	95	...
NICARAGUA	...	24	82(U) y 60(R)	41	...
PANAMA	82	20	83	84	77
PARAGUAY	...	58	57	30	64
PERU	...	4	60	78	39
SAINT LUCIA	100	...	95	...	81
ST. CHRISTOPHER/NEVIS	100	...	...	...	90
ST. VINCENT AND THE GRENADINES	80	...	...	...	82
SURINAME	91	100	100	91	90
TRINIDAD & TOBAGO	99	11	95	95	100
TURKS & CAICOS ISLANDS	100	...	87	100	100
UNITED STATES	...	...	...	...	...
URUGUAY	...	...	...	...	...
VENEZUELA	...	30(R)	74	69	66
VIRGIN ISLANDS (UK)	100	...	...	...	90

... Data not available.
(R) Rural. (U) Urban.

See sources and notes at the end of the tables.

TABLE NO. 3. CHILDREN UNDER 1 YEAR OF AGE COMPLETELY IMMUNIZED AGAINST POLIO, DPT, MEASLES AND TUBERCULOSIS

COUNTRY OR TERRITORY	POLIO			DPT			MEASLES			BCG		
	1978	1983	1987	1978	1983	1987	1987	1983	1987	1978	1983	1987
ANGUILLA	...	99.0	100.0	...	97.0	92.2	...	70.0	81.2	...	96.0	100.0
ANTIGUA & BARBUDA	...	99.0	95.2	...	90.0	93.3	...	48.0	85.5	...	...	...
ARGENTINA	15.9	72.9	85.0*	11.1	56.9	75.0	42.4	68.8	81.0	39.5	61.4	91.0
BAHAMAS	50.4	65.0	81.0*	28.0	65.0	85.0	34.1	66.0	83.0*	68.0	...	...
BARBADOS	55.9	62.0	67.5	63.0	69.0	78.8	...	55.0	84.0*	0.1	...	...
BELIZE	...	60.8	69.0	...	59.0	69.0	...	42.8	64.0	...	80.8	92.0
BERMUDA	...	48.0	88.9	...	48.0	88.9	...	48.0	82.9	...	...	...
BOLIVIA	3.4	10.0	27.7	2.5	9.6	24.1	9.2	12.6	32.7	...	26.9	30.9
BRAZIL	33.6	98.9	89.5	11.3	61.0	56.9	42.3	67.3	54.8	43.8	98.9	68.4
CAYMAN ISLANDS	...	100.0	90.0	...	100.0	90.0	...	98.7	91.0	...	69.0	76.0
CANADA	...	...	85.0	...	...	85.0	...	...	70.0	...	...	...
CHILE	97.8	94.0	95.1	100.0	82.6	92.7	...	28.0	92.0	89.3	87.2	97.0
COLOMBIA	17.1	44.0	81.7	17.4	42.0	58.3	8.2	43.0	59.4	32.9	79.0	79.6
COSTA RICA	57.7	83.8	88.6	63.5	84.1	91.1	72.0	81.5	90.0	74.1	81.0	80.6
CUBA	99.7	93.6	86.0	70.1	99.0	87.1	59.1	93.6	99.9	88.5	96.3	95.7
DOMINICA	20.4	91.9	95.0	62.0	92.6	95.0	55.1	63.0	87.0	...	100.0	98.0
DOMINICAN REPUBLIC	28.1	22.4	79.0	12.6	24.3	80.0	19.1	23.4	71.0	18.2	40.8	...
ECUADOR	9.5	31.7	50.8	...	30.7	50.5	14.5	34.2	46.3	57.5	84.0	84.8
EL SALVADOR	...	20.0	57.3	...	20.8	53.3	...	45.5	48.1	...	47.6	54.6
GRENADA	...	72.0	81.0	...	68.0	80.0	...	7.0	77.0	...	...	...
GUATEMALA	54.7	43.1	17.6	54.9	43.3	15.8	62.8	9.1	24.3	51.9	24.3	33.9
GUYANA	31.3	59.0	76.7	31.7	55.9	67.0	...	43.9	52.2	14.3	72.7	68.6
HAITI	0.8	6.4	27.9	2.4	8.8	27.8	...	...	23.4	...	61.8	45.1
HONDURAS	6.7	51.0	60.7	5.7	51.8	58.4	21.9	48.8	56.5	8.7	55.3	66.4
JAMAICA	...	57.0	82.0	...	58.0	81.0	...	15.0	62.0	...	56.0	92.0
MEXICO	...	88.3	97.0	...	40.9	62.0	...	23.4	54.1	...	51.9	71.0
MONTSERRAT	...	95.0	96.1	...	95.0	96.1	...	83.0	78.2	...	91.0	99.0
NICARAGUA	...	74.5	85.0	...	21.6	43.0	...	37.5	44.0	...	80.2	93.0
PANAMA	40.9	60.1	74.0	38.9	60.5	72.5	43.4	60.4	78.0	65.1	81.0	89.0
PARAGUAY	2.2	47.3	93.0	4.7	44.7	58.0	5.7	36.9	56.2	17.2	54.5	65.7
PERU	20.5	22.0	44.7	18.3	22.7	42.6	21.4	27.6	35.2	67.4	61.0	61.3
SAINT LUCIA	...	80.0	86.0	...	81.0	85.0	...	36.0	81.0	...	69.0	89.0
ST. CHRISTOPHER/NEVIS	...	91.0	98.0	...	90.0	96.0	...	...	91.0	...	...	...
ST. VINCENT AND THE GRENADINES	...	84.0	96.0	...	80.0	97.0	...	59.0	91.0	...	...	90.0
SURINAME	...	83.0	70.3	...	84.6	70.9	...	71.0	69.5	...	...	100.0
TRINIDAD & TOBAGO	45.2	61.0	80.0	39.5	60.0	79.0	...	...	68.0	...	...	...
TURKS Y CAICOS ISLANDS	...	79.0	100.0	...	70.0	100.0	...	32.5	92.1	...	97.5	100.0
UNITED STATES	...	...	...	...	...	...	...	...	...	...	...	...
URUGUAY	51.6	76.6	70.2	52.9	72.9	70.1	21.4	64.6	99.8	93.7	99.0	97.7
VENEZUELA	82.8	77.3	64.4	31.4	57.9	53.9	20.2	42.1	56.7	...	82.2	...
VIRGIN ISLANDS (UK)	...	75.0	100.0	...	90.0	95.9	...	83.0	79.6	...	...	77.0

... Data no available.
*1986.

See sources and notes at the end of the tables.

TABLE No. 4. DEMOGRAPHIC INDICATORS

COUNTRY OR TERRITORY	Pop. (thous)	Rural population	Median Age	Annual rate of growth 1985-90 (%)			Crude death rate (per 1,000 Pop.)			Crude birth rate (per 1,000 Pop.)			Total fertility rate		
	1988	(%)		Total	Urb.	Rural	70-75	80-85	85-90	70-75	80-85	85-90	70-75	80-85	85-90
ANGUILLA	8	...	...	1.7	...	...	...	9.0	...	...	25.0	...	...	...	...
ANTIGUA & BARBUDA	83	...	...	1.5	...	...	...	5.1	...	...	15.2	...	...	...	...
ARGENTINA	31,965	15.4	27.3	1.47	1.86	-0.76	9.0	8.7	8.6	23.4	24.6	23.2	3.1	3.4	3.3
BAHAMAS	243	19.6	...	1.91	...	...	...	5.5	...	...	24.6	...	3.4	2.7	...
BARBADOS	257	57.8	26.2	0.60	1.79	-0.30	8.7	8.7	8.6	20.8	17.8	18.5	2.7	1.9	2.0
BELIZE	177	50.0	...	3.10	...	...	...	4.9	...	...	36.0	...	...	4.3	...
BERMUDA	84	...	...	1.90	...	...	...	7.0	...	...	16.4	...	...	...	...
BOLIVIA	6,918	52.2	18.0	2.80	4.30	1.34	19.0	15.9	14.1	45.4	44.0	42.8	6.5	6.3	6.1
BRAZIL	144,427	27.3	21.6	2.09	3.25	-1.26	9.7	8.4	7.9	33.6	30.6	28.6	4.7	3.8	3.5
CAYMAN ISLANDS	21	...	...	2.13	...	...	...	6.0	...	...	...	...	...	...	...
CANADA	26,229	24.1	31.4	1.02	1.10	0.76	7.7	7.4	7.6	18.6	15.1	14.9	2.0	1.7	1.8
CHILE	12,606	16.4	24.7	1.52	2.02	-1.15	8.6	6.7	6.6	27.0	22.7	22.0	3.5	2.6	2.5
COLOMBIA	30,567	32.6	20.7	2.08	2.94	0.19	9.0	7.7	7.4	33.3	31.0	29.2	4.8	3.9	3.6
COSTA RICA	2,801	50.2	21.1	2.47	4.00	0.86	5.8	4.2	4.2	31.0	30.5	28.5	4.3	3.5	3.3
CUBA	10,317	28.2	25.8	0.98	1.86	-1.40	6.4	6.4	6.7	25.9	16.9	18.2	3.5	2.0	2.0
DOMINICA	79	...	...	1.5	...	...	...	5.2	...	...	22.5	...	...	2.6	...
DOMINICAN R.	6,677	44.3	18.9	2.23	3.91	-0.05	11.0	8.0	7.1	41.9	33.1	30.9	6.3	4.2	3.6
ECUADOR	10,203	47.7	18.7	2.83	4.60	0.74	11.2	8.1	7.6	41.2	36.8	35.4	6.0	5.0	4.6
EL SALVADOR	6,094	60.9	17.5	3.15	3.51	2.92	11.1	8.1	7.9	43.2	40.2	37.9	6.3	5.6	5.1
FRENCH GUIANA, GUADELOUPE MARTINIQUE	881	27.4	...	2.10	...	...	...	6.1	...	...	20.9	...	...	...	...
GRENADA	116	...	...	1.54		...	...	6.7	...	...	26.3	...	...	...	...
GUATEMALA	8,681	61.5	16.9	2.92	3.93	2.23	13.4	10.5	8.9	44.6	42.7	40.8	6.5	6.1	5.8
GUYANA	1,006	67.8	20.9	1.76	3.25	1.02	7.6	5.9	5.4	32.5	28.5	24.8	4.5	3.3	2.7
HAITI	7,121	75.4	18.1	2.66	4.84	1.79	17.4	14.2	12.8	42.7	41.3	40.8	6.1	5.7	5.6
HONDURAS	4,803	63.9	16.0	3.15	5.14	1.73	13.7	10.1	8.4	48.6	43.9	39.4	7.4	6.5	5.6
JAMAICA	2,446	46.2	20.4	1.53	2.92	-0.19	7.4	5.6	5.5	32.5	28.1	26.0	5.4	3.4	2.9
MEXICO	84,971	30.4	18.4	2.42	3.27	0.35	9.2	7.1	6.5	42.7	33.9	31.2	6.4	4.6	4.0
MONTSERRAT	12	10.0	...	1.49	...	...	...	9.4	...	...	21.3	...	...	...	...
NETHERLANDS ANTILLES	274	...	...	1.4	...	...	...	3.5	...	...	17.5	...	...	...	...
NICARAGUA	3,622	43.4	16.5	3.42	4.56	1.86	12.7	9.7	8.0	46.8	44.2	41.8	6.7	5.9	5.5
PANAMA	2,322	47.6	20.6	2.09	2.90	1.10	7.3	5.4	5.2	35.7	28.0	26.7	4.9	3.5	3.1
PARAGUAY	4,007	55.6	18.6	2.82	4.18	1.68	8.1	7.2	6.8	37.5	36.0	34.3	5.7	4.9	4.5
PERU	21,254	32.6	19.4	2.54	3.38	0.72	12.8	10.7	9.2	40.5	36.7	34.3	6.0	5.0	4.5
SAINT LUCIA	140	...	...	1.37	...	...	...	6.6	...	...	32.0	...	...	...	...
ST. CHRISTOPHER/NEVIS	48	...	...	1.41	...	...	...	10.7	...	...	27.0	...	...	...	...
ST. VINCENT AND THE GRENADINES	108	...	...	1.48	...	...	...	7.2	...	...	27.2	...	...	...	...
SURINAME	392	53.3	20.0	1.47	2.29	0.77	7.5	6.8	6.1	34.6	28.8	25.9	5.3	3.6	3.0
TRINIDAD & TOBAGO	1,243	36.1	23.0	1.60	3.21	-1.52	7.2	7.0	6.5	26.6	25.4	24.0	3.5	2.9	2.7
TURK & CAICOS I.	9	...	...	2.38	...	...	...	4.5	...	...	...	...	...	...	...
UNITED STATES	244,252	26.1	31.3	... 0.86	0.91	0.72	9.4	9.1	9.0	16.2	16.0	15.7	2.0	1.8	1.9
URUGUAY	3,081	15.4	29.8	0.76	0.96	-0.39	10.1	10.2	10.2	21.1	19.5	18.9	3.0	2.8	2.6
VENEZUELA	18,755	13.4	19.9	2.65	3.07	-0.25	6.5	5.5	5.4	36.1	33.0	30.7	5.0	4.1	3.8
VIRGIN ISLANDS (UK)	13	...	...	1.3	...	...	...	5.6	...	...	22.0	...	...	...	...

... Data not available.

See sources and notes at the end of the tables.

TABLE No. 5. PERCENTAGE OF POPULATION WITH DRINKING WATER SUPPLY, SEWERAGE OR EXCRETA DISPOSAL SERVICES

COUNTRY OR TERRITORY	DRINKING WATER SUPPLY						SEWERAGE AND EXCRETA DISPOSAL SERVICES					
	TOTAL		URBAN		RURAL		TOTAL		URBAN		RURAL	
	1980	1985	1980	1985	1980	1985	1980	1985	1980	1985	1980	1985
ANGUILLA	...	...	...	...	...	...	...	...	...	...	...	...
ANTIGUA & BARBUDA	...	95	...	...	...	...	...	100	...	...	...	...
ARGENTINA	53	55	62	63	17	17	72	69	80	76	35	35
BAHAMAS	59	87	100	100	...	...	45	90	88	100	...	...
BARBADOS	98	100	99	100	98	100	...	100	...	100	...	100
BELIZE	66	67	99	98	36	...	69	...	62	...	...	...
BOLIVIA	37	53	69	81	10	27	19	36	37	51	4	22
BRAZIL	72	76(1)	83	86(1)	50	53(1)	22	24	32	33	1	2
CAYMAN ISLANDS	100	...	...	...	...	...	...	...	...	...	...	...
CHILE	84	86	100	97	17	22	...	67	...	79	...	21
COLOMBIA	86	91	93	100	73	76	61	68	92	96	4	13
COSTA RICA	93	93	100	100	82	82	93	95	99	100	84	88
CUBA	...	82	...	...	...	...	92	...	...	...	...	...
DOMINICA	77	...	...	...	...	...	86	...	...	...	...	...
DOMINICAN REPUBLIC	...	49	...	72	...	24	...	66	...	72	...	59
ECUADOR	48	58	79	83	20	33	...	57	...	79	...	34
EL SALVADOR	51	51	67	76	40	47	35	62	48	89	26	35
GRENADA	...	85	...	...	...	...	...	...	...	...	...	...
GUATEMALA	45	58	90	89	18	39	29	54	45	73	20	42
GUYANA	79	80	100	100	60	60	76	95	73	100	80	87
HAITI	18	38	51	59	8	32	18	19	42	42	10	14
HONDURAS	...	50	...	51	...	49	31	32	49	22	26	38
JAMAICA	...	96	...	99	...	93	...	91	...	92	...	90
MEXICO	73	82	90	95	40	50	55	57	77	77	12	15
NETHERLANDS ANTILLES	82	...	...	...	...	...	...	...	...	...	...	...
NICARAGUA	39	50	67	77	6	13	18	27	34	35	...	16
PANAMA	81	82	100	100	61	64	71	81	83	99	59	61
PARAGUAY	20	23	39	49	8	8	...	49	...	66	...	40
PERU	48	53	68	73	18	17	35	48	57	67	3	13
SAINT LUCIA	70	...	...	...	...	...	62	...	...	...	...	...
ST. CHRISTOPHER/NEVIS	...	100	...	...	...	...	...	96	...	...	...	...
ST. VINCENT AND THE GRENADINES	75	...	...	...	...	...	88	...	...	...	...	...
SURINAME	85	97	100	100	79	94	85	100	100	100	79	100
TRINIDAD & TOBAGO	97	98	100	100	93	93	93	100	96	100	88	100
TURK & CAICOS ISLANDS	...	100	...	...	...	...	...	89	...	...	...	...
URUGUAY	80	83	96	95	2	27	59	59	59	59	59	59
VENEZUELA	84	84	93	88	53	65	49	...	71	...	12	...
VIRGIN ISLANDS (UK)	...	85	...	...	...	...	...	85	...	...	...	...

... Data not available.
(1) 1986.

See sources and notes at the end of the tables.

TABLE No. 6. SELECTED SOCIOECONOMIC INDICATORS

COUNTRY OR TERRITORY	GNP PER CAPITA	GDP GROWTH PER CAPITA (IN THE PERIOD)		PUBLIC EXTERN. DEBT AS % OF GNP		HEALTH EXPEND. AS % OF GDP	PHC AS % OF HEALTH EXPEND.	% CENTRAL GVMT. EXPEN. ON HEALTH		LITERACY RATE CIRCA 1985			ECONOMICALLY ACTIVE POPULATION IN AGRICULTURE
	1986	1980-87	1985-87	1980	1986	CIRCA 1984		1978	1985	T	M	F	1985
ANGUILLA	2,700	...	...	...	...	...	...	...	9.8	90	...	...	...
ANTIGUA & BARBUDA	2,380	...	...	...	...	6.2	...	...	11.8	90	...	...	9
ARGENTINA	2,350	-14.7	- 1.0	7.2	46.2	8.2	...	2.2	1.3	96	98	95	14.5
BAHAMAS	7,190	- 0.7	...	...	13.0	6.5	...	15.6	15.2	93	...	...	5
BARBADOS	5,150	- 3.0	3.9	...	23.1	4.3	...	11.5	14.6	96	...	...	10
BELIZE	1,170	...	...	...	44.1	3.0	...	...	10.0	93	...	...	37
BERMUDA	...	...	...	...	...	18.7	...	...	...	97	...	...	...
BOLIVIA	600	-27.5	-11.0	36.4	78.5	...	...	8.3	1.4	74	84	65	43.9
BRAZIL	1,810	4.1	12.8	...	31.9	3.5	...	7.3	6.4	78	79	76	27.6
CAYMAN ISLANDS	...	...	...	...	...	...	...	...	8.9	95	...	...	...
CANADA	14,120	13.0	...	...	...	8.6	...	...	6.1	...	...	...	4.2
CHILE	1,320	- 2.5	8.0	18.0	101.2	6.	...	6.9	6.0	98	...	...	14.4
COLOMBIA	1,230	7.3	7.5	12.6	36.6	4.1	...	...	...	82	...	...	30.8
COSTA RICA	1,480	- 9.5	0.3	34.3	90.1	6.9	...	25.4	19.5	93	94	93	27.1
CUBA	...	...	...	...	...	...	...	...	...	98	...	...	21.4
DOMINICA	1,210		...	...	41.2	9.5	...	15	13.5	80	...	...	36
DOMINICAN REPUBLIC	710	0.2	- 0.5	...	52.5	2.3	...	9.4	9.0	77	78	77	40.6
ECUADOR	1,160	- 6.9	- 3.6	24.4	73.9	6.0	...	...	7.3	83	85	80	34.3
EL SALVADOR	820	-14.5	0.1	15.3	38.1	2.1	...	8.9	7.5	72	75	69	40
GRENADA	1,240	...	...	...	55.5	5.7	...	...	11.8	85	...	...	30
GUATEMALA	930	-20.5	- 6.4	6.9	30.1	3.7	...	7.1	...	...	71	55	54
GUYANA	500	-26.7(a)	- 8.0(b)	...	153.8	5.2	...	...	5.1	96	97	95	24.6
HAITI	330	-14.5	- 3.3	...	27.4	3.5	...	...	5.7	37	40	35	67.0
HONDURAS	740	-13.2	- 1.7	36.9	68.7	12.2	...	8.6	...	59	61	58	57.7
JAMAICA	840	- 4.7	- 2.5	...	144.4	2.5	...	...	10	76	...	...	29.1
MEXICO	1,860	-10.5	- 7.5	20.6	62.6	3.8	...	4.0	1.4	90	92	88	33.2
MONTSERRAT	2,950	...	...	...	...	12.6	...	...	15.9	...	...	...	...
NETHERLANDS ANTILLES	...	...	...	...	...	...	...	...	...	98	...	...	...
NICARAGUA	790	-17.2	...	83.0	198.2	5.0	...	10.0	...	...	...	...	42.5
PANAMA	2,330	1.6	2.2	70.1	66.5	10.1	...	15.1	15.8	88	89	88	28.3
PARAGUAY	1,000	- 6.3	- 1.3	14.5	49.1	1.7	...	2.6	3.1	88	91	85	47.3
PERU	1,090	- 4.3	9.7	33.7	45.0	3.0	...	5.6	...	84	91	78	37.3
SAINT LUCIA	1,320	...	...	...	20.6	4.3	...	14.2	13.0	85	...	...	30
ST. CHRISTOPHER/NEVIS	1,700	...	...	...	25.5	5.0	...	...	12.3	90	...	...	33
ST. VINCENT AND THE GRENADINES	960	...	...	...	24.9	7.9	...	...	10.1	80	...	...	20
SURINAME	2,510	-17.7(a)	...	...	...	7.5	...	...	10.7	...	84	76	18
TRINIDAD & TOBAGO	5,360	-27.8(a)	-11.4(b)	...	24.0	2.8	...	6.9	1.6	96	97	95	8.7
TURKS AND CAICOS I.	3,560	...	...	...	...	...	...	...	...	85	...	...	...
URUGUAY	1,900	- 9.4	9.9	10.7	46.4	8.0	...	5.0	4.8	94	93	94	14.6
VENEZUELA	2,920	-20.0	- 1.7	18.0	50.5	3.1	...	...	8.1	87	88	85	13.3
VIRGIN ISLANDS (UK)	2,500	...	...	...	...	5.5	...	11.2	12.1	...	...	...	...

... Data not available.
(a) 1980-86. (b) 1985-86.

See sources and notes at the end of the tables.

Sources and Notes to the Statistical Tables

Table 1: Selected Health Indicators

The data on newborns weighing less than 2,500 grams, children of appropriate weight for their age, maternal mortality, and infant mortality come from the countries' own reports submitted to PAHO in recent years, as well as the Report on the Monitoring of HFA/2000.

The figures on infant mortality (estimates) and life expectancy at birth (male and female) from those countries on which there are data for both periods (1980-85 and 1985-90) were taken from World Population Prospects (ST/THAT/SER.A/98), United Nations, New York, 1986. The remaining figures for the two indicators appearing in the table for 1980-85 were taken from the country reports and from the publications prepared by AID for the Caribbean Region (Caribbean Profiles). In many cases the figure for life expectancy at birth is calculated for the total population without differentiation by sex.

Table 2: Health Services Coverage

All the data for this table come from reports submitted to PAHO on different occasions in recent years, in addition to the Report on the Monitoring of HFA/2000. The figures submitted correspond to a single year during the period 1983-87 and should not be interpreted as average figures for this period. There are very few countries for which there is sufficient information to trace the evolution of coverage; moreover, in many cases there is no specification of the methodology used for calculating the data. Thus, for example, it is not clear whether pregnant women received the complete cycle of tetanus toxoid; the cutoff for the definition of nursing infants may be at different ages (under 1 year, under 2 years, etc.); and the percentage of pregnant women immunized with tetanus toxoid may have been calculated relative to births attended by health personnel rather than to all the births that took place.

Table 3: Percentage of Children Under 1 Year of Age Completely Immunized Against Polio, DPT, Measles, and Tuberculosis

Except for the data from Canada, which were submitted by this country in the Report on the Monitoring of HFA/2000, all the figures in this table come from the Expanded Program on Immunization (EPI) at PAHO Headquarters.

DPT coverage for El Salvador and Guatemala is based on data for the 2nd dose.

Polio coverage for Brazil, Cuba, El Salvador, and Guatemala is based on data for the 2nd dose.

Measles coverage for the Bahamas, Cayman Islands, Costa Rica, Guyana, Mexico, and Suriname is based on data for children 1 year of age, instead of under 1 year, and for Canada the cutoff is under 15 months.

Table 4: Demographic Indicators

For Argentina, Barbados, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Trinidad and Tobago, United States, Uruguay, and Venezuela, all the data in this table come from the following publications of the United Nations: World Population Prospects (ST/THAT/SER.A/98), New York, 1986, and World Demographic Estimates and Projections, 1950-2025 (IS/THAT/SER.R/79), New York, 1988.

The figures on rural population (%) and median age correspond to 1988, the year for which the population is estimated. The remaining figures for the indicators in this table--annual rate of growth, crude death rate, crude birth rate, and total fertility for the aforementioned countries--are average annual estimates for the corresponding periods.

The annual rate of growth is not necessarily the same as the natural rate of growth; therefore, it should not be equated with natality minus mortality.

The data corresponding to the remaining countries were obtained from (a) Health Conditions in the Americas, 1981-1984, Scientific Publication No. 500, PAHO, 1986; (b) World Development Report, World Bank, 1988; and (c) reports submitted by the countries to PAHO in recent years. These are annual figures and have been included under the period for which the information was obtained.

Table 5: Percentage of Population with Drinking Water Supply and Sewerage or Excreta Disposal Services

The data are from the PAHO Environmental Health Program (HPE) and from reports received from the countries in recent years. They include easy access in both urban and rural areas and household connections in the rural area.

Table 6: Selected Socioeconomic Indicators

The data on per capita GNP and Public External Debt as a percentage of GNP were taken from the annual reports published by the World Bank and the Caribbean Development Bank.

The figures on GDP growth per capita during the periods 1980-87 and 1985-87 are from the ECLA Statistical Annual for 1987.

Health expenditure as a percentage of GDP comes from different reports submitted by the countries to PAHO in recent years; they correspond to years around 1984. As with the other indicators, in the great majority of cases there is no indication of the methodology used in the calculation or of the aspects covered by this expenditure.

The sources for the data corresponding to Central Government Expenditure on Health (as a percentage of the total budget thereof) are: Financial Statistical Yearbook of the IMF and the annual reports of the World Bank.

The information on literacy corresponds to years around 1985, and the sources are the UNESCO statistical annual, the AID reports for the Caribbean, and the reports received on the Monitoring of HFA/2000.

Finally, the indicator corresponding to the percentage of economically active population (PEA) working in agriculture was taken from World Demographic Estimates and Projections, 1950-2025 (IS/THAT/SER.R/79), New York, 1988, and from the AID reports for the Caribbean. This indicator attempts to express the countries' degree of development in a synthetic and structural way, starting with the effort they have made to ensure a food supply.