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Pan American Sanitary Bureau,
Pan American Health Organization

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MESSAGE FROM THE DIRECTOR

The *Strategic and Programmatic Orientations (SPO) for the Pan American Sanitary Bureau 1999–2002* represent the fourth in this series of documents. It has now been established as part of our tradition and practice that the Pan American Sanitary Conference, the highest of our authorities should set the directions to be followed in structuring our technical cooperation in health and the SPO contain these directions.

Previous documents embraced the Pan American Health Organization as the Member States and the Secretariat, and established goals that would be the responsibility of both. There are now other documents that set out very clearly the health goals and commitments of Member States. The Renewal of Health for All represented a bold challenge for the countries of the world and the Americas along with the other Regions, enthusiastically embraced the goals set out therein and promised to align their practices to achieve them.

As a result of clear mandates from our Member States, the SPO for 1999-2002 have set out the course that the Pan American Sanitary Bureau, as the Secretariat, should take for the next quadrennium. We are confident that they have been crafted in such a manner that they represent those areas in which our technical cooperation may be most useful and critical.

These SPO must be seen in the context of recent history in the Americas and the extent to which that history incorporates health concerns. They also take account of possible developments that appear likely given the current economic and social trends. But it is equally important to appreciate that they have been elaborated with a clear appreciation of the basic values and principles that guide us. These continue to be the incessant search for more equity in health and the panamerican approach.

The document has been the result of an intensive process of consultation with the countries and agencies in the Americas. Some of the goals may appear to be ambitious, but I believe that it is fitting for us to reach as high as possible, given the results that have been achieved to date. The goals and approaches to achieving them are compatible with those set out in the new policy Health for All in the Twenty–first Century and we believe that our experiences in this Region may help in the more rapid achievement of the global goals.

These SPO will form the basis for our planning and programming, that more than ever must be based on the proper use of information. They will, to the extent possible, inform the structure of the Secretariat without favouring compartmentalization that leads to inefficiency of action.

I hope that this document will be useful to all interested in the health of the Americas, and I trust that at the end of the quadrennium we will be able to show the achievements that have come about through our collective effort to improve health in our place and in our time.

George A. O. Alleyne
Director

1. INTRODUCTION

The Pan American Sanitary Bureau (PASB) is the Secretariat of the Pan American Health Organization (PAHO), an international agency specializing in health. Its mission is to cooperate technically with the Member States and to stimulate cooperation among them, in order that the peoples of the Americas may achieve Health for All and by All while maintaining a healthy environment and charting a course to sustainable human development *(1)*.

As a way to assist the countries in attaining the highest level of health for their populations, PASB cooperates technically with them, promotes technical cooperation among them, and facilitates international coordination in health. Policy orientations have been developed to guide PASB activities and to serve as a frame of reference for the programming of technical cooperation. These same orientations can also serve as a useful reference for the countries, if they consider them appropriate.

The Strategic and Programmatic Orientations (SPOs) constitute the policy guidelines for PASB in each quadrennium. They represent an analysis of conditions and needs in the countries of the Region of the Americas and are geared toward attaining the world goal of Health for All (HFA). Moreover, they represent the response of the Bureau to the new global policy of Health for All in the Twenty-first Century (HFA21) and the General Program of Work (GPW) of the World Health Organization (WHO).

Preparation of the SPOs for the 1999–2002 period has been an eminently participatory process. National consultations and regional technical discussions have been held on their structure, content, and scope. This consensus-building has been enriched by the movement to renew the goal of HFA, as well as the dynamic generated in the preparation of the quadrennial publication *Health in the Americas* (formerly *Health Conditions in the Americas*). Advantage has also been taken of the experience of the countries and the Secretariat in the drafting of the previous Strategic and Programmatic Orientations.

General living conditions, as well as the political, economic, environmental, and social conditions that determine and influence the health conditions that affect the population, are detailed below, along with the anticipated situation for the period 1999–2002. Moreover, the specific problems that will have to be addressed in order to meet the needs of the Region's inhabitants are also described, together with the strategies to be used and the programming orientations that the Secretariat will concentrate on, in its technical cooperation with the Member States of PAHO.

2. CURRENT SITUATION[1]

2.1 General Situation

The Region of the Americas has made significant progress in several aspects of health, such as the eradication of polio, the immunization of children against various pathogens, and significant reductions in mortality and in the incidence of several pathologies. However, in addition to having to address some long-neglected health problems, the Region must now cope with new difficulties and the risks posed by growing urbanization, the aging of the population, rising violence, environmental degradation and pollution, the emergence of new diseases, and the re-emergence of old ones.

The overall improvement in the health status of the Region's population does not mask the differences between countries and between the different population groups. The disparities between those who lack social benefits and those who enjoy greater access to goods and services are deepening.

The health situation of the Region's countries is a product of the interaction among various socioeconomic development factors. Health, in turn, has proved to have an effect not only on the economic, social, and political components of human development considered separately, but also on human development as a whole.

Life for the Region's inhabitants unfolds against a backdrop of a growing globalization that is tied to transnational factors. This process is not only economic, but also social and political, and has led to a redistribution of power among the State, civil society, and the market. Despite a strong market influence, civil society, acting through its organizations, is taking a more proactive role and is offering new options for the development of health. As this new production paradigm takes hold and expands, it will bring about changes in the role that a country's various sectors play, and it will also lead to the replacement of technology links that once reigned supreme by others, created by the advances in computer technology, telematics, and biotechnology. This new paradigm also has an impact on other human activities such as communications, which have produced changes in consumption patterns, urbanization, lifestyles, social representation, and values that are moving the world toward the cultural homogenization of society. These advances in technology are strongly reflected in the socialization of information.

In most of the Region's countries, the growth of international trade in goods and services in the field of health has had a visible impact on the public and the private sectors. Up to now, the effect in the public sector has concentrated in the area of goods—equipment, drugs, biologicals, and medical-surgical materials.[2] In the private

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1 This section highlights the most important aspects of health in the Region of the Americas. Its main source is *Health in the Americas*, 1998 edition, PAHO, Scientific Publication No. 569. See this publication for more detailed information.

2 A significant international market in health services has begun to emerge in the Region. Leasing contracts are already being offered for equipment. These contracts cover preventive maintenance, repairs, and parts, when necessary.

sector, the effect is expressed in expenditures abroad, whether from people who travel outside their countries in search of medical care or from those who procure health services from transnational companies that have established themselves in the countries. In the immediate future, telemedicine services will begin to capture a market share in both sectors.

The driving force is purely economic, and it is tied to globalization and market growth. Some of the areas where there are visible changes in consumption patterns linked with health are food and nutrition; excessive consumption of alcoholic beverages, with its associated traffic accidents; and tobacco use, particularly the growing use by women and young people.[3]

The differential impact of structural processes on health from country to country is mediated by the resources available in each country and by social policies aimed at redistributing the product of national economic development and mitigating the effects of adverse circumstances on the life of the people.

The global processes under way in the Region are not only expected to persist, it is assumed that they will intensify and spread.

2.2 Health Situation

Overall health conditions, measured in terms of the trends in mortality and life expectancy, continue to improve. The health gaps between countries and population groups defined geographically and by sex, income, education, and ethnic group persist and grow, however *(2)*.

Public policies designed to modernize and reform the State and privatize essential services already have found expression in the Region's health sector. For example, environmental and basic sanitation services, including urban water supply, have been privatized to a great extent. Many countries have designed or are already carrying out health sector reforms that include schemes for the decentralization of public health services, greater private sector participation in the medical services delivery, and alternative health care financing models.

At the same time, the Region is undergoing a demographic transition marked by changing patterns of morbidity that affect health care demand and, hence, the education and training of primary health care workers. Thus, while infectious and re-emerging diseases continue to pose a significant problem in the Region, chronic and noncommunicable diseases are on the rise. This shift has brought about an increased demand for curative medicine resources and for promoting healthy behaviors and healthy environments that will facilitate the attainment of optimal health and well being, as well as healthy aging.

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[3] Tobacco and alcohol consumption patterns differ in developed and developing countries, because of public policies adopted. In the United States of America, for example, tobacco consumption has declined dramatically as a result of programs such as ASSIST and the dissemination of information about the dangers of tobacco use.

The proportion of the gross domestic product (GDP) allocated to health in the countries has been increasing, growing from 5.7% of the GDP of the Region in 1990 to 7.3% in 1995. This growth actually translates into higher out-of-pocket expenditures for the population, because public expenditures, which were 43% of total expenditures in 1990, fell to 41.5% in 1995. As the number of private health care providers climbed in response, the steering and regulatory roles, as well as the monitoring of the system, were relegated to the State. The State also retained responsibility for providing coverage for the lower-income population. As a result of these changes, innovative forms of health insurance, financing, and service delivery are being adopted.

Marked differences in the pattern of national health expenditure persist from country to country, however. In the upper-income countries, for example, national health expenditure represents more than 10% of GDP—in per capita terms, more than US$ 1,600 a year. In middle- and lower-income countries, however, this figure is less than US$ 90 and US$ 35, respectively, or nearly 6% of GDP. Generally speaking, countries with higher per capita income spend 45 times more on health than do lower-income countries.

Moreover, it has been observed that the accessibility, coverage, and availability of medical care decrease as GDP per capita falls. These variables also differ depending on a population's geographical location. In several developing countries only 5% to 10% of workers have access to occupational health services, while in industrialized countries, 20% to 50% do.

It also has been observed that the infant mortality rate increases as per capita GDP decreases. A newborn in an upper-income country is some 10 times more likely to survive the first year of life than a child born in a lower-income country. This pattern of inequality also obtains within each country. A similar situation prevails with respect to the proportion of deaths from acute diarrheal diseases in children under 5 years of age—these diseases claim more lives in countries that have a lower per capita GDP.

In short, nearly 105 million people in the Region lack regular access to health services, more than 2 million women a year give birth without professional assistance, and in eight countries, 40% of the population lacks access to the most basic health services.

Progress in the efforts toward renewal is slow, and the results listed in the sectoral reform objectives have not yet materialized. Thus, utilization rates for the available resources and infrastructure are low, despite an increase in the availability of physicians, nurses, and dentists in every country. Hospitals are in the throes of a financial and management crisis that has prevented them from meeting their contractual commitments or offering better wages, thereby jeopardizing the provision of supplies and the maintenance or procurement of equipment—elements that are essential to quality health care delivery.

2.2.1 Mortality

Save for rare exceptions, mortality indicators have improved over the past seven five-year periods for all age groups in every country in the Americas. However, there are vast disparities among and within countries. These disparities become obvious when differential mortality rates by age group and cause of death in a given country are compared with those in another country that is at a similar economic development level, as determined by per capita income adjusted by their currency's purchasing power. Mortality in children under 1 year of age, for example, has remained stable or fallen slightly in middle-income countries, but remains high and continues to rise in lower-income countries. A comparison of mortality by age group between countries with similar incomes reveals reducible gaps and preventable deaths.[4]

It can be said that in countries with higher per capita income, some 4.7% of deaths could have been prevented in the age group 45–64 years old, while in the lower-income countries, up to 62% of deaths in the population under 65 could have been prevented. This indicates that it still is both possible and necessary to make a deliberate effort to prevent foreseeable deaths and reduce the differences among age groups and countries. Deliberate investment by the countries, the acquisition and effective utilization of resources, and the putting in place concrete policies and programs aimed at reducing the risk of dying from certain causes in specific population groups, ensure a path toward the reduction or elimination of these gaps and preventable deaths.

Concerning the differentials in the risk of dying among children under 1 year of age, these decreased in all the countries between the periods 1960–1964 and 1990–1994, and only in a very few did the difference with respect to the country with the lowest risk also decrease. Generally speaking, the values for the relative risk of dying before the first year of life in the countries with the lowest risk in the Region showed some homogeneity. However, a trend has gradually been emerging in which the relative risk of dying in the highest-risk countries is worsening and that in lowest-risk countries is improving.

There are also reducible gaps in mortality from specific causes, which means that the number of deaths from communicable diseases also can be reduced. Thus, 80% of the deaths in children under 1 year of age in the countries with the worst figures could be prevented, as compared with the countries that have attained greater success in the prevention of death from these causes.

It is estimated that if between 1990 and 1994 every country in the Americas had succeeded in reducing mortality in each age group under 65 to the lowest levels achieved by any country of the same economic level in this Region and, in the case of the United States of America and Canada, to the levels achieved by Sweden and Japan, some 1,100,000 deaths a year could have been prevented in persons under the

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[4] In the methodology developed by PASB, which is currently being revised, it is considered that the lowest values observed in a group of countries can be taken as achievable goals and the relative percentage differences between what is observed and the minimum (for the group or the Region) are called "reducible gaps" in mortality.

age of 65. This represents 47% of the estimated deaths in the Region in those ages during that period. The infant mortality rate in the Americas for 1998 would be around 10 per 1,000 live births, and life expectancy at birth would be among the highest in the world—over 75 years.

Every year, more than 25,000 women in the Region die from cervical cancer.

Violence as a cause of death in the Region is responsible for between 7% and 25% of deaths, and the problem is growing, reaching epidemic proportions in some countries.

Work-related deaths are increasing daily, so much so that mortality in the workplace is now as high as mortality from tobacco use. In Latin America and the Caribbean, the average mortality and disability from accidents in the workplace—300 worker deaths per day—is about four times higher than the number reported by developed countries.

2.2.2 Morbidity

Great progress has been made in the struggle against disease in the countries of the Region. Poliomyelitis has been eradicated since 1991, tremendous advances have been made in the eradication of measles and neonatal tetanus, the number of episodes of acute diarrheal disease has decreased, and significant reductions in mortality from intestinal infectious diseases and acute respiratory infections have occurred.

The Region's national immunization programs are having a great impact, reducing morbidity and mortality from vaccine-preventable diseases. Immunization coverage for diphtheria, tetanus, typhoid, poliomyelitis, measles, and tuberculosis for children under 1 year old is over 80%.

Despite this progress, however, diarrheal diseases, acute respiratory infections, and malnutrition remain the leading causes of death in the population under 5 years of age in most of the medium- and lower-income countries of the Region. The cholera epidemic has become endemic in many of the countries, with more than 1.3 million cases to date, and more than 11,500 of them fatal. Chronic undernutrition has replaced acute malnutrition in children, and together with micronutrient deficiencies is characteristic of the nutritional picture in lower-income countries. Furthermore, the levels of iron deficiency and anemia, as well as vitamin A deficiency, remain high. At the same time, overweight, obesity, and chronic diseases linked with diet have increased with urbanization and changing lifestyles.

In addition, new communicable diseases have emerged in the Region, some diseases thought to be well under control have re-emerged, and the resistance of some infectious organisms to antibiotics has grown.

The prevention of blood-borne diseases transmitted by transfusions has improved. Almost all the countries in the Region now have laws and regulations governing blood transfusions. All countries screen blood for syphilis and HIV, and most do so for hepatitis B. Nonetheless, the AIDS epidemic and HIV infection continue to spread.

The incidence of AIDS continued to rise in the Region during the past quadrennium, but at a slower rate than in Africa, Asia, and Eastern Europe. All

countries now have national programs and surveillance systems. The replacement of the Global Program on AIDS by UNAIDS has resulted in the decreased availability of external resources for countries, and a great deal of time and effort has been spent on reestablishing structures, procedures, roles, and working relationships. Meanwhile, massive research efforts have resulted in promising—but expensive and complex—treatment regimes.

Other sexually transmitted diseases (STDs) affect an estimated 40 to 50 million people a year in the Americas. Surveillance systems are not as well developed as they are for HIV/AIDS.

Malaria has expanded its frontiers, and the high-risk population has increased. Morbidity began to rise steadily in the mid-1970s. It fell in 1993, only to rise again in 1994 and 1995, more than doubling the rates recorded two decades ago.

The Region has acted on the WHO resolution to eliminate leprosy as a public health problem (reaching prevalence below 1 case per 10,000 population) by the year 2000. All countries except Brazil, Colombia, and Paraguay have already reached this goal. There has been more than a 75% reduction in prevalence since the initiative began.

A multicountry commitment has resulted in a 90% reduction in house infestation with *Triatoma infestans*—the major vector of Chagas' disease—in the countries of the Southern Cone. Transmission has been interrupted in Uruguay, may be interrupted in Chile before the year 2000, and may be interrupted in Argentina and Brazil in a few years' time.

The incidence of tuberculosis in the Region has remained stable, with approximately 250,000 cases reported each year and an estimated incidence of 400,000 cases per year.

Dengue has re-emerged as a major health problem in the Region, with more than a quarter of a million cases reported in each of the past three years. The vector, *Aedes aegypti*, is now present in all countries of the Region except Bermuda, Canada, and Chile, and all four serotypes of the virus are circulating widely in the Region.

Although already known, some foodborne diseases, are considered emerging because they are occurring more frequently and have produced epidemic outbreaks in several countries in the past 10 years. Salmonella remains a leading cause of outbreaks from contaminated food, chiefly in lower-income countries.

Foot-and-mouth disease has been eradicated from Argentina, Paraguay, and Uruguay and some states in Brazil and Colombia. The incidence of human and canine rabies also has been significantly reduced, with most human cases now occuring in cities with around 50,000 inhabitants. The incidence of bat rabies, on the other hand, continues its steady rise.

Recent outbreaks of Venezuelan equine encephalitis have drawn attention to the need to improve vaccination programs in areas at risk and to continue to develop laboratory diagnostic capacity for epidemiological surveillance in the Region.

While infectious diseases remain an important health threat, there has been increasing recognition of the burden imposed by noncommunicable diseases, which are presently responsible for almost three-quarters of all mortality and morbidity in

Latin America and the Caribbean. The major causes or mortality due to noncommunicable diseases are cardiovascular disease (45%), cancer (20%), injuries (10%), and diabetes.

Diabetes is a growing health problem in the Region, even though its incidence and end results can generally be prevented. Violence, too, is a serious public health problem, and special attention must be paid to programs to prevent injuries.

There has been a marked change in lifestyles in most of the countries as a result of urbanization, a sedentary lifestyle, and stress. Moreover, a high prevalence of mental disorders has been observed in all the countries: some 17 million young people between the ages of 4 and 16 years exhibit moderate or severe psychiatric disorders.

A dual pattern of production, where traditional forms exist alongside new ones such as biotechnology, microelectronics, automation, and mechanization, is generating a dual morbidity and mortality profile among workers. The old and as yet uncontrolled occupational diseases, such as lead and mercury poisoning, asbestosis, silicosis, occupational deafness, occupational dermatitis, and high accident rates persist and are joined by such emerging or re-emerging problems as malaria, tuberculosis, and zoonoses. Moreover, occupational cancer and asthma are spreading, as are new musculoskeletal, reproductive, and mental health disorders associated with new working conditions and risks, and with unemployment and under-employment.

According to studies conducted by WHO, Harvard University, and the World Bank, employment ranks second as the leading cause of disability adjusted life years in the Region. Estimates put the number of work-related accidents at five million a year—36 accidents per minute of work.

2.3 Environmental Situation

The physical environment largely determines the span and quality of a person's life. Different environments, such as housing, work, education, recreation, and the public (or natural) environment, affect the life and health of the population.

Today, analytical and decision-making processes significantly underestimate the true effect of environmental factors upon human health. For example, environmental health problems look very different if viewed from the standpoint of the burden of death, disease, and disability and if the relative importance of the various environmental factors is ranked.

Housing and basic domestic sanitation services are of paramount importance, since a good portion of people's lives is spent in the home. The Economic Commission for Latin America and the Caribbean (ECLAC) *(3)* estimates that the total housing deficit in Latin America and the Caribbean is approximately 50 million dwellings. Some 19 million new dwellings are required, and of the existing housing stock, 23%, though habitable, is unhealthy and reparable; 14% is not reparable. The poorest housing conditions are found in rural and marginalized urban areas. Moreover, in the countries with the largest indigenous populations in the Region, nearly 100% of that population lives in unhealthy dwellings.

Indoor air pollution is a critical problem of housing in the Region. For example, while in urban areas there is a growing tendency to use gas as fuel, thus reducing exposure to smoke from cooking or heating, in rural areas the exposure to smoke from burning wood or coal is still significant. Estimates indicate that approximately 60% of the total burden of acute respiratory infections (ARIs) is related to indoor air pollution and other environmental factors.

Some 73% of the Region's population has domestic water supply. However, in rural areas only 41% has drinking water, while in urban areas the figure is 84%. Of those who have domestic water supply, only 59% receives properly disinfected water. Thirteen percent of the countries report that less than 40% of the drinking water in urban areas is disinfected, and in 45% of the countries the figure is less than 40% in rural areas.

Roughly 69% of the total population has access to wastewater disposal services, with 80% of the urban population and 40% or the rural population covered.This represents a very modest growth in this service, since in 1980 the total coverage was 59%,with 78% in urban areas and 28% in rural areas *(4)*.

Approximately 70% of all the waste produced daily in the Region is collected, but only 30% is disposed of properly. Various methods are used, but the most frequent is the sanitary landfill.

Pollution,especially from industrial activities, the burning of fuel, and transportation, is a growing problem that affects the entire population, although with varying degrees of exposure and risk. Poor areas are the most vulnerable, because of their greater exposure to industrial and domestic waste. In urban areas, the burning of fossil fuels to generate energy for home heating, motor vehicles, and industrial processes constitute the main source of air pollution.

During the Kyoto Conference of December 1997 *(5)*, it was noted that, although industrialized nations account for only 20% of the world's population, they have produced 90% of the world's carbon emissions into the atmosphere since the beginning of the industrial revolution, and they continue to produce two-thirds of those emissions today.

WHO estimates that roughly 30% to 50% of workers are exposed to one or more of over 100,000 chemical products, 200 biological agents, and physical, economic, and psychosocial agents with harmful effects on the health of workers and their families, as well as society as a whole. Of these, 200 to 300 are continuously discharged into the water, soil, air, and biota, despite their mutagenic, carcinogenic, allergenic, or other effects *(6)*.

Some 80,000 chemical substances are currently sold in the Region, and between 1,000 and 2,000 new substances are put on the market annually. It is extremely difficult to make a precise evaluation of the human health consequences of exposure to toxic substances. It is known, however, that acute poisoning is a frequent cause of hospitalization, and chronic poisoning constitutes a serious threat to health. Chemicals in the environment result not only in poisonings, but also in birth defects, cancer, and infertility, as well as behavioral and immune disorders *(7)*.

Some countries have tripled the volume of pesticide use in the past four years, and as a result, pesticide pollution from agriculture is now a significant problem in the Region. Equally important is heavy metal pollution, especially from mining and from the use of these metals as a fuel additive for motor vehicles; these elements remain in the environment for 70 to 200 years.

It is estimated that, out of the five million foreseeable workplace accidents each year, 100,000 deaths occur annually. The total costs associated with these accidents, which exclude accidents in the informal sector, are between 10% and 15% of the regional GDP.

Since industries such as mining, construction, and transportation are likely to assume greater importance as the economies develop, severe occupational health problems in the Region can be anticipated unless urgent preventive action is taken. This is particularly important in the less developed countries, where workers suffer not only from occupational illnesses and accidents, but also from infectious diseases, malnutrition, and other problems linked with poverty.

2.4 Demographic Situation

The population of the Americas in 1998 is calculated at about 800 million, or 13.5% of the world population *(8)*. By the year 2003 this population will exceed 850 million, but its distribution by country will not change substantially.

With rare exceptions, total mortality continues to decline and life expectancy at birth to increase. Estimates indicate that these trends will hold in the next millennium. The percentage of deaths in children under 1 year of age is dropping in all countries, with the most significant decline, in relative terms, occurring in the upper-income countries. In the 65-and-older age group, the most significant increase in the number of deaths has occurred in the countries with the lowest per capita income; Mortality in this age group has remained relatively stable in the upper-income countries, with relatively moderate increases in the others.

Calculations put the 1998 birth rate in the Region at 19.2 per 1,000 population, compared to an average of more than 40 per 1,000 from 1960 to 1970. Fertility also has declined markedly in all the countries. Generally speaking, both the birth rate and the fertility rate are expected to continue their decline, so that total population growth in the Region will remain slow, despite the drop in mortality.

The age structure of the population reflects the increase in the population over age 65, with average growth rates in excess of 3% annually, and this trend is expected to continue. Hence, the aging of the population will mean a predominance of this population group.

The working population constitutes between 40% to 60% of the Region's total population. The economically active population (EAP) was estimated at 357.5 million in 1995, and will reach 399 million by the year 2000. An estimated 19 million children are part of the Region's work force. By the end of the 1990s, the EAP in Latin America is expected to increase by 25.9% and in North America, by 11.1%. If

work in the informal sector and work in the home are included, most of the Region's population is exposed to occupational risks and conditions that, increasingly, are harmful to health.

Geographical trends in population distribution point to higher growth in urban areas and lower growth in rural areas. However, there has been an important change in the concentration in metropolitan areas, whose growth has slowed. This phenomenon implies that midsized cities that can still respond to new demands will grow more rapidly, and the excessive growth pressure on the Region's major cities will abate.

International migration, which in preceding decades resulted from the armed conflicts, is now mainly work-related. There appears to have been a resurgence in these migratory flows, which has placed significant pressure on the health services of the receiving countries. Everything indicates that, for the time being, there will be no substantive changes in this pattern, either in the national or international area.

2.5 Political Situation

Democracy has expanded dramatically in the Hemisphere. Improving the quality of life requires a climate of freedom that inspires confidence and security, as well as a future that ensures increased equity as part of democracy's value system. The stability and continuity of democracy, however, largely depends on the effectiveness of democratic institutions and the credibility of the political system among the population *(9)*. This is related to the impact of economic and sectoral policies on governance.

State reforms in the Americas vary widely from country to country, but all basically seek efficiency, accountability, and participation. These reforms have led to the transfer of certain responsibilities to the private sector and to local government, and this decentralization has fostered growing participation and given a voice to local governments and regions within the countries. This process has affected the development of social policies and social safety systems in the countries. Today, the autonomy of national governments within the international processes of which these governments have become part has shifted *(10)*. Changes also have occurred within the State, linked, on one hand, to the State's delegation of responsibilities within the economic sphere, in the context of expanding market economies, and, on the other, to the strengthening of civil society.

2.6 Socioeconomic Situation

During the 1990s, the countries have implemented economic policies designed to resume economic growth. They also subsequently put in place models of growth tied to social equity. There is a significant difference between earlier efforts that sought to obtain a macroeconomic balance and current efforts that seek growth with social progress.

During the last five-year period,macroeconomic indexes improved overall. In Latin America and the Caribbean,the average GDP growth rate was 1.1% in the preceding decade, increasing to 3.1% between 1991 and 1996. In this latter period it ranged from 3.4% to 5.3%. Average GDP per capita in the preceding decade showed 0.9% negative growth, while growth increased from 1.7% to 3.5% between 1991 and 1996 (excluding 1995).At the same time, inflation fell from 887.4% to 19.3%.An analysis of social expenditure also proved positive. In a sample of 15 countries, 11 increased their social expenditure between 1990 and 1994, and 7 surpassed their 1980 indexes. From 1990 to 1995, per capita social expenditure increased in the Region by nearly 27.5%, and it should be noted that this progress has been greater in countries that have undertaken more extensive reforms. Within this growth, greater priority has been given to the education and social security sectors than to health *(11)*.

The emphasis on education is reflected in the marked rise in literacy in the Americas.Achievements are mixed, however: while some countries have reduced illiteracy to 1%, others have illiteracy rates as high as 57.4% of the general population, with disadvantages for the rural population, the indigenous population, and women in all contexts *(12)*. In addition, there have been quantitative advances in annual school enrollment *(13)*. However, while some countries have achieved 100% enrollment of school-age children, others have achieved only 30%. High grade repetition and dropout rates, along with low performance levels, also can be seen—in 1995, only 66% of the school-age population managed to complete fourth grade, and the average number of years of schooling for the work force did not exceed six years *(14)*.

Despite the growth in real GDP in Latin America and the Caribbean during the 1990s, the subregion's economies still have not reached the levels seen prior to the 1980s *(15–17)*.Thus, GDP in 14 countries of the subregion in 1996, weighted by population and expressed in 1990 dollars, was lower than that of 1980. It also is noteworthy that investment represented the most important component of growth *(18)*. In this regard, the decrease in public investment was substantial *(19,20)*, while net foreign investment rose from US$ 6.6 billion in 1990 to US$ 30.8 billion in 1995.

In addition, Latin America and the Caribbean experienced a real increase of 22% in social expenditure during this period. Social expenditure patterns in health have been different: although health expenditure, as did all social expenditure, began to grow in 1989, it fell in 1991 and 1992, dropping to 1981 levels. In 1993 it began to rise again, reaching levels 22% higher in 1995 *(21)*.

Within foreign trade in Latin America and the Caribbean, intraregional trade has expanded *(22)*, which is a determinant of the health sector's international operations. Furthermore, given the impact of the debt burden on the potential availability of goods for the social sector, and the health sector in particular, it should be noted that the debt burden continued to decrease *(23)*.

Upon analyzing the evolution of poverty, income distribution, unemployment, and employment generation, real wages, salaries, the effect of growth levels and economic performance on living conditions can be appreciated. Some 197 million people were living below the poverty line in 1990, a figure that soared to 209 million in 1994; 65% of this population resided in urban areas, although the proportion of

poor in the rural population was higher *(24)*. In some countries there was greater poverty than in 1980, notwithstanding the proportional growth of per capita GDP and the reduction in the relative magnitude of poverty in the 1990–1994 period. Furthermore, inequality in income distribution has increased in most of the Region's countries *(25)*. In fact,the share of the richest 10% of households in total income has increased (although it varies from country to country), while that of the poorest 40% has remained stable or declined.

Not only the unemployed make up the ranks of the poor; some workers in the formal sector also fall below the poverty line. In 1994, in 7 out of 12 countries in Latin America the percentage of working poor among total wage earners in the private sector, excluding persons working in microenterprises, was between 30% and 50%; in three countries it was between 10% and 20%; and in two countries it was between 5% and 6% *(26)*.

Despite the economic recovery, the average annual rate of urban unemployment in Latin America and the Caribbean has grown uninterruptedly since the late 1980s *(27)*, and women and young people have been hit hardest *(28)*. As unemployment has increased, so has the growth in the informal sector.[5] Thus, 84 out of every 100 jobs created in Latin America and the Caribbean during the 1990–1995 period were in the informal sector, making it the principal generator of employment *(29)*. Moreover, there has been a real drop in the purchasing power of wages *(30)*—even for full-time workers, some 20% to 40% of whom have incomes that are below the minimum threshold required for well-being *(31)*.

Changes in the structure and composition of the workforce, the decrease in real household income, and shifts in family structure, have forced women and children to come up with survival strategies to deal with poverty. The mass entry of women into the informal sector and the early incorporation of adolescents and children in the workforce are manifestations of this situation.

An examination of the findings with respect to poverty, inequality in income distribution,unemployment, real wages, and wage gaps reveals that economic growth in the Region, especially in Latin America and the Caribbean, has not contributed to improve the severe human underdevelopment that persists in these societies.

3. CHALLENGES AND OPPORTUNITIES FOR THE QUADRENNIUM

The closing years of the twentieth century have been punctuated by several widespread phenomena that are found in nearly every country in the world and in

5 The growth of the economy's informal sector has an impact on living conditions,since, under the majority of the social security systems of the Hemisphere, workers and their families would not be eligible for benefits such as health services.These population groups would have to transfer their demands to state health services.This also exacerbates the financial crisis of the social security systems,since the systems no longer receive contributions from workers excluded from the formal sector.

the Region. Their consequences are many, affecting the economic, social, and political life of the countries and the peoples themselves, including aspects of their health. These phenomena have implications in terms of new marketing possibilities in the national economies, cooperation among countries, and consumption patterns. International institutions are not immune to these realities and are also influenced by the changes in the countries.

Perhaps the most important phenomena today are globalization and the revolution in communications technology. Some of the effects of globalization are related to the strengthening of democracy, the adoption of a single economic model throughout the world, the formation of regional and subregional blocs, the changing role of the State, and social participation.

As democracy gathers strength, the population's expectations rise, and citizen participation mechanisms multiply. The number of countries with popularly elected mayors has grown from 3 to 17, and the number with some degree of decentralized public spending has grown from 0 to 16 *(32)*. This is a gradual process, however, and in some cases it is limited to the formal aspects of voting.

In the economic arena, the macroeconomy is becoming homogenized, resulting in an improvement in the overall economic indexes, without a significant reduction in the inequalities in the distribution of goods and services and access to them or in unemployment and underemployment *(33)*. This growth, characterized by regressive income distribution and unmet needs, has led long-neglected sectors to grow tired of waiting, posing a clear threat to the relative prosperity and progress that have been achieved in recent years *(34)*. This has led to political recognition of the need to concentrate efforts in the social sector, and even to a reorientation of the activities of the international financing institutions, which are intervening increasingly in the social sector.

In trade and, hence, in the political sphere, globalization in the Americas is directly reflected as regional and subregional integration processes. The Free Trade Association of the Americas (FTAA) continues its slow but steady advance, and subregional integration has consolidated. Significant examples in this area are the North American Free Trade Agreement (NAFTA), MERCOSUR, the Andean Integration System, the Central American Integration System (SICA), and the Caribbean Community (CARICOM). While the principal motive behind these processes is trade, health is an important negotiating factor associated with the environment and sanitation, food protection, the marketing of pharmaceutical products, and the protection of workers and visitors.

In addition, activities that began in 1994 with the Summit of the Americas in Miami have kept up momentum with the implementation of the Plan of Action. To that end, various agencies of the Inter-American system, such as PAHO, the Organization of American States (OAS), and the Inter-American Development Bank (IDB), have collaborated significantly. The importance of health in this process has been acknowledged. Also in the regional sphere, the Conferences of Wives of Heads of State and Government of the Americas have supported and will continue to support several health initiatives *(35)*.

As part of the hemispheric consensus fostered by the Summits of the Americas, PASB has proposed an initiative called "Health Technologies Linking the Americas," which covers vaccines, essential drugs, health information technology, health surveillance systems, and appropriate technology for basic sanitation.

This phenomenon of political linkage transcends regional borders, as was the case with the Ibero-American Summits of Presidents and Heads of State, which on two occasions have included health as a topic for analysis, proposals, and regional initiatives.

Globalization also affects the financial sector, increasing the availability of investment resources in Latin America and the Caribbean. In fact, as a result of a more favorable regulatory framework, between 1990 and 1996 net foreign investment rose from US$ 6.6 to US$ 30.8 billion *(36)*.

Every country has initiated changes in the role of the State, although these proposals rarely have been planned with a social development or health perspective in mind, having instead come about as a reaction by the health sector. Such reforms express the degree of complexity needed for negotiating resources today and in the future. Indeed,in order to obtain financial resources, the health sector must negotiate with the financial sectors,vying with other social sectors in a competition for which the health sector is not always very well prepared.This is accompanied by the transfer of health functions to the regional (provincial, state, departmental) or local level, which, with some exceptions in the Americas, requires major adjustments and preparation to enable it to assume its new responsibilities and achieve the expected results *(37)*.

In health sector reform, it is recognized that all members of society are parties directly concerned with health and health care, and that their interests are highly diverse. Consequently, almost all the processes in the Region are demanding a gradual and transparent approach, so that those involved directly in them, as well as the population at large, may understand them.As implementation of the plans begins, intergovernmental association and cooperation and the participation of the private sector, nongovernmental organizations, and individuals involved in health and health care become critical.

Far-reaching reform is under way in the multilateral international institutions and bilateral agencies that provide cooperation for development. In the United Nations system, the reforms are geared toward achieving a more coordinated effort on a global scale and particularly in the countries.Indeed, all of the proposed reforms endeavor to have the dialogue on development between the international community and the governments (although not necessarily the sectoral dialogue) be held by the respective interinstitutional and national coordinating entities. It will be difficult for the health sector to carry out this coordination function.

The reforms also seek greater interaction with the international financing institutions *(38)*. In the bilateral sphere, there is a trend toward decentralizing decision-making regarding the allocation of development cooperation resources to the country offices or local embassies *(39)*. The health sector should develop new skills to make optimum use of these circumstances.

Today's extraordinary technology development has not only achieved unprecedented results, but is also increasingly affecting the life of societies and populations. The ease of communication across borders and the development of biotechnology and telematics have brought about unprecedented changes in science, culture, and in the field of health. In addition to their effects on diagnosis and therapy, they also create conditions that could substantially modify and homogenize consumption patterns, behaviors, lifestyles, values, and concepts that are having an enormous impact on the health of the population *(40)*. Thus, fanned by global marketing strategies, products such as alcohol and tobacco are more widely consumed, with major repercussions for health.

As a result, national institutions engaged in research and development of health technology and agencies responsible for the design of national science and technology policies have modified their role and mission. These institutions have had to adapt to the government's new role and the rise of the private sector, the diversification of internal and external financing sources, and the establishment and consolidation of new channels for access to and transfer of scientific and technical know-how. This is particularly true for knowledge regarding the new information technologies, which are distributed unevenly among countries and among groups within the countries.

Thus, it is necessary to incorporate new topics, disciplines, approaches, and methods in health research, in addition to establishing better methods for disseminating knowledge and the technologies needed to improve the effectiveness and increase the impact of public health practice. One of the new disciplines is bioethics, which has become a growing area of study and concern, given the emergence of new ethical dilemmas stemming from the rapid advances in health science and technology, the ethical dimensions of patients' rights, and the issue of justice in allocating health sector resources.

Consequently, the demand for transparency in the management of public affairs has gathered importance. The net effect on the sector is a growing need for States to justify and become accountable for their work in the field of health to populations that are better informed and better educated about their rights and the level of care they expect.

It may be concluded from the foregoing that the health sector should adapt to this new national, hemispheric, and worldwide situation, and the Strategic and Programmatic Orientations of the Secretariat should, accordingly, adapt to these conditions in order to ensure that the search for Health for All will be successful.

The situation described in the preceding sections confirms that the needs expressed upon adoption of the strategic orientations and programmatic priorities for 1991–1994 remain valid today *(41)*. The orientations stressed the need to gradually remove internal structural obstacles to sustainable human development by reducing inequality; giving priority attention to basic human needs, including health; and using every available recourse to combat extreme poverty.

Alongside changes observed in the value system, a moral code of common rights and shared responsibilities is being constructed, based on what is now being termed "global ethics" *(42)*. Among these rights and responsibilities are the right to a secure

life, equitable treatment, equal access to information and the common goods of humankind, freedom, consideration of the impact of individual actions on the well-being of others, the promotion of equity (including gender equity), and protection of the interests of future generations through the achievement of sustainable human development.

In this regard, the Region of the Americas shows persistent inequalities that differentiate the population's access to society's benefits by education and income levels, place of residence, racial or ethnic origin, sex, age, and type of work. These differences are expressed in terms of the ability to participate in political life, the degree to which the economic needs of the population are satisfied, the possibility of attaining basic or higher education, and, in health, the likelihood of survival or death, the risk of contracting diseases, and the degree of access to the benefits of health systems and services. Thus, the Strategic and Programmatic Orientations for 1995–1998 embraced, as their main challenge, the struggle against inequity. Inequity in access to and coverage by the health systems and services remains the principal challenge that must be faced in the 1999–2002 quadrennium by the countries of the Region, both through their own efforts and in conjunction with the Pan American Health Organization.

Clearly, significant achievements have been made in health—life expectancy has increased and communicable diseases have been brought under control, with the consequent reduction in infant mortality due mainly to advances in controlling poliomyelitis, measles, and diphtheria. However, WHO's three evaluations on the progress toward achieving the goal of Health for All by the Year 2000 indicate that enormous efforts remain to be made, since major population groups do not yet have access to basic health services.

In this regard, the targets and goals established in the SPO for 1995–1998 have been largely unmet. An evaluation of the degree to which the goals adopted for the period have been met reveals that the disparities in health conditions have not been reduced, universal access to healthy and safe environments and universal coverage of water supply and sanitation services have not been achieved, and unhealthy lifestyles and behaviors persist.[6] These were the terms of reference for the goals to be met in the quadrennium through action by the countries with the cooperation of the Bureau. This situation justifies making a vigorous effort to attain Health for All, as WHO has proposed, continuing the struggle against inequity in health with the same five strategic orientations that have already been defined, until these commendable goals are achieved.

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6 For further discussion in this regard, see *Strategic and Programmatic Orientations 1995–1998*. Official Document No. 269, and document CD40/24, 4 August 1997, *Third Evaluation of the Implementation of the Strategy for Health for All by the Year 2000*.

4. RESPONSE OF THE PAN AMERICAN SANITARY BUREAU

Among the fundamental purposes of the Pan American Health Organization are prolonging life, combating disease, and seeking the physical and mental well-being of the population of the Americas by coordinating and promoting the efforts made by the countries.It is also recognized that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief, and economic or social condition *(43)*. On these bases, and acknowledging the differences prevailing in health access, coverage, and service delivery among the populations of the Region, the countries have agreed to renew their commitment to attaining the goal of Health for All. PASB's greatest efforts will be directed primarily toward that goal in the next quadrennium and in those to come, until the highest standard of physical,mental, and social well-being is attained for every inhabitant in the Region, reducing and eventually eliminating the inequities presently existing in health.

The new global policy of Health for All in the Twenty-first Century that WHO has approved, is one of the frameworks of action. It represents the renewal of the goal of HFA and is based on the following values:

- an acknowledgement that attaining the highest possible standard of health is a universal right;
- a greater and continuous application of ethics to health policy, research, and service delivery;
- the implementation of equity-oriented policies and strategies that emphasize solidarity; and
- the incorporation of a gender perspective into health policies and strategies.

The new global health policy seeks to attain:

- an increase in life expectancy and an improvement in the quality of life for all;
- narrow equity gaps in health among and within the countries;
- access by all to sustainable health systems and services.

4.1 Regional Goals for the Period[7]

PAHO's Member States, through WHO and other international forums, have subscribed to various global commitments to be realized through a combination of national, regional, and global efforts.At the national level, actions resulting from these commitments correspond to the sovereign action of Member States through the formulation of their national policies and plans for development and health. In the regional arena, actions should be expressed in a manner compatible with the Region's development and with the characteristics, needs, and resources of the countries as a

7 Some of the goals of the new global policy on Health for All in the Twenty-first Century have been adapted to the specific conditions of the Region of the Americas.

whole. The following subsections present the Region's most important goals, expressed according to prevailing conditions in the Hemisphere. The Bureau will support these goals as part of its commitment to provide technical cooperation to the countries,and so assist them to meet their targets.

4.1.1 Health Outcomes

- Life expectancy at birth will increase by at least two years in all countries that had life expectancy figures below 70 years in 1998; infant mortality in all countries will decrease by 10%; perinatal mortality will be reduced by 20%;late neonatal mortality will be reduced by 30%; child mortality will be reduced by 40% and will be fewer than 50 deaths per 1,000 live births;maternal mortality will be reduced by 25%;and at least 60% of women aged 15 to 44 years will have access to contraceptives.
- Fewer than 20% of children under 5 years of age in all countries will be stunted; fewer than 10% of newborns will weigh less than 2,500 g at birth; iodine deficiency diseases will have been eliminated; the prevalence of subclinical vitamin A deficiency in children under 5 years of age will be below 10%; and the prevalence of iron deficiency among pregnant women and women aged 15 to 44 years will be reduced by 30%.
- Elimination of wild poliovirus transmission will be maintained; measles transmission will have been eliminated in all countries; neonatal tetanus incidence will be below 1 per 1,000 live births at the district level (municipal, cantonal, etc.); the prevalence of leprosy will be below 1 per 10,000 inhabitants; the prevalence of endemic dental caries will be reduced by 50%; canine transmission of human rabies will have been eliminated; and transmission of Chagas' disease by *Triatoma infestans* and foot-and-mouth disease will have been eliminated from all Southern Cone countries.

4.1.2 Intersectoral Actions Targeting Health Determinants

- In all countries, at least 80% of the total population will have adequate sewage and excreta disposal services; at least 75% of the total population will have access to safe drinking water; and in those in which more than 75% had access in 1998, coverage will increase by 10%.

4.1.3 Health Policies and Systems

- All countries will have adopted policies to promote Health for All and equitable access to quality health services; all blood for transfusions will be screened for infection with hepatitis B and C, syphilis, *Trypanosoma cruzi*, and HIV, and all

blood banks will participate in quality control programs;all countries will have adopted policies to prevent tobacco use by children and adolescents; all countries will have a health information system that provides core health data that meet the criteria of validity and reliability; and, in coordination with the pertinent entities, fewer than 20% of deaths will be unregistered and fewer than 10% of registered deaths will be attributed to ill-defined causes.

4.2 Strategic and Programmatic Orientations

During the 1995–1998 quadrennium, PAHO established five Strategic and Programmatic Orientations to guide the action of the countries and PASB in establishing national plans and programming actions: Health in Human Development, Health Promotion and Protection,Environmental Protection and Development, Health Systems and Services Development, and Disease Prevention and Control. These five orientations encompass the natural sphere of health; because the challenge that gave rise to them still has not been met, they are considered to be valid. Consequently, they will guide the work of the Secretariat during the 1999–2002 quadrennium, but they will focus more specifically on those topics forecast to be the targets of the Region's efforts.

4.2.1 Health in Human Development

National and regional capabilities must be developed and strengthened in order to analyze and monitor the health situation and the reciprocal relations among health, economic growth, and equity within the context of globalization. Dialogue among social sector, health sector, and economic sector authorities will make it possible to establish a link among economic growth, health, and human development and thus diminish the negative impact of macroeconomic policies on the population's living conditions and on the health situation. In order to achieve this, PASB technical cooperation will concentrate on:

- Defining the conceptual aspects related to inequities in health, developing instruments for their measurement and surveillance at the national and regional level, and bolstering the national analytical capacity to document and evaluate inequities in health and their relation to the impact of the structural adjustment programs, globalization/integration processes, and privatization of health activities, among other determinants.
- Supporting studies and research on the health profiles of neglected population groups, in order to design health interventions based on the impact that such interventions have on social inequities and health in particular.
- Upgrading the training of human resources in health to enable them to analyze the health situation and living conditions of various population sectors, the

prevailing social inequities—particularly those pertaining to health,and their relation to human development.

- Supporting the formation of local, national, subregional, and regional intersectoral networks to assist in policy-making and the preparation of plans, projects, and programs aimed at bridging the gaps in health.
- Promoting systematic research and documentation on the need to invest in health to permit human capital formation,economic activity, and the development of its potential as a mechanism for redistributing income.

In order to produce, disseminate, and utilize public health knowledge and practice in health promotion, health care, and health recovery so as to contribute to sustainable human development and increase the participation of the leading social and political actors in the sector and other sectors of the State and civil society, aimed at making health an important issue on local, subnational, national, subregional, and regional political agendas, and to formulate health policies, technical cooperation will place emphasis on:

- Disseminating knowledge about the impact of structural, macroeconomic, and social policies on the living conditions and health situation of the Region's population and contributing to the use of this information within the sector, in the social and economic cabinets, and in meetings of ministers, parliaments, and heads of State.
- Strengthening the capacity of legislative institutions to draft laws that permit the effective participation of social and political actors in the formulation of policies, plans, and programs in health and in the preparation of national human development projects that integrate economic and social policy in a strategy whose common goal is the population's well-being.
- Developing the capacity to use the gender perspective as a tool for analyzing the impact of globalization on the development process and on structural, macroeconomic, and social policies, with special emphasis on their relation to health.
- Documenting the extent of international trade in health capital, goods, and services in the Region.
- Placing discussion and analysis about health in human development on the agendas of the presidential summits and meetings of the governing bodies of the subregional and regional integration processes, encouraging participation in this effort by the ministries of health, of agriculture, of environment, of family, of labor, and of social development prior to such gatherings.
- Analyzing and documenting the importance of the changes that globalization has produced in the culture of health and, in particular, the impact such changes have had on the health demand of social actors and their support or rejection of health policies.
- Identifying the social and political actors who play an important role in the governance of the health sector, the State, and society, and promote their participation in the debate on ethical issues in health in human development.

The development of public health as a discipline, the research it entails, and the dissemination of the knowledge that it generates requires providing adequate responses to the health needs of the population, particularly the most neglected and excluded groups. For this purpose, technical cooperation will concentrate specifically on:

- Promoting new conceptual and methodological developments in research on health.
- Contributing to the education and training of the human resources involved in the production of knowledge and in carrying out public health activities.
- Supporting the formulation of national and institutional research and health technology policies that will permit the development of the knowledge and technologies necessary for taking effective action in public health.
- Disseminating scientific and technical knowledge and information that can reach the various actors involved in policy-making and the implementation of health activities.

4.2.2 Health Promotion and Protection

Inasmuch as health is the main component of human development, its promotion must, perforce, involve a much broader scope of action than that customarily handled by health systems and services. Most of the considerations related to the health of populations are based on their living conditions; the fulfillment of their basic needs; the quality of their environment; the culture to which they belong;and their knowledge, attitudes, and practices with regard to health. Given the conditions that still persist in the Region, health promotion and protection is considered a powerful strategy in the concept and practice of public health, as well as the fulcrum of a new paradigm aimed at affecting the determinants of health in general.

As a way to jointly create with the countries a new culture of health promotion and protection where health becomes a social value—which implies training individuals and communities, as well as public, nongovernmental, and private institutions to individually and collectively assume their responsibilities for preserving and continually improving their health and well-being—technical cooperation will be provided with a view to:

- Acknowledging the role of health promotion as a tool for empowerment, emphasizing its importance in the regional forums for presidents and heads of state and first ladies of the Region.
- Promoting the formulation of policies, plans, programs, standards, and tools for health promotion.
- Supporting cooperative and operations research through the network of Collaborating Centers.
- Continuing to design and strengthen methodologies and models for the evaluation of health promotion programs and interventions, the development of environmental initiatives or healthy spaces in schools and *municipios*,

and the consolidation of networks of mayors, health secretariats, and school health associations.
- Developing intersectoral work strategies; mobilizing technical, scientific, political, and financial resources in support of health promotion; and developing technical, political, and social support networks at all levels, including strategic alliances between the Pan American Health Organization and both the international community and the relevant organizations in the countries.
- Promoting the use of social communication in health, especially through the mass media.

Inasmuch as the operationalization of the strategies and programs for health promotion and protection are relatively recent in most of the countries and that there are solid indications that this is an absolutely essential strategy that should be part and parcel of all health actions, PASB will devote special efforts to:

- Disseminating scientific and technical information on health promotion and protection to the greatest number and variety of individuals working in public health in the Region and developing national capabilities for the analysis and use of this information.
- Promoting evaluation of both inputs and processes,as well as the short- and long-term effects of the health promotion strategies, and documenting, analyzing, and disseminating information on the national experiences in health promotion, noting the cost-effectiveness of these strategies compared to curative and rehabilitation activities in health.
- Promoting the adoption of healthy lifestyles and risk prevention through anticipatory behaviors.
- Promoting the use of the life cycle, family cycle, and gender approaches.
- Promoting the restructuring of the services to enable them to incorporate these kinds of interventions and make comprehensive health care a reality.

In order to foster human development and prevent disease throughout the life cycle, priority will be given to cooperation in the following areas:

- Family health and population, which attaches special importance to promoting and assessing growth and development at different ages; this includes programs for adolescent health, reproductive health, and health of the elderly.
- Food and nutrition, with special attention to malnutrition, the fortification of food with micronutrients, breast-feeding, supplementary feeding, nutritional guidelines for the different age groups, and food security.
- Healthy lifestyles and mental health, particularly preventing the use of tobacco, alcohol, and drugs; domestic violence; and child abuse, including social communication in health for the entire Organization, as well as health education and community participation, an area that involves initiatives to promote healthy schools, healthy *municipios*, and healthy spaces.

4.2.3 Environmental Protection and Development

In order to advance toward meeting the objectives and goals adopted in Agenda 21 and the Plans of Action of the Summits of Heads of States of the Hemisphere, as well as to adhere to the orientations contained in the Plan of Action of the Pan American Conference on Health and Environment in Sustainable Human Development, PASB will give priority to technical cooperation aimed at:

- Promoting the implementation of national strategies for community mobilization and intersectoral coordination on the environment.
- Contributing to the education and specialization of human resources in environmental epidemiology and toxicology.
- Strengthening the capacity of the ministries of health to exercise leadership and an advisory role in the treatment of environmental health issues in development plans and projects, and developing local capabilities for the operation and maintenance of health systems and services.
- Promoting programs and projects on the effects of the environment on the health of children,aimed at identifying and eliminating or minimizing environmental factors that have a particularly adverse effect on the health of this population due to its greater susceptibility.
- Supporting the promotion and implementation of primary environmental care activities within the context of Health for All, in order to offer communities environments that promote development through the community's active participation in identifying their own needs and in finding solutions.
- Promoting the updating of standards and regulations governing the quality of environmental services and products.
- Promoting the establishment of systems and mechanisms that make it possible to gather, analyze, and utilize data and indicators on the quality of the environment.

To encourage the countries to take action on physical, biologic, chemical, and psychosocial factors, as well as organizational factors and dangerous processes that adversely affect workers' health in both the formal and informal sectors, the technical cooperation of the Bureau will focus on:

- Strengthening the countries'capabilities to anticipate, identify, evaluate, and control or eliminate risks and dangers in the workplace.
- Promoting the updating of workers' health legislation and regulations and the establishment of programs designed to improve the quality of the workplace environment.
- Fostering programs for health promotion and disease prevention in occupational health.
- Promoting better health services for the working population.
- Supporting programs aimed at protecting child workers exposed to environmental and occupational risks.

With respect to water supply and sanitation, concentrating on expanding service coverage, improving the bacteriological quality of drinking water, and intensifying activities aimed at improving water supply and sanitary excreta disposal in rural areas and for indigenous populations, cooperation will be provided to the countries in:

- Disseminating appropriate low-cost technologies.
- Promoting community participation and the participation of nongovernmental organizations and the private sector in the expansion of urban and rural services.
- Participating in sectoral studies, the reform and modernization of the sector and its institutions, the execution of priority projects, and the mobilization of resources.
- Developing regulatory, technical, and technological mechanisms that will result in the best possible disinfection of water in water supply systems and households.

In order to contribute to an improvement in the management of municipal solid waste, given the rapid decentralization and privatization processes, PASB will cooperate in:

- Promoting institutional strengthening and, thus, the regulatory and organizational capacity of the sector.
- Conducting sectoral studies on solid waste management, including hospital waste.
- Identifying investment financing needs and opportunities.

4.2.4 Health Systems and Services Development

The Secretariat's technical cooperation will continue to support health sector reforms in the Region's countries. To this end, it will provide cooperation for strengthening the sector's steering role, organizing health systems and services, and financing sectoral activities. The basic strategies to attain these goals will involve the systematic and periodic sharing of information on national experiences; the development and dissemination of methodologies and tools to help strengthen institutional capabilities for analysis, policy-making, and the implementation and evaluation of sectoral reform programs; and the establishment of a regional system to monitor the dynamics, contents, and impact of the reforms undertaken.

Concerning the strengthening of the sectoral steering capacity, technical cooperation will focus on:

- Improving the sector's capability to develop policies and strategies, draw up master plans, and design concrete proposals for investment in health, as well as coordinating external assistance in an integrated manner.
- Developing the capability to analyze the organization and operation of the sector to redefine the role of the central, regional, and local governments in organizing and managing public health and personal health services, within the context of decentralization.

- Promoting the development and adoption of new management models in the health sector.
- Establishing health care models that support the reorientation of the services with health promotion and disease prevention criteria that improve the quality and comprehensiveness of the interventions and strengthen the operational and problem-solving capability of the services at the different levels of care.
- Promoting and supporting the development of national quality assurance programs for health services.
- Strengthening the regulatory and operational development of health programs and services in oral health, care for the disabled, eye health, and the health of indigenous peoples.
- Strengthening national and subregional capabilities for planning, managing, and regulating human resources development in the sector.
- Developing performance indicators for health systems and services that contribute to informed decision-making in the sector.
- Supporting subregional and regional mechanisms for the regulatory harmonization of essential drugs and inputs.
- Strengthening and developing programs for the planning, operation, maintenance, and renovation of the physical and technology infrastructure of the health sector.
- Promoting the adoption of safety standards for protection against ionizing radiation and for the safety of radiation sources at the country level.

Concerning the organization and management of health systems and services, PASB will concentrate its technical cooperation efforts on:

- Developing national, subregional, and regional capabilities for incorporating and assessing health technologies.
- Supporting the development of programs to improve the job performance of health workers.
- Promoting a reorientation of education for health professionals and continuing education for workers in the sector, while strengthening institutions and supporting integrated processes in public health education.
- Strengthening the sector's institutional capacity for developing and implementing information systems for programs and services.
- Promoting the development of programs in telemedicine to achieve greater coverage of the population.
- Strengthening and developing efficient,high quality pharmaceutical services.
- Supporting the development of supply systems to contain costs and increase availability.
- Provide guidelines for the organization and development of imaging and radiotherapy services and promote the putting in place quality assurance programs.
- Developing and strengthening public health laboratories and national, subregional, and regional diagnostic laboratory networks.

- Supporting improved safety and quality in blood bank operations.
- Strengthening and institutionalizing the health sector's preparedness in coping with any natural, technological, and complex disaster and diminish the vulnerability of health establishments in the face of natural risks.
- Promoting cooperation with other sectors—nongovernmental organizations, civil defense, foreign relations, and others—in each country and among countries that share similar vulnerabilities.

Concerning the financing of sector activities in the next quadrennium, PASB will advocate technical cooperation activities that permit:

- Improvements in the national capacity to analyze health expenditure and resource allocation based on the criteria of equity, efficiency, and effectiveness.
- The conduct of comparative analysis and the dissemination of information on experiences with various forms of payment to providers.

4.2.5 Disease Prevention and Control

In order to confront regional challenges and reduce and control disease, health service programs must include disease prevention and health promotion components. Success will require the community's participation and changes in the behavior of individuals. Sound policies and practices, supported by scientific evidence, must guide such changes.

The Secretariat's technical cooperation in the area of vaccine-preventable diseases will be geared toward:

- Improving the criteria for the adoption of policies governing immunization programs.
- Expanding and improving vaccination carried out by the public and private sectors,including nongovernmental organizations (NGOs).
- Strengthening and supporting national surveillance systems for vaccine-preventable diseases, that operate in conjunction with adequate laboratory support systems, through the expansion of the regional network of diagnostic and quality control laboratories.
- Determining the disease burden and ensuring cost-effective inclusion of vaccines against *Haemophilus influenzae*, MR, or MMR within the basic vaccination series.
- Promoting research and development of vaccines, in collaboration with public sector laboratories,ensuring that local vaccine production is economically and technically viable and adheres to good manufacturing practices, as well as national and international norms and standards.
- Promoting the consortium of public laboratories that produce vaccines and the adoption of good manufacturing practices, and continuing the regional certification process for vaccine producers.

Countries will need to strengthen their national capabilities in order to control, reduce, or eradicate specific diseases. The Bureau will concentrate its technical cooperation on:

- Supporting the countries in applied research and the planning and management of programs to combat tropical diseases, infectious diseases, and emerging and re-emerging diseases, including the utilization of new strategies for control and treatment.
- Encouraging the countries to increase their blood screening and promoting internal and external quality control measures.
- Promoting the application of new techniques to improve regional disease surveillance and developing electronic networks that make it possible to increase the speed with which suspected cases are reported and confirmed.
- Helping the countries to introduce the new International Health Regulations scheduled for adoption by WHO in 1999.
- Disseminating data and knowledge about antibiotic resistance, promoting the standardization of laboratory testing methods, improving quality control in laboratories, and utilizing the results of antibiotic resistance tests.
- Helping the countries to focus more specifically on HIV/AIDS-related health issues, such as program management, the safety of the blood supply, and intervention models that foster healthy behaviors and health care, while continuing to promote a broader intersectoral response.
- Promoting surveillance and programs for the control of sexually transmitted diseases.
- Promoting expanded implementation of the global malaria strategy and, given the existence of drug-resistant *Plasmodium falciparum*, a surveillance system to monitor such resistance in the Amazon countries.
- Supporting adoption of the strategy for Integrated Management of Childhood Illness (IMCI) in selected countries; the strategy focuses on acute respiratory infections, diarrheal diseases, malaria, malnutrition, measles, and dengue.

Enormous health gains are possible if there is commitment; policies and programs based on evidence; and adoption of these by communities, individuals, and clinicians. It is important for health organizations to devote human and financial resources so as to realize these potential gains. The focus of PASB technical cooperation will be on:

- Establishing a regional network of countries that use an integrated approach to noncommunicable disease control, first focusing on cardiovascular disease and adapting the model developed in Europe.
- Disseminating information about demonstration projects to reduce mortality from cervical cancer and support countries in adopting a similar approach.
- Supporting countries in developing efficient policies, models, and working partnerships among physicians, laboratories, and treatment facilities; helping cervical cancer control programs to understand women's attitudes and needs; evaluating demonstration projects; and planning their judicious, result-based expansion.

- Assisting countries with implementation of the Declaration of the Americas on Diabetes.
- Documenting the information and resources available to support the programs for injury prevention.
- Establishing regional and national partnerships for prevention and setting priorities regarding intentional and unintentional injuries, including the prevention of violence from a public health perspective.

Veterinary public health in the countries is and will remain an extremely important area for progress with respect to food security and food safety. Technical cooperation will, therefore, be geared toward:

- Preventing new outbreaks of foot-and-mouth disease in the countries that are free of the disease and expanding eradication zones in the Andean countries and northern Brazil, with special attention to border areas.
- Promoting food protection along the lines of action suggested by PASB.
- Promoting rabies prevention activities, coupled with establishing a laboratory network in which WHO/PAHO Collaborating Centers would participate.
- Promoting the development of laboratory diagnostic capabilities for epidemiological surveillance in the areas at risk for Venezuelan equine encephalitis.
- Promoting the elimination of bovine tuberculosis and brucellosis.
- Supporting the eradication of echinococcus/hydatidosis in the countries of the Southern Cone.

4.3 Technical Cooperation and International Coordination

The technical cooperation of the Secretariat of PAHO and its Member States and their coordination of matters pertaining to international health are constitutional mandates. For effective technical cooperation in 1999–2002, it is essential to bear in mind that technical cooperation is the principal product of the work of PASB and is based on the priorities of the Member States, as set forth in the Organization's Strategic and Programmatic Orientations that are approved by those same Member States. Technical cooperation is proposed, carried out, and evaluated in a social, economic, and political environment that is constantly evolving. It is, therefore, a dependent process subject to ongoing review by PASB.

The SPOs constitute the policy framework for PASB cooperation, and they are being defined and approved for the 1999–2002 period. This framework is intimately linked with two global influences:

- The Ninth General Program of Work of WHO. Covering the 1996–2001 period, and thus currently in force, its orientations include the integration of health and human development in public policy; equitable access to health services; health promotion and protection; and the prevention and control of specific health problems.

- The global policy of Health for All in the Twenty-first Century, which promotes the identification of and action on factors that determine health, when health is placed at the center of human development, and fosters the establishment of sustainable health systems that respond to the needs of the people.

The SPOs coincide with these global guidelines, in terms of objectives and proposed goals, considering the situation of the Region of the Americas, its comparative development in health, and its potential for progress with respect to the other WHO regions.

The SPOs for 1999–2002 will include technical cooperation modalities that offer the best options for addressing the trends and challenges identified. Particular attention will be paid to our understanding of people-centered development, on the one hand, and more effective and efficient cooperation to foster that development, on the other. The changes taking place in each country's society; the reforms in the international system; and the growing linkage and interdependence among the countries in different spheres, including health, make it essential to ensure that technical cooperation be consistent with the different policies that participate in and influence development.

The growing presence of institutions and people other than those that traditionally were involved in health issues in the national and international arenas, justify the incorporation of flexibility and innovation in the design of technical cooperation, in order to foster the development of practical and effective partnerships that will yield better results from cooperation.

The Secretariat understands that technical cooperation is influenced by the criteria and approaches applied to development in general. It attaches special importance to the concept of sustainable development, whose basic characteristics are the formation of human capital, the participation of all sectors (including the private sector),and the protection of the environment—all within the context of equity and social justice. Beyond the traditional "technical" aspects, such as the search for better ways of investigating, teaching, and applying health technologies, PASB's international health agenda will take advantage of the influence exerted on health by socioeconomic development; the strengthening of institutional capacity in policy-making, planning, and advocacy in health; and the organization of specific programs for a country or group of countries.

There is a growing need to shift away from technical cooperation that is centered around the nature of inputs it uses, towards an approach that is based on the purpose of the proposed cooperation. There has also been a tendency to abandon the project-based approach in favor of a more programmatic, multisectoral one that emphasizes the optimum use of national technical expertise. These changes, which will be carefully considered,will make it possible to develop a better-organized, more competitive, and more sustainable technical cooperation.

Some important technical cooperation issues have been identified as areas requiring special attention in the SPOs for 1999–2002. This is the result of PASB's ongoing efforts to rethink technical cooperation in international health *(44)*:

- Health topics should be linked to the social development and macroeconomic policies of the countries and should include investment in capital, human capital formation, and institutional development.
- Technical cooperation should be based on the priorities identified in and by the countries.
- The growing capacity of the countries to launch health initiatives on their own and to administer their own technical cooperation programs should be promoted, opening the way to greater confidence in the knowledge, experience, and resources of the countries.
- Alternative technical cooperation modalities, such as the development of national and international networks, will be adopted and greater technical cooperation among countries will be promoted.
- Coordination will be sought at all levels by taking every possible advantage of the managerial capacity of national institutions to build intersectoral consensus and promote multinational programs through joint efforts and resources.
- Maximum advantage will be taken of modern information and communications technologies to improve the planning, programming, execution, and evaluation of technical cooperation, as well as the coordination and mobilization of resources.

During 1999–2002, PASB will continue its intense promotion of technical cooperation among countries, with special emphasis on Pan American action in health as a powerful cooperation strategy that has proven successful in the past and that will no doubt facilitate regional progress in the complex transition toward the twenty-first century. The Bureau will continue to stress technical cooperation "among countries" and not "among developing countries" to keep from discriminating against any Member State based on its degree of development. Pan Americanism is one of the ruling principles of PASB, and it holds that all the countries of the Americas, regardless of their size or degree of development, can participate in the search for their own health.

For a better understanding of the PASB cooperation strategy, six functional approaches have been identified for classifying program activities in the technical cooperation projects: mobilization of resources (human,financial, physical, political, institutional); dissemination of information; training; development of policies, plans, and standards; promotion of research; and direct technical assistance. Work will continue on completing the first phase of a study on these approaches, which is designed to develop better descriptors that more clearly define the expected results of the technical cooperation projects of the Bureau in 1999–2002. In a second phase of the new quadrennium, an impact assessment of the projects in terms of the fulfillment of their goals will be completed.

PASB employs the AMPES system for planning, programming, monitoring, and evaluating technical cooperation through the identification and measurement of the results of cooperation projects. For the 1999–2002 period, greater simplification of management processes, greater flexibility, and a more expeditious response to the

needs of the countries is envisioned, taking extreme caution to ensure transparency in the use of resources.

The programming of technical cooperation—the foundation of the biennial program budget—focuses on the formulation of national health priorities, the identification of needs for international technical cooperation, and the preparation of technical cooperation projects that PASB will provide, clearly identifying the expected results and defining the indicators for measuring progress. The logical approach for project management will continue to be used, and progress will be made in the development of mechanisms to evaluate technical cooperation.

PASB international cooperation efforts for 1999–2002 will be geared toward strengthening its historic leadership role in international health. Studies conducted by the Bureau *(45)* reveal that there is a proliferation of institutions and actors who participate not only in technical cooperation but in health activities in general. This merits a proactive stance in PASB coordination at several levels: between countries, within countries, and among international organizations *(46)*. PAHO will encourage national governments to take responsibility for coordinating health efforts in their own countries and will help to strengthen this capability, facilitating the necessary coordination among the interested parties in a respectful and innovative manner.

Coordination among countries, particularly horizontal cooperation, will be encouraged, with a view to strengthening the countries' ability to obtain external resources and stimulating their potential for sharing information and experiences, which is the essence of technical cooperation among countries.

As for coordination at the national level, the Secretariat will endeavor to ensure that the programs of the various international organizations work harmoniously with their respective national counterparts. This coordination will be based on comprehensive national development strategies formulated through a participatory intersectoral process.

PASB will foster coordination among international organizations, ensuring that organizations supporting the same programs and geographical areas apply adequate policies and strategies, adopting consistent procedures to prevent resources from being wasted and develop complementary orientations that promote Health for All. ■

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