directing council

PAN AMERICAN
HEALTH
ORGANIZATION

XXXI Meeting

regional committee

WORLD
HEALTH
ORGANIZATION

XXXVII Meeting

Washington, D.C.
September-October 1985

INDEXED

Provisional Agenda Item 32

CD31/22, ADD. I (Eng.)
19 September 1985
ORIGINAL: ENGLISH

EVALUATION OF THE STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000
SEVENTH REPORT ON THE WORLD HEALTH SITUATION

REGION OF THE AMERICAS

REGIONAL EVALUATION
JULY 1985

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REGIONAL CONTRIBUTION TO THE

SEVENTH REPORT ON THE WORLD HEALTH SITUATION

Introduction

The purpose of the following regional and country analyses is to evaluate the progress already made and to establish a baseline against which progress in the health programs of PAHO/WHO and the Member Countries can be measured. This is also the first of a series of evaluations that are to be completed periodically on the progress toward the goal of health for all by the year 2000. In broad terms the report contains the following:

- An analysis of the interrelationships between socioeconomic development and health of the population, focusing on demographic, economic and social trends and the progress made in intersectoral cooperation.

- A summary of actions taken by Member Countries to endorse health for all as a national priority and revise health strategies to accomplish national health goals. The major points of the summary include health policies and strategies, implementation of primary health care, managerial processes, legislative activities, community involvement, manpower development, resource mobilization, health care delivery, health related research, and external assistance and cooperation.

- A review of patterns and trends in specific aspects of the health status of the population and the implications for social and economic policies. The review includes morbidity and mortality, health related behaviors and environmental factors.

- A synthesis of the main effects of national health policies in reducing health problems and the overall impact on the quality of life.

The Common Framework and Format (CFF) for evaluating the strategies for health for all by the year 2000 was discussed in June 1984 at the 92nd Meeting of the PAHO Executive Committee, which adopted a resolution that urged Member Countries to cooperate in field tests of the evaluation instrument and the application of the instrument as adjusted, as a result of the field tests; it was agreed that the results of those tests would be reported to the XXX Meeting of the PAHO Directing Council in September 1984. Four countries--Brazil, Dominican Republic, Jamaica, and Venezuela--were asked to participate in the field tests and return a completed CFF to PAHO Headquarters by the end of August 1984. Prior to sending the CFF to the countries, the Office of Program Analysis and Operations Coordination, using data available at Headquarters, partially completed a CFF for each Member Country participating in the field test.

Based on experience gained in the field tests and the recommendation of the PAHO Secretariat, the Directing Council agreed to a dual approach for completing the CFF in each country.

1. The Secretariat would prepare country narratives based on country statements and statistics, collected as part of the American Region Programming and Evaluation System (AMPES). Each country narrative would contain several summaries: one page listing demographic and social characteristics; two pages describing the country's health system; two pages describing the health status of the country; and one page enumerating achievements; in addition, each would include a statistical annex covering all of the quantifiable global and regional indicators for HFA/2000.

The country narrative would be modular in nature so that modules could be grouped for specific purposes. The result would be a document that could serve various needs: as the narrative portion of the PAHO/WHO program budget statements; as a baseline for future evaluation to determine progress toward achieving national, regional and global health goals; and as a useful briefing tool for officers from the Organization, the United Nations and other agencies sent as consultants to Member Countries. The summary would be updated every two years.

Once the country narrative was completed at Headquarters, it would be sent to each Country Representative for review and clearance with the appropriate national authorities. The approved copy was to be returned to Headquarters by mid January 1985.

2. PAHO/WHO Regional Headquarters staff, using information and data available, were to complete as many portions of the CFF as possible and send

it to each Country Representative, who would complete the document working with the respective national authorities. The completed CFF, approved by the national authorities, was to be returned to PAHO Headquarters by end March 1985.

This document would be used to expand the country narratives and to prepare the regional narrative statement for the Seventh Report on the World Health Situation. The proposed regional narrative was to be sent to each Member Country by the end of July 1985, reviewed during the XXXI Meeting of the PAHO Directing Council in September 1985, and once approved forwarded to WHO/Geneva.

Since only 8 or 10 CFF's had been received by the March deadline, technical and staff units in the Secretariat reviewed the CFF's on hand and prepared sections of the regional narrative; as additional CFF's arrived they were incorporated in the narrative.

In all, 23 CFF's were received: 19 from countries and 4 from other political units. In most cases, the CFF was completed in the PAHO/WHO country office and reviewed by national authorities.

CHAPTER 1. SOCIOECONOMIC DEVELOPMENTS AND THEIR EFFECTS ON THE HEALTH STATUS OF THE POPULATION

1.1 Regional Development Prospects

The prospects for development in the Latin American and the Caribbean portions of the Region have changed significantly in recent years. On the one

hand, after three decades of unparalleled growth, the debt crisis and the general international economic recession produced a downturn that in many countries reduced individual and per capita incomes to levels equal to those of the early 1970s. On the other hand, the overall political situation in the Region registered important positive changes. In the past two years, three countries ended long periods of authoritarian rule with the adoption of new constitutions and the election of civilian democratic governments. In seven other countries, previous transitions to civilian government were reaffirmed through formal adoption of new constitutions or democratic elections which provided for the first peaceful transfer of political power from one democratic government to another. These events generally were accompanied by governments whose development preferences included expanding the degree of equity within economic and social structures.

To a considerable extent, these two major currents--a surge in the number of democratic governments with development goals sympathetic toward the achievement of greater equity within their societies and therefore supportive of health for all objectives, and the limitations imposed by the economic crisis--have come into conflict. The result has been forced restrictions on public spending and particularly on any large-scale expansion of the social sector, including health. As external economic factors have restricted public sector revenues and the requirement to meet foreign debt demands has forced ever-increasing portions of export earnings to be siphoned off into payments of the debt, austerity policies have been the unpleasant antidote forced on many of the new, popularly elected governments.

On the political side, the positive impact of institutional changes can be seen in the human rights improvements cited by the Inter-American Human Rights Commission in countries that previously had drawn sharp criticism from that agency. Specifically, the Commission noted that positive steps had been taken to release political prisoners, to account for the disappeared, and to process those accused of human rights violations through judicial systems whose independence has been significantly strengthened.

The foremost political problems within the Region are concentrated in Central America, where conflicts have spread to many of the countries, resulting in disruptions of normal social and economic life, destroying health and other public facilities, and causing thousands of deaths and injuries. The efforts at achieving negotiated solutions to the conflicts, primarily through the Contadora process, have not yet achieved a successful conclusion. The Central American health initiative, called the Plan on Priority Health Needs of Central America and Panama and carrying the emblem "Health as a Bridge for Peace" has produced some positive actions, including a de facto ceasefire in El Salvador that permitted a nationwide immunization campaign to reach 300,000 children. All countries in the subregion are active participants in development of the respective plan, and several individual health projects--some national and some subregional in scope--have been financed and their implementation begun. Nevertheless, the conflicts continue and the persistence of external military flows into the subregion exacerbates the situation there. Finally, the concentration on military defense has tended to distort the internal political process in many of the countries, resulting in far less attention to social needs and far fewer resources available for allocation to those needs.

In at least two other countries in Latin America, internal terrorism poses a serious threat, creating tension and unease in different regions of those countries.

However, the two factors of overriding importance remain the impact of the economic crisis and the positive directions of institutional political development within the Region as a whole. These two factors and the manner in which they evolve in the near future will determine much of the development of the Region over the next several years.

1.2 Demographic Trends

According to United Nations' estimates[a/], the population of the Americas as a whole increased from about 331 million in 1950 to 670 million in 1985. For the same period, the population of the Latin America and the Caribbean portions of the Region grew from about 165 million to 406 million. On the basis of the recently revised medium-variant projection of fertility, it is estimated that this latter population will increase to 550 million by the year 2000, or 144 million over the next 15 years.

The same estimates indicate that the average annual rate of population growth in the Latin America and the Caribbean portions of the Region peaked at over 2.8% in 1960-1965 and started to decline in 1980-1985, when the rate was

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a/ United Nations. World Population Prospects: Estimates and Projections as Assessed in 1982. Population Studies No. 86, ST/ESA/SER.A/86 (New York, 1985).

2.3%. It is expected that the rate of growth--which varies widely from country to country--will continue to decline, and that by the turn of the 21st Century it could drop to 1.9%. In the period 1980-1985 it ranged from below 2% a year in Argentina, Chile, Cuba, and Uruguay, to above 3% in Ecuador, Honduras, Nicaragua, and Venezuela. If the rate of increase for 1980 is maintained, the population of Latin America and the Caribbean can be expected to double over the next 30 years.

One notable phenomenon in the Region over recent decades has been the enormous growth of the urban population[b/], which went from 68 million in 1950 to 280 million in 1985--a four-fold increase. During the same period the rural population grew from 97 to 126 million. This means that the percentage of the total population living in urban areas increased from 41.8% in 1950 to 69% in 1985. It is projected that by the year 2000 more than 75% of the population of Latin America and the Caribbean will be living in urban settings. Between 1950 and 1975 the proportion of the population living in cities of 4 million or more inhabitants almost tripled. Much of that growth resulted from rural-to-urban migration.

Between 1950-1955 and 1980-1985, the birthrate in the Latin American and the Caribbean portions of the Region dropped from 42 to 32 per 1,000, and is expected to decrease to around 24 per 1,000 during the period 2000-2005.

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b/ As defined in Estimates and Projections of Urban, Rural and City Populations, 1950-2025: The 1980 Assessment. United Nations Department of International Economic and Social Affairs, ST/ESA/SER.R/45 (New York, 1982).

These figures do not reflect the wide variations that exist between countries. In 1980-1985, the rate in Barbados, Cuba, Guadeloupe, Martinique and Uruguay was below 20 per 1,000; however, it was over 40 per 1,000 in Bolivia, Ecuador, El Salvador, Haiti, Honduras, and Nicaragua. This means that, based on the overall fertility rate, a woman in Cuba will have an average of two children, while in Bolivia, Ecuador, Honduras, or Nicaragua she will have more than six. Sizable differences in fertility exist within countries as well, as demonstrated by surveys carried out in several countries of the Americas under the World Fertility Survey Program, which indicated higher fertility of women in rural areas and of those with low levels of schooling.

The age composition of a population at a given time depends on the fertility and mortality rates in the preceding period. It is also affected by major migrations. Populations with high proportions of children and youths are present when mortality, particularly in the first years of life, declines faster than fertility. This is what has happened in most of the developing countries of the Americas. In 1965, 42% of the population in Latin America and the Caribbean was under 15 years of age. As fertility also declines, the adult and aged components become relatively larger, which is what has happened in Canada, the United States, and Uruguay. A similar aging pattern is beginning to emerge in other developing countries of the Region.

The relative size of the population between 15 and 64 years of age has not changed significantly (60% in 1950 to 62% in 1985). However, this age group will have grown considerably by the year 2000, bringing an increase in the demand for employment and social services.

Though education is not a demographic variable, the compostion of the population with respect to schooling should be taken into account because of its importance as an indicator of health status. Percentages of illiteracy in the countries of Latin America and the Caribbean vary between 6% and 70%. The importance of education, namely the mother's level of schooling, is associated, for example, with the differences in infant mortality. It is also clear that education itself can make a difference in infant mortality rates within the same socioeconomic stratum.

1.3 Economic Trends

The economic crisis has been a major factor in the substantial decline in virtually all indicators of socioeconomic development in the majority of the countries of Latin America and the Caribbean during the past few years. The crisis has been characterized by inflation, unemployment, high interest rates, a staggering international debt, and deterioration both in private production and public services.

The economies in the Region have suffered seriously since 1980. By 1983, the average Gross Domestic Product (GDP) per capita (in constant 1970 dollars) declined by 9.5%; 11 countries showed reductions that were worse than that average. In 1984, the decline halted, with the regional GDP per capita virtually stagnant, remaining at 1983 levels; once again, 12 national economies actually showed further decreases. At the end of 1984 the overall average GDP per capita in Latin America and the Caribbean was equal to that of 1976.

When the impact of inflation in the Latin American and the Caribbean portions of the Region, which reached 175% in 1984, is added to the decline in per capita income, the dire consequences for the actual standard of living of most of the people in the Americas are clear. The ability of families to purchase food, clothing, housing, and other services was far less in 1984 than even a full decade earlier.

The most visible obstacle to continuation of the strong levels of economic growth recorded in the two previous decades was the unprecedented foreign debt faced by Governments in the Region. In 1984 alone, there was a net transfer of resources out of the Region totalling some US$26.7 billion, including a nearly 10% increase in interest payments on the outstanding debt. The total external debt rose in 1984 to some US$360 billion. Nevertheless, there were some positive developments for Member Governments in the slowing of the rate of increase in that debt and in an upturn in the balance of trade.

Not surprisingly, during this crisis the countries' public health sectors have been faced with unparalleled demands for services from a still-growing population, one whose ability to expend family income for private health services is at its lowest point in many years. This increased demand for services comes at a time when public health systems, like the public sector in general, have been faced with sharp pressures for reductions rather than expansions in expenditures.

A PAHO/WHO report, "National and International Financial and Budgetary Impact of the Regional Strategies and of the Plan of Action for Health for All by the Year 2000", documented a general situation in which public funding for

health and health-related activities declined. Recent examinations of data from a selected group of countries showed little change in the pressures faced by Governments to reduce public expenditures, including those for health.

Compounding the diminished financial support for the health sector was the lack of sufficient changes necessary to assure efficient utilization of internal resources. The need for those changes became the focus of increasing attention within the Region, with PAHO/WHO seeking to encourage them. Moreover, the Organization's promotion of more effective intra- and intersectoral coordination and linkages aimed to foster greater productivity within the health sector.

1.4 Social Implications of Economic Constraints

It is much easier to measure the economic dimensions of the crisis of recent years than to determine its social impact, however "economic" and "social" factors are differentiated. Some kinds of relevant information are collected only at long intervals and require detailed population surveys--income distribution and nutritional status are primary examples. Other kinds of data are collected regularly, but refer only to spending or to rough measures of output by the public sector--formal education and health are examples. Such measures, in addition to disregarding the importance of private provision of services, do not take account of changes in needs which may be caused by the crisis, of changes in the quality of services, or of the ultimate effect on clients or beneficiaries. These limitations are

particularly important in the case of health, the need for health care having surely increased as a consequence of losses in employment and income.

Inferences from the known changes in economic variables, plus scattered studies of employment and public sector social activities, yield the following view of what has happened in Latin America and the Caribbean over the last few years, with of course some variation both among and within countries. Formal employment has fallen, leading often to dramatic increases in unemployment and probably still more in part-time and/or informal employment. Underemployment has therefore probably increased even more than unemployment; this is reflected in income per capita, which fell steadily through 1983 and only began to recover in 1984. Furthermore, the decline in formal employment has had one definite, and one likely, negative effect. The first is a diminished coverage of social insurance which--especially in the absence of unemployment insurance--reduces people's medical insurance coverage and transfers a greater burden to free public services. The second, which is probable but about which little is known, is a deterioration in the distribution of income, with proportionately greater losses among those with lower incomes. This tendency is partly offset, however, by the fact that in many countries the current crisis has particularly affected the modern industrial sector. Thus urban incomes have sometimes fallen more than rural incomes, and unemployment has affected relatively well-paid workers.

Falling incomes alone would have increased the prevalence of poverty in the last few years, after a long interval of reduction in the proportion of poor people (although not always in their absolute numbers). The increase in

poverty, especially in urban areas, has been worsened in some countries by the reduction, under budgetary pressure of public programs to aid the poor, such as the subsidized or free distribution of food to mothers, children and other groups at risk. These effects, however, are scattered and essentially unmeasured. In some countries, public programs have expanded to offset part of the increase in poverty, although the worsening of income distribution has probably overwhelmed their intended impact.

Increased poverty limits reduced food consumption both in quality and quantity and is thereby translated into poorer health and greater likelihood of mortality. It is important to emphasize that the crisis has been nowhere near long or deep enough to reverse the great gains in life expectancy and reduced mortality--especially of infants and children--achieved over the last two decades. There are, however, disquieting suggestions that infant mortality rates have stopped falling and may even have risen in several countries. Data on health and nutrition status are too fragmentary and usually too outdated to draw clear connections between poverty and mortality in the last few years. However, in spite of reductions in nationally sponsored food aid programs, some countries have expanded coverage with the assistance of bilateral and international food assistance programs. For instance, the World Food Program (WFP) channels food commodities to assist in integrated development projects and to meet emergency needs in many countries in the Region. In 1984, the WFP provided assistance to 20 countries through 42 projects that supplied 396,902 metric tons of food valued at US$270.0 million.

Routine social services such as health and education have been hurt by budget reductions almost everywhere; but the full impact of such changes is not yet clear. While school enrollments and the utilization of medical services have not fallen measurably, they have suffered from decline in quality, distortion of factor combinations, and reduced, deferred, or wasted maintenance and investment. These reactions to the budgetary crisis raise the private cost, especially in health, reduce the benefit to poor clients, and create problems for the longer-term future. The worst social consequences may only become evident after the economy has substantially recovered. In particular, it is to be feared that it will take many years to reverse the inequities caused or aggravated by the economic decline.

1.5 Intersectoral Coordination: Health as a Component of Socioeconomic Development

The Plan of Action for health for all included the "Promotion and improvement of intersectoral linkages and cooperation" as one of the three dominant regional objectives for achieving health for all by the year 2000. Recognition of the vital importance of overall socioeconomic development to improvement in health conditions has been a continuing concern of the Organization during the past year. Underlying this concern are multiple factors. First, conditions of health are dependent on the perception, policies, and actions of non-health sectors, and dependence on these other sectors is as characteristic of less developed countries as it is of highly developed ones; while the nature of the dependence differs, it unquestionably

persists through time. Second, the potential for success in addressing specific health problems can be improved significantly when action is coordinated with other sectors. Third, there are enormous advantages of resources, power, and attention available to the comparatively weak health sector when other sectors join the campaign to meet health needs. Fourth, the health sector can contribute directly and indirectly in both the short and long term to the goals of other sectors. Finally, there is a clear mandate of the Governing Bodies to pursue intersectoral linkages, best expressed in the designation of a specific objective of the regional plan of action to promote intersectoral actions for health.

The economic crisis already referred to compounds the need for intersectoral cooperation, in that it has affected all aspects of the health situation in the Latin America and the Caribbean portion of the Region. Among other of its effects, it has increased the dependence of health workers on other sectors. Rising inflation cuts the value of individual income and results in less money for food, clothing, and housing, and in a lowered standard of living. It also means greater poverty, increased malnutrition and energy-protein undernutrition and rising demands on health care systems. Yet the macroeconomic consequences of the economic crisis also produce pressures for reduced public spending, greater austerity, and fewer resources available to the health sector. PAHO/WHO has carried out a series of studies to identify the consequences of the economic crisis for the health sector in the Latin American and Caribbean countries. It also has engaged the Ministers of Planning of Member Countries in a dialogue on this relationship and is working to establish a permanent linkage between health sector planning and global socioeconomic planning.

PAHO/WHO collaborated with the Latin American Institute for Economic and Social Planning (ILPES) in a number of activities, among them participation in and elaboration of a document for the Fifth Conference of Ministers of Planning of Latin America and the Caribbean in Mexico City in April 1984, during which the focal point was the impact of the economic crisis on the social sectors; conduct of a regional consultation on intersectoral action, and joint development of a training curriculum on intersectoral action for schools of public health. Moreover, the two organizations are moving forward with a three-year research and cooperation program aimed at promoting intersectoral linkages, which focuses on a series of case studies covering both intersectoral action and public policy decision-making.

In addition, the Pan American Center for Human Ecology and Health (ECO) produced several publications and guidelines for environmental protection, aimed at avoiding negative impacts on health conditions from the actions of other sectors.

PAHO/WHO together with other U.N. agencies is promoting intersectoral food and nutrition programs. Beginning in 1984, PAHO/WHO and UNICEF, with the financial support of the Italian government, initiated a program which supports nutrition through primary health care strategies. The program includes Dominica, Haiti, Nicaragua, Peru and St. Vincent and the Grenadines, and concentrates national efforts and resources and health education, agriculture and community development to improve the standard of living of marginal rural and urban population groups. PAHO/WHO is also cooperating with

national legislators to develop seminars for the purpose of exploring legislative avenues for strengthening national commitment and action toward the goal of health for all.

CHAPTER 2. DEVELOPMENT OF THE HEALTH SYSTEM

2.1 Health Policies and Strategies

Considerable progress has been made in recent years toward the formulation of regional and national health policies and plans and in the elaboration of strategies to put them into effect. Since 1981 the Region has had a Plan of Action that serves as a frame of reference for developing or adjusting national health and development plans, based on the regional strategies for health for all adopted by the PAHO/WHO Directing Council in 1980. Those strategies spell out specific targets considered essential to the overall goal of health for all by the year 2000.

The Plan of Action aims to satisfy the health needs of the entire population and, in particular, those of the groups that are especially vulnerable and exposed to high risk, namely children, women of child-bearing age, the elderly and the disabled. To reach these groups many national Governments are reordering their basic priorities to reduce social and economic inequities. Health service systems are to be restructured and expanded to increase efficiency and effectiveness and to ensure greater, more equitable coverage. Economic and social development projects are being

assessed in the light of their impact on the health of people and on the human environment. Finally, and unfortunately at a slower pace, information systems are being established to permit regional and national monitoring of health and health-related projects. Several countries, with support from PAHO/WHO, are establishing food and nutrition monitoring systems. They are using health sector indicators to identify risk groups, support planning for social programs and evaluate the results of the actions of various sectors of national development toward the goal of HFA/2000.

Of the 35 Member Governments, 22 report having adopted national health plans or policies, most of which have been integrated into overall national development policies and plans. It would appear, however, that much remains to be done to implement the strategies at the operating level. Twenty-one Governments affirmed that their health strategies are consistent with and reflect the regional strategies of health for all.

In general, countries appear to have followed the Regional Plan of Action in their selection of priority groups: women and young children were reported as a priority group by 28 countries; the elderly by 15 countries; handicapped people by 8 countries; low-income families or persons by 13 countries; and most countries specified urban poor, rural poor, or both as marginal groups in need of special help.

Environmental issues, especially safe drinking water and excreta and solid waste disposal, are included by most of the countries, reflecting a high

level of concern and programmatic emphasis. Other programs listed as national priorities include food and nutrition, immunization, national insurance, and drugs.

Attempts to strengthen national health systems through the development of policies and strategies are illustrated with the following examples:

- In Argentina, the Secretariat of Health has assumed the responsibility to administer the National Institute of Social Work, a coordinating body for more than 250 medical and social insurance entities.

- In Brazil, the Ministries of Health, Social Welfare and Education have set up a high-level commission which is responsible for sectoral planning and coordination at national level. Similar commissions have been established in each state and major cities, as a mechanism for improving coordination among the federal, state and local health agencies and between the public and private health sectors. The implementation of a country-wide program of integrated health services has become the major concern for these commissions. Experience in sectoral coordination and integration are maturing the establishment of the national health system which is expected to be one of the most important outcomes of the constitutional convention to be called next year.

- In Chile, a Council of Ministers responsible for social areas has been organized to adopt health for all as a policy at the highest level of government, and to coordinate the solution of problems relating to health and the quality of life.

- In Colombia, the policies and strategies of the health sector have been restructured to give more emphasis to the development of the health system infrastructure, as a means of achieving effectiveness, efficiency and impact. For example, the National Program for access to Health Services is now oriented toward: integrating health services at the regional level; developing medical care program in large cities emphasing emergency and ambulatory care; and reorganizing the hospitals.

- In Costa Rica, concrete resources have been applied to consolidate the health sector, through the following strategies: the establishment of the national health system including legislative action, adjustment of administrative functions and levels of care; development of the operational capacity and the managerial process; redesign of the health information system; development of the physical infrastructure; adjustment of financial systems; strengthening of health research; and further development of priority programs such as environmental sanitation, nutrition, epidemiologic surveillance, chronic diseases, maternal and child health, care of the elderly and oral health.

- In El Salvador, the national health policy has been integrated with the National Plan for Economic and Social Development, 1985-1989, and the country is sponsoring education programs to assure that the concept of health for all is understood to mean the same thing by everyone involved in its application.

- In Guatemala, the Ministry of Public Health and Social Assistance was reorganized to reorient it toward achieving the goals of the National Development Plan, which has been expanded to include actions to strengthen primary health care.

- In Jamaica, integration of health policy into the National Development Plan has resulted in emphasis on certain areas that affect health, minimum wages, maternity leave and benefits, food supplements, and rural development.

- In Mexico, the establishment and consolidation of the national health system and the effective execution of health sector programs includes the application of five strategies, sectorization, decentralization, administrative modernization, intersectorial coordination and community participation. The sectorization of health institutions under normative and programatic coordination of the Secretaria de Salubridad y Asistencia (SSA), the articulation of the health sector with other sectors of the federal public administration and the production of extensive community participation are strategies based on the democratic mandate made explicit in the general health law.

- In Nicaragua the process of consolidation of the National Health System started in 1979 through the definition of a legal and economic framework. The principal strategy is regionalization, involving the managerial process together with the organization of levels of care; the most important achievement in this endeavor was seen in the establishment of methods and infrastructure for local programming of health services with clear definition of geographic and population boudaries. Additional strategies include: develpment of health education and social mobilization; full implementation of the immunization program; development of an intensive program for strengthening of the physical and functional infrastructure of the hospitals; implementation of the National Policy on Essential Drugs; and further development of training programs for health personnel at all levels.

2.2 Organization of Health Systems Based on the Primary Health Care Strategy

Institutional Composition of the Systems. Health care in the Latin American and the Caribbean portions of the Region is basically the responsibility of the Government, with the Ministries of Health acting as regulatory and coordinating agencies for the system.

The structure of health services in the Region is for the most part multi-institutional, with each country having its own characteristics. A

general appraisal of the forms of organization in this sector has made it possible to categorize the countries into four principal types, according to the most significant trends.

- Countries with national health systems, wherein the responsibility for the provision of services is exclusively or primarily under the Ministry of Health, which has developed individual or integrated systems with limited, if any, participation of the private subsector. This group includes Cuba and Nicaragua.

- Countries where health care depends predominantly on various forms of financing from social security, mutual insurance, insurance funds, or private insurance systems. Services are provided in establishments that are owned by the social security system, the Ministry of Health, or the private sector through various forms of contracting. This group includes Argentina, Brazil, Chile, Costa Rica, Haiti, Mexico, Panama and Venezuela. The systems in effect in Canada and the United Sates of America have characteristics consistent with their advanced level of development, and they are also included in this trend.

- Countries where care is provided mainly through the Ministries of Health, at their own facilities and with financing from public funds (government revenue) with participation by the social security system. This group comprises Barbados, Belize, Bolivia,

Colombia, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Jamaica, Paraguay, Peru, Suriname, Trinidad and Tobago and the smaller English-speaking countries of the Caribbean; Antigua and Barbuda, Bahamas, Dominica, Grenada, St. Christopher and Nevis, St. Lucia and St. Vincent and the Grenadines.

. Countries where health care is provided in equal, or almost equal, proportions by the Ministry of Health and the social security system. The only example of this type of system is Uruguay.

In all these countries, a more or less organized private practice exists; its role in the provision of services cannot be quantified accurately, however, due to the lack of reliable information.

Practically all the countries have provisions to facilitate accessibility of the lower-income population to services. Nevertheless, as a result of restrictions in the general availability of resources and limitations in the organizational structure of services, the actual utilization of these services suffers from deficiencies in coverage and in the composition of services provided to major segments of the population.

Organization of the Services. Most of the countries of the Region have adopted regionalized administrative systems as a means of rationalizing the utilization of resources and rendering the provision of services to the community more effective and equitable. The decentralization of functions

related to the programming, execution, and evaluation of services is reflected in a general trend toward increasing the capacity of local levels of the system, enabling them to assume greater responsibility in solving health problems of the population in their area of influence.

Definition of the area of responsibility of health establishments is a matter of concern for all countries, regardless of how that area of responsibility is termed, e.g. "integrated health areas" (Bolivia, Guatemala, Honduras, Nicaragua, Paraguay), "health sectors" (Cuba and Panama), or "health districts" and "regional units" in other countries.

All the countries have a formally defined programming structure, wherein priority is assigned to the eight components considered to be essential to primary health care. National policies emphasize the need to extend the coverage of services to the entire population.

Within this format, there are various forms of community participation aimed at finding a solution to the mainly environmental risk factors that affect health, the mobilization of resources, development of self-care, and the rational utilization of services. Programs for social participation have been variously described as "popular health committees" (Bolivia), "community health and development associations" (Argentina, Colombia and Costa Rica), and "health committees" (Ecuador, Honduras, Panama, Peru).

On occasion, community organizations have attained advanced levels of development and manage their own resources, such as is the case of private pharmacies (Bolivia, Colombia, Haiti), milk distribution centers and daycare centers for children, oral rehydration units, and temporary shelters for pregnant women.

Proportion of the Population with Access to Primary Health Care. The geographical zone of coverage of those health services having some level of capability to provide services related to the eight components of primary care has increased noticeably in all the countries, as a result of expansion of the peripheral network of services, better utilization of resources, including community resources, and expansion of communication and transportation facilities. However, the measurement of real coverage, in terms of level of use by the various population groups, suffers from deficiencies in available information, which does not include data on the composition of services. In general terms, improvements have been recorded in the indicators for immunization coverage, maternal and child care, diarrheal disease control, actions in health education, detection and treatment of chronic and acute diseases, and care in cases of accidents.

The methodologies for measuring progress are, however, still in an incipient stage. In some countries, and in some sections within countries, systems have been developed for continuous surveillance based on household visits or community surveys. The continuous flow of information made possible by records kept at the services is supplemented by the activities of

supervisory teams, who--on their visits to the local levels--detect changes and quantify the supply and utilization of services. In some countries, analyses have been made on the basis of existing health records at health centers; these indicate a real comprehensive coverage of over 80% (Barbados, Chile, Costa Rica, Cuba, Dominica, Panama, Uruguay, and Venezuela). The main problem centers on the actual access to the different levels of complexity that are necessary for solving health problems, in circumstances where the real resources for the financing of diagnostic, therapeutic, and rehabilitative activities as well as the general operating expenses of establisments have been showing a regressive trend. Even when the countries have various categories of human resources available (professional, technical, and auxiliary), the possibilities for expanding personnel resources in basic community services are practically nil.

2.3 Management Process

The health system situation was reassessed in several countries as a basis for the design of strategic plans. Efforts were made by the Ministries of Health to achieve an intra-sectoral coordination with the services of the social security system, notably in Costa Rica, Honduras, Panama, Nicaragua and Colombia. Likewise, Mexico adopted legal instruments and actions to coordinate the services of the social security with those of the official health sector within a more comprehensive framework for the extension of coverage through the strategies of decentralization and integration of services at the state level. Argentina and Uruguay also developed important

actions to coordinate and regulate the operation of the particular institutions, providing services to corporative population groups (MOH's, mutual associations, workers union, etc.).

After a thorough assessment of the coverage, the health status, the organization and the financing of the health services, Uruguay initiated a process of reorganization of its health system. Venezuela and Nicaragua, under different curcumstances and conceptual framework also initiated transformations under the leadership of their Ministries of Health.

National health plans were prepared in Belize and Mexico. Other countries faced the restrictions ot the development of their health systems through ad-hoc or specific measures and strategic approaches.

Regionalization and decentralization as instruments for the extension of coverage and implementation of primary health care was consolidated in Chile and gained momentum in Bolivia, Costa Rica, Panama, Colombia, Nicaragua and Guatemala. Most of the revision of planning and administrative methods and procedures was the focus of particular interest in several countries. In particular, a seminar was held for all the countries of the English-speaking Caribbean in October to evaluate current initiatives and to discuss the relevance of the management process for national health development. New approaches to strategic planning and administration to provide solutions to problems posed by the "crisis" were discussed in two regional seminars held in Merida (Mexico) and Rio de Janeiro (Brazil). The development of appropriate

instruments to make feasible the new approaches to planning are in progress in two schools of public health (Medellin and Rio) as well as in other countries under the auspices of PAHO/WHO.

The development of health information systems has been promoted through the organization of four subregional workshops by PAHO/WHO. Progress is still slow but is accompanying the development of the different components of the managerial process.

2.4 Health Legislation

As a complement to its support to Government efforts to improve and consolidate the juridical and legal basis of service systems, in September 1984 PAHO/WHO convened a group of consultants from seven countries to consider legislation in public and private administration for the purpose of drawing up a plan of future action in that area. The group analyzed legislative problems arising from the development of health systems in the participants' countries and reached the following conclusions:

- Legislative action has not always been used to support, channel, or even guide government policies on the design, integration, composition, and consolidation of the health system.

- Different juridical administrations for health clearly suffer from a dispersal of their provisions among legal instruments of various

kinds, a dispersal which--together with the formal rigidity of those provisions--hinders their applicability in dynamically developing health systems.

- Health is today regarded as both part of the social estate of a people and a basic right of every individual, to be guaranteed first and foremost by the law.

- Health law, to be effective, must stem from technical and scientific bases; hence health science experts and jurists specializing in health should participate in drafting health law.

On the basis of these briefly stated conclusions, the group recommended that PAHO/WHO encourage studies of existing and required health legislation, promote the gathering and exchange of information on health laws, and sponsor the training of health resources in this field.

2.5 Community Participation

In the Americas, community participation in the development and provision of health services is not a new concept or practice. On the contrary, the countries of the Region have a long-standing tradition of involving community members in health and integrated rural development programs. Important contributions--among them, labor, materials, and

equipment--have been made by volunteer workers, health promoters, health committees, sanitation boards, rural water supply boards, mothers' and expectant mothers' clubs, and volunteer women's clubs. Extremely valuable experience exists in rural water supply and latrine construction programs, while malaria, nutrition, immunization, and diarrheal disease control programs offer further examples of the level of community support achieved in many of the countries.

In implementing the goal of health for all by the year 2000, with its basic strategy of primary care, the need to promote, strengthen, and recruit the latent resources of the community at large in matters related to individual and collective health has become apparent. Consequently, some health plans underscore the need to secure community participation as a means toward attaining that goal.

National health policies and the strategies for implementing them in 19 countries whose documentation PAHO/WHO has examined emphasize the important role of informed and committed community participation in the diagnosis of the health situation and in the planning, execution, and evaluation of improvement programs. While the degree of development attained is not the same in all countries, numerous cases demonstrate the importance attached to community involvement in the various components of primary health care.

Nevertheless, a number of obstacles constrain the mobilization of effective community involvement. Most noteworthy of these obstacles are the

variety of institutions haphazardly promoting different patterns of local organization, often with little regard for genuine participation, and the inability of governments, whether for political reasons or for want of the necessary resources, to satisfy the demands of communities.

A basic element often mentioned is the need to develop or define new models for social participation which, while taking the traditional forms of participation into account, are directed toward greater awareness and direct participation by community members.

The value of health education as the basic element in developing an informed community, conscious of its health problems and needs and prepared to play an active part in solving them, is recognized in every case. Interpersonal actions, group activities, and the use of mass media are considered extremely useful in public health education. For example, nongovernmental organizations and private groups make substantial contributions to programs for diabetes, cancer, and blindness prevention.

The countries, with PAHO/WHO cooperation, are providing training to private groups and individual volunteers--whether referred to as health promoters or community workers--to define their functions and responsibilities clearly, and to provide them with adequate systems of supervision and continuing education.

2.6 Health Personnel

Activities have been undertaken with the countries of the Region to define health personnel development policies and to establish plans to carry them out. To that end, national, intrasectoral and intersectoral and multiprofessional groups or committees have been established, which have framed policies that have subsequently been approved by the respective Governments in Bolivia, Brazil, Colombia, Costa Rica, Guatemala, Honduras, Mexico, Panama, and Venezuela. In other countries, notably Cuba and Nicaragua, health personnel development policy is already very well defined within a planned government system. These policies embody general principles or a conceptual framework on which training and utilization of personnel are to be based, in accordance with national, regional, and global commitments to attain health for all by the year 2000. Most of these policies set forth such principles as the integration of medical education and medical care; the definition of occupation profiles and the description of health teams, whose composition varies depending on the health policy of each country; planning for the full utilization of human resources; and evaluation of performance as a basis for supervision and continuing education.

To ensure that health personnel development does not become merely an academic exercise, personnel needs must reflect the status of the health sector. Other issues that personnel planning will have to take into account to be effective include employment and unemployment, oversupply of professionals, new types of professionals or health agents, social demands for

health services--which are not always the same as the real needs--and alternative sources of financing.

Most of the countries of Central America, some in South America, and Mexico are beginning to define health teams, as part of their formulation of personnel development policy, that reflect the combination of resources needed to deliver a specified service in the most efficient and effective way. In so doing, they are attempting to determine the occupational profile of each type of personnel needed on the team. Recently, a study of the technical skills needed for dietetic and nutritional personnel was begun to meet the scientific and technical demands imposed by the development of primary health care.

Specific studies in the field of nursing personnel are being carried out in six countries of the Region (Brazil, Colombia, Ecuador, Honduras, Mexico, and Peru), using a comparative research model. These studies will define working conditions in nursing, trends in the number and quality of nurses, and the role nursing plays in primary care. In addition, analysis of health personnel and the "sociology of professions"--i.e., the individual and collective behavior and productivity of health professionals--have been singled out as priority research projects. It is hoped that these projects will facilitate the utilization of human resources through a better understanding of personnel administration, the impact of policy on the development of human resources in general, and the importance of employment policies at the national level. These research projects will be carried out with national groups in Argentina, Brazil, Central America, Mexico, and Panama.

Health personnel development policies should provide clear directives and sufficient orientation in regard to the proper training of health personnel. In most of the countries policy directives on training at the professional level depend on collaboration from universities, that is, the educational sector--which does not always completely accept those directing--whereas training of technical and auxiliary personnel comes under the ministries of health or social security institutions and is thus more tailored to the needs of the services. In Cuba and Nicaragua training at all levels depends on the plans of the Ministry of Health, although educational guidelines are issued by the Ministry of Education. In the remaining countries the training of professional personnel tends to reflect prevailing health practice, which is usually not consistent with the strategy of primary health care and the goal of health for all.

Supervision and continuing education training programs have scored progress in the reorientation and readaptation of service personnel in Bolivia, Brasil, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Panama, and Peru. These programs initially received financial support from the Canadian International Development Agency (CIDA).

Efforts made with a view to changing educational institutions include the initiation of an evaluation of faculties of medicine; conduct of a review of the status of nursing education; publication of such documents as "Frame of Reference for Medical Training in Latin America" and "Training of Technical Personnel in Latin America"; and support to the reorganization of some schools

and the establishment of others with innovative characteristics in most of the countries.

Training of personnel in public health and health administration has received special attention, with priority given to the needs of health services. The Program of Advanced Studies in Health Administration (PROASA) provided excellent of technical training in Argentina, Brasil, Chile, Colombia, Costa Rica, Mexico, and Peru. Training of health leaders as part of the Program of Training in International Health, in which training institutions throughout the Region are participating, is being directly coordinated by PAHO/WHO.

The production of professional-level health personnel has not showed any decrease; on the contrary, in recent years the number of schools of medicine and nursing has risen, with consequent increases in the number of persons trained. Despite this growth, many countries have not achieved the desired ratio of professionals to population. Largely as a result of poor distribution, many countries will not be able to provide their communities access to the health professionals they need. Thus, the inability of health service systems to properly utilize existing personnel gives rise to unemployment and underemployment.

Consultations on the administration of personnel at the institutional level have begun in Brazil, Mexico, and Peru and in the English-speaking Caribbean, and are expected to contribute to the work of a WHO expert group on that subject, scheduled to meet in 1987.

Despite the severe economic crisis, the countries are endeavoring to meet, and are making progress toward, their commitments to health for all by using innovative strategies and instruments such as coordination between trainer and user institutions, definition of explicit policies, and application of the processes of monitoring and evaluation.

2.7 Mobilization of Resources

PAHO/WHO cooperates with the countries in mobilizing external financial resources, primarily by identifying potential sources of financial cooperation and providing orientation as to how to obtain it; in the latter regard, a document entitled "Guidelines on External Financial Resource Mobilization for Health in the Region of the Americas" was prepared and circulated throughout the hemisphere in 1984.

The guidelines offer orientation on sources, procedures, and a strategy for mobilization. The strategy takes into account that the main sources of external support for health are the official governmental, multilateral, nongovernmental, and UN sources of development-oriented and multisectoral cooperation. Potential recipient governments and institutions are encouraged to apply and negotiate directly with representatives of external sources. The Regional Office emphasizes the need to support potential recipients in identifying sources, preparing preliminary proposals, and negotiating such proposals through official, nationally authorized channels for external financing.

In 1983, the latest year for which information is available on most external sources of funding, concessional financing for all development purposes in the Americas increased by over US$100 million from US$3.26 billion (1982) to US$3.37 billion. Approximately 25.5% of this total external financial flow (US$866.7 million) was allocated for health, nutrition, population, water supply and sanitation projects in 1983. Approximately three-quarters of that expenditure was for water supply and sanitation programs, however, and only 6.9% of overall external financing for development was spent on health programs other than water and sanitation.

For 1983, the major sources of external financing were the World Bank (US$457.5 million), Inter-American Development Bank (US$179.3 million) and the European Economic Community (US$1.8 million). In 1983, 93% of World Bank loans were invested in water supply and sanitation. In 1983, 92% of all IDB loans were for water and sanitation, the rest being for support to rural health services in Paraguay. The Fund for Special Operations made loans to Bolivia, the Dominican Republic, Guatemala, Mexico, Paraguay and Peru. All loans were for water supply.

Of 14 sources of bilateral development cooperation in the Region, eleven were actively involved in support of health: Canada, Denmark, the Federal Republic of Germany, France, Japan, Hungary, the Netherlands, Norway, the United Kingdom, the United States of America and the USSR. Health cooperation in 1983 totaled US$103.4 million, 73% of which was committed for health activities other than water and sanitation.

The Region made efforts during 1983 and 1984 to develop a capacity to identify and mobilize nongovernmental resources. Early emphasis is being given to develop the requisite statistical base. Some 174 private agencies involved in health have been identified. Examples of foundations actively participating in health include W.K. Kellogg, Ford, Rockefeller, Edna McDonnell Clark and the Thrasher Research Fund. The W.K. Kellogg Foundation alone provided US$5.9 million for health in 1983.

In February 1985, the Regional Office and the Kellogg Foundation jointly convened a special meeting in Washington to exchange views on Foundation support to health in the Americas.

It is estimated that more than US$100 million in external resources have been identified through the Plan on Priority Health needs of Central America and Panama and negotiations are in advanced stages for additional financing.

Promotion of technical cooperation among countries of the Region, with an emphasis on cooperation among developing countries, has received increasing attention. Special studies have been undertaken aimed at identifying methods for countries to designate resources available for TCDC, cataloguing potential donor and recipient needs, and analyzing potential obstacles. Financial mechanisms are being created to foster TCDC.

2.8 Health Care

Expansion of networks of less complex health facilities and services and improvement of access to them for various population groups--a programatic application of the primary health care strategy--has resulted in increased health service coverage, although that increase is difficult to quantify, given differences in definitions and deficiencies in instruments used for measurement. Notwithstanding, judging by such indicators as reduced mortality and prevalence rates, several countries have experienced favorable changes in the level and structure of health service delivery with respect to some common diseases.

Extension of the coverage of preventive services--in particular, immunization and maternal and child health activities--has become more efficient. Since its inception in 1977, the Expanded Program on Immunization (EPI) program in the Americas has made considerable progress. More than 15,000 health workers have been trained in EPI workshops. A cold chain regional focal point in Cali, Colombia has trained over 150 technicians in cold chain equipment, maintenance and repair. Schools of Public Health in the Region have been actively involved in EPI training. Most countries have made notable strides in improving and expanding the equipment and procedures used in the cold chain to assure the potency of vaccines. PAHO/WHO created the EPI Revolving Fund which has assisted countries in the Region with vaccine purchases worth more than US$19 million. This Fund has contributed to improved vaccine quality and the ready availability of vaccines at the country

level. The improvements in the control of paralytic poliomyelitis in the Americas since the start of the EPI initiative have been remarkable. In the Americas, the proportion of children less than one year of age who have received the recommended three doses of polio vaccine has increased from 34.6% in 1978 to more than 75% in 1984. The number of reported cases of paralytic polio has decreased by 90% from the 4,728 reported cases in 1979 to 525 in 1984. A major contribution to the increased polio vaccine coverage and decreased paralytic polio morbidity have been special immunization programs emphasizing oral polio vaccination in Bolivia, Brazil, Colombia, Mexico, Dominican Republic, and Nicaragua.

In most of the countries, however, many poor people continue to have difficulty in gaining access to health services because of economic, cultural, and institutional factors. Efforts are being made to strengthen the health services, especially peripheral units of the service network, to respond to the needs of marginal population groups living in urban and rural areas.

Some Governments have made political commitments to increase health services coverage by emphasizing integrated social development, which includes the health component, at a time when economic constraints dictate the need to rationalize the utilization of limited financial resources.

Community members have participated actively in immunization campaigns in a number of countries--an experience which has demonstrated the catalytic effect of community involvement in the development of health.

To assure the comprehensiveness of health care, the countries have adopted the approach of programming health services at the local level, through the regionalization of health care networks that aim to satisfy the health need of well-defined population groups in accordance with geographical, demographic, epidemiological, and administrative conditions. Regionalization is based on consistent development of personnel resources, rationalized use of medical and health technology, and efficient operation of administrative and logistic support systems to ensure the availability of laboratory equipment, drugs and other supplies critical to the operation of services.

Coordination among the institutions responsible for providing services, in particular ministries of health and social security institutions, is essential for the strengthening of regional service networks and requires that differences in the kind and quality of services for different groups of users be eliminated, financial constraints that affect access to services of greater complexity be reduced, and the utilization of available human and physical resources be improved.

Intermediate-type hospitals throughout the Region are beset with problems stemming from the lack of resources, primarily financial ones, needed for their operation. These problems should be analyzed and new forms of hospital organization instituted to improve productivity and performance, particularly in light of the progress achieved by coverage extension programs, which is generating increases in demand towards care levels of higher complexity.

In this regard, low-cost improvements are being undertaken in the physical infrastructure, in the operating condition of medical and laboratory equipment through maintenance programs, and in the training of personnel at all levels.

2.9 Issues in Health Research

The absence of concretely defined policies represent the greatest obstacle to the conduct of health service research programs. Policies should provide mandates or guidelines for scientific agencies, services, or higher education institutions; the research structure; the definition of priorities; the specification of the human and financial resources required to conduct research. Policies are becoming increasingly more difficult to draft and apply because in most of the countries a large number of institutions within the health system participate in service delivery. Difficulties are compounded by inadequate political/administrative linkages, absence of inter- and intra-institutional coordination mechanisms, lack of governmental interest and support, and the view that research is a mere expenditure rather than an investment.

Programs suffer from lack of continuity, inconsistencies, interruptions, and delays occurring because of changes in the management of the agencies, particularly financing agencies. Inadequate human, financial, and methodological resources are the natural consequences of these drawbacks.

The development of human resources for health service research is plagued by existing quantitative and qualitative deficiencies, scarce identification of consolidated groups, lack of coordination among research workers, poor communication and dissemination of findings, unsatisfactory working conditions, and low salaries. Moreover, the structure for furthering the processes of continuing education and scientific exchange through collaboration at the national and institutional levels is generally weak.

All the countries admit to a shortage of financial resources for the conduct of health service research, a situation that is worsened year after year by continuing devaluation of local currencies, which in turn makes it difficult to sustain funding for research projects.

Furthermore, since concrete policies are lacking, resources for conducting projects that have already been approved or are underway are often delayed or interrupted. This interferes with the efficient conduct of research, disrupts the consolidation of groups of investigators, and thwarts the efforts of individuals already trained in specific research areas. Not surprisingly, then, a study by PAHO revealed that a basic need in the field of health service research is to establish clearly defined policies that take into account the development level of each country, the economic and social conditions, and the organization of science and technology.

Distinguished research workers from 15 countries in the Region participating in a PAHO/WHO-sponsored meeting held in Mexico in 1984 urged that health research be encouraged and developed in Latin America and the Caribbean and recommended:

- Establishing consultative groups in the ministries of health and as part of science and technology councils that would include representation of teams of researchers and that would bring them together with the providers of services, so as to assure broad participation in the definition of health research priorities and thus guarantee a better allocation of resources for development of the field.

- Disseminating the concepts, methods, and findings of health service research among health service administrators and planners to increase the use of research by the services.

- Strengthening, technically and financially, centers dedicated to health service research.

- Convening discussion groups on health service research at the national level for the purpose of stimulating the exchange of experience and information and the achievement of academic excellence.

- Developing of human resources to undertake health service research. Strengthening existing training programs through exchange and communication at the intercountry and regional level.

- Establishing multi-institutional and multidisciplinary consortia for tackling complex problems.

- Exchanging information on research findings, trends, and project activities among the countries.

- Encouraging collaboration among the countries in research on common concerns such as the application and evaluation of health technologies and the identification of resources essential to the provision of services.

- Allocating PAHO/WHO financial resources for conducting Latin American and Caribbean research projects.

It should be realized, of course, that many of the countries are endeavoring to develop and strengthen their research infrastructure. Bolivia, Honduras, and Nicaragua have established research units in their ministries of health. Ecuador has recently created a national research council, with a unit responsible for health research. The other, more established research councils in the Region--for example those in Argentina, Brasil, Colombia, Mexico, Peru and Venezuela--continue to promote and foster biomedical research. These councils have encouraged contacts between research workers and health program administrators as a means of defining research priorities. Nevertheless, financial difficulties and in some cases an insufficient number of trained personnel militate against the effective conduct of research.

2.10 Coordination Within Health Sector and with Other Sectors

Health service systems in virtually all of the countries are characterized by the involvement of a number of different institutions whose

effectiveness depends directly on the level of coordination attained among them. There is a tendency towards strengthening intersectoral approaches that will enable health institutions to coordinate their collective resources without losing their individual identity and harmonize their operations to avoid duplications and contradictions and more effectively contribute to the achievement of major national objectives.

The experience of those countries in the hemisphere that are moving toward integration of their health services indicates that their effectiveness depends on the definition, at the highest political levels, of social and economic objectives and the adaptation and articulation of complementary institutional policies for achieving those objectives.

The solution of environmental health problems requires that the health sector coordinate with other sectors, i.e. the development of urban water supply and sewerage systems requires coordination with public works and housing authorities. Further the solution of pollution problems requires coordination with industrial, water, agricultural, tourist and other government and private sector authorities.

Within this framework, analysis has begun of three central elements of political decision critical to the process of coordination among ministries of health, social security institutions, and other sector agencies; i.e definition of the composition of the health system, financing of services and coverage of the population.

Given the regional tradition of institutionalization of health services, institutions will doubtless continue to play a central role in the formalization and organization of health service systems. Experience with new sectoral approaches points to the need to incorporate the private sector in reviewing institutional roles in the coordination of service delivery.

With respect to financing, an essential approach is the adoption of appropriate policies that will guarantee recognition of the right to health care of the entire population and thus help eliminate discrimination. Public sector and social security resources must be efficiently managed and utilized, and means should be found to optimize the use of available private sector resources.

In those countries that provide multi-institutional services, actual health care coverage is not known, although it is generally agreed that large population groups do not have access to minimum health services. Although information is available about the nominal coverage of health services through social security institutions, figures for the population that actually receives health care are influenced by many factors that make it impossible to determine true coverage.

Intersectoral coordination in countries throughout the Region was the subject of discussion at the XXX Meeting of the PAHO Directing Council (1984), and participation of social security institutions in the plan to meet priority needs in Central America and Panama was dealt with at the Joint Meeting of Ministers of Health and Directors of Social Security Institutions held in

Medellín, Colombia, in July 1984. The subject is also on the agenda of the Second Regional Technical Consultation Meeting on Strategies for the Conduct of the Health Programs of Social Security Institutions organized by ILO in 1985. A clear indication of the progress made toward greater coordination was the resolution adopted by the Conference of Ministers of Health of Central America and Panama to have representatives of social security institutions participate in its annual meetings.

2.11 Intercountry Cooperation

There has been a marked trend toward increased, systematic utilization of intercountry cooperation as an effective tool for mobilizing and using technical resources in the Region. The XXX Meeting of the PAHO Directing Council adopted guidelines and recommendations for promoting, facilitating, and systematizing technical and economic cooperation among developing countries (TCDC) in the health sector, and it reiterated the urgent need for legal, administrative, and financial measures by individual countries to foster collective and bilateral actions in the field of health.

Bilateral cooperation has been a common practice among countries in the Region, often based on mutual understandings and formal agreements. Mexico's National Virology Institute and National Reference Laboratory cooperated with Bolivia, Chile, Colombia, Guatemala, Honduras, Nicaragua, Panama, and Peru in verifying the stability and potency of the DPT, rabies and poliomyelitis vaccines. The same Mexican institutions likewise extended consulting services to Cuba in the area of measles vaccine and DPT production and held a regional seminar on quality testing of viral vaccines.

Intercountry exchanges of reagents involving Brazil, Chile, Cuba, and Mexico were carried out, and nearly 900 reagents were supplied to 11 requesting countries. Similarly, Argentina offered to supply Trypanosoma cruzi antigen for the diagnosis of Chagas' disease. Cuba and Nicaragua formally agreed to cooperate in the development of human resources for the latter country's health sector through 1984.

Barbados, because of its high standard of health services and its personnel resources, has regularly made available through specific intergovernmental arrangements specialized health services to neighboring islands in such areas as surgery, radiotherapy, opthalmology, and laboratory testing. Caribbean islands participate in the CARICOM bulk purchasing scheme, which reduces their costs for essential drugs.

Paraguay, Brazil, and Argentina have closely collaborated in monitoring the ecological changes and instituting measures to protect the health situation related to the construction of large hydroelectric power plants in Itaipu and Yacyreti. Argentina signed bilateral agreeements with Bolivia, Paraguay, and Uruguay in 1978 to cooperate on border health issues, and these agreements continue to be implemented.

Mexico and Belize have signed an agreement to work together on health problems along their common border. Mexico and the United States have worked closely together for more than 30 years in promoting health along their 2000-mile-long border. Guatemala and Mexico have an agreement to work together in meeting the health needs and solving the problems of border and displaced persons.

Cuba collaborates with several Third World countries through its fellowship program, which has benefited students from 77 countries, and by detailing its health workers to 28 countries in Africa, Asia, and Latin America.

The growth of regional networks of national centers for human resources, maternal and child health, environmental health and food and nutrition resulted in an intensified exchange of experience and technical information. Several advances also were made at the subregional level. In the Central American countries, joint action by some 200 health officials made it possible to identify priority areas and formulate national and intercountry projects within the Plan on Priority Health Needs of Central America and Panama. In human resources, the Community Health Training Program for Central America and Panama (PASCCAP) consolidated the network of national centers for joint study, programming, and training of health personnel throughout Central America. The Andean countries--Bolivia, Colombia, Ecuador, Peru, and Venezuela--sponsored national and intercountry courses to train drug supply systems managers and established a subregional information system for drug registration. In the Caribbean Community (CARICOM), countries continued to utilize TCDC in nutrition and disease control programs with the support of CFNI and CAREC, respectively, and to collaborate in training programs for health and veterinary personnel.

PAHO/WHO's Regional and Subregional Centers have been operating as instruments of intercountry cooperation for many years. INCAP serves as a

vehicle for generating and diseminating information, training personnel and providing technical cooperation on nutrition among the countries of Central America and Panama. CLAP provides technical cooperation in the area of perinatal care. BIREME disseminates medical and health information. CEPIS and ECO collaborate with and bring together countries in matters pertaining to environmental health. CEPANZO and PANAFTOSA provide the same services related to zoonoses and foot-and-mouth disease. As mentioned above, CAREC and CFNI provide cooperation to the countries of the Caribbean in areas of epidemiology and nutrition, respectively.

Initiatives on essential drugs provide another significant example of joint action. In addition to the above-mentioned collaboration among countries of the Andean group, Argentina, Brazil, and Mexico agreed to conduct joint and support activities, especially in the production of raw materials. The countries of Central America have also formulated a subregional essential drugs program.

The managers of national water supply and sanitation institutions from the Central American countries and Panama created a committee to facilitate and develop cooperative action to reinforce their individual actions. This committee has supported the establishment of a training program for mid-level personnel on the water supply and sanitation area. The project is being executed by PAHO/WHO and financed by the Interamerican Development Bank (IDB) and the German Agency for Technical Cooperation (GTZ).

2.12 PAHO/WHO Cooperation

Development and Implementation of National Strategies

Formulation of national strategy. Eighteen of the 23 countries and territories that responded to the CFF included an assessment of PAHO/WHO cooperation. The Governments of 10 of those 18 requested and received technical cooperation in the formulation of national strategies for health for all and/or a plan of action.

PAHO/WHO continued to provide grants and technical cooperation to the schools of public health of Buenos Aires, Medellín, Mexico City, and Rio de Janeiro and to collaborate in this respect with ILPES. The teaching staffs of participating schools took part in an exchange program aimed at the preparation of courses that would target development of complementary approaches. PAHO/WHO further supported development by the Medellín School of Public Health of a strategic approach to health planning.

Project formulation, management, and evaluation has emerged as a critical field in the area of health planning. In regard to specific projects, PAHO/WHO has collaborated in developing methodologies, providing direct technical cooperation, and promoting coordination of activities among international technical and financial cooperation agencies. In 1984, to meet the needs of the Plan on Priority Health Needs of Central America and Panama, technical cooperation with those countries became more intense.

Personnel development. Brazil highlights the interministerial program for the development of human resources in health, established, coordinated and executed jointly by the Ministries of Health, Social Welfare, and Education and Culture with cooperation from PAHO/WHO. Paraguay mentions personnel planning and development as one of the most significant areas in which the country has received technical cooperation from PAHO/WHO, including--in addition to the more standard forms of cooperation in this area--support in carrying out a national census of human resources, revising the curriculum of the School of Medical Sciences, and training in educational technology and design of the future Center for the Training of Human Resources in Health. Most of the other countries in the Region have received cooperation in human resource development through fellowships, seminars, courses, and the Textbooks and Educational Materials Program.

Courses and seminars have been developed which cover the principal program components of PAHO/WHO; including, diarrheal diseases, child growth and development, respiratory diseases and perinatal care. Representatives of more than 18 countries have attended these training sessions. PAHO/WHO assisted in obtaining funds for integrated maternal child health and family planning projects in 28 countries. Also, PAHO/WHO renewed an agreement with the Kellogg Foundation to support the development of maternal child health programs in 10 countries.

Mobilization of financial resources for use at the national level. This is a concern for most Member Countries. El Salvador, in particular, stresses the need to obtain external financial resources from bilateral

agencies or international banks, to be able to carry out health projects. PAHO/WHO is assisting in obtaining funds to support the Plan on Priority Health Needs of Central America and Panama.

Research promotion and development. PAHO/WHO has supported research projects covering risk, maternal mortality, child growth and development, family planning, diarrheal diseases and acute respiratory infections. These projects have been carried out in one or more of the following countries: Argentina, Brazil, Chile, Colombia, Costa Rica, Cuba, Guatemala, Mexico, Peru and Uruguay. In many cases the research projects are jointly funded by PAHO/WHO and other agencies.

Development and Implementation of the Regional and Global Strategies

Regional strategies, targets, and the Plan of Action. The Plan of Action for implementing regional strategies for health for all, approved by the PAHO Directing Council in 1981, constitutes the frame of reference for formulating and adjusting national plans. The structure and contents of the Plan are based on regional objectives and goals, but actions of a regional nature included in the document are analyzed, selected, and adapted to each national reality.

Intercountry activities in support of national strategies. TCDC is of particular significance in the Caribbean area, where the countries have created institutions that make this form of cooperation uniquely possible. To strengthen this approach, PAHO/WHO is promoting adoption of a plan for

Caribbean cooperation in health, which will involve the entire Caribbean but focus initially on the smaller islands of the Eastern Caribbean.

Fostering and supporting cooperation among countries. Both El Salvador and Guatemala emphasize the importance of PAHO/WHO participation in the Plan on Priority Health Needs of Central America and Panama to solve common priority health problems. The plan, which enjoys the support of the Contadora Group (Colombia, Mexico, Panama, and Venezuela) is bringing health to the attention of the international community, as a basic social objective which can serve as a bridge to understanding, cooperation, solidarity, justice, and peace. A special fund has been created to foster cooperation among countries. The fund can only be used for projects which are based on intercountry cooperation.

Mobilization of resources at the regional level. PAHO/WHO, with the collaboration of UNICEF, has been asked by the Governments of Central America and the Contadora Group to coordinate the development of the priority health needs plan and to cooperate in the search for funding sources. Several international agencies, including the Inter-American Development Bank, have already expressed their support.

Establishment of agreements on issues relevant to the strategies. Technical cooperation agreements in support of the goal of health for all were signed by PAHO/WHO and UNICEF for the development of joint activities in Colombia, Cuba, and Honduras. Several "umbrella" agreements have also been signed with other organizations for collaboration in support of regional

health strategies including the Ministry of Health of Spain; the Secretariat of the Latin American Economic System; the Latin American System for Social and Economic Planning; the Iberoamerican Association of Social Security; and the Inter-American Children's Institute.

Development, Implementation, and Evaluation of the Strategies

Evaluation process at regional level. The PAHO/WHO planning, programming, budgetary and evaluation system (AMPES) is the mechanism used to evaluate cooperation with the countries. Evaluation is carried out annually and consists of an analysis of the delivery of programmed cooperation and the factors that have affected it, as well as an assessment of the efficiency and effectiveness of the technical cooperation.

Efficiency of the use of PAHO/WHO resources. The following constraints and proposed solutions are representative of those that were mentioned by the countries that responded to the CFF:

- Occasional failures in submitting requests for technical cooperation through the appropriate channels. Proposed solution: adherence to proper procedures.

- Increasing demand for the services of PAHO/WHO often beyond its capacity to provide them. Proposed solution: concentration of PAHO/WHO cooperation on high priority projects.

- Lack of absorptive capacity and of qualified personnel at the national level to use technical cooperation effectively. Proposed solution: intensify the training of national personnel.

- Lack of country/environment-specific expertise on the part of international agencies and their consultants that is needed to give practical technical cooperation and guidance in primary health care strategies, although they have other useful basic theories applicable to countries with appropriate levels of development. Proposed solution: utilization of operations research methodologies for problem identification, team building for implementing solutions, and integration of an educational infrastructure for health sectors to change the strategy for implementing primary health care.

- Multiplicity of consultants, some of whom visit a country only for a few days, resulting in diminished productivity and lack of integration with general program activities; the high cost of these consultantships could be more profitably applied to other types of cooperation; the mode of operation of the consultants seems to be concentrated in the production of manuals and similar documents, whose abundance makes it difficult to apply and carry out their recommendations. Proposed solution: reinforce national health authority's management of external aid and tailor it to fit the country plan of action and strengthen working relationships with PAHO/WHO and its participation in the orientation, programming,

monitoring, and evaluation of technical cooperation and in adapting it to the changing needs of the country.

- Budgeting restrictions; relative shortage of national technical personnel; delays in the adoption of corrective measures; limited capacity to fully absorb available technical cooperation resources; lack of coordination in programming technical cooperation, with the result that in some instances, there are no national counterparts to continue project activities after the departure of the international consultants. Also, it occurs that at times several international agencies are involved simultaneously in the same geographical and cooperation areas, causing unnecessary duplications. Another constraint is excessive bureaucratization in the ministry of health, which often retards transactions with the customs office regarding entry into the country of imported materials and equipment destined for the health sector. (No solutions are proposed).

CHAPTER 3. PATTERNS AND TRENDS IN HEALTH STATUS

3.1 Patterns and Trends in Morbidity, Disability, and Mortality

In the Latin American and Caribbean portions of the Region life expectancy at birth has risen from 49.3 years in 1950-1955 to 61.8 years in 1980-1985. In the latter period, 12 countries and political units (7% of the

total population) have already attained the goal of 70 years set in the Plan of Action for the year 2000; five (10% of the population) have a life expectancy at birth of 60 years or less; and 17 (83% of the population) have life expectancies that range between 60 and 70 years.

According to United Nations projections, by the period 2000-2025, the countries in which the life expectancy is already 70 years or more will be joined by Barbados, Chile, El Salvador, Grenada, St. Lucia, St. Vincent and the Grenadines, Mexico, Suriname and Venezuela. Optimistic as this prospect may seem, projections show that, in the year 2000, 55% of the population of the Latin American and the Caribbean countries will still be living in countries with life expectancies at birth below 70 years. This confirms the urgency of bolstering health measures in those countries, particularly those aimed at reducing infant mortality as the main determinant of life expectancy. At the same time, however, those measures must not be discontinued in the countries projected to reach the goal by the year 2000, as they still have severely deprived populations whose situation is not reflected in the national average; for example, a study of life expectancy at birth in Brazil during the decade 1960-1970, showed differences of 17.7 years for regions at extreme values, and a difference of 11.6 years between the groups with the highest and lowest incomes.

In the Latin American and Caribbean portions of the Region, the infant mortality rate has gone down from 100 per 1,000 live births in 1960-1965 to 63 per 1,000 live births in 1980-1985. The regional goal of reducing infant

mortality to less than 30 deaths per 1,000 live births has been attained in 18 countries and other political units (5.7% of the population). Another 8 countries (5.8% of the population) are close to the goal with rates between 30.0 and 39.9 per 1,000 live births. For 30% of the population the rate is between 52 and 68 per 1,000 live births, and almost half of the population (47%) lives in countries with rates ranging between 71 and 124 per 1,000 live births. In two of the latter countries the rate is higher than 100.

In the Latin American and Caribbean portions of the Region acute respiratory infections are among the principal causes of death for children under five years and the chief reason for seeking medical attention. In 1984, 12 countries began programs based on diagnosis and simple treatment tied to first level care to combat acute respiratory infections among children.

In countries with infant mortality rates over 60 per 1,000 live births, the leading causes of death are invariably the acute respiratory infections, diarrheal diseases, and perinatal problems, with malnutrition the main contributing condition. The conditioning factors are known for all of these causes, and techniques for their prevention and cure exist. This lays a heavy responsibility on the health sector, particularly considering that several developing countries in the Region have been able to significantly reduce mortality from these causes. In addition to a political decision, an essential requisite in this effort is the participation of other sectors that can help avert these deaths even, or especially, when economic development is slow.

Another indicator of the status of health in childhood is mortality between the ages of 1 and 4 years. The leading causes of death in this age group, which are mostly controllable, include respiratory, diarrheal, and infectious diseases preventable by immunization, and accidents. Malnutrition also plays a very important role as a contributing condition.

According to the UN estimates of mortality rates, in 1980 there were about two and a half million deaths in the Latin America and Caribbean countries. If conditions had been the same as in 1960, this number of deaths would have been higher by more than one million. The present level is still high, however, when compared to those of developed countries; more importantly, when compared with rates attained by some developing countries in the Region--such as Chile, Costa Rica, Cuba and Panama--it is obvious that mortality rates still leave much room for improvement.

3.2 Patterns and Trends in Health-Related Behaviors

Family Planning and Population. Fundamental changes have occured in the Americas in recent years in the areas of family planning and population, in response in part to increased awareness worldwide of the importance of these issues.

Both the World Population Conference (Bucharest, 1974) and the International Conference on Population (Mexico, 1984) recognized that, while nations are sovereign in defining policies geared to their needs, the dignity

of the individual, the respect of the human person, and his self-determination --in accordance with the universally recognized standards of human rights--must be respected in application of those policies. Likewise, both conferences emphasized the close relationship between health, demography, and family planning.

Colombia, Costa Rica, Dominican Republic, El Salvador, Guatemala, Jamaica, Mexico, and Peru have explicit policies for reducing the growth of the population through family planning activities linked to the health sector and community education and information activities. The Governments of Argentina, Bolivia and Chile have explicit policies for increasing the rate of population growth. On the other hand, Brazil, Cuba, Ecuador, Haiti, Honduras, Nicaragua, Panama, Paraguay, Uruguay, Venezuela, and some of the English-speaking Caribbean countries do not have explicit population growth policies, but all of them carry out family planning programs that seek health rather than demographic objectives.

From 1965 to date, the position of many Governments in the Region on population growth policies has changed radically. Whereas in 1965 only one country was offering family planning services in its health programs; in 1975, 17 countries were providing such services through their governmental structures. In 1985, 32 countries recognize and support, albeit with different degrees of emphasis, the integration of family planning into maternal and child health services as a valuable means of reducing fertility and helping to reduce maternal and child mortality and morbidity.

According to the World Fertility Survey and other surveys, in the Latin America and Caribbean portions of the Region 33% of all married women and common law wives use contraceptives. However, despite the implicit or explicit support Governments give to family planning and their statements on and commitments to population policy, these surveys continue to show high rates of unwanted pregnancies. In addition, in many areas, the unsatisfied need for family planning services of women of reproductive age who are sexually active, do not wish to become pregnant, and do not use any method of contraception exceeds 10% in women in the age group 15-44 years and is between 15 and 30% for common law wives.

This unsatisfied need continues to be heavily concentrated in the low-income group of women whose educational level is likewise low and who live in urban shantytowns or rural areas. Accordingly, if family planning programs aimed at satisfying the demands of women in this respect, responding to maternal and child health needs and reducing population growth, are to be effective they will have to be extended beyond large urban centers to cover the entire population so that couples, regardless of their socioeconomic level or geographical location, can freely decide the number and spacing of children they wish to have.

The XXX Meeting of the PAHO Directing Council approved a document that set forth the bases for the definition of an action policy of the Organization in population matters, including the philosophy, proposed objectives, and strategy for family planning. With that and other demonstrations of national

and international political support and technical cooperation, it is expected that the goal of enabling the entire population to plan its families in an enlightened, conscious, and responsible way can become a reality in the not-too-distant future.

With respect to geographical distribution and internal migration Argentina, Bolivia, Brazil, Colombia, Cuba, Jamaica, Mexico, Nicaragua, and Panama have explicit policies. While the other countries do not, their Governments are aware of the adverse consequences of an uneven geographical distribution of the population.

As for international migration, most Governments concur that it is a process that has reached significant, unsatisfactory levels, regardless of the direction of the migration.

Smoking, Alcohol, and Drug Abuse. Approximately one-third of the adult population of the United States and Canada and almost one-half of the adult population of the Latin American and Caribbean countries are habitual smokers. Although the habit has shown a declining trend in all socioeconomic groups since the 1960s, the trend is slower among the poor and, particularly, among women. Smoking is highly prevalent among adolescents, and in most of the countries more young women smoke than young men.

Diseases and conditions associated with tobacco are among the 10 leading causes of death in the Region, including the developing countries.

Awareness of the risks of smoking is growing throughout the hemisphere, and regulatory policies have been adopted in some countries. Only a few, however, are applying legal and fiscal measures to effectively combat the problem, because in many countries the tobacco industry is protected by the government.

Alcohol abuse is an important public health problem in the Americas. Alcohol consumption has increased steadily over the past two decades, especially among adolescents and young adults. It is estimated that 3-5% of the adult population suffer from the alcohol-dependency syndrome, and 15-25% drink excessively on a regular basis. The problem is particularly critical in the marginal neighborhoods of Latin American cities and in Indian communities, where dependency rates run as high as 15% of all adults, according to some surveys.

Alcohol-related health, social, and economic problems are highly prevalent in the Region, where the numbers of suicides, homicides, and accidental deaths--with alcohol as one of the causative factors in a large proportion of cases--have been very high in the past 10 years, accounting for 10% to 15% of all deaths in some countries. In one country, for instance, alcohol-related accidents are the leading cause of death in the 15-24 age group.

Cirrhosis of the liver is one of the five principal causes of death of people in the 45-64 age group in 17 countries of the Region and of people in the 15-44 age group in six countries. There are strong indications that alcohol is associated with this high ranking.

The use of dependency-inducing substances has climbed to epidemic levels in the Americas, with adolescents and young adults the groups at greatest risk. The substance most commonly used is Cannabis which, after peaking in the 1970s, has shown a tendency to level off in the past five years. In North America, 10-15% of secondary school students and young adults are habitual marihuana smokers. In Latin America and the Caribbean a prevalence of 4-6% is estimated for the same group. Opiate abuse is significant from a public health standpoint only in North America, and its frequency is tending to stabilize.

The chewing of coca leaves is a widely prevalent practice among the Indians of the Andean area, one rooted in their culture and linked to their poverty. Its frequently tends to decline as education levels are raised. Consumption of the pure alkaloid and byproducts of coca processing has reached epidemic proportions throughout the hemisphere. In the United States it is estimated that cocaine was used at least once by 12 million people during the year preceding the survey and that 18% of the country's young adults used it in 1979. A stabilizing trend has been observed in the past six years. In countries that grow the coca plant, a sharp increase has been reported in the number of people consuming basic coca paste, a byproduct of cocaine production, with users in a single Andean city estimated at 50,000.

Practically all the Governments in the Region have recognized the seriousness of drug dependency and have taken legal and fiscal steps to curtail the availability of abusive substances. In addition, educational

efforts have been carried out to reduce the population's demand for these substances. In most of the countries, however, such actions have only begun to be taken, and the problems of public health, public order, and economic distortion posed by drug traffic and the medical and social consequences of dependency constitute a major challenge--one which the countries will continue to face in the years ahead.

3.3 Environmental Health

Many environmental factors have been shown to have an adverse effect on human health and well-being. This has been recognized for some time in differing degrees in the various countries of Latin America and the Caribbean, and over time the response has varied widely from place to place as well. Since the late 1950s and early 1960s, the more developed countries with large industrialized metropolitan areas, but to an extent many of the lesser developed ones as well, became concerned about the pollution issues and active in environmental protection because of the rise of a number of serious problems related to contamination. That period was characterized by disclosure of the serious adverse impact of pollution on health and well-being, identification of major sources of pollution and increased perception of its extent and trends. During that period, there was also a growing emphasis on the development of technical capability. This was followed by the promotion of public awareness, the establishment of environmental pollution control agencies and institutions and as means of coping with the problem, regulatory legislation, and a recognition of the international and global nature of environmental degradation.

These problems and efforts to solve them have continued into the late 1970s and early 1980s, during which time the list of pollutants, contaminants, and hazardous substances affecting humans and the environment has expanded at an alarming rate. Unfortunately, during this same period the economic crisis that has plagued the Region has seriously restricted the needed increase in environmental pollution control efforts; in fact, reducing expenditures for pollution control has become commonplace in most of the countries.

Water pollution control activities have been carried out and legislation enacted, but with the exception of only a few countries conditions have deteriorated. Rivers, lakes, and oceans continue to receive domestic, agricultural, and industrial pollutants, adversely effecting drinking water supplies and fisheries and resulting in severe eutrophication problems in lakes and reservoirs. Groundwater contamination is beginning to occur with long-term consequences for this valuable resource, which is the major source of drinking water for many communities.

Air pollution control has shown progress in some of the major municipal areas. The establishment of monitoring networks and pollution control measures, such as the ban on individual solid waste incinerators, has produced noticeable positive effects in some urban areas. Industrial and vehicle emissions continue, however, to be a growing problem. The introduction of gasahol has not been analyzed for its potential pollution and health risk. Mineral processing plants and petroleum and chemical industries also continue to be a major contributor to air pollution. Additionally, noise pollution is apparently on the increase.

Collection of solid wastes, especially in urban areas, has improved in many countries, but this has compounded the negative environmental effects of unsanitary and inadequate solid waste disposal practices, which are creating environmental problems in the water, soil, and air. The disposal of hazardous wastes from various origins is also being recognized as a serious threat to human health and the ecology.

Population growth, urbanization, widespread industrialization, and increased development and marketing of chemicals for use in industry, agriculture, commerce, and the home will assure continuation and aggravation of pollution problems. Unless mitigated through effective pollution control measures, increased human exposure to harmful biological, chemical, and physical agents will result.

The provision of a safe water supply and excreta disposal continue to demand priority attention in the majority of the countries in spite of the improvements achieved over the past 20 years. Water services coverage in the urban areas has been improved significantly and it is opportune to make major efforts to increase coverage in peripheral urban areas and in rural areas. Coverage for sanitary disposal of excreta is still low. To be effective, environmental pollution prevention and control must be a long-term, continuous effort. Institutions as well as human resources need continuous strengthening. Monitoring and surveillance programs should be expanded and improved rather than reduced. Studies of priority pollutants and their effect on man and the environment continue to be needed. Community education and public awareness will remain essential ingredients for the success prevention

and control programs. Finally, a comprehensive intersectoral approach which utilizes the best scientific, management, and legal tools available, must be undertaken. Several Governments have created specific ministries and agencies charged with the responsibility for resolving environmental problems--an encouraging step that may result in more rapid progress in the future.

3.4 Implications for social and economic policies

The preceding description of the trends in mortality, morbidity and major disease categories as well as the nutrition status of children and the shifts in lifestyle related to disease have important implications for social and economic policies of Member Countries. The existing social and economic policies must be reviewed and targeted more clearly on the changing pattern of health risks and made more sensitive to the impact of those policies on health conditions.

The persistent disease problems associated with underdevelopment dominated the morbidity and mortality profile among the poorest countries. But they also dominated the morbidity and mortality patterns within population groups left out of economic progress in middle income developing countries. In those countries, the diseases of underdevelopment still represent the greatest risk to significant portions of the population, ranging anywhere from 40 to 60% of the people. Usually, those groups are concentrated in small rural communities or in the urban fringes of the large cities. Even within the most developed countries, poverty related diseases persist among still significant though small population groups.

In all of these countries, economic and social policies must be designed with an awareness of their impact on the various groups in society. In particular, they must be designed with a recognition of the different health conditions of those groups. Economic and social policies emphasizing integrated rural development are essential among most developing countries. In general, economic and social policies must be analyzed in terms of their impact on the well-being of all social groups within the population and should be aimed at promoting greater equity. For all groups, there is a need to ensure that the environmental impact of economic and social policies is taken into account. Devastation of the environment damages future possibilities for the nation and all its people.

Within this analysis, the vital importance of intersectoral action is clear. The economic decision-makers must understand the implications of their policies for the health conditions of the various groups before they make their decisions. They also must be assured that the health sector is utilizing the funds available in the most productive and efficient manner. The health sector must become an integral part of the decision-making process, able to provide relevant and timely information, to those engaged in national economic and social policy-making.

CHAPTER 4. ASSESSMENT OF ACHIEVEMENTS

4.1 Impact and Effectiveness of Strategy

Judging by the replies from 13 countries which addressed item 26, it is evident that specific methodologies or evaluation studies have neither been

developed nor carried out to assess the impact and effectiveness of the strategy. The countries based their responses on direct or indirect health indicators or on practical experience within the health sector. Some countries--namely Barbados, Guatemala, and Haiti--noted in their reports that it was as yet premature for them to assess impact and effectiveness of the strategy. Two countries, El Salvador and Peru, reported that in spite of applying the strategy, health status had shown very modest changes, and in some areas indicators had in fact worsened. However, 11 countries replied (85%) that the strategy has had a positive impact on health status and that health systems and general socioeconomic development have interacted synergistically to improve the quality of life. Further, the strategy is seen as having mobilized action toward greater social equity and justice.

In Argentina, where health care is perceived as universal and in the interest of all, the primary health care strategy seeks to promote involvement of the private, public, and social security sectors in order to attain equitable health coverage for the entire population.

Countries reporting improvement in health indicators saw that change as evidence of the positive impact of the strategy on health status, although no controlled studies have been carried out on the possible influence of other variables such as housing, employment, and gross national product. Nevertheless, in support of the countries' assessments, it is significant to note that during the same period that the strategy has been applied, regional data show progressive improvement, notably in crude death, infant mortality, and maternal mortality rates, and in the incidence and prevalence of certain

parasitic and infectious diseases. Concomitantly, there have been increases in life expectancy at birth, coverage by health care services, number of skilled health personnel, and health infrastructure. The Expanded Program on Immunization (EPI) and oral rehydration therapy (ORT) have been shown to have had a direct impact on child and infant survival. In Paraguay a study conducted to assess the financial impact of the measles vaccination campaign estimated that it had the potential to save almost US$15 million annually in lives saved, reduced health care costs, greater productivity, and enhanced infrastructure development.

Infant mortality rates in 7 of the 23 countries that responded are already below target levels set as part of the health for all by the year 2000 campaign. Six of those countries showed life expectancies of more than 70 years, and five more than 65 years. The number of health personnel, in particular primary health care workers, has increased as have hospital-based facilities, both of which indicate greater accessibility to care for the population in general. Table 1 shows these trends in selected data over the period 1975-1980 and 1981-1984.

In Costa Rica, the effect of the strategy has been the improvement in global indicators, which, in some cases are at the same level as those of developed countries: the infant mortality rate is 18.5; life expectancy, 73.7; and drinking water supply coverage, 92.8%. Medical care facilities have increased and the ratio of physicians to the population at large is 1 per 1,000. Immunization coverage is now estimated at almost 80% of the target

TABLE 1

	Infant Mortality Per 1000 Live Births		Life Expectancy at Birth		Gross Domestic Product Per Capita		Literacy Population Over 15 Years %		Immunization Coverage for Children Under 1 Year			
	Around 1980	Around 1984a/	1975-80	1980-85	Around 1980	Around 1984a/	1975-80	1981-84	Polio 1980	Polio 1984	DPT 1980	DPT 1984
Antigua and Barbuda	31.5	11.1	...	70.0b/	...	299	89.0	90.0	36.0	92.0	...	94.0
Argentina	33.0	35.3	68.7	69.7	...	2,366	93.7	94.2	31.0	64.0	42.0	66.0
Bahamas	26.0	20.3	...	69.3d/	4,647	6,646	93.0	...	35.0	62.0	40.0	62.0
Barbados	22.3	24.5	70.0	71.6	2,243	3,381	98.0	96.4	99.0	77.0	60.0	83.0
Belize	36.2	24.1	...	70.0b/	426	970	91.0	93.0	21.0	54.0	...	54.0
Bolivia	138.2	124.4	48.6	50.7	387	135	63.2	66.1	14.0	56.0	20.0	24.0
Brazil	79.0	71.4	61.8	63.4	1,738	1,639	76.1	74.0	99.0	99.0	40.0	67.0
Canada	10.4	8.5	74.2	74.9	...	12,983	99.5	96.0	...	...	...	...
Chile	31.9	21.8	65.7	67.0	950	1,355	94.0	98.0	91.0	86.0	85.0	84.0
Colombia	59.4	53.3	62.2	63.6	...	806	78.0	...	16.0	60.0	15.0	60.0
Costa Rica	19.1	18.6	71.4	73.0	1,455	1,270	89.8	92.5	67.0	81.0	67.0	82.0
Cuba	19.6	16.8	72.8	73.4	...	...	95.4	97.8	99.0	99.0	67.0	88.0
Dominica	21.9	6.9	67.4	.....	460	...	...	59.5	53.0	82.0	63.0	84.0
Dominican Republic	73.1	63.5	60.3	62.6	877	1,260	69.0	72.4	46.0	99.0	36.0	20.0
Ecuador	86.0	77.2	60.0	62.6	907	1,385	79.0	83.9	14.0	36.0	21.0	36.0
El Salvador	42.0	42.2	62.2	64.8	706	752	64.0	69.8	42.0	44.0	43.0	44.0
Grenada	21.0	21.2	...	...	544	679	...	...	32.0	75.0	25.0	76.0
Guatemala	85.9	79.9	57.8	60.7	1,023	1,202	46.2	57.0	43.0	53.0	43.0	54.0
Guyana	47.9	40.5	66.4	68.2	540	1,559	86.0	86.0	42.0	41.0	36.0	43.0
Haiti	120.9	124.0	50.7	52.7	197	300	...	37.0	2.0	12.0	5.0	12.0
Honduras	95.4	81.5	57.1	59.9	451	633	40.5	56.9	32.0	84.0	30.0	48.0
Jamaica	30.1	26.5	69.0	70.3	921	2,983	90.0	75.7	34.0	56.0	34.0	57.0

	Physicians per 10,000 Population		Nurses per 10,000 Population		Nurse Auxiliaries per 10,000 Population		Hospital Beds Per 1000 Population		Potable Water Coverage %	
	Around 1980	Around 1984a/	Around 1980	Around 1984a/	Around 1980	Around 1984a/	Around 1980	Around 1984a/	Around 1980	Around 1984a/
Antigua and Barbuda	4.3	4.5	16.9	16.0	19.2	19.0	6.3	6.9	40.0	95.0
Argentina	26.7	24.8	7.2	5.8	8.5	8.9	5.4	5.4	57.0	69.0
Bahamas	8.8	9.8	20.0	42.9	24.1	7.9	3.8	4.3	...	...
Barbados	8.0	8.5	30.4	30.0	17.2	12.0	8.6	8.0	100.0	100.0
Belize	2.6	5.1	14.4	17.2	3.1	7.0	2.6	2.5	66.0	70.0
Bolivia	4.7	5.1	1.7	...	4.0	...	1.1	1.8	36.0	...
Brazil	7.1	8.6	1.9	...	12.6	...	4.3	4.4	71.0	93.7b
Canada	18.2	19.5	64.8	86.9	31.6	86.9	8.9	16.2	87.0	97.0
Chile	5.2	10.0	3.2	4.0	20.7	...	3.5	3.8	84.0	99.0
Colombia	5.1	7.9	1.1	1.8	10.2	8.2	1.7	1.8	92.0	64.6
Costa Rica	7.2	10.1	5.5	9.6	21.9	22.8	3.4	3.5	84.0	92.8
Cuba	14.8	19.1	14.3	26.5	13.2	9.0	4.0	6.1	59.0	61.2
Dominica	1.8f/	3.6	...	16.0	4.2	4.1	4.3	3.0	83.0	77.0
Dominican Republic	6.0	5.9	0.9	1.0	7.3	10.2	1.3	1.2	59.0	65.0
Ecuador	9.0	13.9	2.6	3.4	12.0	13.4	1.8	1.8	45.0	38.2
El Salvador	2.9	3.4	3.8	...	7.7	5.9	1.8	1.6	51.0	58.8
Grenada	2.3	4.0	9.7	14.7	3.4	15.7	6.8	3.2	...	85.0
Guatemala	2.9	6.0	1.1	2.6	5.6	10.8	1.8	1.7	42.0	49.8
Guyana	1.0	1.1	11.8	...	9.0	...	4.5	4.5	93.0	...
Haiti	1.2	1.4	1.5	1.9	2.3	3.6	0.8	0.8	12.0	32.0
Honduras	3.2	3.8	1.5	1.5	8.1	14.8	0.9	0.8	55.0	69.0
Jamaica	3.5	1.9	10.4	8.0	5.4	4.6	3.6	2.6	87.5	90.0

a/ Data for 1984 or most recent year available. b/ Data for 1983. c/ Excludes physicians only in private practice.
[illegible]a for 1980. e/ Data for 1981. f/ [illegible]

TABLE 1 (cont'd.)

	Infant Mortality Per 1000 Live Births		Life Expectancy at Birth		Gross Domestic Product Per Capita		Literacy Population Over 15 Years %		Immunization Coverage for Children Under 1 Year				Physicians per 10,000 Population		Nurses per 10,000 Population		Nurse Auxiliaries per 10,000 Population		Hospital Beds Per 1000 Population		Potable Water Coverage %	
									Polio		DPT											
	Around 1980	Around 1984[a/]	1975-80	1980-85	Around 1980	Around 1984[a/]	1975-80	1981-84	1980	1981	1980	1984	Around 1980	Around 1984[a/]	Around 1980	Around 1984[a/]	Around 1980	Around 1984[a/]	Around 1980	Around 1984[a/]	Around 1980	Around 1984[a/]
Mexico	38.5	35.7	64.1	65.7	...	1,524	78.0	87.2	43.0	91.0	26.0	26.0	8.0	8.2	5.4	4.9	8.2	6.1	1.2	0.8	71.0	71.0
Nicaragua	101.3	75.2	56.3	59.8	380	...	90.0	...	99.0	73.0	...	32.0	3.6	7.2	3.7	4.1	15.7	...	1.9	...	46.0	43.8
Panama	22.0	20.0	69.2	71.0	660	961	79.0	88.1	45.0	70.0	46.0	70.0	8.5	10.4	11.0	10.4	18.2	15.8	3.4	3.2	100.0	90.0
Paraguay	48.6	45.0	64.1	65.1	458	902	81.0	81.1	14.0	59.0	17.0	58.0	5.7	7.3	1.7	2.0	4.6	...	1.3	1.5	18.0	25.0
Peru	95.0	99.0	56.9	58.6	705	605	80.0	81.0	16.0	26.0	14.0	26.0	6.8	9.0	4.6	6.4	1.9	...	1.9	1.9	47.0	49.0
St. Christopher and Nevis	53.0	41.2	69.1	65.0[e/]	...	3,064	97.0	87.0	76.0	97.0	...	97.0	3.6	4.0	22.7	...	9.3	...	4.1	...	100.0	75.0
St. Lucia	25.9	26.1	...	...	565	965	51.7	85.0	58.0	84.0	56.0	83.0	2.4	5.8	37.3	56.7	1.1	0.9	5.0	5.6	70.0	...
St. Vincent and the Grenadines	60.2	32.5	...	68.5[d/]	...	544	76.2	...	26.0	90.0	26.0	86.0	2.9	2.6	10.4	...	9.7	...	5.9	2.4	75.0	75.0
Suriname	39.2	33.8	67.8	69.4	1,679	3,382	65.0	86.9	24.0	79.0	17.0	80.0	5.5	8.4	16.0	20.8	7.6	16.7	5.3	...	85.0	95.0
Trinidad and Tobago	34.6	29.9	68.7	70.1	3,619	6,691	94.0	95.0	38.0	66.0	23.0	66.0	6.9	10.5	33.7	28.3	9.1	...	3.9	4.1	98.0	95.0
United States of America	12.6	10.9	73.2	74.0	11,795	13,918	99.5	99.4	...	...	...	...	19.1	19.0	50.1	59.0	64.8	33.0	6.3	5.7	100.0	100.0
Uruguay	37.4	33.2	69.6	70.3	1,635	2,183	93.9	94.0	59.0	83.0	53.0	57.0	18.8	19.3	4.4	...	51.8	...	5.2	4.8	...	75.0
Venezuela	44.8	38.6	66.2	67.8	2,789	4,714	82.0	87.2	95.0	59.0	46.0	27.0	11.2	12.1	6.9	8.1	21.0	23.4	2.5	2.7	81.0	90.3
Territories																						
Anguilla	...	26.7	...	...	...	...	...	90.0	86.0	73.0	...	69.0	6.1	5.0	...	17.0	...	13.0	3.6	3.6	...	...
Bermuda	13.6	11.6	...	73.0[d/]	...	13,500	...	97.4	39.0	41.0	...	40.0	11.2	13.7	79.3	77.6	...	...	6.6	6.3	...	100.0
British Virgin Islands	34.9	45.2	...	...	...	2,456	...	...	95.0	85.0	...	85.0	4.2	8.0	16.7	31.7	20.0	22.5	3.5	4.7	90.0	90.0
Cayman Islands	24.3	14.0	...	...	...	...	...	...	47.0	90.0	...	90.0	9.4	11.1	34.1	...	21.8	...	2.9	2.7	99.0	66.0
Montserrat	...	40.2	...	...	...	3,565	...	76.3	38.0	82.0	...	84.0	6.4	3.4	39.1	34.1	11.8	...	5.6	13.4	53.1	...
Netherlands Antilles	...	15.8	...	72.8[d/]	1,300	1,300	98.4	...	...	...	...	...	8.3	10.8	...	19.4	...	16.5	8.1	10.4	...	81.8[j]
Turks and Caicos Islands	15.2	25.0	...	...	...	...	...	...	44.0	70.0	...	60.0	5.0	9.4	45.0	20.0	3.3	28.0	3.5	4.6	...	39.0

groups. Community participation, increased coverage by the Social Security System, and extension of potable water coverage are considered to be key factors contributing to these improvements.

In Paraguay, the impact of the strategy on principal health indicators is also considered to have been beneficial to health, the quality of life, and general socioeconomic development, due largely to the results of such programs as maternal and child health surveillance, control of acute respiratory illnesses, the EPI, oral rehydration, improved institutional care, and projects undertaken in the areas of water supply, sanitation, and health facilities construction. Moreover, there has been increased generation of foreign exchange due to external agency-funded projects, stepped-up development of health institutions, greater stimulation of medical technology, and increased production of goods and services.

In Cuba, the effectiveness of the strategy and its impact are amply demonstrated by the high levels of health and health care coverage attained over the past quarter-century.

In Brazil, it is recognized that many variables intervene in determining changes in health status. Nevertheless, the lives saved through implementation of the EPI program are considered a major health sector contribution to socioeconomic development and improved quality of life. The EPI and oral rehydration programs are credited with having contributed directly to reduction of the infant mortality rate from 100 per 1,000 in 1975

to 55.1 per 1,000 in 1981. Programs are being developed to further reduce child mortality, which is presently responsible for 15% of all deaths.

In Suriname, noteworthy improvement is reported in the global health indicators and in the control of specific health problems such as malaria, schistosomiasis, and leprosy. However, due to economic constraints, present levels of health funding may be reduced in an attempt to more rationally utilize national resources by channeling them to other sectors of the economy.

In Saint Lucia, the main effects of the strategy have been a marked improvement in: the nutritional status of the population--in particular, the child population; maternal and child health; rehabilitation services; general environmental health services and housing conditions; the health infrastructure; health personnel training and utilization; immunization services; and health legislation.

The countries also reported on factors that have impeded the effectiveness of the strategy, as noted below.

In Guatemala, frequent changes of government authorities have contributed to a lack of continuity in the manner in which the strategy has been developed and applied, resulting in a discrepancy between initial concepts and actual implementation. Present expectations are that the common framework and format evaluation exercise will provide the Government with a basis on which to establish clear lines of orientation for applying the health strategy.

In Peru, health status improvement has not kept pace with that of other countries in the Region. The crude death rate at 11 per 1,000 is higher than the average regional figure of 8 per 1,000. Infant mortality remained high at 99 per 1,000 in 1982. In addition, in spite of the application of health and medical technology and programs, it is estimated that the risk of illness for the population has increased, with incidence and prevalence rates of infectious diseases still high in special groups, particularly mothers, and children 0-5 years old. In the latter group, levels of protein-calorie malnutrition have not shown the expected reduction. It is now estimated that 48% of all deaths are in children 0-5 years old. Health service coverage is considered insufficient: in 1983 an estimated 3 million people were not covered by any form of health care, as compared to 1.6 million previously. Problems in improving these health indicators have been attributed to, among other factors, deficiencies in the organization and functioning of the health system; insufficient primary health care activities--more than one-half of all health institutions have no such activities; and the lack of community participation, with only 20% of community members actively involved.

Several countries have reported that, despite undeniable, overall improvements in health status, distribution of the benefits has been unequal. Increasing growth of the population, rapid geographical shifts of that population, continued reinforcement of urban-centered medical care, and an unstable economic climate have left many people not only beyond the reach of the health care system as presently organized but in absolute or near absolute poverty. For example in Suriname, unsatisfactory health conditions persist in certain geographical and economic subgroups.

In Brazil, while national achievements have been scored, there still remain interregional inequalities that unfavorably affect the North and Northeast. The prevalence of parasitic and infectious diseases is 8% in the two states of the South (Rio Grande do Sul and Santa Catarina), while in the Northeast Regions prevalence for these diseases is 26% and 21% respectively --far above the national average of 14.8%. Consequently, the health system recognizes political and social justice as the principal objective in the medium term to assure universal access to both curative and preventive care.

In Peru, as far as mortality is concerned two distinct groups have been identified: a nonmarginal urban group in which pathologies are similar to those of developed countries--i.e., neoplasms, cardiovascular diseases, and other degenerative diseases as leading causes of death; and a marginal urban and rural group with pathologies--which constitute the country's top-ranked causes of death--that are linked to poverty.

In a small group of countries, social and political events and civil strife have had a destabilizing effect on all aspects of development, and the strategy has thus not had the necessary conditions for proper application. El Salvador recognizes that there has been little progress and that in fact much that had been achieved has been lost. Though the present Government is resolved to support the strategy, its impact will not be felt immediately in the climate of social, political, and economic crisis currently affecting the country.

In conclusion, 85% of the countries responding to this question on the CFF evaluation have reported that the strategy has been effective. However, in most country reports the impact of improvements in the status of health on the quality of life was not directly addressed. Six of the countries thought it was too early to assess impact. There is great disparity from country to country in levels of health attained, and positive changes in health status within a given country have not been equitably distributed. Demographic changes, inadequate reorientation and reorganization of the health system, and the prevailing social, political, and economic crisis are factors inhibiting full effectiveness of the strategy. It is felt, however, that the strategy has contributed in most cases to improvement in overall health indicators. Programs most frequently reported as having had the greatest impact are EPI, ORT, maternal and child health care, water and sanitation, and health personnel training as well as efforts to achieve a more equitable distribution of health services.

4.2 Satisfaction with Results

Most of the 14 countries responding to this section of the CFF have not employed specific methods to measure and evaluate community satisfaction. Ten of them were either in the process of developing an evaluation mechanism or have not yet considered this aspect of the health system. On the other hand, some countries have attempted informal assessment of community satisfaction. Cuba states that indirect indications of the degree of community involvement and satisfaction with the results obtained were the

ready availability of qualified human resources and the high level of health care as compared with the first years of that country's revolution. El Salvador has evaluated its rural health worker and traditional birth attendant programs using a methodology based on a mix of structured interviews and assessments by experts. Guatemala reports that studies undertaken to assess the degree of community participation showed that there has not been adequate or active explanation to the community of health system benefits nor of the critical importance of full community involvement to assure the effectiveness of health services.

The level of satisfaction among the authorities with the results of the strategy was high: 6 countries were very satisfied with the strategy; 2 felt that the results, though modest, had encouraged them to try harder; and 3 countries felt it was as yet too early to express satisfaction with the results. Brazil was satisfied with the overall economic and social results, although the Government recognized that greater efforts would have to be made to reduce inequality of access to health care and to raise it to an acceptable standard. Cuba was very satisfied with the results of the country's strategy for social and economic development toward the year 2000. Costa Rica based its grounds for satisfaction on the highly satisfactory results achieved (see 4.1). Saint Lucia also expressed satisfaction with the results of the strategy. Argentina drew its satisfaction from the fact that the strategy has been effective, having had a visible impact on improving health status. Paraguay's satisfaction was linked to the results obtained namely increases in community participation, health services coverage, the rates of hospital beds

to population, human and material resources, physical accessibility of services, and the operating capacity of the technical and administrative systems.

CHAPTER 5. OUTLOOK FOR THE FUTURE

The economic crisis continues to pose serious problems for the Region, thereby jeopardizing prospects for the implementation of national and regional strategies to attain health for all by the end of this century. The external debt, recession and inflation have resulted in notable deterioration in the indicators of employment, income distribution, and access to basic goods and services. Those factors combine to produce a further reduction in the level of well-being of vast portions of the population of the Americas and to widen the existing gap between the Region's social classes.

At the same time, the health sectors within the countries have been faced with unprecedented demands for services from a still-growing population. Morbidity and mortality patterns are also changing as the traditional diarrheal, respiratory, and other infectious diseases and malnutrition associated with underdevelopment persist side by side with emerging chronic illnesses and environmental health problems associated with the developed world. The countries inevitably find themselves with strictly limited resources to face these new demands, as they confront the challenge of extending coverage to those who even today remain without access to primary health care.

In this context, four critical challenges face the Organization and its Member Countries as they seek to improve the quality of health in the Americas. The first is to implant the PAHO-promoted management strategy and other mechanisms to ensure the most effective utilization of available resources. Joint evaluation of the use of national and international resources is essential to channel manpower and money to the priority needs of each country.

The second challenge is to deepen understanding of the relationship of the health sector and its priorities to the overall socioeconomic development process. More and more, health policies, which are designed to contribute to a more equitable society, can be put into effect only with the support and through the actions of the economic sectors. Too often, the decision-making circle within nations is closed to the impact of its decisions on national health goals. Opening that circle to the health sector, not solely in terms of its own goals but in relation to the broader goals of society, must be a conscious concern of the countries during the coming years.

The third challenge is to expand the health system's capability to understand and manage its own technology, which will require that the traditional attitude of health institutions toward new technology undergo a marked transformation. The development of new technology and the control of that technology must be directed toward the same end--making greater use of national and international resources for the achievement of national health goals.

The final challenge is to increase dramatically the direct participation by Member Countries in the daily life of PAHO/WHO. The countries must become convinced that their more active engagement in setting goals, implementing programs, and evaluating results is directly relevant to meeting the basic health needs of their populations.

The degree to which these challenges are met will determine whether progress will be made toward realizing the goals of health for all. Plans and tactics may have to be adjusted to respond to national realities and to the changed socioeconomic and political environment, but the primary health care strategy and its component elements remain the crucial vehicle for advancing toward greater equity and improved health for the people of the Americas.

ANALYSIS OF GLOBAL INDICATORS

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Table No. 1

National Reports

	National Reports Expected	National Reports Received	Coverage %
Member States	35	19 a/	
Territories	7	4 b/	
Total	42	23 c/	

a/ Argentina
Barbados
Bolivia
Brazil
Chile
Costa Rica
Cuba
Dominican Republic
El Salvador
Guatemala
Haiti
Jamaica
Mexico
Paraguay
Peru
Saint Lucia
Suriname
Trinidad and Tobago
Venezuela

b/ Bermuda
British Virgin Islands
Cayman Islands
Netherlands Antilles

c/ As of 30 June 1985

Table No. 2

Population Used in the Evaluation Report

Countries	Population Total 1984	Live[a] Births e/country (year)	Children 0-4 1984	Adults[b] Males 1984	Adults[b] Females 1984
Member States					
Antigua and Barbuda	79,000	1,174 (1983)	10,800	23,500	24,700
Argentina	30,100,000	706,979 (1983)	3,019,000	10,697,000	10,908,000
Bahamas	230,000	5,280 (1983)	31,500	69,000	72,700
Barbados	250,000	4,614 (1983)	21,400	82,300	93,900
Belize	158,000	5,861 (1982)	28,600	39,300	41,100
Bolivia	6,249,000	263,000 (1980-85)	1,068,000	1,735,000	1,823,000
Brazil	132,580,000	3,929,000 (1980-85)	18,273,000	41,118,000	41,460,000
Canada	25,130,000	373,689 (1983)	1,836,000	9,620,000	9,997,000
Chile	11,880,000	264,957 (1983)	1,344,000	3,975,000	4,147,000
Colombia	28,220,000	845,000 (1980-85)	4,197,000	8,368,000	8,452,000
Costa Rica	2,502,000	72,953 (1983)	333,000	775,000	771,000
Cuba	9,980,000	165,647 (1983)	1,180,000	3,214,000	3,082,000
Dominica	78,000	1,753 (1982)	12,000	20,900	22,800
Dominican Republic	6,100,000	195,000 (1980-85)	1,034,000	1,581,000	1,612,000
Ecuador	9,110,000	353,000 (1980-85)	1,664,000	2,473,000	2,476,000
El Salvador	5,404,000	156,796 (1982)	957,000	1,475,000	1,487,000
Grenada	110,000	...	17,200	28,900	30,700
Guatemala	7,600,000	288,502 (1983)	1,285,000	2,154,000	2,175,000
Guyana	935,000	26,000 (1980-85)	133,000	279,000	282,000
Haiti	5,180,000	311,978 (1982)	801,000	1,452,000	1,628,000
Honduras	4,232,000	177,000 (1980-85)	793,000	1,115,000	1,113,000
Jamaica	2,288,000	61,500 (1982)	293,000	654,000	707,000
Mexico	76,790,000	2,530,662 (1983)	14,185,000	20,548,000	20,815,000
Nicaragua	3,175,000	135,132 (1983)	544,000	785,000	868,000
Panama	2,130,000	55,222 (1983)	304,000	655,000	628,000
Paraguay	3,280,000	123,000 (1980-85)	539,000	942,000	929,000
Peru	19,200,000	651,200 (1982)	3,123,000	5,468,000	5,508,000
St. Christopher and Nevis	52,000	1,093 (1983)	7,200	15,700	16,800
Saint Lucia	128,000	3,914 (1983)	23,400	28,300	36,000
St. Vincent and the Grenadines	102,000	3,295 (1983)	16,000	26,500	27,900
Suriname	351,000	10,000 (1980-85)	60,500	76,900	91,800

[a] Information needed for tables 13-18, 20-23 and 25.

[b] Population 15 years of age and older; information needed for tables 30 and 31.

Table No. 2 (Cont.)

Population Used in the Evaluation Report

Countries	Population Total 1984	Live[a/] Births	Children 0-4 1984	Adults[b/] Males 1984	Adults[b/] Females 1984
Member States					
Trinidad and Tobago	1,169,000	27,000 (1980-85)	117,000	398,000	384,000
United States of America	236,158,000	3,614,000 (1983)	17,816,000	88,289,000	96,135,000
Uruguay	2,990,000	54,194 (1982)	272,000	1,068,000	1,124,000
Venezuela	16,850,000	598,000 (1980-85)	2,715,000	4,830,000	4,913,000
Subtotal 35	650,770,000	16,016,395	78,053,000	214,079,300	223,882,400
Territories					
Anguilla	7,000	...	840	1,884	2,121
Bermuda	60,000	928 (1983)	4,100	22,300	24,000
British Virgin Islands	13,000	244 (1982)	1,827	3,867	4,082
Cayman Islands	20,000	347 (1981)	2,770	6,110	6,980
Montserrat	13,000	260 (1982)	1,770	3,910	4,130
Netherlands Antilles	258,000	...	35,800	76,600	81,900
Turks and Caicos Islands	8,000	204 (1982)	1,110	2,420	2,530
Subtotal 7	379,000	1,983	48,217	117,091	125,743
Total 42	651,149,000	16,018,378	78,101,217	214,196,391	224,008,143

a/ Information needed for tables 13-18, 20-23 and 25.

b/ Population 15 years of age and older; information needed for tables 30 and 31.

Table No. 3

Percentage of the Gross Domestic Product (GDP) Spent on Health

(Global Indicator No. 3)

Proportion of GNP Spent on Health	Number of Member States	Population 1984 (in thousands) No.	%
Less than 1.0%	0	0	0
1.0-1.9%	2 (MEX, TRT)	77,959	12.0
2.0-2.9%	0	0	0
3.0-3.9%	6 (BLZ, DOR, GUT, HAI, JAM, VEN)	38,176	5.9
4.0-4.9%	5 (BAR, DOM, PAR, PER, SAL)	22,936	3.5
5.0-5.9%	7 (BAH, BRA, COL, BRV[a/], COR, GUY, SAV)	164,582	25.3
6.0-6.9%	4 (ANI, BOL, CHI, ECU)	27,318	4.2
7.0-7.9%	1 (HON)	4,232	0.6
8.0-8.9%	2 (CAN, NEA[a/])	25,388	3.9
9.0-9.9%	0	0	0
10% or more	3 (BER[a/], PAN, USA)	238,348	36.6
Subtotal	30	598,939	92.0
No Data	12 (ANG[a/], ARG, CAY[a/], CUB, ELS, GRA, MOT[a/], NIC, SCN, SUR, URU, TCA[a/]	52,210	8.0
Total	42	651,149	100.0

a/ Territory

Table No. 4

Percentage of the Gross National Health Expenditure Devoted to Primary Health Care

(Global Indicator No. 4)

Proportion of National Health Expenditure Spent on Primary Health Care	Number of Member States	Population 1984 (in thousands) No.	%
Less than 10%	3 (COR, HAI, PER)	26,882	4.1
10-19%	3 (BAR, BER[a], GUT)	7,910	1.3
20-29%	1 (BRV[a])	13	
30-39%	0	0	0
40-49%	0	0	0
50-59%	0	0	0
60-69%	0	0	0
70% or more	1 (ELS)	5,404	0.8
Subtotal	8	40,209	6.2
No Data	34 (ANG[a], ANI, ARG, BAH, BLZ, BOL, BRA, CAN, CAY[a], CHI, COL, CUB, DOM, DOR, ECU, GRA, GUY, HON, JAM, MEX, MOT[a], NEA[a], NIC, PAN, PAR, SCN, SAV, SAL, SUR, TRT, TCA[a], USA, URU, VEN)	610,940	93.8
Total	42	651,149	100.0

a/ Territory

Table No. 5

Equitable Distribution of Resources

(Global Indicator No. 5)

Resource Item: Ministries of Health and Social Welfare Brazil[a/]
Expenditure on Health

Year: 1984

Population Groups	Population Size (In Thousands)	Resources Total for PHC (Cr. in Thousands)[b/]	PHC Resources Per Capita (Cr. in Thousands)[b/]	Norm (If Established)
North	7,311	56,111,317	7,675	...
Northeast	38,002	239,274,696	6,296	...
Southeast	57,549	69,933,318	1,215	...
South	20,175	30,169,590	1,495	...
Central-West	8,940	42,695,508	4,776	...
Whole country	131,976	438,184,429	3,320	...

a/ Information provided by other countries was insufficient

b/ Rate of exchange approximately Cr. 1700 to a U.S.$

Table No. 6

Safe Water in the Home or within 15 Minutes Walking Distance (Total)

(Global Indicator No. 7)

Proportion of Population with Safe Water (Total)	Number of Member States		Population 1984 (in thousands)	
			No.	%
Less than 10%	0			
10-19%	0			
20-29%	1	PAR	3,280	0.5%
30-39%	2	HAI, TCA a/	5,188	0.8%
40-49%	1	BOL	6,249	1.0%
50-59%	8	BAH, BAR, ECU, ELS, GUT, MOT a/, NIC, PER	44,982	6.9%
60-69%	7	ARG, BLZ, CAY a/, CUB, DOR, HON, PAN	52,720	8.1%
70-79%	7	BRA, DOM, JAM, MEX, SAL, SAV, SCN	212,018	32.5%
80-89%	9	CHI, COR, GRA, GUY, NEA a, b/, SUR, TRT, URU, VEN	37,045	5.7%
90-99%	4	ANI, BRV a/, CAN, COL	53,442	8.2%
100%	2	BER a/, USA	236,218	36.3%
Subtotal	41		651,142	100.0%
No Data	1	ANG a/	7	
Total	42		651,149	100.0%

a/ Territory

b/ Only Curaçao

Table No. 7

Safe Water in the Home or within 15 Minutes Walking Distance (Urban)

(Global Indicator No. 7)

Proportion of Population with Safe Water (Urban)	Number of Member States		Population 1984 (in thousands) No.	%
Less than 10%	0			
10-19%	0			
20-29%	0			
30-39%	0			
40-49%	1	PAR	3,280	0.5%
50-59%	1	BAH	230	
60-69%	0			
70-79%	5	ARG, BOL, ELS, HAI, PER	66,133	10.2%
80-89%	3	BRA, DOR, VEN	155,530	23.9%
90-99%	11	COR, ECU, GUT, HON, JAM, MEX, NIC, PAN, SUR, TRT, URU	112,337	17.3%
100%	7	BAR, BER[a/], BLZ, CHI, COL, GUY, USA	277,661	42.6%
Subtotal	28		615,171	94.5%
No Data	14	ANG[a/], ANI[a/], BRV[a/], CAN, CAY[a/], CUB, DOM, GRA, MOT[a/], NEA[a/], SAL, SAV, SCN, TCA[a/]	35,978	5.5%
Total	42		651,149	100.0%

a/ Territory

Table No. 8

Safe Water in the Home or Within 15 Minutes Walking Distance (Rural)

(Global Indicator No. 7.1.1)

Proportion of Population with Safe Water (Rural)	Number of Member States	Population 1984 (in thousands)	
		No.	%
Less than 10%	1 (NIC)	3,175	0.5
10-19%	5 (ARG, BOL, CHL, PAR, PER)	70,709	10.9
20-29%	6 (BAR, ECU, GUT HAI, PAN, URU)	27,260	4.2
30-39%	2 (BLZ, DOR)	6,258	1.0
40-49%	2 (ELS, MEX)	82,194	12.6
50-59%	2 (BRA, HON)	136,812	21.0
60-69%	2 (GUY, VEN)	17,785	2.7
70-79%	1 (COL)	28,220	4.4
80-89%	2 (COR, SUR)	2,853	0.4
90-99%	2 (JAM, TRT)	3,457	0.5
100%	0		
Subtotal	25	378,723	58.2
No Data	17 (ANG[a/], ANT, BAH, BER[a/], BRV[a/], CAN, CAY[a/], CUB, DOM, GRA, MOT[a/], NEA[a/], SAL, SAV, SCN, TCA[a/], USA)	272,426	41.8
Total	42	651,149	100.0

a/ Territory

Table No. 9

Adequate Sanitary Facilities in the Home or Immediate Vicinity (Total)

(Global Indicator No. 7)

Proportion of Population with Adequate Sanitary Facilities (Total)	Number of Member States	Population 1984 (in thousands)	
		No.	%
Less than 10%	0		
10-19%	1 (HAI)	5,180	0.8
20-29%	4 (BOL, BRA, DOR, NIC)	148,104	22.7
30-39%	3 (CUB, GUT, PER)	36,780	5.6
40-49%	4 (ECU, ELS, HON, VEN)	35,596	5.5
50-59%	2 (MEX, URU)	79,780	12.3
60-69%	6 (BAH, BLZ, CAN, COL, PAN, SAL)	55,996	8.6
70-79%	2 (ANG[a/], COR)	2,509	0.4
80-89%	7 (ARG, BRV[a/], CAY[a/], CHL, DOM, PAR, SAV)	45,473	7.0
90-99%	5 (GUY, JAM, SCN, TRT, USA)	240,602	37.0
100%	5 (ANT, BAR, BER, NEA[b/], SUR)	998	0.1
Subtotal	39	651,018	99.9
No Data	3 (GRA, MOT[a/], TCA[a/])	131	0.1
Total	42	651,149	100.0

a/ Territory

b/ Only Curaçao

Table No. 10

Adequate Sanitary Facilities in the Home or Immediate Vicinity (Urban)

(Global Indicator No. 7)

Proportion of Population with Adequate Sanitary Facilities (Urban)	Number of Member States	Population 1984 (in thousands)	
		No.	%
Less than 10%	0		
10-19%	0		
20-29%	0		
30-39%	1 (BRA)	132,580	20.4
40-49%	4 (BAR, BOL, DOR, HON)	16,831	2.6
50-59%	7 (ELS, GUT, GUY, HAI, PER, URU, VEN)	58,159	8.9
60-69%	4 (BAH, BLZ, ECU, PAN)	11,628	1.8
70-79%	1 (NIC)	3,175	0.51
80-89%	0		
90-99%	5 (ARG, COL, JAM, MEX, PAR)	140,678	21.6
100%	4 (CHL, COR, SUR, TRT)	15,902	2.4
Subtotal	26	378,953	58.2
No Data	16 (ANG[a/], ANT, BER[a/], BRV[a/], CAN, CAY[a/], CUB, DOM, GRA, MOT[a/], NEA[a/], SAL, SAV, SCN, TCA[a/], USA)	272,196	41.8
Total	42	651,149	100.0

a/ Territory

Table No. 11

Adequate Sanitary Facilities in the Home or immediate vicinity (Rural)

(Global Indicator No. 7, 7.1.2)

Proportion of Population with Adequate Sanitary Facilities (Rural)	Number of Member States		Population 1984 (in thousands)	
			No.	%
Less than 10%	5	(BOL, BRA, CHI, PER, VEN)	186,759	28.7
10-19%	5	(COL, DOR, HAI, MEX, NIC)	119,465	18.3
20-29%	2	(GUT, ECU)	16,710	2.6
30-39%	2	(ARG, ELS)	35,504	5.5
40-49%	2	(COR, HON)	6,734	1.0
50-59%	1	(URU)	2,990	0.5
60-69%	1	(BLZ)	158	
70-79%	1	(PAN)	2,130	0.3
80-89%	1	(GUY)	935	0.1
90-99%	4	(JAM, PAR, SUR, TRT)	7,088	1.1
100%	0			
Subtotal	24		378,473	58.1
No Data	18	(ANG[a/], ANI, BAH, BAR, BER[a/], BRV[a/], CAN, CAY[a/], CUB, DOM, GRA, MOT[a/], NEA[a/], SAL, SAV SCN, TCA[a/], USA)	272,676	41.9
Total	42		651,149	100.0

a/ Territory

Table No. 12

Number of Countries Reporting on Immunization

(Global Indicator No. 7)

	Full Immunization Against					
	All EPI Target Diseases	D.P.T.	Measles	Polio-myelitis	TB	Tetanus Pregnant Women
Member States	0 a/	35 b/	30 c/	35 b/	25 d/	13 e/
Territories	0 a/	7 f/	5 g/	7 f/	3 h/	1 i/
Total	0 a/	42	35	42	28	14

a/ None of the countries which submitted a CFF included the percentage of children immunized against all EPI target diseases, nor is this information available for any of the other countries
b/ ANG, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GRA, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PAR, PER, SCN, SAL, SAV, SUR, TRT, URU, USA, VEN
c/ ARG, BAH, BAR, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GRA, GUT, GUY, HON, JAM, MEX, NIC, PAN, PAR, PER, SAV, SUR, TRT, URU, USA, VEN
d/ ARG, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PAR, PER, SCN, URU, VEN
e/ ANG, BAH, BAR, BLZ, COR, DOM, GUY, HAI, HON, JAM, PAR, PER, SAV
f/ ANG, BER, BRV, CAY, MOT, NEA, TCA
g/ ANG, BRV, MOT, NEA, TCA
h/ ANG, MOT, TCA
i/ BRV

Table No. 13

Immunization Against all EPI Diseases

(Global Indicator No. 7)

Proportion of Infants Fully Immunized Against all Six EPI Diseases	Number of Member States	Live Births No.	Live Births %
Less than 10%	...		
10-19%	...		
20-29%	...		
30-39%	...		
40-49%	...		
50-59%	...		
60-69%	...		
70-79%	...		
80-89%	...		
90-99%	...		
100%	...		
Subtotal	0		
No Data	23a/		
Total	23		

a/ None of the 23 countries which submitted a CFF included the percentage of children immunized against all six EPI diseases in their report

Table No. 14

Immunization Against Diphtheria, Tetanus and Whooping Cough

(Global Indicator No. 7)

Proportion of Infants Fully Immunized Against DPT	Number of Member States	Live Births	
		No.	%
Less than 10	0		
10-19	1 (HAI)	311,978	1.9
20-29	5 (BOL, DOR, MEX, PER, VEN)	4,237,862	26.5
30-39	2 (ECU, NIC)	488,132	3.1
40-49	4 (BER a/, ELS, GUY, HON)	360,724	2.3
50-59	5 (BLZ, GUT, JAM, PAR, URU)	533,057	3.3
60-69	7 (ANG a/, ARG, BAH, BRA, COL, TCA a/, TRT)	5,513,463 b/	34.4
70-79	2 (GRA, PAN)	55,222 c/	0.3
80-89	10 (BAR, BVI a/, CHI, COR, CUB, DOM, MOT a/, SAL, SAV, SUR)	527,637	3.3
90-99	3 (ANI, CAY a/, SCN)	2,614	-
100	0		
Subtotal	39	12,030,689	75.1
No Data	3 (CAN, NEA a/, USA)	3,987,689 d/	24.9
Total	42	16,018,378	100.0

a/ Territory
b/ Live births for Anguilla not available
c/ Live births for Grenada not available
d/ Live births for Netherlands Antilles not available

Table No. 15

Immunization Against Measles

(Global Indicator No. 7)

Proportion of Infants Fully Immunized Against Measles	Number of Member States	Live Births No.	Live Births %
Less than 10%	0		
10-19%	5 (BOL, DOR, HAI, TRT, URU)	851,172	5.3
20-29%	2 (GUT, VEN)	886,502	5.5
30-39%	5 (GRA, GUY, MEX, NIC, PER)	3,342,994[b]	20.9
40-49%	5 (BER[a], BLZ, ECU, ELS, TCA[a])	516,789	3.2
50-59%	3 (COL, HON, PAR)	1,145,000	7.2
60-69%	3 (BAH, JAM, SAL)	70,694	0.5
70-79%	5 (ANG[a], ANI, CAY[a], CHI PAN)	321,700[c]	2.0
80-89%	8 (BAR, BRA, BVI[a], COR, CUB, DOM, SCN, SUR)	4,185,304	26.1
90-99%	2 (ARG, SAV)	710,274	4.4
100%	0		
Subtotal	38	12,030,429	75.1
No Data	4 (CAN, MOT[a], NEA[a], USA)	3,987,949[d]	24.9
Total	42	16,018,378	100.0

a/ Territory
b/ Live births for Grenada not available
c/ Live births for Anguilla not available
d/ Live births for Netherlands Antilles not available

Table No. 16

Immunization Against Poliomyelitis

(Global Indicator No. 7)

Proportion of Infants Fully Immunized Against Poliomyelitis	Number of Member States	Live Births No.	Live Births %
Less than 10%	0	0	0
10-19%	1 (HAI)	311,978	1.9
20-29%	1 (PER)	651,200	4.1
30-39%	1 (ECU)	353,000	2.2
40-49%	3 (BER[a/], ELS, GUY)	183,724	1.1
50-59%	6 (BOL, BLZ, GUT, JAM, PAR, VEN)	1,339,863	8.4
60-69%	4 (BAH, TRT, COL, ARG)	1,584,259	9.9
70-79%	7 (ANG[a/], BAR, GRA, NIC NIC, PAN, SUr	205,172[b/]	1.3
80-89%	8 (RV[a/], DOM, MOT[a/], SAL, COR' HON, CHI, URU)	575,275	3.6
90-99%	8 (ANI, CAY[a/], CUB, DOR, SCN, SAV, MEX, BRA)	6,826,218	42.6
Subtotal	30	12,030,689	75.1
No Data	3 (CAN,NEA[a/],USA)	3,987,689[c/]	24.9
Total	42	16,018,378	100.0

a/ Territory

b/ Number of live births for Anguilla and Grenada not available.

c/ Number of live births for Netherland Antilles not available.

Table No. 17

Immunization Against Tuberculosis

(Global Indicator No. 7)

Proportion of Infants Fully Immunized Against Tuberculosis	Number of Member States	Live Births No.	Live Births %
Less than 10%	0	0	0
10-19%	0	0	0
20-29%	5 (ELS, MEX, NIC, BOL, VEN)	3,683,590	23.0
30-39%	2 (SAV, GUT)	291,797	1.8
40-49%	4 (DOR, JAM, HON, GUY)	459,500	2.9
50-59%	2 (HAI, PER)	963,178	6.0
60-69%	2 (CAY[a/], COL)	845,347	5.3
70-79%	6 (ANG[a/], PAN, BRA, ECU, PAR, ARG)	5,167,201[b/]	32.3
80-89%	5 (DOM, MOT[a/], SAL, BEL, CHI)	276,745	1.7
90-99%	2 (CUB, TAC[a/])	165,851	1.0
Subtotal	28	11,853,209	74.0
No Data	14 (BER[a/], CAN, USA, ANT, BAH, BAR, BRV[a/], GRA, NEA[a/], SCN, TRT, COR, SUR, URU)	4,165,169[c/]	26.0
Total	42	16,018,378	100.0

a/ Territory
b/ Live births for Anguilla not available
c/ Live births for Grenada and Netherland Antilles not available

Table No. 18

Immunization of Pregnant Women Against Tetanus

(Global Indicator No. 7)

Proportion of Pregnant Women Immunized Against Tetanus	Number of Member States	Live Births No.	Live Births %
Less than 10%	1 (PER)	651,200	4.0
10-19%	1 (DOM)	1,753	
20-29%	1 (HAI)	311,978	1.9
30-39%	2 (BAR, PAN)	59,836	0.4
40-49%	1 (JAM)	61,500	0.4
50-59%	3 (BAH, GUY, HON)	208,280	1.3
60-69%	2 (BLZ, SAV)	9,156	0.1
70-79%	0		
80-89%	2 (BRV[a/], PAR)	123,244	0.8
90-99%	2 (ANI, COR)	74,127	0.5
100%	0		
Subtotal	15	1,501,074	9.4
No Data	27 (ANG[a/], ARG, BER[a/], BOL, BRA, CAN, CAY[a/], CHI, COL, CUB, DOR, ECU, ELS, GRA, GUT, MEX, MOT[a/], NEA[a/], NIC, SCN, SAL, SUR, TCA[a/], TRT, USA, URU, VEN)	14,517,304[b/]	90.6
Total	42	16,018,378	100.0

a/ Territory

b/ Live births for Anguilla, Grenada and Netherland Antilles not available.

Table No. 19

Availability of Health Care within One-Hour Walk or Travel Including at Least 20 Essential Drugs

(Global Indicator No. 7)

Proportion of Population for whom Health Care is Available within One-Hour Walk or Travel Including at least 20 Essential Drugs	Number of Member States	Population	
		No.	%
Less than 10%	0		
10-19%	0		
20-29%	0		
30-39%	0		
40-49%	0		
50-59%	1 (HAI)	5,180	0.8
60-69%	0		
70-79%	1 (BLZ)	158	
80-89%	2 (GUY, SAV)	1,037	0.2
90-99%	5 (CHI, COR, SCN, SUR, USA)	250,943	38.5
100%	7 (ANG[a/], ANI, BAR, BVI[a/], DOM, MOT[a/], SAL)	568	0.1
Subtotal	16	257,886	39.6
No Data	26 (ARG, BAH, BER[a/], BOL, BRA, CAN, CAY[a/], COL, CUB, DOR, ECU, ELS, GRA, GUT, HON, JAM, MEX, NEA[a/], NIC, PAN, PAR, PER, TCA[a/], TRT, URU, VEN)	393,263	60.4
Total	42	651,149	100.0

Table No. 20

Pregnant Women Attended during Pregnancy by Trained Personnel

(Global Indicator No. 7)

Proportion of Women Attended During Pregnancy by Trained Personnel	Number of Member States	Live Births	
		No.	%
Less than 10%	0		
10-19%	0		
20-29%	0		
30-39%	0		
40-49%	2 (HAI, PER)	963,178	6.0
50-59%	1 (COR)	72,953	0.5
60-69%	3 (PAN, PAR, SAV)	181,517	1.1
70-79%	2 (BRA, JAM)	3,990,500	24.9
80-89%	2 (ANG[a/], BLZ)	5,861[b/]	
90-99%	6 (BAR, BER[a/], CHI, DOM, GUY, SAL)	302,166	1.9
100%	1 (MOT[a/])	260	
Subtotal	17	5,516,435	34.4
No Data	25 (ANI, ARG, BAH, BOL, BRV[a/], CAN, CAY[a/], COL, CUB, DOR, ECU, ELS, GRA, GUT,HON, MEX, NEA[a/], NIC, SCN, SUR, TCA[a/], TRT, USA, URU, VEN)	10,501,943[c/]	65.6
Total	42	16,018,378	100.0

a/ Territory

b/ Live births for Anguilla not available.

c/ Live births for Grenada and Netherland Antilles not available.

Table No. 21

Pregnant Women Attended During Delivery by Trained Personnel

(Global Indicator No. 7)

Proportion of Women Attended During Delivery by Trained Personnel	Number of Member States		Live Births No.	Live Births %
Less than 10%	0			
10-19%	0			
20-29%	2	(HAI, PAR[a/])	434,978	2.7
30-39%	1	(PER)	651,200	4.1
40-49%	0			
50-59%	1	(HON)	177,000	1.1
60-69%	0			
70-79%	2	(BRA, SAV)	3,932,295	24.5
80-89%	7	(ANI, BLZ, GRA, JAM, PAN SUR[a/], VEN)	731,757[c/]	4.6
90-99%	13	(BAR, BER[b/], CAN, CHI, COR, CUB, DOM, DOR, GUY, MOT[b/], SAL, SCN, USA)	4,724,808	29.5
100%	1	(ANG[b/])	N.D.	
Subtotal	27		10,652,038	66.5
No Data	15	(ARG, BAH, BOL, BRV[b/], CAY[b/], COL, ECU, ELS, GUT, MEX, NEA[b/], NIC, TCA[b/], TRT, URU)	5,366,340[d/]	33.5
Total	42		16,018,378	100.0

a/ Institutional delivery

b/ Territory

c/ Live births for Grenada not available.

d/ Live births for Netherland Antilles not available.

Table No. 22

Infants Attended by Trained Personnel

(Global Indicator No. 7)

Proportion of Infants Under 1 Year Attended by Trained Personnel	Number of Member States		Live Births No.	Live Births %
Less than 10%	0			
10-19%	0			
20-29%	0			
30-39%	0			
40-49%	1	(PAN)	55,222	0.4
50-59%	0			
60-69%	2	(GRA, JAM)	61,500[b]	0.4
70-79%	3	(BAR, HON, PAR)	304,614	1.9
80-89%	3	(CHI, SAL, SAV)	272,166	1.7
90-99%	8	(ANG[a], BER[a], BLZ, BRV[a], DOM, GUY, MOT[a], SCN)	36,139[c]	0.2
100%	1	(ANI)	1,174	
Subtotal	18		730,815	4.6
No Data	24	(ARG, BAH, BOL, BRA, CAN, CAY[a], COL, COR, CUB, DOR, ECU, ELS, GUT, HAI, MEX, NEA[a], NIC, PER, SUR, TCA[a], TRT, URU, USA, VEN)	15,287,563[d]	95.4
Total	42		16,018,378	100.0

a/ Territory

b/ Live births for Grenada not available.

c/ Live births for Anguilla not available.

d/ Live births for Netherland Antilles not available.

Table No. 23

Newborns with Birth Weight Under 2500g[a]

(Global Indicator No. 8)

Proportion of Newborns[a] with Birth Weight Under 2500g	Number of Member States	Live Births No.	Live Births %
Less than 5%	2 (ANG[b], COL)	845,000[c]	5.3
5- 9%	17 (ANI, BER[b], CAN, CHI, COR, CUB, ELS, HON, MOT[b], PAN, PAR, PER, SAL, SCN, URU, USA, VEN)	6,314,027	39.4
10-14%	7 (BOL, DOM, GRA, GUT, JAM, SAV, SUR)	628,050[d]	3.9
15-19%	3 (GUY, HAI, NIC)	473,110	3.0
20-24%	0		
25-29%	0		
30-34%	0		
35-39%	0		
40% or more	0		
Subtotal	29	8,260,187	51.6
No Data	13 (ARG, BAH, BAR, BLZ, BRA, BRV[b], CAY[b], DOR, ECU MEX, NEA[b], TRT, TCA[b])	7,758,191[e]	48.4
Total	42	16,018,378	100.0

a/ Table changed from "at least 2500g" to under 2500g

b/ Territory

c/ Live births for Anguilla not available.

d/ Live births for Grenada not available.

e/ Live births for Netherland Antilles not available.

Table No. 24

Weight for Age of Children 0-5 Years of Age

(Global Indicator No. 8, 8.2)

Percentage of Children 0-5 Years of age with Weight corresponding to or Exceeding the Referencce Values	Number of Member States	Children 0-5 years[b]	
		No.	%
Less than 10%	0		
10-19%	0		
20-29%	3 (HAI, HON, JAM)		
30-39%	0		
40-49%	0		
50-59%	1 (GUY)		
60-69%	2 (COR, PAR)		
70-79%	1 (ANI)		
80-89%	2 (CHI, SUR)		
90-99%	3 (BER[a], BLZ, MOT[a])		
100%	1 (SCN)		
Subtotal	13		
No Data	29 (ANG[a], ARG, BAH, BAR, BOL, BRA, BVI[a], CAN, CAY[a], COL, CUB, DOM, DOR, ECU, ELS, GRA, GUT, MEX, NEA[a], NIC, PAN, PER, SAL, SAV, TRT, TCA[a], USA, URU, VEN)		
Total	42		

a/ Territory
b/ Population not available for this age group

Table No. 25

Infant Mortality Rate

(Global Indicator No. 9)

Infant Mortality Rate Per 1000 Live Births	Number of Member States	Live Births	
		No.	%
Less than 10	2 (CAN, DOM)	375.442	2.3
10.0- 19.9	7 (ANI, BER[a/], CAY[a/], COR, CUB, NEA[a/], USA)	3,855,049[b/]	24.1
20.0- 29.9	11 (ANG[a/], BAH, BAR, BLZ, CHI, GRA, JAM, PAN, SAL, TCA[a/], TRT)	428,552[c/]	2.7
30.0- 39.0	7 (ARG, GUY, MEX, SAV, SUR, URU, VEN)	3,929,130	24.5
40.0- 49.9	5 (BVI[a/], ELS, MOT[a/], PAR, SCN)	281,393	1.8
50.0- 59.9	1 (COL)	845,000	5.3
60.0- 69.9	1 (DOR)	195,000	1.2
70.0- 79.9	4 (BRA, ECU, GUT, NIC)	4,705,634	29.4
80.0- 89.9	1 (HON)	177,000	1.1
90.0- 99.9	1 (PER)	651,200	4.0
100.0-119.9	0	-	-
120.0-149.9	2 (BOL, HAI)	574,978	3.6
150.0-199.9	0		
200 or more	0		
Subtotal	42	16,018,378	100.0
No Data	0		
Total	42	16,018,378	100.0

a/ Territory
b/ Live births for Netherlands Antilles not available
c/ Live births for Anguilla and Grenada not available

Table No. 26

Life Expectantcy at Birth (Both Sexes)

(Global Indicator No. 10)

Life Expectancy at Birth for Both Sexes (In Years)	Number of Member States	Population 1984 (in thousands)	
		No.	%
Less than 40.0	0		
40.0-44.9	0		
45.0-49.9	0		
50.0-54.9	2 (BOL, HAI)	11,429	1.8
55.0-59.9	3 (HON, NIC, PER)	26,607	4.1
60.0-64.9	6 (BRA, COL, DOR, ECU, ELS, GUT)	189,014	29.0
65.0-69.9	10 (ARG, BAH, CHI, GUY, MEX, PAR, SAV, SCN, SUR, VEN)	140,570	21.6
70.0-74.9	13 (ANI, BAR, BER a/, BLZ, CAN, COR, CUB, JAM, NEA a/, PAN, TRT, URU, USA)	283,152	43.4
75.0 or more	0		
Subtotal	34	650,772	99.9
No Data	8 (ANG a/, BRV a/, CAY a/, DOM, GRA, MOT a/, SAL, TCA a/)	377	0.1
Total	42	651,149	100.0

a/ Territory

Table No. 27

Life Expectancy at Birth (Males)
(1980-1985)
(Global Indicator No. 10)

Life Expectancy at Birth (Males) (In Years)	Number of Member States	Male population	
		Thousands	%
Less than 40.	0		
40.0-44.9	0		
45.0-49.9	1 (BOL)	3,084	1.0
50.0-54.9	1 (HAI)	2,520	0.8
55.0-59.9	4 (GUT, HON, NIC, PER)	17,070	5.3
60.0-64.9	10 (ANG[a/], BRA, CHI, COL, DOR, ECU, ELS, GRA, MEX, PAR)	136,757	42.4
65.0-69.9	10 (ARG, BAR, GUY, JAM, PAN, SUR, TRT, URU, USA, VEN)	143,242	44.5
70.0-74.9	3 (CAN, COR, CUB)	18,801	5.8
Subtotal	29	321,474	99.8
No Data	13 (ANI, BAH, BEL, BER[a/], BRV[a/], ,CAY[a/], DOM, MOT[a/], NEA[a/], SCN, SAL, SAV, TCA[a/])	590	0.2
Total	42	322,064	100.0

a/ Territory

Table No. 28

Life Expectancy at Birth (Females)
(1980-1985)
(Global Indicator No. 10)

Life Expectancy at Birth (Females) (In Years)	Number of Member States	Female population	
		Thousands	%
Less than 40.0	0		
40.0-44.9	0		
45.0-49.9	0		
50.0-54.9	2 (BOL, HAI)	5,825	1.8
55.0-59.9	0		
60.0-64.9	6 (ECU, DOR, GUT, HON, NIC, PER)	24,710	7.5
65.0-69.9	6 (BRA, COL, ELS, GRA, MEX, PAR)	123,149	37.4
70.0-74.9	10 (ARG, BAR, CHI, JAM, GUY, PAN, SUR, TRT, URU, VEN)	34,584	10.5
75.0 or more	5 (ANG[a/], CAN, COR, CUB, USA)	140,208	42.6
Subtotal	29	328,476	99.8
No Data	13 (ANI, BAH, BLZ, BER[a/], BRV[a/], CAY[a/], DOM, MOT, NEA[a/], SCN, SAL[a/], SAV, TCA[a/])	609	0.2
Total	42	329,085	100.0

a/ Territory

b/ See Table 26 for data on life expectancy for both sexes

Table No. 29

Adult Literacy Rate (Both Sexes)

(Global Indicator No. 11)

Adult Literacy Rate (Both Sexes)	Number of Member States	Population, 15 years old and over	
		Thousands	%
Less than 10%	0		
10-19%	0		
20-29%	0		
30-39%	1 (HAI)	3,080	0.7
40-49%	0		
50-59%	3 (DOM, GUT, HON)	6,601	1.5
60-69%	2 (BOL, ELS)	6,520	1.5
70-79%	6 (BRA, COL, DOR, JAM, MOT[a/], SAV)	104,014	23.7
80-89%	10 (ECU, GUY, MEX, PAN, PAR, PER, SCN, SAL, SUR, VEN)	71,012	16.2
90-99%	15 (ANG[a/], ANI, ARG, BAH, BAR, BER[a/], BLZ, CAN, CHI, COR, CUB, NEA[a/], TRT, URU, USA)	245,239	56.0
100%	0		
Subtotal	37	436,466	99.6
No Data	5 (BRV[a/], CAY[a/], GRA, NIC, TCA[a/])	1,739	0.4
Total	42	438,205	100.0

a/ Territory

Table No. 30

Adult Literacy Rate (Males)

(Global Indicator No. 11)

Adult Literacy Rate (Males)	Number of Member States	Male Population, 15 Yrs. and Over 1984 (in thousands) No.	%
Less than 10%	0		
10-19%	0		
20-29%	0		
30-39%	0		
40-49%	0		
50-59%	0		
60-69%	1 (ELS)	1,475	0.7
70-79%	2 (BOL, BRA)	42,853	20.0
80-89%	3 (PAN, SUR, VEN)	5,562	2.6
90-99%	2 (CUB, URU)	4,282	2.0
100%	0		
Subtotal	8	54,172	25.3
No Data	34 (ANG[a/], ANI, ARG, BAH, BAR, BLZ, BER[a/], BRV[a/], CAN, CAY[a/], CHI, COL, COR, DOM, DOR, ECU, GRA, GUT, GUY, HAI, HON, JAM, MEX, MOT[a/], NEA[a/], NIC, PAR, PER, SCN, SAL, SAV, TRT, TCA[a/], USA)	160,024	74.7
Total	42	214,196	100.0

a/ Territory

Table No. 31

Adult Literacy Rate (Females)

(Global Indicator No. 11)

Adult Literacy Rate (Females)	Number of Member States	Female Population, 15 years and over (in thousands) No.	%
Less than 10%	0		
10-19%	0		
20-29%	0		
30-39%	0		
40-49%	0		
50-59%	2 (BOL, ELS)	3,310	1.5
60-69%	0		
70-79%	1 (BRA)	41,460	18.5
80-89%	3 (PAN, SUR, VEN)	5,633	2.5
90-99%	2 (CUB, URU)	4,206	1.9
100%	0		
Subtotal	8	54,609	24.4
No Data	34 (ANG[a], ANI, ARG, BAH, BAR, BLZ, BER[a], BRV[a], CAN, CAY[a], CHI, COL, COR, DOM, DOR, ECU, GRA, GUT, GUY, HAI, HON, JAM, MEX, MOT[a], NEA[a], NIC, PAR, PER, SCN, SAL, SAV, TRT, TCA[a], USA)	169,399	75.6
Total	42	224,008	100.0

a/ Territory

Table No. 32

Gross Domestic Product Per Capita

(Global Indicator No. 12)

Amount Per Capita	Number of Member States	Population (in thousands) No.	%
Less than $100	0		
$ 100- 199	1 (BOL)	6,249	1.0
$ 200- 299	1 (ANI)	79	
$ 300- 399	1 (HAI[a/])	5,180	0.8
$ 400- 499	1 (DOM)	78	
$ 500- 599	1 (SAV)	102	
$ 600- 699	3 (GRA, HON, PER)	23,542	3.6
$ 700- 799	1 (ELS)	5,404	0.8
$ 800- 899	1 (COL)	28,220	4.4
$ 900- 999	4 (BLZ, PAN, PAR, SAL)	5,696	0.9
$ 1000-1999	9 (BRA, CHI, COR, DOR, ECU, GUT, GUY, MEX, NEA[b/]	247,755	38.1
$ 2000-2999	4 (ARG[a/], BRV[b/], JAM, URU,	35,391	5.4
$ 3000-3999	4 (BAR, MOT[b/], SCN, SUR[a/]	666	0.1
$ 4000-4999	1 (VEN)	16,850	2.6
$ 5000-5999	0		
$ 6000-6999	2 (BAH, TRT)	1,399	0.2
$ 7000-7999	0		
$ 8000-8999	0		
$ 9000-9999	0		
$10000 or more	3 (BER[a/],[b/], CAN, USA)	261,348	40.1
Subtotal	37	637,959	98.0
No data	5 (ANG[b/], CAY[b/], CUB, NIC, TCA[b/]	13,190	0.2
Total	42	651,149	100.0

a/ Gross National Production (GNP)

b/ Territory