The Director's report examines the current situation and recommends modifications in the Organization's action policy on population matters which must be made in light of the changes that have taken place as well as future changes.

The document reaffirms, reexamines and expands on the importance of sexuality and maternal and child health on the overall health of the populations. It also stresses the role played by fertility regulation as a fundamental element of reproductive health.

Within this framework, the document emphasizes the need to view sexuality and reproductive health as essential elements in the process of sustainable and impartial development and it underscores the significance of granting special attention to the most vulnerable groups, who do not always have access to related services.

The document examines fertility regulation in the Region in terms of policies, programs, coverage and prevalence of contraceptive usage; it provides a comparative study of the indicators that better establish the correlation between socioeconomic and health aspects.

It draws attention to future needs and requirements and recommends moving toward an integrated approach for implementing programs and activities related to reproductive health with special emphasis on fertility regulation.

The document puts forth working strategies for future strengthening of the Organization's action policy on population matters.

Financially, it recommends that the governments of the individual countries make the financial commitments to guarantee services for the most vulnerable sectors. In addition, it states the importance of establishing shared financial responsibility among the public sector, the private sector and nongovernmental agencies to bear the necessary costs in the future.

It considers the great importance of interprogram cooperation among the ministries of public health, the local health systems and PAHO's Maternal and Child Health and Population Program in order to generate proposals and mobilize technical and financial resources, both foreign and domestic, to implement activities related to reproductive health among the population at large.

The document makes recommendations for the revision of legislative policies related to this issue, formulates strategies in order to reach the most vulnerable groups and asserts the need to develop qualitative research, which will provide a broader dimension of reality.

It requests that individual governments make a special effort to assume responsibility for interagency coordination at the local level in order to avoid duplication of efforts.

It also requests that the directing bodies provide a mandate to seek, in conjunction with or in representation of PAHO's member countries, new sources of financial cooperation to fund effective actions and measures that will result in enhanced reproductive health for the population of the Americas.

It focuses on quality of care as a substantive element in achieving established goals. Finally, it contends that reproductive health is a human right for each and every individual in the population.
1. BACKGROUND

Since the early 1970s, the Pan American Health Organization (PAHO) has assumed responsibility and leadership in promoting family planning because it is an element of utmost importance to maternal and child health. With this objective in mind, and in conjunction with its member countries, PAHO strove to develop projects supported by the Agency for International Development (USAID) in order to increase its own resources and those available at the country level.

After the United Nations Population Fund (UNFPA) was established in 1972 and the United States Government began contributing to this international agency, PAHO continued promoting family planning, and, at the request of the UNFPA and PAHO member countries, subsequently assumed responsibility for executing, in a tripartite fashion until 1992, most of the family planning projects financed by UNFPA in the American Region and within the PAHO service area. Between 1985 and 1987 PAHO implemented up to 80% of the support projects aimed at institutionalizing family planning in the Latin American countries and was able to put into effect regional projects which made it possible to face problems common to the countries of the Region.

In order to create a framework that would allow the accomplishment of this work in a more sound and organized way, during the XXX Meeting of the Directing Council in 1984, the members and Secretariat were given a mandate to execute the Organization's Action Policy in Population Matters through Resolution VIII. Since then three progress reports have been presented to the Directing Councils in 1985, 1988 and 1991, in which the policies, recommendations, lines of action and activities have undergone constant modification to fit the realities imposed by the current situation.

To the extent that these activities relate to Health Planning and the organization of services, the Action Policy's mandate to the countries and to the Organization made it possible to concentrate efforts on the following priorities:

- Promoting participation of social leaders from all sectors and especially from the health sector in the formulation and application of a population policy suitable to specific national developmental plans;

- Stimulating studies on mortality, fertility, and other demographic variables and introducing measures designed to alleviate the deficiencies revealed by these studies, not only in the health field but in other developmental areas as well;

- Conducting research and providing assistance to train the human resources needed in order to get effective family-planning projects off the ground;

- Ensuring the use of demographic data for identifying health problems related to population growth and to unprotected groups, and other priority groups; defining
service needs; and structuring the services required based upon the needs and demands of the population;

- Inducing active involvement of the health sector in perfecting the quality of demographic data, vital statistics and services to be used as building blocks by the agencies responsible for health planning;

- Ensuring that human reproduction programs and related activities become integral parts of maternal and child health programs and that these reach the whole population with a view to granting parents the right and ability to make sound decisions concerning the number of children to have and the spacing between births. Consequently, the health risks related to the reproductive process will be reduced and there will be an increased likelihood that demographic growth will not outpace the economic and social policies that further development;

- Extensive and intensive dissemination of information on family planning to the community with the objective of enabling it to participate in the decisions and activities relevant to the human reproductive process;

- Focusing on the problem of adolescent pregnancy, promoting and supporting adequate education on family-life issues for young men and women;

- Intensifying coordination of efforts between the Organization and United Nations agencies, as well as with other governmental and nongovernmental organizations, with a view to activating and redistributing resources in support of maternal and child health programs and family planning.

The Organization’s Action Policy in Population Matters was reaffirmed through specific mandates to prevent and reduce maternal death (CSP23.R2 and CSP23.R17, 1990), as well as to promote comprehensive adolescent health (CD36.R9, 1992). Because of their importance, these topics demand additional joint actions to strengthen activities currently under way, and to empower and enhance the health of women, children, and adolescents, all of whom continue to be priority groups for the countries of the Region. The relevance of these actions to reproductive health is underscored within the context of the topics discussed.

The political and technical consensus attained by PAHO Member Countries, the international community and the agencies providing technical and financial assistance during the World Summit for Children held in New York in 1990, and endorsed by the Heads of State of the Americas, cemented lines of action and activities (consistent with those formulated in Alma-Ata in 1973; Mexico, 1984; Nairobi, 1985 and Amsterdam, 1990 and with those proposed by the Region of the Americas) to be established. These actions are targeted for 1995 and the year 2000 and will provide a point of reference for an assessment of the progress made. Some of the goals are designed to enhance overall maternal health, reduce maternal mortality by 50% and child mortality by 30%, make fertility-regulation services accessible to all couples and prenatal care accessible to all pregnant women, and eliminate prenatal tetanus. Other goals aim
at reducing infant malnutrition and female anemia, as well as at eradicating poliomyelitis.

Global changes are unfolding at all levels, among them: 1) technical and financial cooperation agreements that favor bilateral over multilateral support; 2) the quantity of technical and financial assistance is diminishing during crises; 3) new action plans are being implemented by UNFPA, which is moving toward technical cooperation and direct implementation with member countries; 4) international banking policies that grant credit to countries are broadening to focus on the social sector; 5) new political and economic trends - such as democratization and administrative decentralization are being generated which enable the initiation of economic recovery; 6) changes are also taking place in the conceptualization of sexuality and reproductive health. These changes were in part responsible for the recent decision to assign the Special Program for Maternal and Child Health and Population to the Office of the Director. The Director himself proposed at the XIX Meeting of the Planning and Programming Subcommittee that family planning be addressed at the XX Meeting in April 1993; this proposition was affirmed.

Given the importance of this issue to the Organization, this document presents an analysis of the present situation and suggests recommendations to improve the Program's strategy and plans so that the Organization and the countries can overcome obstacles and be better equipped to tackle future problems. Strategies chosen within this plan of action should mobilize national and international resources to enable the Organization and the countries not simply to sustain but also to expand activity in the reproductive health field.

The proposal presented by the Special Program on Maternal and Child Health and Population was thoroughly examined during the Technical Discussions in February 1993 at Headquarters and in the countries. Modifications and revisions have been made to comply with the recommendations. It is expected that upon further review by PAHO's Planning and Programming Subcommittee, guidelines will be issued for the technical cooperation programs of the Organization and the countries.

2. CONTEXT AND FRAMEWORK

This document is to be interpreted within the context, including demographic variables, the Health Sector's actual participation in carrying out population policies. The great diversity of issues associated with sexuality, reproductive health, and fertility regulation and their relationship to the comprehensive health of the population are outside the scope of this paper. The most significant aspects will be briefly discussed in order to establish a conceptual framework for this proposal.

2.1 Population and Sustainable Development.

The concept of "sustainable development" as an objective internationally envisioned for the 21st century, is defined as "improvement of the quality of life without overburdening the
carrying capacity of the ecosystems on which it depends. Sustainable development maintains its natural-resources baseline and is able to continue evolving by adapting and perfecting its knowledge, organization and technical competence."

"Sustainable development" is attainable through economic strengthening and enhancement of the population's well-being, which are, in turn, functions of technical progress, productive employment and investment in human resources. This is the central working assumption of the proposal for a productive and equitable transformation made by ECLAC during its 1991 and 1992 sessions. The following goals are thereby deemed possible: 1) guaranteed access to education and health services, drinking water and sanitation; 2) assertion that health is the foundation for the economic and social development of human potential and that its improvement increases an individual's capacity to lead a productive life and reap economic benefits; and 3) guaranteed respect for political and judicial rights, as well as equal opportunities for all without discrimination based on social class or gender. (1, 5) (Table 1, Graph 1)

Sustainable development goes beyond the elimination of extreme poverty, since development must also focus on the aspirations of the population at the intermediate economic strata. Similarly, sustainable development presupposes reducing environmental costs, lowering excessive consumption patterns and preventing environmental deterioration, which endangers human well-being.

In terms of the environment, consideration must also be given to the wide spectrum of environmental factors that can alter complex and delicate reproductive cycles. The price of this damage is frequently very high and leads to decreased fertility, spontaneous abortion, delayed intrauterine development, fetal mortality and some congenital defects. Infectious diseases, malnutrition and inadequate living conditions are important causes of reproductive health problems typical of developing countries. Chemical contamination, radiation and stress have become the major threats in the industrialized world. Numerous and well-known surveys attest to the adverse effect that these factors have on the ovarian cycle and ovogenesis, as well as on conception and gestation. The decreased quality of human sperm in the last 50 years - characterized by a decline in spermatic count and increased testicular deficiencies - has prompted scientists to call attention to the countless risks to human existence. (6)

Sustainable development does not only call for increased productivity but, fundamentally, for the impartial distribution of socially generated wealth and respect for the principle of equity among countries and within each one of them. It entails equitable development irrespective of social class, gender or ethnicity, without endangering the future, and ensuring a legacy for future generations that is at least equivalent to that inherited by the present one. Reasonably, it is necessary to obtain a new temporal perspective with projections which go beyond a few decades. Sustainable development similarly implies respect for human rights in its most profound sense. It lays the groundwork for the right to life, equality, social justice, education and work, among others; and underscores the need for deep respect for the culture and values that characterize each human group and which are ingrained in its identity. Within the context of human rights are those decisions concerning the exercise of sexuality, as well as
those related to the number of children to have and the timing of their birth.

To achieve this development, high priority must be accorded to improving the quantitative and qualitative aspects linked to the characteristics of the population, as well as insuring that there is no harmful impact on the equilibrium of the ecosystems that support it. The size, growth rate, structure and distribution of the population are regarded as being among the important quantitative factors.

There are many unknown factors that have yet to be identified and that will need to be overcome. It is presently accepted, however, that the population - subject, object and backbone of development - the environment and health are closely interrelated. (1, 2)

Protection of the environment, attainment of health and the promotion of economic and social development are not isolated goals, since they are linked to many political and social factors. Accelerated population growth, for instance, can have profound effects on the environment and economic development. However, it must be made clear that other factors must be met simultaneously; among those worth mentioning are internal and international mechanisms for equitable distribution of wealth.

2.2 Sexuality - Reproductive Health - Fertility Regulation

2.2.1 Health and Sexuality

It is important to point out that a new concept of sexuality and reproductive health has been developed over the last few decades; this new approach now forms an integral part of the framework for discussing the health of the population, transcending the conventional mother-and-child concept. In this new perspective, health promotion and lifestyle choices frequently constitute determining factors of health. Increasing attention is being given to the gender factor in epidemiological interpretation, as sexual stereotypes may pose an additional element of risk to health. The analysis of maternal, perinatal and infant mortality, sexually transmitted diseases, particularly AIDS emphasize the relevance of human sexuality. Other causal factors are undoubtedly linked to significant socioeconomic, cultural and demographic changes; for instance, the rapid scientific and technical progress being made with respect to birth control methods.

Within this new approach, human sexuality is closely linked to the health of the population; because of its effects on people and their lifestyles, its impact cannot be overlooked when considering comprehensive health. Yet, it is important to emphasize that the health sector has only partial responsibility for the promotion of healthy sexuality; ultimate responsibility is shared with other sectors and social entities.

2.2.2 Reproductive Health

Reproductive health takes great importance and is a subject in which the health sector has made enormous progress. The great contributions made in the past in this area by maternal
and child health programs helped to lower maternal and infant mortality rates in the Region, although the prevailing precarious conditions of unprotected social groups are still to be remedied.

During recent years, the emphasis of reproductive health has been placed on the mother-child pair, the care of pregnant women, prenatal monitoring, adequate nutrition, labor in medically equipped facilities or assisted by trained staff, nursing under hygienic and nutritionally adequate conditions and immunization of the newborn.

Nevertheless, it is desirable to point out that the burden of these problems is unevenly distributed between the sexes. The woman is at a great disadvantage, as she must face the unfolding of pregnancy and labor and all of the resulting physical, emotional and social consequences. Maternal and child care has failed to stress the importance of male participation in the procreation process.

When a couple faces a decision concerning the use of birth-control methods, the responsibility for the choice, acquisition and use of the selected method usually falls on the woman. With regard to infertility, although it is the couple's concern and one in whose etiology men and women participate with equal regularity, it is women who endure most of the testing and treatment and who show greater psychological and social consequences. Similarly, sexually transmitted diseases, in general, have more serious consequences for women than for men. Furthermore, abortion continues to be a very serious problem for women's health and for society in general. It is the leading cause of maternal death in eight countries of the Region and the second most important cause in four. (9) (Chart 6)

The concept of reproductive health is becoming broader and, within the context of WHO's definition of health, it means not simply an absence of illness or disorders in the reproductive process, but a situation in which this process evolves to a state of physical, social and mental well-being.

The implication of this is that people have or can easily attain the capacity to reproduce whenever they deem it timely, that couples or women who so decide can have a pregnancy, the peri-partum and post-partum periods are healthy, and that children can survive and develop in a healthy environment. By extension, this concept asserts people's right to embrace wholesome and enriching sexuality as an element conducive to the welfare of the person and family. It also implies that when they choose freely and responsibly to engage in sexual relations, these can be mutually gratifying and not be distorted through fear of unwanted pregnancy or sexually transmitted disease. (10, 11)

Departing from this conceptualization of reproductive health, a place of prominence is given to all relevant measures that can offer people adequate methods to exercise options concerning their fertility. This is tantamount to providing them with the necessary educational
elements and specific procedures to regulate their fertility; it also means that they will have access to treatment in case of infertility.

The term *Family Planning* has been frequently used in this Region to label these concepts. Presently, the term Fertility Regulation is being considered, since it is more encompassing and embraces all people at different stages of their reproductive life and under various circumstances. Through the decades, the objectives of reproductive health have been modified to include demographic considerations and improvement in the quality of life of the population, without losing sight of individual needs (12). Some of these aspects are dealt with elsewhere in this document, but what must be stressed is the role that fertility regulation plays in the reproductive health of the population.

2.2.3 Fertility Regulation

Fertility regulation is regarded as a human right, an important lifestyle choice that is socially acceptable to a large percentage of the population, both individuals and couples. It is a very important health intervention, with ramifications that go beyond health benefits and contraception, since it has the advantage of being cost efficient. For these and other reasons, fertility regulation should be made available to the entire population without exception. It contributes to a woman's ability to make decisions about her body; it also allows her to transfer this experience of autonomy to other areas of life, enabling her to choose among different opportunities for future development. Fertility regulation assists her in achieving her desired sexual realization, and to prevent unwanted and high-risk pregnancies and abortion. It allows her to decide at what age she wishes to have her children, their spacing and number. (10, 11, 13, 14, 15, 16, 17, 18)

It is important to point out that improved status and education of women promote greater social mobility for women, improve their fertility and the health of their children, all of which ultimately benefits the nuclear family and society at large. It is essentially an attempt to give women their basic human right to health, which they are frequently denied. (1, 2, 13, 16, 19)

There is still no ideal contraceptive and one must keep in mind the beneficial effects as well as the potential side effects of each of them. The protective effects of some hormonal contraceptives must be considered, as in some malignancies such as cervical and ovarian cancer, as well as the preventive effects against ectopic pregnancy that some intrauterine devices may have. (20). Some contraceptives, such as male and female condoms, also prevent sexually transmitted diseases, and AIDS in particular. Fertility regulation can prevent conceiving children who, given a risk situation, could fall ill or die. Simply spacing pregnancies by two years can reduce child mortality by 50% in those groups characterized by high fertility and high infant mortality. Naturally, spacing children's births also benefits the children that parents already have. (14, 20, 21, 22, 23, 24, 25)

It is important to remember that fertility regulation encompasses the prevention, diagnosis and treatment of infertility, as well as the provision of medically assisted conception.
All this undoubtedly contributes to the modification of family formation patterns, since it provides greater opportunities for family members to attain a greater development. (10, 17, 26)

Fertility regulation also concerns men and allows them to assume their responsibility in the reproductive process. Men must assume a more receptive and participatory attitude, not just by deciding to have children and how to have them, but also through ample fulfillment of the responsibilities that child rearing entails, which transcends his role as family provider. (27, 28, 29)

Educational and health interventions have direct effects on the demographic variables of mortality and fertility, as well as on family-formation patterns, family size and population growth. Scientific evidence reveals the role played by family planning in the demographic changes of the Region over the last 30 years, and indicates that it is an excellent indicator for evaluating the level of development and the impact that activities related to reproductive health have on the population.

It is important to recall the positions adopted at international conferences on population in Bucharest, 1974; Mexico, 1984; Amsterdam, 1990; Summit on the Environment, Rio de Janeiro, 1991; Saint Lucia, 1992 and Mexico 1993 and in regional and national fora in which countries of Latin America and the Caribbean rejected programs dealing with "population or birth control"; and supported those in which governments and national delegations affirmed and supported the humanistic policies of respect for human rights, health benefits and the enhancement of the role played by women and the family in society.

2.3 Adolescence

Adolescents have special needs associated with reproductive health that deserve particular attention and consideration, even at developmental stages prior to adolescence. At the crucial time of identity integration, it is imperative to support the development of their self-esteem, communication skills with peers and adults, as well as their ability to manage the pressure and messages conveyed by society. Promoting the development of a critical mind makes it feasible for adolescents to adopt lifestyles and sexual behavior rooted in a value system that allows the practice of wholesome, healthy and responsible sexuality. It also helps them to protect themselves from sexual abuse and exploitation. (28, 30, 31, 32, 33, 34). A beneficial result would be the reduction in the rates of adolescent pregnancy.

It should not be overlooked that adolescents constitute a high-risk group for contracting sexually transmitted diseases, of which HIV-AIDS infection bears dramatic health and social consequences, particularly during this developmental stage, including the heavy burden imposed on newborn and older children affected by and infected with their parents’ diseases.

2.4 Ethics - Sexuality and Reproductive Health

All health activities must be treated within a bioethical framework. This approach should be a determinant in all activities related to sexuality and reproductive health of the
Health workers must be highly skilled in order to understand the precise possibilities and limitations of their role. They should refrain from making value judgments that may prove detrimental to the people with whom they deal and from trying to force their values and beliefs on others by means of their decisions and instructions. Only through deep respect for the culture and group values of their clients can educational and formative work be conducive to promoting the adoption of healthy and self-directing behavior.

3. **THE PRESENT SITUATION**

Our analysis of the current situation reflects the prevailing approach of maternal and child health and family planning and is based on the available data concerning tendencies, policies and contraceptive use.

3.1 **Trends**

Despite the significant progress made in the last 30 years, there still remains much to be accomplished to reach the goal of health for all by the year 2000 and to achieve the objectives agreed upon during the United Nations World Summit for Children.

Birth rates at the regional level decreased by 40% between 1950-1955 and 1990-1995, reaching 27 per 1,000 in 1992 (Graph 2). Population growth rates decreased, going from 3.6% to 1.9% in 1992, and the length of time needed for the population to double increased from 20 to 34 years. The population in the Americas will continue to increase until it stabilizes, possibly by the year 2050. The most significant growth will occur in Latin America and the Caribbean. The population is expected to increase by 90.4 million between 1990 and 2000, mainly in urban areas, which will translate into additional needs and demands of the population and a widening of existing gaps.

Life expectancy increased from approximately 55 to 68 years between 1960 and 1992 (Table 4, Graph 3); 71.9% of the population of the Americas, approximately 520 million people, will have reached a life expectancy of 67 years or more which represents 80% of the goal set twenty years ago. Unfortunately, seven countries, accounting for 26% of the population, will have a life expectancy of 65 to 66 years, and only two, with 2% of the population will not have reached a life expectancy of 60 at birth. (Graphs 4, 5)

Similarly, overall fertility decreased by 46% from 1965 to 1969 and from 1990 to 1995, declining from 6.0 to 3.2 children per woman. (Graphs 4, 5) Fertility by age group continued to decrease, especially in groups of women aged over 20 and declined to a much lower rate in the younger-than-twenty group, indicating variations from 10 to 35% in the last 15 years. (28) Adolescent fertility increased in Brazil and Peru.

Infant mortality continued to decrease from 100 to 48 per 1,000 live births between
1960–1965 and between 1990–1995, which represents a decrease of 54% (Table 5, Graphs 6, 7). Nevertheless, the rate of decrease has slowed in recent years so that it would be wise to follow the development of this indicator closely; living conditions could continue to deteriørate and children might not survive due to the delayed effects of adjustment policies resulting from the economic crisis. In effect, those policies have been characterized by reduced investment in the social sector and have resulted in rendering the very poor - the women and children - even more vulnerable. (19)

Conditions that originate in the perinatal period are the leading causes of infant mortality; diarrhea and acute respiratory conditions follow as the second and third causes of death.

Maternal mortality rates have been slow to decline. This is an alarming fact given that the initiative for Safe Motherhood in Nairobi was approved seven years ago, and the Action Plan for Prevention and Reduction of Maternal Mortality in the Americas Region was established three years ago. The most optimistic estimates made by the WHO (Graph 8) indicate a 17% decrease between 1986 and 1989; however, there are still 11 countries in the Region with mortality rates exceeding 100. (Graph 9) Some correlations are not new: a direct correlation between maternal mortality and high fertility and between induced abortion and maternal mortality, and an inverse correlation between maternal mortality and the availability of professional medical care during labor. (Table 6, Graph 10) Infectious diseases, the occurrence of AIDS in mothers, children and adolescents, and the need to adequately manage invasive procedures make it imperative to train and support medical staff in order to prevent their accidental infection as well as the patients. The increased rate of sexually transmitted diseases, especially congenital syphilis, is unacceptable.

Likewise, the results of analyses of indicators associated with maternal and child health for countries outside the Region (The Netherlands, Sweden and Japan) (36, 37), within the Region (the United States, Canada, Costa Rica, Cuba and Chile) and within a country (northeast Brazil, Huancavelica in Peru, Oaxaca in Mexico, northeast Argentina, etc.) are equally alarming. Efforts to provide health care to the most underprivileged social groups have not been sufficiently equitable nor effectively planned. There is no other course of action left if this alarming situation is to be remedied than to formulate unequivocally effective and innovative strategies and to target those countries which have the most serious needs. That is, there is no other choice is if the concept of sustainable development is to be kept alive, and if the goals set during the United Nations World Summit for Children are to be achieved.

3.2 Policies

At present, the national constitutions of seven countries of the Region cover specific aspects concerning population matters or fertility regulation. Thirty-three out of 36 countries in the Region reported to the United Nations about fertility levels; of these, 18 countries consider it high, and of these, in turn, 11 claim to be implementing programs toward reducing it; 14 consider it satisfactory and only one considers its level to be too low. Furthermore, all countries of the Region support family-planning programs and all related activities, and regard their application as ethically and medically valuable. In addition, most of these activities are included
in the mother-and-child health programs. (37, 38)

In spite of the fact that some countries have restrictions on the use of specific contraceptive methods, in practice the population has access to most of the ones that exist, particularly those sectors of the population that have the means to pay for the services. The same applies to the practice of induced abortion. This is not considered a family-planning method, nor is it legal for this purpose in most countries. Unfortunately it is practiced illegally by individuals who generally are not qualified, and the method is used by a significant number of women to interrupt unwanted pregnancies with concomitant risks to their health and life. (39, 40, 41, 42, 43)

Abortion rates in the Americas are the highest in the developing world and this is reflected by the fact that induced abortion, as a percentage of causes of maternal mortality, ranks first in eight countries: Trinidad and Tobago, 55%; Argentina and Chile, 35%; and second in three countries. (Table 6) The cost of medical care for high-risk abortion must be added to the already strained health resources.

The prevention of unwanted pregnancies through access to high quality family planning services, as well as early medical care for initiated, incomplete, or complicated abortion, offers more effective and less costly choices for the reduction of morbidity and mortality. Several countries are now exploring the possibility of making abortion unpunishable because the far reaching and adverse consequences of unsafe abortions affect individuals, families and the entire society. Attempts to legalize abortion have given rise to intense controversy. Similarly, a large number of countries have tax policies that benefit large families, some that limit or prohibit access to contraceptive methods and some that support marriage at a young age. An in-depth analysis of maternal and child health policies is now necessary as well as timely. (38)

3.3 Programs and Access to Reproductive Health Services

Activities relating to reproductive health are neither unified nor well-coordinated in the Region. They fall under the Maternal and Child Health, Sexually Transmitted Diseases, Comprehensive Care for Women, Care of Adolescents, and Genital Cancer Prevention programs. The Alternative Health for Women Programs also offer some services. It is of the utmost importance to coordinate all interprogram activities to prevent duplication and to perform increase efficiency.

Data on the accessibility of family planning were published in 1992. (40). The survey includes 124 countries where 95% of the world population lives as well as 19 countries if the Americas covering approximately the same percentage of the population. The evaluative model looks at ten indicators, which yield a maximum of 100 points when added. Three indicators are used to evaluate different aspects of access to family planning: available options, technical competence of care providers and availability of information and services. As Table 7 shows, most of the countries are considered to have good and fair programs. Those demanding more attention for further development are: Bolivia, Guatemala, Guyana, Haiti, Nicaragua, and Paraguay.
Between 1987 and 1992 some countries of the Region improved their programs: Honduras, Peru and Trinidad and Tobago. Conversely, three countries deteriorated: Panama, Brazil and Jamaica. Seven countries were regarded as having good access, obtaining 75 points or greater. Nine countries got between 50 and 74 points, which categorizes them as having acceptable programs. (Table 7)

Access in four countries was deemed poor, as they received 25 to 49 points. Guyana, French Guyana, Nicaragua and Suriname were not studied. The Netherlands and Sweden obtained 95 points each.

Coverage for contraceptive services has improved greatly at the country level in recent years as a result of an increase and strengthening of complementary activities supported by private agencies, governmental and nongovernmental agencies. Groups working on Alternative Health for Women Program have been extremely valuable in their contributions to education and reproductive health. In recognition of the health needs of women, they have worked creatively and with few resources and have been able to generate enriching experiences which should be emulated in other programs. It is estimated that 50% of all contraceptive users are covered by governmental agencies and 50% by the private sector, which includes both free and for-profit services. It should be recognized that governmental agencies have penetrated more deeply into scattered rural areas, while there still is some duplication of efforts and competition in areas surrounding urban population centers. It is therefore very important that governments take a decisive step to coordinate their activities with other sectors and that they revise their policies of community distribution and social marketing. Evidence supporting the benefits attainable through this practical scheme already exists within the Region. Community distribution of contraceptives is already practiced in 17 countries and social marketing exists in 13 countries. (27, 33, 38, 44, 45, 46)

Only a few countries have well-defined goals for contraceptive coverage at the national level or plans as to how to achieve objectives through active participation of the various local institutions. It is difficult to obtain reliable data on the available resources and expenses incurred by programs for family planning, maternal and child health and reproductive health. There is no doubt that the proportion of the investment contributed by the individual countries is considerably higher than that provided through external cooperation. Many countries remain dependent on external resources, which are used largely for the acquisition of contraceptives. These items are not included on the basic medication lists of many countries. Thus, the ability to carry out future reproductive health programs is problematic. It is therefore advisable to implement the available practical alternatives and to devise new ones.

Furthermore, few programs have information systems for continued monitoring and evaluation. The nongovernmental sector has made greater advances in this area. As a result, at least ten countries have opted to carry out periodic surveys on population and health (DHS). They have been successful thus far because they included recent, timely and good-quality data, and have allowed not simply the documentation of the advances made but also the comparison of data between countries. Although these surveys are costly, the cost incurred is still smaller
than that needed to support bureaucratic information systems, which, by producing inaccurate and outdated information, are not conducive to timely and rational decision-making.

3.4 Coverage of Contraceptive Methods

No significant progress has been made since the Directing Council's report (C.D. 35/17) in terms of reproductive health coverage since 1991. Sixty percent of the 13 million births reported benefit from prenatal care; 72% of all labors take place in a medical institution and 28% are still assisted by traditional midwives or relatives. Growth monitoring is either limited or unreported, and it is estimated that no more than 60% of all children receive follow-up care.

The focus on adolescent health has been improved over the past two years as a result of the approval of new policies specific to this purpose. Data on sexual education programs and the ability of programs to combat sexually transmitted diseases are unavailable, and the availability of data on perinatal AIDS is minimal.

In terms of family planning services, the prevalence of contraceptive use for women aged 15-49, married or living with a partner, has undergone a dramatic increase from 11% in 1960 to 60% in 1992. (Graph 11) For usage of especially effective methods, this drops to 48% - a maximum of 67% and a minimum of 10%. In Japan, Holland, and Norway, the average percentages are 60, 72 and 65, respectively. (Tables 7, 8)

3.4.1 Distribution of Contraceptive Methods

With regard to different contraceptive methods used by women of child bearing age who have a partner, the most frequently used method is female sterilization with 20%, followed by oral contraceptives with 16%, 5% for intrauterine devices and 5% for condoms and natural methods. Approximately 40% do not use any contraceptive method at all. (Graph 12) (47)

In the twenty countries for which data are available, female sterilization is the leading contraceptive method, with variations from 30% in Puerto Rico to 18% in Ecuador. Oral contraceptives constitute the leading method in nine countries, with a range of percentages from 20% in Jamaica to 4% in Haiti. Traditional methods are still the primary contraceptives used in Peru and Bolivia: 24% and 19%, respectively.

It should be stressed that male sterilization is practiced by less than 1% of the population, with the exception of Puerto Rico where it reaches 4%. Total male use of condoms barely reaches 1% or less, with the highest percentages reported by Trinidad and Tobago and Costa Rica - 12% - and Jamaica, 9%. This is a clear indication of the extremely low participation by men in the practice of family planning. The rate of contraceptive use in recent years, with a view to family planning, especially the use of condoms, does not appear to be correlated with the efforts being made to increase utilization.

The use of injectable contraceptives is only 2% or less in the Region, with the exception
of Jamaica (8%), Paraguay (5%) and Mexico (3%). The use of vaginal barriers is 1% or less, except in Colombia, which reported 2%, and Trinidad and Tobago, 5%. Therefore, users resort mainly to sterilization and oral contraceptives for protection. It is necessary to collect information on both the availability of contraceptive methods and the importance placed on the dissemination of information, the promotion of related practices, and the monitoring of contraceptive users. An examination of the psychosocial and cultural elements which determine contraceptive use within the population remains to be done. (38)

The prevalence of contraceptive use indicates different patterns among the various groups. For instance, adolescents make minimal use of contraceptives. There are also variations according to location, as prevalence is higher in urban areas than in rural ones. Sterilization, oral contraceptives and intrauterine devices are more widely used in urban areas, while oral contraceptives, barrier methods and conventional methods which are ineffective are more widely used in rural areas.

Women and couples also report differences based on length of use, type of method and individual preference. Some of the reasons they give for choosing contraceptives are: protection against sexually transmitted diseases; the desire to prevent unwanted pregnancy, especially in the absence of a permanent relationship with a partner; spacing between pregnancies; the desire to delay the first pregnancy and blocking fertility for prolonged periods of time.

However, users do not always have the option to make free and rational decisions according to their preferences and health conditions. The choice generally depends on the availability of various services and the skill, information and attitudes of the care providers who have access to the contraceptives.

3.4.2 Continuity of Use

Continuity of use also shows marked variation among countries, programs, health units and the fluctuating needs of the users at various stages of life. This does not exclude other factors, such as the availability of contraceptives; the relationship that the user has with the providers; the time the provider devotes to assessing the real needs of the user to determine the most appropriate method; the cost in time and money and the determining cultural factors on which the selection is based.

Frequently, the providers of contraceptives lack the time and skills to offer sound information and guidance on the various contraceptive methods available, the possible options, and the timely identification of side effects and the serious complications that may arise. As a result of this information gap, the users develop doubts and fears and ultimately interrupt or discontinue use of the method. Many other individuals who wish to practice contraception refrain from doing so from the onset due to reservations and fear. The availability of services that offer different contraceptive options and a constellation of services has a positive influence on the continued use of contraceptives.
Population and health surveys provide convincing evidence that a large number of women of child-bearing age do not wish to have children but, despite this fact, do not use contraceptives. Some of the reasons given are: lack of services, few transportation options, the price of contraceptives and fear of their use. These women often live in isolated rural and marginal urban areas.

Countries where high needs for contraceptive use remain unmet are Bolivia, Guatemala and Peru, where 36, 29 and 28% of women, respectively, do not have access to reproductive health or contraceptive-related services. (47) A correlation exists between the level of education and that of unmet needs, with the exception of Guatemala, where all age groups share similar needs, and Mexico, where information is unavailable. The percentage of unmet need is high for the group aged 24-29 and greater still for the one aged 15-19.

Global fertility trends, usage patterns, effectiveness of the method and continuity of use influence the correlation between total fertility and the prevalence of contraceptive usage. The influence exerted by breast feeding during six months after childbirth, induced abortion and age of marriage is also recognized; in some countries the legal age for marriage is 16 or below. Thus, not all countries with similar contraceptive coverage exhibit similar fertility rates. (Table 8)

The Organization's assessment on conditions of efficiency for over 3,000 Maternal and Child Health Services in 22 countries reveals that Family Planning services have been inadequate, some are poorly managed and others limit their services to the distribution of contraceptives but lack an educational component. This results in obstructed access to contraceptives and difficulty in the continuity of use.

4. THE FUTURE SITUATION

When reproductive health is placed within the framework of sustainable development, there are multiplicity of demands which exceed the capacity of the health sector.

4.1 Needs and Demands

It is estimated that by the year 2000, the Region will have a population of 538 million, 65% of whom will be participating in the programs in maternal, child and adolescent care. There will be approximately 13 million births.

The challenges presented by reproductive health under the terms being defined will demand greater efforts and resources from public, private, governmental, nongovernmental and international support agencies. To attain this goal, it is imperative that services be distributed effectively, based on adequate and accurate information. It will also become necessary to increase the technical and financial resources to facilitate redirecting programs in order to make them consistent with the concept of comprehensive health.
In terms of fertility regulation, an enormous effort will have to be made to achieve the goal of 70% of women of child-bearing age (15–49 years old) who have a partner using contraceptives. To achieve 65 million users of fertility regulation services by the year 2000, the annual increase will have to be 3% - twice the annual growth percentage in recent years. This objective is feasible only if the benefits of fertility regulation and other reproductive health services can reach those groups which are presently deprived of them for cultural, economic and geographical reasons. Adolescents and the poor from marginal and isolated areas are considered priority groups. It is necessary to increase the coverage of the groups age 20-24 and, above all, the group age 19 years and under. It is also necessary to increase the participation of men of all ages in activities associated with contraception, giving priority to the younger age group. The effort must be directed toward optimal planning of health services to promote improvement in the quality of care in four areas: access, opportunity, continuity of health care received and user satisfaction. The objective would then be attainable.

4.2 Strategies and Lines of Action

The strategies approved in 1984, 1985, 1988 and 1991 remain valid and include the following:

- Improvement in collecting demographic and statistical data to allow better identification of groups showing the most serious problems, especially those within the Local Health Systems.
- Promotion of research and training in order to make reproductive health care viable.
- Support of activities that promote participation of the community.
- Integration of fertility regulation services into services of comprehensive care for the population and the family.
- Coordination among agencies and sectors for optimal use of resources.
- Technical assistance to the countries with a view toward increasing competency in the skills necessary to design, execute, monitor and evaluate plans, programs and projects for the development of reproductive health services that achieve increased coverage and quality of care.

With the objective of making these strategies operational within the updated reproductive health context, some necessary modifications are recommended for PAHO member countries and the Organization.

4.2.1 Costs and Financial Strategy

All estimates of the necessary costs to implement activities associated with reproductive health and fertility regulation are merely speculative since future economic conditions remain uncertain. Nevertheless, whatever the amount of the investment, it will have to be defrayed by both the government and nongovernmental sectors. Potential user fees to finance the investment
may also be needed.

Because the present economic circumstances of the Region are erratic and yield unstable costs, it is recommended that shared financial schemes be devised to make the programs sustainable in order to avoid neglecting, at any given time, those with the greatest needs. Thus, the State must assume a protective role and guarantee reproductive health services by subsidizing them for the poor. (27, 44, 46, 48)

Giving priority to fertility-regulation activities will be essential, as they are at the core of reproductive health. Devising adjustments in the policies, strategies, programs and services of PAHO’s technical cooperation will also be essential in order to maximize coverage and quality in order to attract more users and retain them.

Efforts will have to be continued to ascertain the real costs of reproductive health because these data are minimal in the Region. Sound information can lead to more effective alternatives.

It is advisable that countries bear the necessary costs for the procurement of contraceptives as this will relieve them from the dependency they now have on external donations. This would reaffirm their political and financial commitment and, without a doubt, lessen their vulnerability, especially if external sources of assistance to Latin America continue to diminish.

The joint efforts of the health sector, especially those that originate locally and from PAHO, have great importance for the generation of operational proposals. These cooperative efforts will facilitate access to funds designed for social development available from the Inter American Development Bank (IDB), the World Bank and PAHO/WHO. Bolivia, Ecuador, Peru, Mexico and Venezuela are presently using this resource and other countries can resort to this financial avenue in the future. Proposals for obtaining bilateral or multilateral assistance must be generated and presented at fund-raising meetings.

4.2.2 Political Support

Future strategies should aim at obtaining the highest level of political support.

With respect to external political support, three goals should be:

- Fulfillment of the goals set forth at the 1990 United Nations Summit for Children in New York;
- Participation of the health sector in the Third International Conference on population in September 1994 in Cairo;
- Participation of the health sector in the Conference on Women and Development in 1995.

Delegates to these Conferences and representatives from governmental agencies, the social security system, the private sector and non-profit health organizations should take part in
national discussions to define the role of the State, and to agree upon the policies and programs that are necessary for progress in reproductive health to occur. The coming together of the various institutions that provide services and that are involved in reproductive health in order will foster and reinforce a spirit of cooperation in devising innovative and effective strategies.

Similarly, the activities of the health sector during the International Year of the Family in 1994 will be important to evaluate needs and generate proposals based on them, so that governments can later present them during the Conference on Women and Development to be held in 1995. Efforts made on these interrelated aspects will give the countries the opportunity to revise their plans to further national development in the 21st century.

At the national level, the health sector should initiate an open dialogue with the national agencies responsible for social and economic planning to achieve greater influence in the formulation of developmental plans, population policies and resource allocation. It is necessary that the health sector disseminate information on the progress being made in reproductive health. Scientific findings and updated information can be instrumental for negotiating policies and accentuating the potential gains of decreased fertility rates. Combining forces with governmental agencies responsible for population and health matters has proved to be an effective avenue in several countries.

4.2.3 Legislative Strategies

Governments could make reproductive health and fertility regulation services more accessible to the population by eliminating restrictions on the acquisition of contraceptives and added production as well as eliminating import taxes on contraceptives. It is also important that properly trained staff distribute contraceptives to the community.

Legislative revisions concerning the minimal age to marry are also advisable in order to make it compatible with social trends and adequate health practices. Sex education must be incorporated into the educational system. Sex education should begin early to develop permanent roots in individuals and society. Given that current laws foster the existence of illegal abortion clinics where abortion is performed under precarious conditions, laws must encompass appropriate treatment for induced abortion in the beginning stages and for complicated cases as well, without making criminal charges against the physicians and/or women involved.

It is also important for countries to increase accessibility to contraceptives by making necessary revisions in the laws that prohibit the acquisition and use of contraceptives. Ensuring the promotion of breast-feeding until the newborn is six months of age and revising laws which give tax exemptions to large families would also constitute substantive efforts.

4.2.4 Participation by the Least-Protected Groups

The programs in the Americas have reached a coverage level that demands that the populations for whom the services are intended be clearly identified, and that the plan of action be equally well-delineated for each group. Specific objectives and indicators should be
established for all intended activities. By doing so, monitoring and continued assessment of the actual outreach of services to the targeted groups can be improved. All members of marginal urban areas, isolated rural groups, adolescent and adult males should receive special care which is consistent with the economic and social conditions of the country. Governments and communities should determine the priorities to be followed, although it is recommended that adolescents be given highest priority, as they are exposed to innumerable risks and they hold the key to the future.

Mechanisms should also be developed to urge and guarantee active participation from the community and specific target groups to define the kinds and constellation of reproductive health care services needed. Program objectives must be revised to focus more on quality control of the services provided than on expansion of conventional coverage.

4.2.5 New Sources for the Delivery of Services

Opening new channels of outreach and distribution, such as community based distribution and social marketing, in response to the needs for fertility regulation should be assessed. This is a particularly important proposal given the limited ability of government services to reach all scattered rural areas, and the information already available on the practicality of programs and acceptance by the community of all related activities.

4.2.6 Quality of Care

The quality of services offered is considered a key element. Therefore, it will be necessary to train health care staff to focus on sexuality and reproductive health as components of the comprehensive health of the population. In addition to technical education, training should teach health care workers to be aware of their potential as well as their limitations of and instill respect for the population's reproductive health needs. The issue of values should also be a substantive element of training, by imparting the fundamental notion that value judgements and disregard for the opinions of others are a great disservice to health care patients. A bioethical approach is crucial to all levels of sexuality and reproductive health care.

New technologies and alternatives developed in recent years will probably help to influence and eventually reshape contraceptive use patterns. Recent developments include: the expansion of the post-partum programs; extension of the use of oral contraceptives for women up to the age of 45 and the use of intrauterine devices for as long as nine years; the approval of Depoprovera as a contraceptive method; the introduction of Norplant, Cyclofen and RU486, post-coital emergency contraception and new vasectomy and salpingectomy techniques. These changes should be considered when program guidelines undergo revisions. Nevertheless, these changes will also be subject to the flexibility that social attitudes, programs and services exhibit in adopting available technologies. (49, 50, 51, 52, 53)

Contraceptives should be included in the medical procurement list of the individual countries, and the appropriate resources should be guaranteed to ensure easy access to a wide
array of services. Standards should reflect the latest information on contraceptive prescription and, on this basis, decisions should be made concerning what available methods will be included in the programs. It would be ideal to offer a reasonable number of alternatives so that men and women can have the opportunity to choose among them according to their own needs.

The need for programs to include all methods is not envisioned. However, it is essential that each program offer adequate and timely information concerning all the available methods and a series of options from which users can choose.

The foregoing considerations indicate the urgent need to introduce the concept of quality care with a view to eliminating existing gaps. To this end the following measures are recommended: provision of complete and accurate information on the various methods; availability of a variety of methods in sufficient quantities to allow users to select the desired method; assurance that personnel have the necessary technical competence and skills to discuss the risks associated with each method; assurance that personnel have the social and verbal skills necessary to communicate effectively geared toward the user's education level; monitoring services to promote continuity of contraceptive use; an operational logistics system to ensure permanent availability of methods; provision of a wide array of services; extension of the hours during which services are offered; and continued inquiries on the perception of the users to ascertain if their needs are being met in a satisfactory way.

It must be remembered that interrupted and discontinued use, as well as the use of unreliable methods, contribute to the inability of some countries with high coverage to achieve the expected positive results. Finally, by creating a situation of easy access to various contraceptive options, the likelihood that a large percentage of couples will resort to contraceptives is highly increased.

4.2.7 Research Strategies

Given the important role of WHO’s Special Program on Human Reproduction and Training on Reproductive Research, it is recommended that its research policies and priorities be widely disseminated.

It is necessary to have a broad spectrum of information from basic information to new evidence on the development of new contraceptive methods, include these methods in the programs and evaluate their effectiveness and safety. It is also essential to have knowledge on the psychosocial and cultural aspects that influence the use of these methods.

The decentralization of the Program to the Region of the Americas should be strengthened, by developing and magnifying the existing networks of 13 collaborating centers and 74 institutions that participate in the Program. The further support and development of the Latin American Society for Research on Human Reproduction is equally important.
PAHO and its Member Countries will need to complement resources for their investment in operational research, which will enlighten and bring us closer to uncovering the factors that determine whether or not priority groups can be reached by reproductive health services. Other valuable information will be ascertaining the level of satisfaction that people express concerning the services, and the reasons that they have for using or discontinuing the use of contraceptives.

In recognition of the rich experience developed by women's groups delivering services in the Region, their approach should be considered and incorporated into this research. It is necessary to examine what kinds of services women want and how they can become actively involved in the process of organizing and evaluating these services.

4.2.8 Managerial Strategies

The achievement of the above proposals will require special efforts to improve the management of operational programs, projects and services. The current circumstances demand strategic programming and administration which guarantee a high degree of flexibility in adjusting to local situations and programs, the level of development of the services and the actual conditions of each country.

Decentralization of decisions and resources to local health systems will be encouraged, seeking ways in which programming can be conducted in accordance with the particulars and needs of the individuals and the population, and inviting greater participation and shared responsibility at the local level.

Training and supervision of technical and administrative personnel will constitute the main focus of the programs. The trainees will be in a position to bridge the system's gaps through provision of competent and quality care and the identification of people's needs and wishes associated with the promotion of health.

Furthering the development of systems of information on management and monitoring of reproductive health care will be of marked importance. The process should guarantee that data collected are essential to facilitate the decision-making process at the different levels of work within one sector or among sectors. To this end, greater analytical capability will be necessary as will widespread dissemination of the results of the analyses.

The inclusion of questions related to reproductive health in periodic household surveys needs to be promoted. Also, population and health surveys need to be conducted in the countries that lack current information. Research and data collection should be integral parts of the monitoring and evaluation processes, resulting in upgraded integration and revision of the program's objectives and work plans to reflect current needs and trends.

The systems of logistics will place emphasis on timely procurement and distribution of contraceptive methods in adequate numbers to prevent both under provision and overstocking, which would lead to additional costs.
The great need for good collaboration strategies is reiterated. These must be coherent and should complement managerial and technical strategies to produce activities that are designed for effective planning, implementation and evaluation of the Programs.

The fundamental aspects of the approach presented in this document are supported by the experience gained from various reproductive health services in different countries of the World and the Region. Nevertheless, the aim is to bring about a serious debate and assessment of the reproductive health practices of the population at the country level. The outcome of the process should be the revision and formulation of policies and programs associated with reproductive health which promote comprehensive health for individuals and groups, who, in turn, will contribute to the sustainable development of the population.

In summary, based on the proposals made throughout this report, the main modifications proposed in PAHO's Program of Technical Cooperation are:

a) To promote extensive use of census data, demographic health survey results and service statistics for reproductive health programming, monitoring and evaluation, especially at the level of local health systems. These must be complemented by an increase in information syntheses and dissemination of scientific and technical information on successful case studies and recent advances in the field of reproductive health and fertility regulation. Special emphasis must be placed on the aspects of new or improved contraceptive technology feasible for inclusion in the programs.

b) Technical support for the development of comprehensive review of policies programs and norms related to reproductive health and fertility regulation to allow a more rational use and coordination with intersectoral institutions such as the Ministries of Education, Labor, Finance and Planning, a better partnership within Government, private for profit and non governmental organizations. Proposals to update standards will be developed to improve the use of the scarce available resources. National and regional meetings will be held to discuss how diverse reproductive health activities can be integrated. Standards for contraceptives available to programs, prescriptions and especially counselling in reproductive health will be reviewed and further developed.

c) PAHO will ensure that regional courses supported by the Organization included updated knowledge on reproductive health. At all levels of human resources development, counselling skills will be included in the training of service delivery personnel. Updated standards and norms will be used as teaching tools in order to pursue skill oriented training.

d) Operational research will be a priority, especially research oriented toward understanding qualitative aspects of fertility regulation and reproductive health such as non-users perceptions of fertility regulation messages and services and the
decision-making processes for accepting the use of methods.

e) Mobilization of international resources to allow the implementation of PAHO's technical program and national reproductive health program development will be a priority. Projects specifically geared to reproductive health teaching at the school level will be developed and supported. Male participation in reproductive health and fertility regulation activities and projects will be presented to international donors and promoted within the national programs. The development of services for males and adolescent populations is the greatest challenge to the development of PAHO's projects.

Resources to develop national and regional projects will be available at the country levels. Special consideration will be given to explore the possibility of including some reproductive health projects financed by PAHO's Investment Plan on Health and Environment.

PAHO will continue to strengthen population, reproductive health and fertility regulation activities, where appropriate, through the Organization's new structure and programs. Coordination of the activities and programs will be more vigorous, with programs on women's health and development, disease control, health systems development and health policies programs.

PAHO's attitude and practice towards interagency coordination will continue to be a top priority and, in every possible way, will try to avoid the duplication of activities. However, an aggressive search for extra budgeting funds will be pursued in order to increase the feasibility of the proposed activities and the future development of these approaches at the country level.
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