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# PROGRAM BUDGET

PAN AMERICAN HEALTH ORGANIZATION, PROPOSAL, 1994-1995
WORLD HEALTH ORGANIZATION, REGION OF THE AMERICAS, 1994-1995
PAN AMERICAN HEALTH ORGANIZATION, PROJECTION, 1996-1997
WORLD HEALTH ORGANIZATION, REGION OF THE AMERICAS, PROJECTION, 1996-1997

**PAN AMERICAN HEALTH ORGANIZATION**
**Pan American Sanitary Bureau, Regional Office of the**
**WORLD HEALTH ORGANIZATION**

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# LETTER OF TRANSMITTAL

THE DIRECTOR OF THE PAN AMERICAN SANITARY BUREAU, REGIONAL OFFICE OF THE WORLD HEALTH ORGANIZATION, HAS THE HONOR TO PRESENT THE FOLLOWING FOR CONSIDERATION:

1. THE PROPOSED PROGRAM BUDGET OF THE PAN AMERICAN HEALTH ORGANIZATION FOR THE FINANCIAL PERIOD 1994-1995

2. THE PROGRAM BUDGET OF THE WORLD HEALTH ORGANIZATION FOR THE REGION OF THE AMERICAS FOR THE FINANCIAL PERIOD 1994-1995

3. THE PROVISIONAL DRAFT OF THE PROGRAM BUDGET OF THE PAN AMERICAN HEALTH ORGANIZATION FOR THE FINANCIAL PERIOD 1996-1997

4. THE PROVISIONAL DRAFT OF THE PROGRAM BUDGET OF THE WORLD HEALTH ORGANIZATION FOR THE REGION OF THE AMERICAS FOR THE FINANCIAL PERIOD 1996-1997

CARLYLE GUERRA DE MACEDO
DIRECTOR

## SOURCES OF FUNDS

PAHO

PR - PAHO REGULAR BUDGET

PA - INCAP MEMBERSHIP AND MISCELLANEOUS FUNDS
PN - INCAP GRANTS AND CONTRACTUAL AGREEMENTS
PM - INCAP AID/ROCAP GRANT
PC - CAREC MEMBERSHIP AND MISCELLANEOUS FUNDS
PJ - CAREC GRANTS AND CONTRACTUAL AGREEMENTS
PH - CAREC BUILDING FUND

PB - BUILDING FUND
PD - NATURAL DISASTER RELIEF VOLUNTARY FUND
PG - GRANTS AND CONTRACTUAL AGREEMENTS
PK - SPECIAL FUND FOR HEALTH PROMOTION
PL - SPECIAL FUND FOR ASSOCIATED AGENCY: UNDP AGREEMENTS
PU - SPECIAL FUND FOR ANIMAL HEALTH RESEARCH
PX - PROGRAM SUPPORT COSTS

WHO

WR - WHO REGULAR BUDGET

INCOME FROM UNITED NATIONS SOURCES:

DP - UNITED NATIONS DEVELOPMENT PROGRAM (UNDP)
DR - UNDP SPECIAL PROGRAM RESOURCES
FB - ASSOCIATE PROFESSIONAL OFFICERS
FD - UNITED NATIONS FUND FOR DRUG ABUSE CONTROL
FP - UNITED NATIONS POPULATION FUND

TRUST FUNDS:

FX - GLOBAL PROGRAM ON AIDS
ST - SASAKAWA HEALTH FUND

VOLUNTARY FUND FOR HEALTH PROMOTION:

VB - SPECIAL ACCOUNT FOR PREVENTION OF BLINDNESS
VC - SPECIAL ACCOUNT FOR DIARRHEAL DISEASES INCLUDING CHOLERA
VD - SPECIAL ACCOUNT FOR MISCELLANEOUS DESIGNATED CONTRIBUTIONS (OTHER)
VG - SPECIAL ACCOUNT FOR MEDICAL RESEARCH (SPECIFIED)
VI - SPECIAL ACCOUNT FOR THE EXPANDED PROGRAM ON IMMUNIZATION
VL - SPECIAL ACCOUNT FOR LEPROSY PROGRAM
VW - SPECIAL ACCOUNT FOR COMMUNITY WATER SUPPLY
VY - SPECIAL ACCOUNT FOR YAWS PROGRAM

AS - SPECIAL ACCOUNT FOR SERVICING COSTS
EF - REAL ESTATE FUND

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## GLOBAL CONTEXT

### I. Political

1. The 1994-1995 biennial program budget is the first to be designed entirely in the post cold war era. The bi-polar strategic competition which for 45 years had dominated the international arena and established the fundamental laws of nation-state relations ended finally with the break-up of the Soviet Union and the re-establishment of national identities more familiar in 19th century world maps.

2. The movements toward greater political freedom and more open economies were halting, although apparently irreversible. However, few have achieved stability. The struggle for national identity in the former Soviet Union and in Eastern Europe produced a level of violence in some cases which challenged the response capacity of the international community. In the former Yugoslavia, open civil war yielded additional evidence of the virulence of ethnic rivalries along with massive human suffering and physical destruction.

3. Past security, political and economic arrangements among Western European nations required revision and adjustment. The final shapes and configurations of those relations also remain somewhat ambiguous. At the same time, while the unification of Germany and the strides toward greater European monetary and political integration held great promise, they also added somewhat to the level of political uncertainty. Nevertheless, it appeared clear that trends toward integration were continuing, along with rising demands for international resources no longer committed to the costs of the East-West confrontation. Those resources once were presumed to be a peace dividend available for meeting third world development needs.

### II. Economic

4. Instead, the political changes took place amid the decline of the economic strength of the former Soviet Union and the transformation of that nation from a provider of international aid to a major recipient. The former Eastern European countries also faced a change from state-directed economies with heavy subsidization of capital and consumer industries to market-oriented economies. The consequent adjustments yielded rising unemployment and reductions, hopefully temporary, in output and social well-being. Those conditions placed additional demands on the international system for assistance.

5. The global economic system, although recovering from the debt crisis which had dominated much of the economic debate of the 1980s and the recession of the early 1990s which affected many of the largest industrial nations, clearly has not yet embarked on a path of self-sustaining growth.

6. Virtually every industrial country has sought to maintain controls on public sector spending in order to reduce fiscal deficits and the pressures on foreign assistance, particularly bilateral aid, have intensified.

7. Finally, the economic strategies of both the developed and the developing world have been forced to cope with the threat of environmental degradation. The consequence of the United Nations Conference on Environment and Development (UNCED) in Rio de Janeiro, Brazil was to confirm the requirement for all nations to create institutions, undertake research, and adjust economic plans to avoid environmental risks. All of these actions, while essential to healthier societies, also competed with the health sector for attention and resources.

### III. United Nations Reform

8. There are three basic forces driving the current reform movement in the United Nations. The first is the end to the East-West conflict and the distortions it produced in the decisionmaking, priority-setting, and resource allocations of the UN system. As many have noted, the UN's potential to fulfill its original mandate in promoting international security, advancing democratic values and protecting individual rights has leaped forward simply by the removal of cold war constraints. Nevertheless, as events in Bosnia, Somalia and Angola demonstrate, there is no automatic expansion of the UN capacity to realize that potential. However, the global hope and expectation is that the resources will become available, new methods will evolve and, over time, new international instruments will be created to enable the UN to successfully accomplish its peace-building, peace-making and peace-keeping roles.

9. The second force is linked to the first, because within the peace-building role, is the resolution of underlying causes of conflict. Among those causes is the global disparity in social, economic and political development, most evident in the 1.7 billion people who live in poverty today, 1.5 billion of them in the developing world. Finding ways to contribute to the goals of human development, as defined in health for all, in the world summit of children, and in UNCED constitute a challenge that the Secretary General has called an essential part of his Agenda for Peace.

INTRODUCTION (Cont.)

10. A third force for change are, as previously noted, the limits on the resource availability to finance international assistance, including the work of international organizations. The UN reform, designed to improve the system's efficiency, has altered the structure of the UNDP and other institutions, which in the past have collaborated with PAHO in promoting health objectives.

IV. World Health Organization

11. These three factors have combined to raise the competitive stakes for supporting the health sector and the World Health Organization, in particular. In addition, the break-up of the Soviet Union has not yet been followed by sufficient economic recovery of the new member states to enable them to replace the previous WHO quota contributions of the USSR. The consequence during the current biennium has been a 10% reduction in the previously approved WHO budget allocation to the Region of the Americas (AMRO).

12. This unexpected reduction has deepened a trend previously noted for an ever smaller share of WHO resources to be allocated to the countries of the Region of the Americas. This shift also has taken place at a time of extended economic difficulties in the Americas.

REGIONAL CONTEXT

V. Political

13. Within the Western Hemisphere, the dominant political fact remains the restoration of the democratic ethos throughout the region. Only a few countries have withstood the general political movement incorporating constitutional reform, acceptance of free and open electoral processes, and formal acceptance of the obligation to protect human rights. Although there are any number of tears in that political and ideological fabric, they constitute aberrations which not only are condemned but draw multilateral action, both by the Organization of American States and by the United Nations, to seek to repair the damage.

VI. Economic

14. The decade of the 1980s constituted a watershed in the economic development process in Latin America and the Caribbean. The debt crisis, the economic adjustment process, trade liberalization and privatization altered the region's economic profile. Fiscal deficits began to be reduced. Inflation was lowered significantly in most of the nations of the region and trade barriers were removed. Nevertheless, overall per capita income declined 9% during the decade, leaving incomes at average levels similar to those in 1977. For the region, the declining levels of family income meant nearly 60 million more people living in poverty by the end of the decade.

15. Recovery clearly began in 1991 and, in 1992, the region's end-year economic picture contrasted favorably with that of the previous decade, according to the UN Economic Commission for Latin America and the Caribbean (ECLAC). First, gross domestic product increased by some 2.4% for the region, the second year in a row of growth. If Brazil is excluded, the average regional growth was 4.3%, despite declines also experienced by Haiti, Peru and Barbados. Regional per capita GDP actually rose by .5%--also the second year in a row. Second, most countries were able to control the level of inflation--with Brazil again an exception. Consumer prices rose by 410% in the region as a whole. Excluding Brazil, inflation rose by an average of 22%. Third, despite a net balance of trade deficit of nearly $6 billion, $57 billion in new capital flowed into Latin America and the Caribbean, producing the most favorable net transfer of resources into the region in a decade, $24 billion. Equally positive is the reduction in the percentage of exports required to service the external debt--19%, again the lowest in a decade.

16. The terms of trade for Latin America and the Caribbean have continued to worsen over time, as the relative values of the region's exports against imports is 22% lower today than in 1984. Nevertheless, exports rose for the third year in a row in 1992 to $126 billion. Imports increased far more steeply--some 18% to a level of $132 billion. The future trade perspective is positive. The movement toward the North American Free Trade Zone, advances toward subregional free trade zones in Central America, the Southern Cone (Mercosur) and the signing of a series of bilateral free trade agreements demonstrated the vigor of the hemispheric commitment to trade as a driving force for economic growth.

17. These indicators of economic recovery in many countries also were paralled by a general acceptance of a more market-oriented economic approach and the liberalization of national economies, regardless of the political party in power. The negative side to the coin, however, was evidence of still rising numbers of people dropping below the poverty line. The consequences of the adjustment process and of the initial failure to produce effective social safety nets have damaged basic living conditions. More than 200 million persons now live in poverty, according to ECLAC, some 46% of the population, up from a third of the population in 1980.

## VII. Health conditions

18. Health conditions in the Americas must be examined in light of the current demographic contours. Since 1950, the population has climbed to more than 718 million, 277 million in the industrial nations of North America which increased by 40% and 441 million in Latin America and the Caribbean where the population climbed 167%. By the year 2025, the industrial nations will have reached 341 million, a 23% increase and the countries of Latin America and the Caribbean, 702 million, a 59% increase. Although there has been a continuing decrease in the rates of population growth for all countries, the differences among the countries remain marked, with a few still facing rates of growth as high as any in the world.

19. Within the Latin American and Caribbean population, the proportion below the age of 20 remains a majority and, although the trend lines are moving toward a larger elderly population cohort more similar to that of the US and Canada, little change will appear in the near term. Even by the year 2000, the median age will remain 22. Nevertheless, there will be growing numbers of older Americans. In 1950, there were 5 million over the age of 65 in Latin America and the Caribbean; today, there are 21 million. Similarly, the population remains heavily urban, with the entire region, north and south, close to 75% urban. In fact, 90% of the total population growth between 1950 and 1990 in Latin America and the Caribbean took place in urban communities.

20. All of these factors impact on the character of the health problems facing the region and the nature of the demands for health services. It is evident that the rate of investment in the basic infrastructure of water, sanitation, housing, education and health facilities did not keep pace with the burgeoning population. Particularly in the larger cities, where the population growth was concentrated, the lack of adequate facilities and the failure to expand the labor market yielded a deterioration in living conditions, contamination of water and air, growing violence and massive poverty.

21. The infant mortality rate (IMR) has declined throughout the region during the previous three decades, from an average of 125 deaths per 1000 live births to an IMR of 53. The IMR range spans countries as low as 9 IMR to those with as high as 98 IMR. In general, North America remains near an IMR of 9, the English Caribbean at 21, and Latin America at 55. Ten Latin American countries still have IMRs greater than 60. The average rate of reduction slowed considerably during the decade of the 1980s, partly because of the increased difficulty to achieve reductions at lower levels and partly due to the impact of the economic crisis. The latter factor, along with the consequences of civil conflicts, produced reports of actual increases in infant mortality in two countries.

22. Overall mortality rates also have continued to decline and life expectancy at birth has risen to 67. Again the range varies from 55 to 75 years. The reductions in mortality can be attributed generally to reductions in deaths from diarrheal diseases and acute respiratory infections in children under five; perinatal causes and reductions in deaths due to childhood diseases preventable by immunization, tuberculosis and malaria. In each of these instances, the direct intervention of the health sector has been a major factor, as access has been increased at the local community level to oral rehydration therapy, appropriate ARI control measures, immunization and access to appropriate medical treatment.

23. The current profile of mortality and morbidity shows both the prevalence of the traditional diseases of developing countries and the transition to the diseases of modernity. Diarrheal diseases and acute respiratory infections still account for between 30 and 40% of all child deaths. While communicable diseases such as malaria and dengue fever are less prominent as causes of mortality than in the past, the region is seeing an increase in the incidence of both diseases. At the same time, those traditional diseases increasingly are being challenged by a rise in the prevalence of cardiovascular diseases and cancer, by violence and by AIDS.

24. In virtually every country, the disparities between different regions and vulnerable population groups remain a matter of great concern. For example, for every 100 persons living in urban areas with access to health, water or sanitation, the numbers are nearly cut in half for those living in rural communities. Access to health services remains unavailable to some 130 million Americans, among them are 90 million women of child-bearing age and children. It is important to recognize that among the five principal causes of death among women of child-bearing age are complications relating to pregnancy, birth or the post-partum period. Today there are also 130 million people who do not have access to safe drinking water. Some 220 million do not have adequate sanitation facilities and barely 10% of the total volume of wastewater is treated before it is dumped into the rivers and seas of the region. Until those statistics are reduced, hundreds of thousands of the region's citizens will die needlessly.

## VIII. Development strategy

25. For a decade, PAHO and WHO have argued strongly that the social and human consequences of the adjustment process were not receiving sufficient attention. The arguments initially set forth in the World Health Assembly technical discussions of 1986 on intersectoral action for health, and in PAHO studies on the impact of the economic crisis and adjustment on health and on health and development, now appear to have acquired advocates in other sectors. The first of the arguments related to the right of human beings, as spelled out in the International and American Covenants on Human Rights, to have access to basic

conditions of health, and within societies, not to be discriminated against in receiving those services. The second related to the indivisible nature of many health threats, in which small groups of individuals could not survive unaffected by unhealthy conditions afflicting the majority of their neighbors. A third argument was based on the demonstrated proof that preventive interventions within a primary health care strategy were available, feasible, and effective.

26. A final argument was based on a conviction that the economic growth models being established required capable labor forces, an expanding national consumer market, and rising, as opposed to declining, levels of public satisfaction with the political and economic order. Economic development and the modernization of the regional economies clearly demanded time for the benefits to be realized. Unless some more direct response to social needs and to the gaps in health, education and housing were found, it was doubtful that many democratic societies could retain their social cohesion to provide that time.

27. The echoes to that argument now are being heard in many corridors of power. They have become part of the stance presented by the IDB and the World Bank to justify increasing the portion of their lending dedicated to the social sectors and to health, in particular. They have become a significant part of the dialogue with member countries in looking at their new economic planning and budgeting over the remainder of the decade. When defined as investment in human capital, they also have become a key element in the platforms of leaders of developed nations as to their long-term strategies for keeping their own societies competitive in the coming decades. Nevertheless, those views are still not fully evident in national, regional and global economic development resource allocations.

## DEVELOPMENT AND ANALYSIS OF THE PROGRAM BUDGET FOR 1994-1995

### IX. Transition

28. Within that global and regional context, therefore, one sees a transition in the dominant political and economic theses affecting Latin American and Caribbean development. The 1994-1995 program budget occurs within a time of transition and also constitutes in many ways a transition towards the new millennium.

29. Within the Organization, the 1994-1995 budget spans the conclusion of the Strategic Orientations and Program Priorities 1991-1994 (SOPP), the adoption of the SOPP 1995-1998 and the first year of implementation of that policy document. Therefore, the program budget has been constructed in part based on the evaluation of the first two years of the current SOPP and a conscious attempt to look forward to the lines of health development already appearing on the horizon and likely to become more solid and permanent as we move toward the end of the century. The budget development process also reflected the first conclusions to the examination of the trends being produced in the preparation of Health Conditions of the Americas 1991-1994.

30. Another aspect to the proposed program budget's transitional nature is the clear direction already marked out in the proposed Ninth General Program of Work of WHO. The four major lines of action are; integrating health and human development in public policies, ensuring equitable access to health services, promoting and protecting health, and preventing and controlling specific health problems. For PAHO, these lines of action offer additional support to the priorities of the Organization since each of these orientations can be found previously in PAHO's 1991-1994 SOPP. In addition, in the Region of the Americas, the health impact of inadequate levels of water and sanitation and the concerns for reducing levels of pollution have given the area of environment and health a level of priority equal to those other areas of strategic concern.

31. Finally the budget is a transition toward the final chapter in the quarter-century drive for Health for All by the year 2000. The quadrennial evaluations of progress toward those goals have demonstrated important advances; although many nations in the region still are distant from one or more of the regional HFA goals.

### X. Structure and priorities of the budget

32. The Biennial Program Budget is the Organization's instrument for translating the SOPP, General Program of Work and other global and regional policy decisions into its two-year program of technical cooperation and its allocation of resources to carry out that program. Its preparation required the joint review of the existing PAHO/WHO program of technical cooperation, regional policy goals and strategies and national needs.

33. Country programs were analyzed in light of those policies, the country's socioeconomic and health situation, national health development goals and its strategies and plans. Examining the available national and external resources, the gaps in country needs are defined and national programs of technical cooperation designed. Country program allocations continue to represent both the largest single component of the budget and the lodestone of the Organization's

technical cooperation. Technical cooperation among countries also is one of the important strategies within the Organization and a specific program was created to promote that strategy. Specific Country programs constitute 38.3% of the program budget of the Organization, increased from 37.2% in 1992-1993, reflecting both the mandate of the governing bodies and the managerial strategy of the Organization. The Organization's total technical cooperation in the countries reaches 82.7% of the proposed budget.

34. The managerial and general direction of the Organization encompasses both the Governing Bodies and the General Program Development and Management. Its objective is to assure that all of the resources of the Organization are focussed on fundamental strategic goals in the most efficient and effective manner. Given the quantitative limits on financial resources and the increasing scarcity of the needed human resources, the managerial strategy is even more crucial in assuring the right people in the right places to respond to the fundamental health challenges facing the nations of the Americas. It is here that the overall planning and programming system of the Region of the Americas is coordinated. The basic executive functions also are carried out through the executive management and other programs within this area. In addition, the external coordination activities of the Organization, not only crucial with reference to mobilization of financial resources but maintenance of relations with other international agencies, both public and non-governmental, are financed through this program. The Director's Development program, which provides the only specific flexibility to respond to emergencies, innovative and unexpected situations during the biennium, also is conducted in this program area. The proposed budget reduces an already low percentage of budget funds dedicated to these activities to 7.8%.

35. All regional programs are developed from an awareness of the status of health development in Member Countries and a primary vision of how regional technical cooperation can improve those conditions. The allocations among regional programs also respond to the strategies and priorities defined in the Organization's guiding policy documents.

36. The health system infrastructure part of the budget encompasses the program budget chapters of health policy development, managerial process for national health development, health situation and trend assessment, health services based on primary health care, human resources development, health information support and research promotion and technology development. It encompasses the entire relationship of health to other sectors as well as the structure, financing and efficient delivery of services within the health sector. As health is seen more and more as an essential contribution to economic growth and a critical factor in the human development equation, the program budget attempts to engage the Organization in assisting countries to meet these strategic goals. Those goals encompass the role that health can play in strengthening and responding to the democratic transition which has helped change the political features of the hemisphere. Similarly within this broad program area, the Organization recognizes the importance of promoting a new recognition of the status of women in health and in society, of the discrimination experienced by women within the health care system and in both de jure and de facto terms in the economy at large. The program seeks to open new opportunities for women and, through this process, also to press for improvements in the health conditions of women.

37. The concern for promoting the extension of health services through decentralization and strengthening of local health systems continues to dominate the Organization's effort to ensure equitable access to quality health services. Past analyses have shown inequities in access to services and inequalities in health conditions affecting vulnerable population groups. That challenge remains a major organizing concept in the proposed program budget. The overall program of health system infrastructure will receive a 49.3% share of the budget.

38. The social debt from the 1980s had its reflection in the appearance of cholera and in the evident and growing inadequacies in the health, water and sanitation infrastructure around the region. The Organization responded with a broad and comprehensive 12-year plan to remedy those conditions which drew the approval of the 2nd Iberoamerican Presidential Summit in Madrid in 1992 and set in motion a key element of the new strategy for the coming biennium and the decade itself. On its own, the plan spelled out one important way to respond to the health, environment and development paradigm which had been defined at the Rio UNCED conference. The proposed budget reflects that priority.

39. The proposed program budget also reflects an effort to expand the environmental protection technical cooperation offered to the countries as many find those issues rising on their national political, economic and health agendas. Both in pursuing access to additional sources of clean water supply and assisting countries in assuring the quality of drinking water, the Organization will be expanding its environmental health technical cooperation program. Similarly, the Organization will assist member countries in formulating, monitoring and enforcing regulations to prevent contamination of water and air from pollutants, and the spread of toxic chemical waste. The budget chapter share for all environmental protection activities has increased from 7.6% to 8.0%.

40. Also within the part of the budget related to health science and technology, maternal and child health programs have been given higher bureaucratic visibility within the administrative structure of PAHO and increased attention in terms of financial resources as well. Not only within the general policy mandates

of the Organization but within the political demands of the chief executives of the member countries at the World Summit on Children, the goals of the maternal and child health program were assigned highest priority. The capability of the immunization, ARI, and ORT interventions to improve health conditions is no longer questioned. Nor is the efficacy of prenatal care and effective integration of family planning education and methods. The critical issue is how to assure access to those services across all social strata within the member countries. The 1994-1995 budget is designed to help advance that process, assigning 5.0% to that program.

41. Also within this part is the program area of communicable diseases to which the Organization has continued to assign a high priority. The recent success in eradicating the transmission of poliomyelitis not only constitutes a proud accomplishment; but it also serves as a model to replicate with respect to other disease control, eradication and elimination targets for the future. The budget reflects these concerns along with the previous decisions of the governing bodies to pursue the elimination of measles, leprosy, chagas and neo-natal tetanus. Similar eradication targets exist with respect to onchocerciasis and non-venereal treponematosis. AIDS and other sexually transmitted diseases also constitute areas of dramatic concern within the mortality and morbidity patterns prevalent in the region. The rising rates of infection from malaria and dengue fever also require increased attention. Disease prevention and control programs now constitute 6.0% of the budget.

42. In this area, food and nutrition and veterinary public health programs are located. There is an obvious linkage between the two, as the first pursues more adequate knowledge and use of nutritional foods, reducing and ideally eliminating diseases linked to iodine, vitamin A and other nutritional deficiencies and the second is linked to protection of foods, eradication of foot-and-mouth disease and prevention and control of zoonoses, all of which have a direct impact on individual nutrition and well-being.

43. In the program area of Health Promotion, efforts with respect to alcohol, drug abuse and tobacco use will continue to receive high priority. However, the trend will be to emphasize integrated strategies such as social communication, promoting healthy communities and healthy life styles and creating public policies which assess technologies with the aim of reducing risk factors and of improving health care. In addition, the growth of violence as a public health problem in the region has generated a judgment that more resources will need to be dedicated to assisting countries in responding to this threat. Health promotion already has been given a far sharper presence within the structure of the Organization and in resources, it will reach 2.9% of the budget in the 1994-1995 biennium.

## XI. Analysis of the Budget

44. The provisional draft of the 1994-1995 PAHO/WHO program budget was previously projected in Official Document No. 239 of May 1991. The projected increase at that time was estimated to be 12.4% over the 1992-1993 budget which had suffered program reductions in excess of $9.3 million due to United Nations mandated increases, overall cost increases caused by inflation, and by WHO funds for this Region being restricted to an increase of 9.9%, at the time the cost increase between 1990-1991 and 1992-1993 was 19.7%. Despite the program reduction of $9.3 million, reflecting a decrease of 4.8%, the 1992-1993 increase was 14.9%, even after the elimination of 74 posts. Since this Region's portion of the WHO regular budget had been limited to an increase of 9.9%, the PAHO portion of the regular program budget required an unusual increase of 17.3%. During the current 1992-1993 operating period, the financial situation of WHO has worsened due to the lack of quota contributions, and the Director General of WHO imposed a 10.0% internal reduction. This reduction, amounting to $7,149,100 for this Region, more than offset the already restricted increase of 9.9%.

45. The WHO portion of the 1994-1995 proposal, amounting to $80,070,000 and reflecting an increase of 12.0%, was recommended to the Director General of WHO by the September 1992 Directing Council, acting as the WHO Regional Committee for the Americas. In an effort to hold the global WHO budget increase to approximately 12.0%, the May 1993 World Health Assembly approved a global budget of $822,101,000 which represents an overall increase of 11.86% and requires an overall quota increase of 14.07%. The budget for the Region of the Americas was reduced to $79,794,000, an increase of 11.61%.

46. The formulation of the combined PAHO/WHO regular program budget proposal started over a year after the formulation of the regional WHO budget. The combined tentative proposal was discussed with the Subcommittee on Planning and Programming this past April. The $250,958,000 tentative proposal was composed of $80,070,000 on WHO regular funds and $170,888,000 on PAHO regular funds. The increase on both funds was 12.0% over 1992-1993, comprised of 12.2% cost increases related to inflation and mandatory United Nations increases and program reductions of $452,800 or 0.2%. The tentative proposal would have meant an annual increase of approximately 6.0%.

47. While the tentative PAHO/WHO proposal was viewed as reasonable, the Subcommittee, as well as the Director, expressed concern with the resulting PAHO quota increase of 17.74%. The reason for this substantial quota increase is due to the composition of the base 1992-1993 funding. The PAHO budget for 1992-1993 is $152,576,000. This budget is funded by $136,903,000 from Member Country contributions, $9,700,000 in projected Miscellaneous Income, and $5,973,000 for the Exchange/Inflation Rate Differential, the latter unavailable in 1994-1995 since the funds have been utilized. Member Country contributions currently fund 89.7% of the PAHO budget. Since the Exchange/Inflation Rate Differential will not be available in 1994-1995 and Miscellaneous Income is projected at the same level of $9,700,000, Member Country contributions toward the PAHO regular budget proposal of $170,888,000 would amount to $161,188,000 or 94.3% of the total.

48. The proposal for 1994-1995 contained in this document amounts to $244,260,000, composed of WHO regular funds of $79,794,000 and PAHO regular funds of $164,466,000. This revised 1994-1995 proposal is $6,698,000 less than the tentative proposal presented to the Subcommittee. The details of the proposal are explained in the various tables in the document as described below. The overall increase over 1992-1993 is $20,193,000 or 9.0%, approximately 4.4% annually. This is an extremely conservative proposal which requires program reductions, as was the case in the 1992-1993 proposal, although not as drastic. The program reductions amount to $2,674,300 or 1.2%. Cost increases are being held to 10.2%.

49. As mentioned above, the PAHO regular portion of the proposal is $164,466,000, an increase of only 7.8% over 1992-1993. This reflects an annual increase of approximately 3.8%. The Director is proposing that the $164,466,000 PAHO regular budget be funded by Member Country contributions of $152,766,000; projected Miscellaneous Income of $9,700,000, and expectations that 1992-1993 income will exceed the budget requirements by $2,000,000. By funding the 1994-1995 budget in this manner, overall Member Country contributions will only increase by 11.59%, rather than the 17.74% increase previously discussed with the Subcommittee.

50. There are several tables and graphs which present the program budget in the various ways requested by the Governing Bodies. Explanations of these tables and graphs are included in the following paragraphs.

51. Table A on page 9 summarizes the PAHO and WHO regular regional budget history since 1970. The PAHO regular portion of the 1994-1995 proposal is 67.3%, while the WHO regular portion is 32.7%.

52. Table B on page 10 is divided between posts on PAHO/WHO regular funds and posts on extrabudgetary funds. On the PAHO/WHO regular funds, there is an overall reduction of 13 posts, only four of which were in country programs. Over the four year period, 1992-1995, 87 posts will have been eliminated. The decline in posts on extrabudgetary funds is caused by the inability to predict commitments in future years.

53. Graphs I and II on pages 11-12 illustrate the information provided in Table C on page 13. Table C provides an analysis of the PAHO/WHO regular program budget by location categories and by program and cost increases or decreases. Program increases relate to those new items in the location category which were not included in the 1992-1993 program. A program decrease pertains to those items which were included in the 1992-1993 program but were eliminated in the 1994-1995 proposal. Cost increases include estimates of inflation and United Nations mandated increases such as salaries, post adjustments, per diem rates, etc.

54. The cost increase factors change by location. All posts in the regular proposal are costed based upon the latest actual post costs by grade and location of the post. For general elements such as supplies and equipment and general operating expenses, the cost increase factor used is 8.2% for Washington or approximately 4.0% annually. The latest US Government figures show inflation at 4.3%. An overall cost increase of 13.4% is being used for field locations. This amounts to approximately 6.5% annually. According to the United Nations Economic Commission for Latin America and the Caribbean (ECLAC), inflation in Latin America and the Caribbean, excluding Brazil, averaged 22.0% in 1992. If this average inflation continues, the proposal will have to absorb the difference. The remaining two cost factors used relate to short-term consultant months and fellowship months. The STC average has been increased from $8,000 to $8,300 or 3.75%. The fellowship average of $2,000 has been held to the 1992-1993 level.

55. Table C shows the overall increase of 9.0%, composed of the cost increase of 10.2% and program decreases of 1.2%. Of this $2,674,300 program decrease, 74.9% comes from Technical and Administrative Direction, which was reduced from 15.6% of the program in 1992-1993 to 14.6% in 1994-1995. The smallest program decrease by far was made in country programs - only $98,500 or 0.1%. Country programs increased from 37.2% of the total in 1992-1993 to 38.3% in 1994-1995. In compliance with resolutions of the Governing Bodies, at least 35.0% of the PAHO/WHO regular funds are to be budgeted in direct country programs. The large program increase in multicountry programs relates primarily to the establishment of the Executive Secretariat of the Regional Plan for Investment in the Environment and Health and the new program related to Promotion of Bioethics. This latter program, which was initially presented to the Subcommittee at the level of $1,160,000, has been reduced to $760,000.

INTRODUCTION (Cont.)

56. Table D on pages 14 and 15 is a summary of the various funds committed to the Organization for 1992-1993 at this time. The 1992-1993 amount for extrabudgetary funds, $179,188,000, is the most accurate presentation of these funds since future commitments from external sources cannot be predicted for 1994-1995 and beyond at this time. For this reason, extrabudgetary funds beyond 1992-1993 appear to drastically decrease. Three funds in particular have decreased rather sharply even in the current 1992-1993 period compared to 1990-1991; the United Nations Population Fund is almost $9,000,000 lower, the Global Program on AIDS is almost $6,000,000 lower, and the United Nations Development Program is about $1,000,000 lower.

57. The various graphs and tables under Table E between pages 16 and 33 present the proposal, separated by funding source, in the program classification structure with the addition of the Promotion of Bioethics (HBE) program. The most logical presentation of the program is shown under Table E-3 starting on page 22 which combines the PAHO and WHO regular funds. These two funds constitute the core program of the Organization and should be considered together when analyzing the program budget.

58. Graphs III and IV on pages 32 and 33 illustrate the four main parts of the program. Part I, Direction, Coordination, and Management is 7.8% of the 1994-1995 proposal, down from 9.1% in 1992-1993. Part II, Health System Infrastructure accounts for 49.3% and Part III, Health Science and Technology is 31.9%. These latter two parts comprise 81.2% of the proposal and receive 99.2% of the overall budget increase proposed. While these two parts increase 11.2%, the other two parts, Part I and Part IV, Program Support, increase by a mere 0.3%.

59. Part IV, Program Support, referred to as indirect costs or overhead, accounts for 11.0% of the proposal, decreasing from 11.1% in 1992-1993. This percentage for administrative support is the lowest of any international organization. When combined with the current level of extrabudgetary funds, Program Support falls to below 8.0% of the total.

60. The various tables under Table F starting on page 34 show the budget in the traditional object of expenditure allocations (personnel, duty travel, fellowships, etc.). Table F-2 on page 35 shows the increases and decreases within the expenditure allocations. Post costs increase by 9.1% even though 13 posts were eliminated.

61. Section II (yellow tab) of this document contains a general analysis and description of the classified list of programs. Each program category has a narrative description together with a presentation of the funds devoted to the program.

62. Section III (green tab) of the document contains subsections related to the main locations of the programs (Country Programs, Multicountry Programs, etc.). These subsections by location categories are an elaboration of the overall summary shown previously under Table C on page 13.

63. Section IV (pink tab) provides a description of the organizational structure and the funds related to it.

64. The last part of the document includes an annex which presents the entire program budget by fund category in the structure of the WHO classified list of programs.

65. Finally, it is the responsibility of the June 1993 Executive Committee to make recommendations to the September 1993 Directing Council. The Directing Council approves the 1994-1995 PAHO regular program budget.

## TABLE A

PAHO REGULAR AND WHO REGULAR REGIONAL BUDGET HISTORY

| BUDGET PERIOD | PAHO REGULAR | | | WHO REGULAR | | | TOTAL PAHO AND WHO REGULAR | |
|---|---|---|---|---|---|---|---|---|
| | AMOUNT | % OF TOTAL | % INCREASE | AMOUNT | % OF TOTAL | % INCREASE | AMOUNT | % INCREASE |
| 1970-71* | 30,072,422 | 68.2 | | 14,053,685 | 31.8 | | 44,126,107 | |
| 1972-73 | 37,405,395 | 68.6 | 24.4 | 17,150,800 | 31.4 | 22.0 | 54,556,195 | 23.6 |
| 1974-75 | 45,175,329 | 68.8 | 20.8 | 20,495,900 | 31.2 | 19.5 | 65,671,229 | 20.4 |
| 1976-77 | 55,549,020 | 69.3 | 23.0 | 24,570,200 | 30.7 | 19.9 | 80,119,220 | 22.0 |
| 1978-79 | 64,849,990 | 67.8 | 16.7 | 30,771,500 | 32.2 | 25.2 | 95,621,490 | 19.3 |
| 1980-81** | 76,576,000 | 67.1 | 18.1 | 37,566,200 | 32.9 | 22.1 | 114,142,200 | 19.4 |
| 1982-83 | 90,320,000 | 67.2 | 17.9 | 44,012,000 | 32.8 | 17.2 | 134,332,000 | 17.7 |
| 1984-85 | 103,959,000 | 67.2 | 15.1 | 50,834,000 | 32.8 | 15.5 | 154,793,000 | 15.2 |
| 1986-87 | 112,484,000 | 66.0 | 8.2 | 57,856,000 | 34.0 | 13.8 | 170,340,000 | 10.0 |
| 1988-89*** | 121,172,000 | 66.8 | 7.7 | 60,161,000 | 33.2 | 4.0 | 181,333,000 | 6.5 |
| 1990-91 | 130,023,000 | 66.7 | 7.3 | 65,027,000 | 33.3 | 8.1 | 195,050,000 | 7.6 |
| 1992-93 | 152,576,000 | 68.1 | 17.3 | 71,491,000 | 31.9 | 9.9 | 224,067,000 | 14.9 |
| 1994-95**** | 164,466,000 | 67.3 | 7.8 | 79,794,000 | 32.7 | 11.6 | 244,260,000 | 9.0 |

* INCLUDES THE SUPPLEMENTAL BUDGET OF $982,992 WHICH REPRESENTS THE ASSESSMENT OF CANADA WHEN IT JOINED PAHO IN 1971.

** FIRST BIENNIAL BUDGET PERIOD. THE PAHO REGULAR AMOUNT INCLUDES THE SUPPPLEMENTAL BUDGET OF $1,041,400 FOR 1980.

*** THE WHO REGULAR AMOUNT REFLECTS THE $2,470,000 REDUCTION IN THIS REGION RELATED TO THE $25,000,000 GLOBAL REDUCTION.

**** THE PAHO REGULAR AMOUNT FOR 1994-95 IS PROPOSED. THE WHO REGULAR AMOUNT FOR 1994-95 WAS CONSIDERED WITHIN THE OVERALL WHO REGULAR PROPOSAL BY THE JANUARY 1993 EXECUTIVE BOARD AND WAS APPROVED BY THE MAY 1993 WORLD HEALTH ASSEMBLY.

# TABLE B

## POST ANALYSIS - PAHO AND WHO REGULAR FUNDS

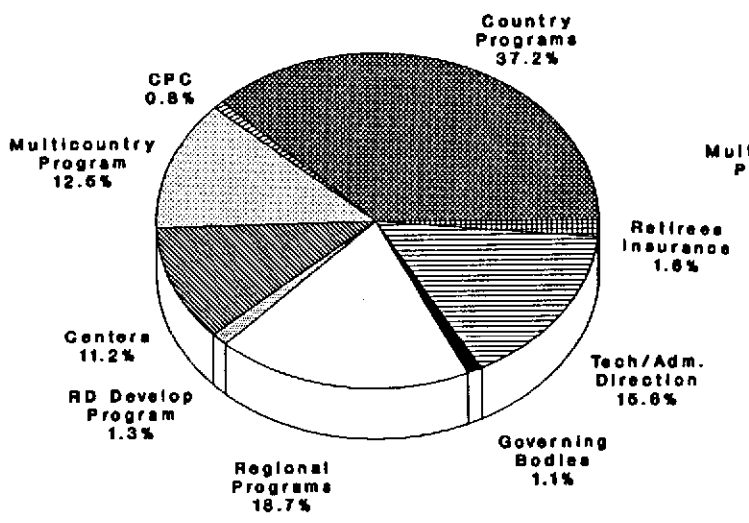
| LOCATION | 1992-1993 PROFESSIONAL | 1992-1993 LOCAL | 1992-1993 TOTAL | 1994-1995 PROFESSIONAL | 1994-1995 LOCAL | 1994-1995 TOTAL | 1996-1997 PROFESSIONAL | 1996-1997 LOCAL | 1996-1997 TOTAL |
|---|---|---|---|---|---|---|---|---|---|
| A. COOPERATION WITH COUNTRIES | | | | | | | | | |
| A.1 COUNTRY PROGRAMS | 136 | 156 | 292 | 131 | 165 | 296 | 131 | 165 | 296 |
| A.2 CARIBBEAN PROGRAM COORDINATION | 3 | 9 | 12 | 3 | 8 | 11 | 3 | 8 | 11 |
| A.3 MULTICOUNTRY PROGRAMS | 32 | 7 | 39 | 33 | 8 | 41 | 33 | 8 | 41 |
| A.4 REGIONAL PROGRAMS | 139 | 130 | 269 | 136 | 132 | 268 | 136 | 132 | 268 |
| A.5 CENTERS | 60 | 77 | 137 | 60 | 72 | 132 | 60 | 72 | 132 |
| SUBTOTAL: COOPERATION WITH COUNTRIES | 370 | 379 | 749 | 363 | 385 | 748 | 363 | 385 | 748 |
| B. TECHNICAL AND ADMINISTRATIVE DIRECTION | 73 | 130 | 203 | 64 | 127 | 191 | 64 | 127 | 191 |
| C. GOVERNING BODIES | 3 | 4 | 7 | 3 | 4 | 7 | 3 | 4 | 7 |
| GRAND TOTAL: | 446 | 513 | 959 | 430 | 516 | 946 | 430 | 516 | 946 |

## POST ANALYSIS - EXTRABUDGETARY FUNDS

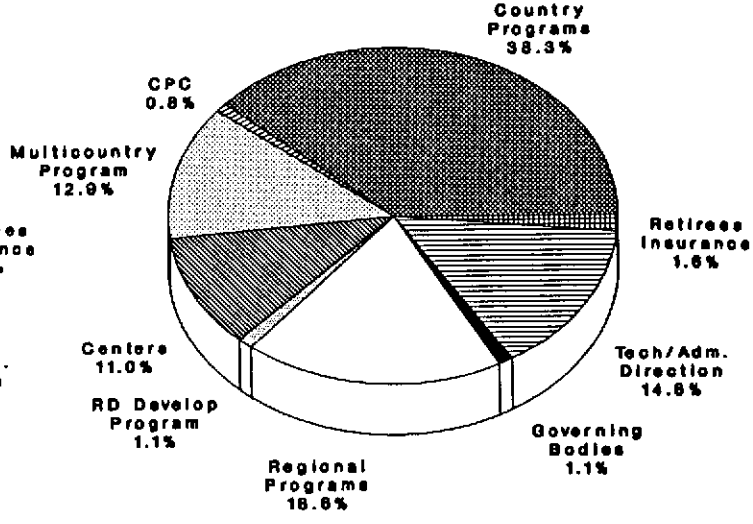
| LOCATION | 1992-1993 PROFESSIONAL | 1992-1993 LOCAL | 1992-1993 TOTAL | 1994-1995 PROFESSIONAL | 1994-1995 LOCAL | 1994-1995 TOTAL | 1996-1997 PROFESSIONAL | 1996-1997 LOCAL | 1996-1997 TOTAL |
|---|---|---|---|---|---|---|---|---|---|
| A. COOPERATION WITH COUNTRIES | | | | | | | | | |
| A.1 COUNTRY PROGRAMS | 24 | 15 | 39 | 9 | 13 | 22 | 0 | 12 | 12 |
| A.3 MULTICOUNTRY PROGRAMS | 20 | 6 | 26 | 10 | 1 | 11 | 2 | 0 | 2 |
| A.4 REGIONAL PROGRAMS | 25 | 46 | 71 | 17 | 37 | 54 | 7 | 29 | 36 |
| A.5 CENTERS | 9 | 31 | 40 | 6 | 28 | 34 | 3 | 27 | 30 |
| SUBTOTAL: COOPERATION WITH COUNTRIES | 78 | 98 | 176 | 42 | 79 | 121 | 12 | 68 | 80 |
| B. TECHNICAL AND ADMINISTRATIVE DIRECTION | 8 | 29 | 37 | 8 | 29 | 37 | 8 | 29 | 37 |
| GRAND TOTAL: | 86 | 127 | 213 | 50 | 108 | 158 | 20 | 97 | 117 |

## GRAPH I

PAHO/WHO REGULAR PROGRAM BUDGET BY LOCATION: PER CENT OF TOTAL



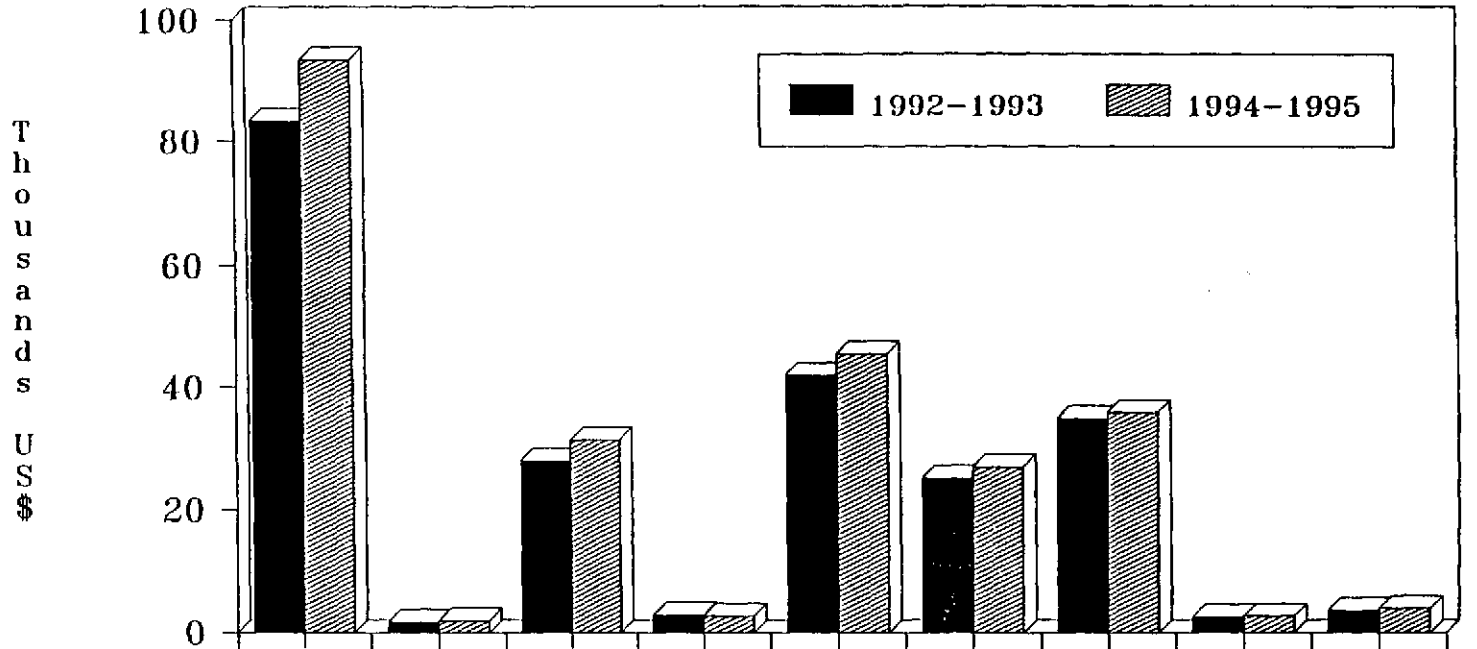

1992-1993




1994-1995

## GRAPH II

### PAHO/WHO PROGRAM BUDGET BY LOCATION: PER CENT INCREASES/DECREASES




| | Country Programs | Caribbean Prog.Coord. | Multicountry Programs | D's Development Program | Regional Programs | Centers | Tech/Admin Direction | Governing Bodies | Retirees' Insurance |
|---|---|---|---|---|---|---|---|---|---|
| | 12.1 % | 12.4 % | 12.4 % | - 8.8 % | 8.4 % | 7.3 % | 2.6 | 4.3 | 8.2 |
| 1992-1993 | 83.417 | 1.755 | 27.932 | 2.945 | 41.863 | 25.08 | 34.886 | 2.536 | 3.65 |
| 1994-1995 | 93.524 | 1.974 | 31.406 | 2.686 | 45.387 | 26.918 | 35.769 | 2.645 | 3.949 |

## TABLE C

### ANALYSIS OF REAL AND COST INCREASES/DECREASES - PAHO/WHO REGULAR BUDGET BY LOCATION

| Location | 1992-1993 Appropriation | | Real Increase (Decrease) | | Cost Increase (Decrease) | | Total Increase (Decrease) | | 1994-1995 Proposal | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Amount | % of Total | Amount | % | Amount | % | Amount | % | Amount | % of Total |
| A. Cooperation with Countries: | | | | | | | | | | |
| A.1 Country Programs | 83,417,100 | 37.2 | (98,500) | (0.1) | 10,205,800 | 12.2 | 10,107,300 | 12.1 | 93,524,400 | 38.3 |
| A.2 Caribbean Program Coordination | 1,755,700 | 0.8 | 0 | 0.0 | 218,300 | 12.4 | 218,300 | 12.4 | 1,974,000 | 0.8 |
| A.3 Multicountry Programs | 27,932,000 | 12.5 | 1,314,900 | 4.7 | 2,159,100 | 7.7 | 3,474,000 | 12.4 | 31,406,000 | 12.9 |
| A.4 Regional Director's Development Program | 2,945,200 | 1.3 | (462,500) | (15.7) | 203,600 | 6.9 | (258,900) | (8.8) | 2,686,300 | 1.1 |
| A.5 Regional Programs | 41,863,500 | 18.7 | (533,000) | (1.3) | 4,056,700 | 9.7 | 3,523,700 | 8.4 | 45,387,200 | 18.6 |
| A.6 Centers | 25,080,700 | 11.2 | (891,400) | (3.6) | 2,728,700 | 10.9 | 1,837,300 | 7.3 | 26,918,000 | 11.0 |
| Subtotal, Cooperation with Countries | 182,994,200 | 81.7 | (670,500) | (0.4) | 19,572,200 | 10.7 | 18,901,700 | 10.3 | 201,895,900 | 82.7 |
| B. Technical and Administrative Direction | 34,886,300 | 15.6 | (2,003,800) | (5.7) | 2,886,600 | 8.3 | 882,800 | 2.6 | 35,769,100 | 14.6 |
| C. Governing Bodies | 2,536,500 | 1.1 | 0 | 0.0 | 109,200 | 4.3 | 109,200 | 4.3 | 2,645,700 | 1.1 |
| D. Contribution to Retirees' Health Insurance | 3,650,000 | 1.6 | 0 | 0.0 | 299,300 | 8.2 | 299,300 | 8.2 | 3,949,300 | 1.6 |
| TOTAL | 224,067,000 | 100.0 | (2,674,300) | (1.2) | 22,867,300 | 10.2 | 20,193,000 | 9.0 | 244,260,000 | 100.0 |

# TABLE D

ALL FUNDS

| | | 1992-1993 BIENNIUM APPROVED | | INCREASE (DECREASE) 1994-1995 OVER 1992-1993 | 1994-1995 BIENNIUM PROPOSED | | INCREASE (DECREASE) 1996-1997 OVER 1994-1995 | 1996-1997 BIENNIUM PROVISIONAL | |
|---|---|---|---|---|---|---|---|---|---|
| | | AMOUNT $ | % OF TOTAL | | AMOUNT $ | % OF TOTAL | | AMOUNT $ | % OF TOTAL |
| REGULAR BUDGET: | | 224,067,000 | 55.4 | 9.0 | 244,260,000 | 70.8 | 9.5 | 267,452,000 | 85.9 |
| PR | PAHO REGULAR BUDGET | 152,576,000 | 37.7 | 7.8 | 164,466,000 | 47.7 | 9.7 | 180,357,000 | 57.9 |
| WR | WHO REGULAR BUDGET | 71,491,000 | 17.7 | 11.6 | 79,794,000 | 23.1 | 9.2 | 87,095,000 | 28.0 |
| EXTRABUDGETARY FUNDS: | | | | | | | | | |
| | PAN AMERICAN HEALTH ORGANIZATION | 138,261,000 | 34.3 | (49.4) | 69,911,000 | 20.3 | (44.5) | 38,800,000 | 12.5 |
| PA | INCAP MEMBERSHIP & MISCELLAN. FUNDS | 1,200,000 | .3 | .0 | 1,200,000 | .4 | .0 | 1,200,000 | .4 |
| PN | INCAP GRANTS & CONTRACT. AGREEMENTS | 13,000,000 | 3.2 | .0 | 13,000,000 | 3.8 | .0 | 13,000,000 | 4.2 |
| PM | INCAP AID/ROCAP GRANT | 67,000 | * | 4.5 | 70,000 | * | (100.0) | 0 | .0 |
| PC | CAREC MEMBERSHIP & MISCELLAN. FUNDS | 3,244,100 | .8 | 9.8 | 3,561,000 | 1.0 | 4.3 | 3,714,000 | 1.2 |
| PJ | CAREC GRANTS AND CONTRACT.AGREEMENT | 2,340,900 | .6 | (65.3) | 811,800 | .2 | (100.0) | 0 | .0 |
| PH | CAREC BUILDING FUND | 300,000 | .1 | (100.0) | 0 | .0 | .0 | 0 | .0 |
| PB | BUILDING FUND | 1,926,200 | .5 | (27.3) | 1,400,000 | .4 | 7.1 | 1,500,000 | .5 |
| PD | DISASTER RELIEF VOLUNTARY FUND | 6,130,200 | 1.5 | (100.0) | 0 | .0 | .0 | 0 | .0 |
| PG | GRANTS AND CONTRACTUAL AGREEMENTS | 96,343,600 | 23.9 | (53.1) | 45,219,800 | 13.1 | (67.4) | 14,735,700 | 4.7 |
| PK | SPECIAL FUND FOR HEALTH PROMOTION | 761,500 | .2 | (71.6) | 216,200 | .1 | (75.0) | 54,100 | * |
| PL | SPECIAL FUND FOR ASSOCIATED AGENCY | 4,510,500 | 1.1 | (100.0) | 0 | .0 | .0 | 0 | .0 |
| PU | SPECIAL FUND FOR ANIMAL HEALTH | 13,800 | * | (100.0) | 0 | .0 | .0 | 0 | .0 |
| PX | PROGRAM SUPPORT COSTS | 8,423,200 | 2.1 | (47.4) | 4,432,200 | 1.3 | 3.7 | 4,596,200 | 1.5 |

## TABLE D (CONT.)

ALL FUNDS

| | | 1992-1993 BIENNIUM APPROVED AMOUNT $ | % OF TOTAL | INCREASE (DECREASE) 1994-1995 OVER 1992-1993 | 1994-1995 BIENNIUM PROPOSED AMOUNT $ | % OF TOTAL | INCREASE (DECREASE) 1996-1997 OVER 1994-1995 | 1996-1997 BIENNIUM PROVISIONAL AMOUNT $ | % OF TOTAL |
|---|---|---|---|---|---|---|---|---|---|
| | WORLD HEALTH ORGANIZATION | 40,927,000 | 10.3 | (24.7) | 30,823,000 | 8.9 | (83.8) | 4,995,000 | 1.6 |
| DP | UN DEVELOPMENT PROGRAM (UNDP) | 1,096,400 | .3 | (77.2) | 250,000 | .1 | (100.0) | 0 | .0 |
| DR | UNDP SPECIAL PROGRAM RESOURCES | 1,174,800 | .3 | (73.5) | 311,800 | .1 | (100.0) | 0 | .0 |
| FB | ASSOCIATE PROFESSIONAL OFFICERS | 1,365,600 | .3 | (98.4) | 22,200 | * | (100.0) | 0 | .0 |
| FD | UN FUND/DRUG ABUSE CONTROL (UNFDAC) | 22,900 | * | (100.0) | 0 | .0 | .0 | 0 | .0 |
| FP | UN POPULATION FUND (UNFPA) | 6,797,800 | 1.7 | (69.2) | 2,097,200 | .6 | (99.6) | 8,000 | * |
| FX | TRUST FUND FOR GLOBAL AIDS PROGRAM | 16,299,100 | 4.0 | 20.6 | 19,652,900 | 5.7 | (100.0) | 0 | .0 |
| ST | SASAKAWA HEALTH TRUST FUND | 250,700 | .1 | (100.0) | 0 | .0 | .0 | 0 | .0 |
| VB | VFHP-PREVENTION OF BLINDNESS | 30,000 | * | (100.0) | 0 | .0 | .0 | 0 | .0 |
| VC | VFHP-DIARRHEAL DISEASE INCL.CHOLERA | 2,323,400 | .6 | 7.5 | 2,498,000 | .7 | (100.0) | 0 | .0 |
| VD | VFHP-MISCELL. DESIGNATED CONTRIBUT. | 6,280,400 | 1.6 | (81.7) | 1,152,000 | .3 | (100.0) | 0 | .0 |
| VG | VFHP-MEDICAL RESEARCH | 3,600 | * | (100.0) | 0 | .0 | .0 | 0 | .0 |
| VI | VFHP-EXPANDED PROGRAM ON IMMUNIZAT. | 727,500 | .2 | (68.6) | 228,300 | .1 | (100.0) | 0 | .0 |
| VL | VFHP-LEPROSY PROGRAM | 15,000 | * | (100.0) | 0 | .0 | .0 | 0 | .0 |
| VW | VFHP-COMMUNITY WATER SUPPLY | 76,600 | * | (100.0) | 0 | .0 | .0 | 0 | .0 |
| VY | VFHP-YAWS PROGRAM | 19,200 | * | (100.0) | 0 | .0 | .0 | 0 | .0 |
| AS | SPECIAL ACCOUNT FOR SERVICING COSTS | 4,228,700 | 1.1 | 9.0 | 4,610,600 | 1.3 | 8.2 | 4,987,000 | 1.6 |
| EF | REAL ESTATE FUND | 215,300 | .1 | (100.0) | 0 | .0 | .0 | 0 | .0 |
| | TOTAL BUDGET | 403,255,000 | 100.0 | (14.5) | 344,994,000 | 100.0 | (9.8) | 311,247,000 | 100.0 |

* LESS THAN .05 PER CENT

# TABLE E-1

## PROGRAM BUDGET - PAHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| I. DIRECTION, COORDINATION AND MANAGEMENT | | 17,697,600 | 11.6 | 16,481,600 | 10.1 | 17,841,100 | 10.0 |
| GOVERNING BODIES | | 2,176,100 | 1.4 | 2,262,600 | 1.4 | 2,455,700 | 1.4 |
| GOVERNING BODIES | GOB | 2,176,100 | 1.4 | 2,262,600 | 1.4 | 2,455,700 | 1.4 |
| GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT | | 15,521,500 | 10.2 | 14,219,000 | 8.7 | 15,385,400 | 8.6 |
| EXECUTIVE MANAGEMENT | EXM | 2,902,600 | 1.9 | 3,295,600 | 2.0 | 3,566,500 | 2.0 |
| REGIONAL DIRECTOR'S DEVELOPMENT PROGRAM | DGP | 2,789,200 | 1.8 | 2,566,300 | 1.6 | 2,776,700 | 1.5 |
| GENERAL PROGRAM DEVELOPMENT | GPD | 3,446,800 | 2.3 | 2,765,600 | 1.7 | 2,979,800 | 1.7 |
| EXTERNAL COORD. FOR HEALTH AND SOCIAL DEVELOPMENT | COR | 1,242,400 | .8 | 1,118,600 | .7 | 1,209,000 | .7 |
| INFORMATICS MANAGEMENT | ISS | 5,140,500 | 3.4 | 4,472,900 | 2.7 | 4,853,400 | 2.7 |
| II. HEALTH SYSTEM INFRASTRUCTURE | | 72,744,400 | 47.9 | 78,274,700 | 47.8 | 86,021,000 | 47.9 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 24,726,200 | 16.3 | 30,254,600 | 18.7 | 33,635,100 | 18.9 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 23,772,700 | 15.7 | 29,456,000 | 18.2 | 32,767,600 | 18.4 |
| ADMINISTRATIVE ANALYSIS | AAN | 953,500 | .6 | 798,600 | .5 | 867,500 | .5 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 2,645,700 | 1.7 | 3,001,100 | 1.8 | 3,388,000 | 1.9 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 2,645,700 | 1.7 | 3,001,100 | 1.8 | 3,388,000 | 1.9 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 4,381,700 | 2.9 | 3,058,000 | 1.9 | 3,333,800 | 1.8 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 4,381,700 | 2.9 | 3,058,000 | 1.9 | 3,333,800 | 1.8 |
| HEALTH POLICY DEVELOPMENT | | 5,744,000 | 3.8 | 6,745,500 | 4.1 | 7,327,800 | 4.1 |
| HEALTH POLICY ANALYSIS AND DEVELOPMENT | HDP | 3,651,300 | 2.4 | 2,281,000 | 1.4 | 2,497,800 | 1.4 |
| HEALTH ECONOMICS AND FINANCING | HDE | 992,600 | .7 | 1,717,500 | 1.0 | 1,858,000 | 1.0 |
| HEALTH LEGISLATION | HLE | 464,200 | .3 | 1,135,100 | .7 | 1,221,300 | .7 |
| WOMEN, HEALTH AND DEVELOPMENT | WHD | 635,900 | .4 | 851,900 | .5 | 928,400 | .5 |
| PROMOTION OF BIOETHICS | HBE | 0 | - | 760,000 | .5 | 822,300 | .5 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 15,245,300 | 10.0 | 14,717,000 | 8.9 | 15,999,700 | 8.8 |
| HEALTH SERVICES DEVELOPMENT | DHS | 12,733,700 | 8.3 | 11,824,300 | 7.2 | 12,861,700 | 7.1 |
| ESSENTIAL DRUGS AND VACCINES | EDV | 445,500 | .3 | 758,300 | .5 | 831,500 | .5 |
| ORAL HEALTH | ORH | 430,700 | .3 | 389,000 | .2 | 422,300 | .2 |
| DISASTER PREPAREDNESS | DPP | 630,300 | .4 | 677,200 | .4 | 735,400 | .4 |
| CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY | CLR | 560,700 | .4 | 642,500 | .4 | 690,400 | .4 |
| HEALTH EDUCATION AND COMMUNITY PARTICIPATION | HED | 0 | - | 18,300 | .* | 20,800 | .* |
| REHABILITATION | RHB | 444,400 | .3 | 407,400 | .2 | 437,600 | .2 |

## TABLE E-1 (CONT.)

PROGRAM BUDGET - PAHO REGULAR FUNDS (CONT.)

| | PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|---|
| | HUMAN RESOURCES DEVELOPMENT | | 8,997,200 | 5.9 | 8,435,200 | 5.1 | 9,192,900 | 5.1 |
| | HUMAN RESOURCES TRAINING | HRC | 4,062,200 | 2.7 | 3,922,900 | 2.4 | 4,260,900 | 2.4 |
| | HUMAN RESOURCES PLANNING AND POLICY | HRP | 530,900 | .3 | 319,600 | .2 | 349,000 | .2 |
| | HUMAN RESOURCES EDUCATION | HRE | 4,404,100 | 2.9 | 4,192,700 | 2.5 | 4,583,000 | 2.5 |
| | HEALTH INFORMATION SUPPORT | | 7,088,000 | 4.7 | 7,852,200 | 4.7 | 8,604,900 | 4.8 |
| | OFFICIAL AND TECHNICAL PUBLICATIONS | HBP | 2,582,200 | 1.7 | 2,200,500 | 1.3 | 2,395,000 | 1.3 |
| | PUBLIC INFORMATION | HBF | 1,638,400 | 1.1 | 1,929,900 | 1.2 | 2,112,100 | 1.2 |
| | LANGUAGE SERVICES | HBL | 642,300 | .4 | 691,800 | .4 | 753,000 | .4 |
| | SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION | HBD | 2,225,100 | 1.5 | 3,030,000 | 1.8 | 3,344,800 | 1.9 |
| | RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT | | 3,916,300 | 2.6 | 4,211,100 | 2.6 | 4,538,800 | 2.5 |
| | RESEARCH PROMOTION AND DEVELOPMENT | RPD | 3,039,900 | 2.0 | 3,037,500 | 1.8 | 3,277,000 | 1.8 |
| | HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT | HDT | 488,800 | .3 | 747,900 | .5 | 804,100 | .4 |
| | RESEARCH AND DEVELOPMENT IN THE FIELD OF VACCINES | RDV | 387,600 | .3 | 425,700 | .3 | 457,700 | .3 |
| III. | HEALTH SCIENCE AND TECHNOLOGY | | 44,126,300 | 28.7 | 49,362,500 | 29.9 | 54,347,600 | 29.9 |
| | FOOD AND NUTRITION | | 5,462,200 | 3.6 | 5,610,200 | 3.4 | 6,205,400 | 3.4 |
| | FOOD | FOD | 1,069,600 | .7 | 1,030,400 | .6 | 1,151,300 | .6 |
| | NUTRITION | NUT | 4,392,600 | 2.9 | 4,579,800 | 2.8 | 5,054,100 | 2.8 |
| | ENVIRONMENTAL HEALTH | | 9,979,400 | 6.5 | 11,982,400 | 7.3 | 13,106,200 | 7.2 |
| | COMMUNITY WATER SUPPLY AND SANITATION | CWS | 5,985,800 | 3.9 | 6,975,600 | 4.2 | 7,660,400 | 4.2 |
| | SOLID WASTES AND HOUSING HYGIENE | RUD | 277,400 | .2 | 338,300 | .2 | 363,200 | .2 |
| | CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 3,189,300 | 2.1 | 4,086,500 | 2.5 | 4,453,000 | 2.5 |
| | WORKERS' HEALTH | OCH | 526,900 | .3 | 582,000 | .4 | 629,600 | .3 |
| | MATERNAL AND CHILD HEALTH | | 5,775,700 | 3.7 | 7,230,400 | 4.3 | 7,946,600 | 4.3 |
| | GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 4,695,900 | 3.1 | 5,954,900 | 3.6 | 6,567,300 | 3.6 |
| | ADOLESCENT HEALTH | ADH | 63,700 | .* | 67,700 | .* | 70,500 | .* |
| | ACUTE RESPIRATORY INFECTIONS | ARI | 184,600 | .1 | 198,100 | .1 | 211,300 | .1 |
| | IMMUNIZATION | EPI | 156,800 | .1 | 284,900 | .2 | 323,100 | .2 |
| | DIARRHEAL DISEASES | CDD | 674,700 | .4 | 724,800 | .4 | 774,400 | .4 |
| | COMMUNICABLE DISEASES | | 4,787,800 | 3.1 | 5,990,900 | 3.7 | 6,543,000 | 3.7 |
| | GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 2,811,700 | 1.8 | 4,558,100 | 2.8 | 4,991,700 | 2.8 |
| | TROPICAL DISEASE RESEARCH | TDR | 119,100 | .1 | 139,600 | .1 | 150,900 | .1 |
| | TUBERCULOSIS | TUB | 196,200 | .1 | 209,600 | .1 | 226,900 | .1 |
| | ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 359,000 | .2 | 376,800 | .2 | 403,500 | .2 |
| | VECTOR-BORNE DISEASES | VBC | 331,100 | .2 | 308,100 | .2 | 333,300 | .2 |
| | MALARIA | MAL | 880,400 | .6 | 302,000 | .2 | 334,200 | .2 |
| | PARASITIC DISEASES | PDP | 90,300 | .1 | 96,700 | .1 | 102,500 | .1 |

## TABLE E-1 (CONT.)

PROGRAM BUDGET - PAHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| HEALTH PROMOTION | | 3,944,300 | 2.5 | 4,737,500 | 2.8 | 5,158,000 | 2.8 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 3,662,000 | 2.4 | 4,514,200 | 2.7 | 4,920,600 | 2.7 |
| TOBACCO OR HEALTH | TOH | 57,700 | .* | 62,000 | .* | 66,000 | .* |
| CANCER | CAN | 57,000 | .* | 0 | - | 0 | - |
| ACCIDENT PREVENTION | APR | 50,300 | .* | 53,800 | .* | 56,900 | .* |
| PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE | ADA | 117,300 | .1 | 107,500 | .1 | 114,500 | .1 |
| VETERINARY PUBLIC HEALTH | | 14,176,900 | 9.3 | 13,811,100 | 8.4 | 15,388,400 | 8.5 |
| FOOD SAFETY | FOS | 1,208,100 | .8 | 1,878,300 | 1.1 | 2,055,000 | 1.1 |
| FOOT-AND-MOUTH DISEASE | FMD | 8,586,100 | 5.6 | 8,341,700 | 5.1 | 9,383,500 | 5.2 |
| ZOONOSES | ZNS | 4,382,700 | 2.9 | 3,591,100 | 2.2 | 3,949,900 | 2.2 |
| IV. PROGRAM SUPPORT | | 18,007,700 | 11.8 | 20,347,200 | 12.2 | 22,147,300 | 12.2 |
| ADMINISTRATION | | 18,007,700 | 11.8 | 20,347,200 | 12.2 | 22,147,300 | 12.2 |
| BUDGET AND FINANCE | BFI | 5,976,500 | 3.9 | 6,490,700 | 3.9 | 7,085,000 | 3.9 |
| GENERAL SERVICES & HEADQUARTERS OPERATING EXPENSES | PGS | 8,636,700 | 5.7 | 9,934,400 | 6.0 | 10,783,900 | 6.0 |
| PERSONNEL | PER | 2,260,000 | 1.5 | 2,704,300 | 1.6 | 2,954,300 | 1.6 |
| PROCUREMENT | SUP | 1,134,500 | .7 | 1,217,800 | .7 | 1,324,100 | .7 |
| GRAND TOTAL | | 152,576,000 | 100.0 | 164,466,000 | 100.0 | 180,357,000 | 100.0 |

* LESS THAN .05 PER CENT

## TABLE E-2

PROGRAM BUDGET - WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| I. DIRECTION, COORDINATION AND MANAGEMENT | | 2,903,100 | 4.1 | 2,419,700 | 3.1 | 2,619,000 | 3.0 |
| GOVERNING BODIES | | 360,400 | .5 | 383,100 | .5 | 414,500 | .5 |
| GOVERNING BODIES | GOB | 360,400 | .5 | 383,100 | .5 | 414,500 | .5 |
| GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT | | 2,542,700 | 3.6 | 2,036,600 | 2.6 | 2,204,500 | 2.5 |
| EXECUTIVE MANAGEMENT | EXM | 339,000 | .5 | 371,500 | .5 | 397,500 | .5 |
| REGIONAL DIRECTOR'S DEVELOPMENT PROGRAM | DGP | 156,000 | .2 | 120,000 | .2 | 129,800 | .1 |
| GENERAL PROGRAM DEVELOPMENT | GPD | 1,326,600 | 1.9 | 1,052,200 | 1.3 | 1,143,800 | 1.3 |
| INFORMATICS MANAGEMENT | ISS | 721,100 | 1.0 | 492,900 | .6 | 533,400 | .6 |
| II. HEALTH SYSTEM INFRASTRUCTURE | | 35,808,900 | 50.2 | 41,782,500 | 52.2 | 45,694,900 | 52.4 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 5,532,800 | 7.7 | 6,113,300 | 7.6 | 6,859,900 | 7.9 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 5,286,400 | 7.4 | 6,016,500 | 7.5 | 6,758,800 | 7.8 |
| ADMINISTRATIVE ANALYSIS | AAN | 246,400 | .3 | 96,800 | .1 | 101,100 | .1 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 6,200,200 | 8.7 | 6,951,700 | 8.7 | 7,572,900 | 8.7 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 6,200,200 | 8.7 | 6,951,700 | 8.7 | 7,572,900 | 8.7 |
| HEALTH POLICY DEVELOPMENT | | 574,100 | .8 | 852,500 | 1.1 | 936,200 | 1.1 |
| HEALTH POLICY ANALYSIS AND DEVELOPMENT | HDP | 475,900 | .7 | 534,000 | .7 | 592,400 | .7 |
| HEALTH ECONOMICS AND FINANCING | HDE | 98,200 | .1 | 318,500 | .4 | 343,800 | .4 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 15,296,000 | 21.5 | 17,725,400 | 22.1 | 19,338,000 | 22.2 |
| HEALTH SERVICES DEVELOPMENT | DHS | 13,232,100 | 18.6 | 15,702,200 | 19.6 | 17,141,100 | 19.7 |
| ESSENTIAL DRUGS AND VACCINES | EDV | 858,700 | 1.2 | 819,200 | 1.0 | 893,600 | 1.0 |
| ORAL HEALTH | ORH | 280,000 | .4 | 299,400 | .4 | 324,700 | .4 |
| CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY | CLR | 312,500 | .4 | 345,000 | .4 | 374,700 | .4 |
| HEALTH EDUCATION AND COMMUNITY PARTICIPATION | HED | 612,700 | .9 | 559,600 | .7 | 603,900 | .7 |
| HUMAN RESOURCES DEVELOPMENT | | 4,311,200 | 6.1 | 5,330,600 | 6.7 | 5,766,400 | 6.6 |
| HUMAN RESOURCES TRAINING | HRC | 1,483,700 | 2.1 | 2,182,800 | 2.7 | 2,378,300 | 2.7 |
| HUMAN RESOURCES PLANNING AND POLICY | HRP | 618,200 | .9 | 773,200 | 1.0 | 829,200 | 1.0 |
| HUMAN RESOURCES EDUCATION | HRE | 2,209,300 | 3.1 | 2,374,600 | 3.0 | 2,558,900 | 2.9 |

# TABLE E-2 (CONT.)

PROGRAM BUDGET - WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| HEALTH INFORMATION SUPPORT | | 3,353,500 | 4.7 | 4,113,500 | 5.2 | 4,462,600 | 5.1 |
| OFFICIAL AND TECHNICAL PUBLICATIONS | HBP | 2,109,800 | 3.0 | 2,764,700 | 3.5 | 3,001,700 | 3.4 |
| PUBLIC INFORMATION | HBF | 124,900 | .2 | 137,300 | .2 | 147,000 | .2 |
| LANGUAGE SERVICES | HBL | 963,700 | 1.3 | 1,042,100 | 1.3 | 1,130,600 | 1.3 |
| SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION | HBD | 155,100 | .2 | 169,400 | .2 | 183,300 | .2 |
| RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT | | 541,100 | .7 | 695,500 | .8 | 758,900 | .8 |
| RESEARCH PROMOTION AND DEVELOPMENT | RPD | 443,000 | .6 | 349,900 | .4 | 384,000 | .4 |
| HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT | HDT | 98,100 | .1 | 106,300 | .1 | 115,200 | .1 |
| RESEARCH AND DEVELOPMENT IN THE FIELD OF VACCINES | RDV | 0 | - | 239,300 | .3 | 259,700 | .3 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 25,881,400 | 36.0 | 29,173,900 | 36.6 | 31,798,700 | 36.6 |
| FOOD AND NUTRITION | | 1,903,400 | 2.7 | 2,012,800 | 2.6 | 2,222,100 | 2.6 |
| FOOD | FOD | 196,200 | .3 | 213,900 | .3 | 231,500 | .3 |
| NUTRITION | NUT | 1,707,200 | 2.4 | 1,798,900 | 2.3 | 1,990,600 | 2.3 |
| ENVIRONMENTAL HEALTH | | 6,839,700 | 9.5 | 7,543,700 | 9.4 | 8,262,200 | 9.4 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 4,662,600 | 6.5 | 5,109,000 | 6.4 | 5,593,100 | 6.4 |
| SOLID WASTES AND HOUSING HYGIENE | RUD | 259,800 | .4 | 243,500 | .3 | 263,700 | .3 |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 1,882,700 | 2.6 | 2,157,100 | 2.7 | 2,367,800 | 2.7 |
| WORKERS' HEALTH | OCH | 34,600 | .* | 34,100 | .* | 37,600 | .* |
| MATERNAL AND CHILD HEALTH | | 4,265,300 | 5.9 | 5,046,500 | 6.2 | 5,473,400 | 6.2 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 2,090,600 | 2.9 | 2,584,800 | 3.2 | 2,808,100 | 3.2 |
| ACUTE RESPIRATORY INFECTIONS | ARI | 224,800 | .3 | 250,800 | .3 | 271,100 | .3 |
| IMMUNIZATION | EPI | 1,516,600 | 2.1 | 1,618,400 | 2.0 | 1,747,000 | 2.0 |
| DIARRHEAL DISEASES | CDD | 433,300 | .6 | 592,500 | .7 | 647,200 | .7 |
| COMMUNICABLE DISEASES | | 7,563,000 | 10.5 | 8,669,600 | 11.0 | 9,441,800 | 11.0 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 3,011,000 | 4.2 | 3,598,000 | 4.5 | 3,959,900 | 4.5 |
| TROPICAL DISEASE RESEARCH | TDR | 0 | - | 209,600 | .3 | 226,900 | .3 |
| TUBERCULOSIS | TUB | 232,400 | .3 | 243,400 | .3 | 261,300 | .3 |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 15,700 | .* | 241,700 | .3 | 269,600 | .3 |
| VECTOR-BORNE DISEASES | VBC | 2,668,200 | 3.7 | 2,302,100 | 2.9 | 2,483,300 | 2.9 |
| MALARIA | MAL | 952,100 | 1.3 | 1,340,400 | 1.7 | 1,447,000 | 1.7 |
| PARASITIC DISEASES | PDP | 286,400 | .4 | 319,800 | .4 | 347,000 | .4 |
| LEPROSY | LEP | 349,300 | .5 | 363,900 | .5 | 394,200 | .5 |
| SEXUALLY TRANSMITTED DISEASES | VDT | 47,900 | .1 | 50,700 | .1 | 52,600 | .1 |

## TABLE E-2 (CONT.)

PROGRAM BUDGET - WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| HEALTH PROMOTION | | 2,504,800 | 3.5 | 2,667,400 | 3.3 | 2,889,800 | 3.3 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 1,212,700 | 1.7 | 1,394,300 | 1.7 | 1,518,200 | 1.7 |
| PREV/TREAT. OF MENTAL AND NEUROLOGICAL DISORDERS | MND | 464,900 | .7 | 482,800 | .6 | 520,400 | .6 |
| HEALTH OF THE ELDERLY | HEE | 464,000 | .6 | 481,600 | .6 | 518,700 | .6 |
| PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE | ADA | 299,500 | .4 | 250,800 | .3 | 271,100 | .3 |
| OCULAR HEALTH | PBD | 63,700 | .1 | 57,900 | .1 | 61,400 | .1 |
| VETERINARY PUBLIC HEALTH | | 2,805,200 | 3.9 | 3,233,900 | 4.1 | 3,509,400 | 4.1 |
| FOOD SAFETY | FOS | 924,200 | 1.3 | 928,700 | 1.2 | 1,007,200 | 1.2 |
| ZOONOSES | ZNS | 1,881,000 | 2.6 | 2,305,200 | 2.9 | 2,502,200 | 2.9 |
| IV. PROGRAM SUPPORT | | 6,897,600 | 9.7 | 6,417,900 | 8.1 | 6,982,400 | 8.0 |
| ADMINISTRATION | | 6,897,600 | 9.7 | 6,417,900 | 8.1 | 6,982,400 | 8.0 |
| BUDGET AND FINANCE | BFI | 1,672,900 | 2.3 | 1,487,900 | 1.9 | 1,630,300 | 1.9 |
| GENERAL SERVICES & HEADQUARTERS OPERATING EXPENSES | PGS | 3,572,200 | 5.0 | 3,172,300 | 4.0 | 3,442,800 | 4.0 |
| PERSONNEL | PER | 1,253,400 | 1.8 | 1,321,000 | 1.7 | 1,436,300 | 1.6 |
| PROCUREMENT | SUP | 399,100 | .6 | 436,700 | .5 | 473,000 | .5 |
| GRAND TOTAL | | 71,491,000 | 100.0 | 79,794,000 | 100.0 | 87,095,000 | 100.0 |

# TABLE E-3

## PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| I. DIRECTION, COORDINATION AND MANAGEMENT | | 20,600,700 | 9.1 | 18,901,300 | 7.8 | 20,460,100 | 7.7 |
| GOVERNING BODIES | | 2,536,500 | 1.1 | 2,645,700 | 1.1 | 2,870,200 | 1.1 |
| GOVERNING BODIES | GOB | 2,536,500 | 1.1 | 2,645,700 | 1.1 | 2,870,200 | 1.1 |
| GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT | | 18,064,200 | 8.0 | 16,255,600 | 6.7 | 17,589,900 | 6.6 |
| EXECUTIVE MANAGEMENT | EXM | 3,241,600 | 1.4 | 3,667,100 | 1.5 | 3,964,000 | 1.5 |
| REGIONAL DIRECTOR'S DEVELOPMENT PROGRAM | DGP | 2,945,200 | 1.3 | 2,686,300 | 1.1 | 2,906,500 | 1.1 |
| GENERAL PROGRAM DEVELOPMENT | GPD | 4,773,400 | 2.1 | 3,817,800 | 1.6 | 4,123,600 | 1.5 |
| EXTERNAL COORD. FOR HEALTH AND SOCIAL DEVELOPMENT | COR | 1,242,400 | .6 | 1,118,600 | .5 | 1,209,000 | .5 |
| INFORMATICS MANAGEMENT | ISS | 5,861,600 | 2.6 | 4,965,800 | 2.0 | 5,386,800 | 2.0 |
| II. HEALTH SYSTEM INFRASTRUCTURE | | 108,553,300 | 48.5 | 120,057,200 | 49.3 | 131,715,900 | 49.4 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 30,259,000 | 13.3 | 36,367,900 | 15.2 | 40,495,000 | 15.3 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 29,059,100 | 12.8 | 35,472,500 | 14.8 | 39,526,400 | 14.9 |
| ADMINISTRATIVE ANALYSIS | AAN | 1,199,900 | .5 | 895,400 | .4 | 968,600 | .4 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 2,645,700 | 1.2 | 3,001,100 | 1.2 | 3,388,000 | 1.3 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 2,645,700 | 1.2 | 3,001,100 | 1.2 | 3,388,000 | 1.3 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 10,581,900 | 4.7 | 10,009,700 | 4.1 | 10,906,700 | 4.1 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 10,581,900 | 4.7 | 10,009,700 | 4.1 | 10,906,700 | 4.1 |
| HEALTH POLICY DEVELOPMENT | | 6,318,100 | 2.8 | 7,598,000 | 3.1 | 8,264,000 | 3.1 |
| HEALTH POLICY ANALYSIS AND DEVELOPMENT | HDP | 4,127,200 | 1.8 | 2,815,000 | 1.2 | 3,090,200 | 1.2 |
| HEALTH ECONOMICS AND FINANCING | HDE | 1,090,800 | .5 | 2,036,000 | .8 | 2,201,800 | .8 |
| HEALTH LEGISLATION | HLE | 464,200 | .2 | 1,135,100 | .5 | 1,221,300 | .5 |
| WOMEN, HEALTH AND DEVELOPMENT | WHD | 635,900 | .3 | 851,900 | .3 | 928,400 | .3 |
| PROMOTION OF BIOETHICS | HBE | 0 | - | 760,000 | .3 | 822,300 | .3 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 30,541,300 | 13.7 | 32,442,400 | 13.3 | 35,337,700 | 13.2 |
| HEALTH SERVICES DEVELOPMENT | DHS | 25,965,800 | 11.6 | 27,526,500 | 11.3 | 30,002,800 | 11.2 |
| ESSENTIAL DRUGS AND VACCINES | EDV | 1,304,200 | .6 | 1,577,500 | .6 | 1,725,100 | .6 |
| ORAL HEALTH | ORH | 710,700 | .3 | 688,400 | .3 | 747,000 | .3 |
| DISASTER PREPAREDNESS | DPP | 630,300 | .3 | 677,200 | .3 | 735,400 | .3 |
| CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY | CLR | 873,200 | .4 | 987,500 | .4 | 1,065,100 | .4 |
| HEALTH EDUCATION AND COMMUNITY PARTICIPATION | HED | 612,700 | .3 | 577,900 | .2 | 624,700 | .2 |
| REHABILITATION | RHB | 444,400 | .2 | 407,400 | .2 | 437,600 | .2 |

## TABLE E-3 (CONT.)

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| | PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|---|
| | HUMAN RESOURCES DEVELOPMENT | | 13,308,400 | 6.0 | 13,765,800 | 5.6 | 14,959,300 | 5.6 |
| | HUMAN RESOURCES TRAINING | HRC | 5,545,900 | 2.5 | 6,105,700 | 2.5 | 6,639,200 | 2.5 |
| | HUMAN RESOURCES PLANNING AND POLICY | HRP | 1,149,100 | .5 | 1,092,800 | .4 | 1,178,200 | .4 |
| | HUMAN RESOURCES EDUCATION | HRE | 6,613,400 | 3.0 | 6,567,300 | 2.7 | 7,141,900 | 2.7 |
| | HEALTH INFORMATION SUPPORT | | 10,441,500 | 4.7 | 11,965,700 | 4.8 | 13,067,500 | 4.8 |
| | OFFICIAL AND TECHNICAL PUBLICATIONS | HBP | 4,692,000 | 2.1 | 4,965,200 | 2.0 | 5,396,700 | 2.0 |
| | PUBLIC INFORMATION | HBF | 1,763,300 | .8 | 2,067,200 | .8 | 2,259,100 | .8 |
| | LANGUAGE SERVICES | HBL | 1,606,000 | .7 | 1,733,900 | .7 | 1,883,600 | .7 |
| | SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION | HBD | 2,380,200 | 1.1 | 3,199,400 | 1.3 | 3,528,100 | 1.3 |
| | RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT | | 4,457,400 | 2.1 | 4,906,600 | 2.0 | 5,297,700 | 2.0 |
| | RESEARCH PROMOTION AND DEVELOPMENT | RPD | 3,482,900 | 1.6 | 3,387,400 | 1.4 | 3,661,000 | 1.4 |
| | HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT | HDT | 586,900 | .3 | 854,200 | .3 | 919,300 | .3 |
| | RESEARCH AND DEVELOPMENT IN THE FIELD OF VACCINES | RDV | 387,600 | .2 | 665,000 | .3 | 717,400 | .3 |
| III. | HEALTH SCIENCE AND TECHNOLOGY | | 70,007,700 | 31.3 | 78,536,400 | 31.9 | 86,146,300 | 32.0 |
| | FOOD AND NUTRITION | | 7,365,600 | 3.3 | 7,623,000 | 3.1 | 8,427,500 | 3.1 |
| | FOOD | FOD | 1,265,800 | .6 | 1,244,300 | .5 | 1,382,800 | .5 |
| | NUTRITION | NUT | 6,099,800 | 2.7 | 6,378,700 | 2.6 | 7,044,700 | 2.6 |
| | ENVIRONMENTAL HEALTH | | 16,819,100 | 7.6 | 19,526,100 | 8.0 | 21,368,400 | 8.0 |
| | COMMUNITY WATER SUPPLY AND SANITATION | CWS | 10,648,400 | 4.8 | 12,084,600 | 4.9 | 13,253,500 | 5.0 |
| | SOLID WASTES AND HOUSING HYGIENE | RUD | 537,200 | .2 | 581,800 | .2 | 626,900 | .2 |
| | CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 5,072,000 | 2.3 | 6,243,600 | 2.6 | 6,820,800 | 2.6 |
| | WORKERS' HEALTH | OCH | 561,500 | .3 | 616,100 | .3 | 667,200 | .2 |
| | MATERNAL AND CHILD HEALTH | | 10,041,000 | 4.4 | 12,276,900 | 5.0 | 13,420,000 | 5.0 |
| | GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 6,786,500 | 3.0 | 8,539,700 | 3.5 | 9,375,400 | 3.5 |
| | ADOLESCENT HEALTH | ADH | 63,700 | .* | 67,700 | .* | 70,500 | .* |
| | ACUTE RESPIRATORY INFECTIONS | ARI | 409,400 | .2 | 448,900 | .2 | 482,400 | .2 |
| | IMMUNIZATION | EPI | 1,673,400 | .7 | 1,903,300 | .8 | 2,070,100 | .8 |
| | DIARRHEAL DISEASES | CDD | 1,108,000 | .5 | 1,317,300 | .5 | 1,421,600 | .5 |
| | COMMUNICABLE DISEASES | | 12,350,800 | 5.6 | 14,660,500 | 6.0 | 15,984,800 | 6.0 |
| | GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 5,822,700 | 2.6 | 8,156,100 | 3.3 | 8,951,600 | 3.3 |
| | TROPICAL DISEASE RESEARCH | TDR | 119,100 | .1 | 349,200 | .1 | 377,800 | .1 |
| | TUBERCULOSIS | TUB | 428,600 | .2 | 453,000 | .2 | 488,200 | .2 |
| | ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 374,700 | .2 | 618,500 | .3 | 673,100 | .3 |
| | VECTOR-BORNE DISEASES | VBC | 2,999,300 | 1.3 | 2,610,200 | 1.1 | 2,816,600 | 1.1 |
| | MALARIA | MAL | 1,832,500 | .8 | 1,642,400 | .7 | 1,781,200 | .7 |
| | PARASITIC DISEASES | PDP | 376,700 | .2 | 416,500 | .2 | 449,500 | .2 |
| | LEPROSY | LEP | 349,300 | .2 | 363,900 | .1 | 394,200 | .1 |
| | SEXUALLY TRANSMITTED DISEASES | VDT | 47,900 | .* | 50,700 | .* | 52,600 | .* |

# TABLE E-3 (CONT.)

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| HEALTH PROMOTION | | 6,449,100 | 2.8 | 7,404,900 | 2.9 | 8,047,800 | 2.9 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 4,874,700 | 2.2 | 5,908,500 | 2.4 | 6,438,800 | 2.4 |
| TOBACCO OR HEALTH | TOH | 57,700 | .* | 62,000 | .* | 66,000 | .* |
| PREV/TREAT. OF MENTAL AND NEUROLOGICAL DISORDERS | MND | 464,900 | .2 | 482,800 | .2 | 520,400 | .2 |
| CANCER | CAN | 57,000 | .* | 0 | - | 0 | - |
| ACCIDENT PREVENTION | APR | 50,300 | .* | 53,800 | .* | 56,900 | .* |
| HEALTH OF THE ELDERLY | HEE | 464,000 | .2 | 481,600 | .2 | 518,700 | .2 |
| PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE | ADA | 416,800 | .2 | 358,300 | .1 | 385,600 | .1 |
| OCULAR HEALTH | PBD | 63,700 | .* | 57,900 | .* | 61,400 | .* |
| VETERINARY PUBLIC HEALTH | | 16,982,100 | 7.6 | 17,045,000 | 6.9 | 18,897,800 | 7.0 |
| FOOD SAFETY | FOS | 2,132,300 | 1.0 | 2,807,000 | 1.1 | 3,062,200 | 1.1 |
| FOOT-AND-MOUTH DISEASE | FMD | 8,586,100 | 3.8 | 8,341,700 | 3.4 | 9,383,500 | 3.5 |
| ZOONOSES | ZNS | 6,263,700 | 2.8 | 5,896,300 | 2.4 | 6,452,100 | 2.4 |
| IV. PROGRAM SUPPORT | | 24,905,300 | 11.1 | 26,765,100 | 11.0 | 29,129,700 | 10.9 |
| ADMINISTRATION | | 24,905,300 | 11.1 | 26,765,100 | 11.0 | 29,129,700 | 10.9 |
| BUDGET AND FINANCE | BFI | 7,649,400 | 3.4 | 7,978,600 | 3.3 | 8,715,300 | 3.3 |
| GENERAL SERVICES & HEADQUARTERS OPERATING EXPENSES | PGS | 12,208,900 | 5.4 | 13,106,700 | 5.4 | 14,226,700 | 5.3 |
| PERSONNEL | PER | 3,513,400 | 1.6 | 4,025,300 | 1.6 | 4,390,600 | 1.6 |
| PROCUREMENT | SUP | 1,533,600 | .7 | 1,654,500 | .7 | 1,797,100 | .7 |
| GRAND TOTAL | | 224,067,000 | 100.0 | 244,260,000 | 100.0 | 267,452,000 | 100.0 |

* LESS THAN .05 PER CENT

# TABLE E-4

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| I. DIRECTION, COORDINATION AND MANAGEMENT | | 812,000 | .5 | 952,700 | 1.0 | 845,600 | 1.9 |
| GOVERNING BODIES | | 19,000 | .* | 0 | - | 0 | - |
| GOVERNING BODIES | GOB | 19,000 | .* | 0 | - | 0 | - |
| GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT | | 793,000 | .5 | 952,700 | 1.0 | 845,600 | 1.9 |
| GENERAL PROGRAM DEVELOPMENT | GPD | 149,100 | .1 | 267,800 | .3 | 291,800 | .7 |
| EXTERNAL COORD. FOR HEALTH AND SOCIAL DEVELOPMENT | COR | 460,700 | .3 | 471,900 | .5 | 322,300 | .7 |
| INFORMATICS MANAGEMENT | ISS | 183,200 | .1 | 213,000 | .2 | 231,500 | .5 |
| II. HEALTH SYSTEM INFRASTRUCTURE | | 59,401,200 | 33.2 | 16,194,000 | 16.2 | 2,476,600 | 5.7 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 2,220,200 | 1.3 | 893,500 | .9 | 956,100 | 2.2 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 1,741,800 | 1.0 | 461,000 | .5 | 490,000 | 1.1 |
| ADMINISTRATIVE ANALYSIS | AAN | 478,400 | .3 | 432,500 | .4 | 466,100 | 1.1 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 1,699,900 | .9 | 113,000 | .1 | 0 | - |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 1,699,900 | .9 | 113,000 | .1 | 0 | - |
| HEALTH SITUATION AND TREND ASSESSMENT | | 5,650,100 | 3.2 | 0 | - | 0 | - |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 5,650,100 | 3.2 | 0 | - | 0 | - |
| HEALTH POLICY DEVELOPMENT | | 985,500 | .5 | 1,361,500 | 1.4 | 0 | - |
| HEALTH POLICY ANALYSIS AND DEVELOPMENT | HDP | 22,600 | .* | 0 | - | 0 | - |
| HEALTH ECONOMICS AND FINANCING | HDE | 30,000 | .* | 0 | - | 0 | - |
| WOMEN, HEALTH AND DEVELOPMENT | WHD | 932,900 | .5 | 1,361,500 | 1.4 | 0 | - |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 42,237,000 | 23.7 | 10,053,900 | 10.0 | 137,000 | .3 |
| HEALTH SERVICES DEVELOPMENT | DHS | 24,651,700 | 13.9 | 8,649,900 | 8.6 | 137,000 | .3 |
| ESSENTIAL DRUGS AND VACCINES | EDV | 4,903,900 | 2.7 | 0 | - | 0 | - |
| ORAL HEALTH | ORH | 51,300 | .* | 0 | - | 0 | - |
| DISASTER PREPAREDNESS | DPP | 11,236,200 | 6.3 | 274,000 | .3 | 0 | - |
| CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY | CLR | 105,800 | .1 | 0 | - | 0 | - |
| HEALTH EDUCATION AND COMMUNITY PARTICIPATION | HED | 52,700 | .* | 0 | - | 0 | - |
| REHABILITATION | RHB | 1,235,400 | .7 | 1,130,000 | 1.1 | 0 | - |

# TABLE E-4 (CONT.)

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| HUMAN RESOURCES DEVELOPMENT | | 1,700,300 | .9 | 2,663,400 | 2.6 | 260,000 | .6 |
| HUMAN RESOURCES TRAINING | HRC | 415,700 | .2 | 403,400 | .4 | 260,000 | .6 |
| HUMAN RESOURCES PLANNING AND POLICY | HRP | 1,117,000 | .6 | 2,260,000 | 2.2 | 0 | - |
| HUMAN RESOURCES EDUCATION | HRE | 167,600 | .1 | 0 | - | 0 | - |
| HEALTH INFORMATION SUPPORT | | 2,174,800 | 1.2 | 1,048,700 | 1.1 | 1,059,000 | 2.5 |
| OFFICIAL AND TECHNICAL PUBLICATIONS | HBP | 387,100 | .2 | 63,700 | .1 | 68,000 | .2 |
| PUBLIC INFORMATION | HBF | 467,900 | .3 | 85,000 | .1 | 91,000 | .2 |
| LANGUAGE SERVICES | HBL | 20,900 | .* | 0 | - | 0 | - |
| SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION | HBD | 1,298,900 | .7 | 900,000 | .9 | 900,000 | 2.1 |
| RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT | | 2,733,400 | 1.5 | 60,000 | .1 | 64,500 | .1 |
| HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT | HDT | 56,000 | .* | 60,000 | .1 | 64,500 | .1 |
| RESEARCH AND DEVELOPMENT IN THE FIELD OF VACCINES | RDV | 2,677,400 | 1.5 | 0 | - | 0 | - |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 112,092,500 | 62.5 | 78,979,700 | 78.2 | 35,515,700 | 81.0 |
| FOOD AND NUTRITION | | 15,807,400 | 8.8 | 14,879,500 | 14.8 | 14,872,400 | 33.9 |
| FOOD | FOO | 55,200 | .* | 70,500 | .1 | 77,400 | .2 |
| NUTRITION | NUT | 15,752,200 | 8.8 | 14,809,000 | 14.7 | 14,795,000 | 33.7 |
| ENVIRONMENTAL HEALTH | | 6,337,700 | 3.5 | 5,167,900 | 5.1 | 1,470,800 | 3.3 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 3,480,400 | 1.9 | 810,100 | .8 | 668,100 | 1.5 |
| SOLID WASTES AND HOUSING HYGIENE | RUD | 400 | .* | 0 | - | 0 | - |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 2,482,300 | 1.4 | 4,341,800 | 4.3 | 802,700 | 1.8 |
| WORKERS' HEALTH | OCH | 374,600 | .2 | 16,000 | .* | 0 | - |
| MATERNAL AND CHILD HEALTH | | 44,425,800 | 24.9 | 21,243,500 | 21.1 | 6,184,900 | 14.1 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 15,716,800 | 8.8 | 6,622,500 | 6.6 | 2,844,600 | 6.5 |
| ADOLESCENT HEALTH | ADH | 511,500 | .3 | 247,000 | .2 | 271,500 | .6 |
| ACUTE RESPIRATORY INFECTIONS | ARI | 1,541,100 | .9 | 1,341,600 | 1.3 | 205,900 | .5 |
| IMMUNIZATION | EPI | 16,934,400 | 9.5 | 9,645,400 | 9.6 | 2,862,900 | 6.5 |
| DIARRHEAL DISEASES | CDD | 9,722,000 | 5.4 | 3,387,000 | 3.4 | 0 | - |
| COMMUNICABLE DISEASES | | 32,595,700 | 18.2 | 28,424,500 | 28.0 | 3,796,900 | 8.7 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 3,038,300 | 1.7 | 4,427,500 | 4.4 | 3,714,000 | 8.5 |
| TUBERCULOSIS | TUB | 3,700 | .* | 0 | - | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 21,869,500 | 12.2 | 19,811,400 | 19.5 | 82,900 | .2 |
| VECTOR-BORNE DISEASES | VBC | 799,800 | .4 | 0 | - | 0 | - |
| MALARIA | MAL | 5,669,100 | 3.2 | 4,179,400 | 4.1 | 0 | - |
| PARASITIC DISEASES | PDP | 632,500 | .4 | 0 | - | 0 | - |
| LEPROSY | LEP | 392,900 | .2 | 0 | - | 0 | - |
| SEXUALLY TRANSMITTED DISEASES | VDT | 189,900 | .1 | 6,200 | .* | 0 | - |

## TABLE E-4 (CONT.)

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| HEALTH PROMOTION | | 1,380,500 | .7 | 0 | - | 0 | - |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 290,100 | .2 | 0 | - | 0 | - |
| TOBACCO OR HEALTH | TOH | 62,300 | .* | 0 | - | 0 | - |
| PREV/TREAT. OF MENTAL AND NEUROLOGICAL DISORDERS | MND | 30,400 | .* | 0 | - | 0 | - |
| CANCER | CAN | 414,800 | .2 | 0 | - | 0 | - |
| HEALTH OF THE ELDERLY | HEE | 141,000 | .1 | 0 | - | 0 | - |
| PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE | ADA | 62,900 | .* | 0 | - | 0 | - |
| OCULAR HEALTH | PBD | 379,000 | .2 | 0 | - | 0 | - |
| VETERINARY PUBLIC HEALTH | | 11,545,400 | 6.4 | 9,264,300 | 9.2 | 9,190,700 | 21.0 |
| FOOD SAFETY | FOS | 2,052,200 | 1.1 | 2,421,000 | 2.4 | 2,700,000 | 6.2 |
| FOOT-AND-MOUTH DISEASE | FMD | 6,720,000 | 3.8 | 4,520,000 | 4.5 | 4,520,000 | 10.3 |
| ZOONOSES | ZNS | 2,773,200 | 1.5 | 2,323,300 | 2.3 | 1,970,700 | 4.5 |
| IV. PROGRAM SUPPORT | | 6,882,300 | 3.8 | 4,607,600 | 4.6 | 4,957,100 | 11.4 |
| ADMINISTRATION | | 6,882,300 | 3.8 | 4,607,600 | 4.6 | 4,957,100 | 11.4 |
| BUDGET AND FINANCE | BFI | 2,005,900 | 1.1 | 1,887,000 | 1.9 | 2,037,900 | 4.7 |
| GENERAL SERVICES & HEADQUARTERS OPERATING EXPENSES | PGS | 3,651,500 | 2.0 | 1,542,000 | 1.5 | 1,653,600 | 3.8 |
| PERSONNEL | PER | 355,100 | .2 | 271,600 | .3 | 289,800 | .7 |
| PROCUREMENT | SUP | 869,800 | .5 | 907,000 | .9 | 975,800 | 2.2 |
| GRAND TOTAL | | 179,188,000 | 100.0 | 100,734,000 | 100.0 | 43,795,000 | 100.0 |

* LESS THAN .05 PER CENT

# TABLE E-5

## PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS WITH PER CENT INCREASES/DECREASES

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | INCREASE/DECREASE 1994-1995 OVER 1992-1993 | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL |
|---|---|---|---|---|---|---|
| I. DIRECTION, COORDINATION AND MANAGEMENT | | 20,600,700 | 9.1 | (8.2) | 18,901,300 | 7.8 |
| GOVERNING BODIES | | 2,536,500 | 1.1 | 4.3 | 2,645,700 | 1.1 |
| GOVERNING BODIES | GOB | 2,536,500 | 1.1 | 4.3 | 2,645,700 | 1.1 |
| GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT | | 18,064,200 | 8.0 | (10.0) | 16,255,600 | 6.7 |
| EXECUTIVE MANAGEMENT | EXM | 3,241,600 | 1.4 | 13.1 | 3,667,100 | 1.5 |
| REGIONAL DIRECTOR'S DEVELOPMENT PROGRAM | DGP | 2,945,200 | 1.3 | (8.8) | 2,686,300 | 1.1 |
| GENERAL PROGRAM DEVELOPMENT | GPD | 4,773,400 | 2.1 | (20.0) | 3,817,800 | 1.6 |
| EXTERNAL COORDINATION FOR HEALTH & SOCIAL DEVELOPMENT | COR | 1,242,400 | 0.6 | (10.0) | 1,118,600 | 0.5 |
| INFORMATICS MANAGEMENT | ISS | 5,861,600 | 2.6 | (15.3) | 4,965,800 | 2.0 |
| II. HEALTH SYSTEM INFRASTRUCTURE | | 108,553,300 | 48.5 | 10.6 | 120,057,200 | 49.3 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 30,259,000 | 13.3 | 20.2 | 36,367,900 | 15.2 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 29,059,100 | 12.8 | 22.1 | 35,472,500 | 14.8 |
| ADMINISTRATIVE ANALYSIS | AAN | 1,199,900 | 0.5 | (25.4) | 895,400 | 0.4 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 2,645,700 | 1.2 | 13.4 | 3,001,100 | 1.2 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 2,645,700 | 1.2 | 13.4 | 3,001,100 | 1.2 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 10,581,900 | 4.7 | (5.4) | 10,009,700 | 4.1 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 10,581,900 | 4.7 | (5.4) | 10,009,700 | 4.1 |
| HEALTH POLICY DEVELOPMENT | | 6,318,100 | 2.8 | 20.3 | 7,598,000 | 3.1 |
| HEALTH POLICY ANALYSIS AND DEVELOPMENT | HDP | 4,127,200 | 1.8 | (31.8) | 2,815,000 | 1.2 |
| HEALTH ECONOMICS AND FINANCING | HDE | 1,090,800 | 0.5 | 86.7 | 2,036,000 | 0.8 |
| HEALTH LEGISLATION | HLE | 464,200 | 0.2 | 144.5 | 1,135,100 | 0.5 |
| WOMEN, HEALTH AND DEVELOPMENT | WHD | 635,900 | 0.3 | 34.0 | 851,900 | 0.3 |
| PROMOTION OF BIOETHICS | HBE | 0 | - | - | 760,000 | 0.3 |

## TABLE E-5 (CONT.)

**PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS WITH PER CENT INCREASES/DECREASES (CONT.)**

| | PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | INCREASE/DECREASE 1994-1995 OVER 1992-1993 | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| | HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 30,541,300 | 13.7 | 6.2 | 32,442,400 | 13.3 |
| | HEALTH SERVICES DEVELOPMENT | OHS | 25,965,800 | 11.6 | 6.0 | 27,526,500 | 11.3 |
| | ESSENTIAL DRUGS AND VACCINES | EDV | 1,304,200 | 0.6 | 21.0 | 1,577,500 | 0.6 |
| | ORAL HEALTH | ORH | 710,700 | 0.3 | (3.1) | 688,400 | 0.3 |
| | DISASTER PREPAREDNESS | DPP | 630,300 | 0.3 | 7.4 | 677,200 | 0.3 |
| | CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY | CLR | 873,200 | 0.4 | 13.1 | 987,500 | 0.4 |
| | HEALTH EDUCATION AND COMMUNITY PARTICIPATION | HED | 612,700 | 0.3 | (5.7) | 577,900 | 0.2 |
| | REHABILITATION | RHB | 444,400 | 0.2 | (8.3) | 407,400 | 0.2 |
| | HUMAN RESOURCES DEVELOPMENT | | 13,308,400 | 6.0 | 3.4 | 13,765,800 | 5.6 |
| | HUMAN RESOURCES TRAINING | HRC | 5,545,900 | 2.5 | 10.1 | 6,105,700 | 2.5 |
| | HUMAN RESOURCES PLANNING AND POLICY | HRP | 1,149,100 | 0.5 | (4.9) | 1,092,800 | 0.4 |
| | HUMAN RESOURCES EDUCATION | HRE | 6,613,400 | 3.0 | (0.7) | 6,567,300 | 2.7 |
| | HEALTH INFORMATION SUPPORT | | 10,441,500 | 4.7 | 14.6 | 11,965,700 | 4.8 |
| | OFFICIAL AND TECHNICAL PUBLICATIONS | HBP | 4,692,000 | 2.1 | 5.8 | 4,965,200 | 2.0 |
| | PUBLIC INFORMATION | HBF | 1,763,300 | 0.8 | 17.2 | 2,067,200 | 0.8 |
| | LANGUAGE SERVICES | HBL | 1,606,000 | 0.7 | 8.0 | 1,733,900 | 0.7 |
| | SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION | HBD | 2,380,200 | 1.1 | 34.4 | 3,199,400 | 1.3 |
| | RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT | | 4,457,400 | 2.1 | 10.1 | 4,906,600 | 2.0 |
| | RESEARCH PROMOTION AND DEVELOPMENT | RPD | 3,482,900 | 1.6 | (2.7) | 3,387,400 | 1.4 |
| | HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT | HDT | 586,900 | 0.3 | 45.5 | 854,200 | 0.3 |
| | RESEARCH AND DEVELOPMENT IN THE FIELD OF VACCINES | RDV | 387,600 | 0.2 | 71.6 | 665,000 | 0.3 |
| III. | HEALTH SCIENCE AND TECHNOLOGY | | 70,007,700 | 31.3 | 12.2 | 78,536,400 | 31.9 |
| | FOOD AND NUTRITION | | 7,365,600 | 3.3 | 3.5 | 7,623,000 | 3.1 |
| | FOOD | FOD | 1,265,800 | 0.6 | (1.7) | 1,244,300 | 0.5 |
| | NUTRITION | NUT | 6,099,800 | 2.7 | 4.6 | 6,378,700 | 2.6 |

## TABLE E-5 (CONT.)

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS WITH PER CENT INCREASES/DECREASES (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | INCREASE/DECREASE 1994-1995 OVER 1992-1993 | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL |
|---|---|---|---|---|---|---|
| ENVIRONMENTAL HEALTH | | 16,819,100 | 7.6 | 16.1 | 19,526,100 | 8.0 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 10,648,400 | 4.8 | 13.5 | 12,084,600 | 4.9 |
| SOLID WASTES AND HOUSING HYGIENE | RUD | 537,200 | 0.2 | 8.3 | 581,800 | 0.2 |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 5,072,000 | 2.3 | 23.1 | 6,243,600 | 2.6 |
| WORKERS' HEALTH | OCH | 561,500 | 0.3 | 9.7 | 616,100 | 0.3 |
| MATERNAL AND CHILD HEALTH | | 10,041,000 | 4.4 | 22.3 | 12,276,900 | 5.0 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 6,786,500 | 3.0 | 25.8 | 8,539,700 | 3.5 |
| ADOLESCENT HEALTH | ADH | 63,700 | * | 6.3 | 67,700 | * |
| ACUTE RESPIRATORY INFECTIONS | ARI | 409,400 | 0.2 | 9.6 | 448,900 | 0.2 |
| IMMUNIZATION | EPI | 1,673,400 | 0.7 | 13.7 | 1,903,300 | 0.8 |
| DIARRHEAL DISEASES | CDD | 1,108,000 | 0.5 | 18.9 | 1,317,300 | 0.5 |
| COMMUNICABLE DISEASES | | 12,350,800 | 5.6 | 18.7 | 14,660,500 | 6.0 |
| GENERAL COMMUNICABLE DISEASE PREVENTION AND CONTROL | OCD | 5,822,700 | 2.6 | 40.1 | 8,156,100 | 3.3 |
| TROPICAL DISEASE RESEARCH | TDR | 119,100 | 0.1 | 193.2 | 349,200 | 0.1 |
| TUBERCULOSIS | TUB | 428,600 | 0.2 | 5.7 | 453,000 | 0.2 |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 374,700 | 0.2 | 65.1 | 618,500 | 0.3 |
| VECTOR-BORNE DISEASES | VBC | 2,999,300 | 1.3 | (13.0) | 2,610,200 | 1.1 |
| MALARIA | MAL | 1,832,500 | 0.8 | (10.4) | 1,642,400 | 0.7 |
| PARASITIC DISEASES | PDP | 376,700 | 0.2 | 10.6 | 416,500 | 0.2 |
| LEPROSY | LEP | 349,300 | 0.2 | 4.2 | 363,900 | 0.1 |
| SEXUALLY TRANSMITTED DISEASES | VDT | 47,900 | * | 5.8 | 50,700 | * |
| HEALTH PROMOTION | | 6,449,100 | 2.8 | 14.8 | 7,404,900 | 2.9 |
| HEALTH PROMOTION, PREV./CONTROL OF NONCOMMUNICABLE DIS. | NCD | 4,874,700 | 2.2 | 21.2 | 5,908,500 | 2.4 |
| TOBACCO OR HEALTH | TOH | 57,700 | * | 7.5 | 62,000 | * |
| PREVENT/TREAT. OF MENTAL AND NEUROLOGICAL DISORDERS | MND | 464,900 | 0.2 | 3.9 | 482,800 | 0.2 |
| CANCER | CAN | 57,000 | * | (100.0) | 0 | - |
| ACCIDENT PREVENTION | APR | 50,300 | * | 7.0 | 53,800 | * |
| HEALTH OF THE ELDERLY | HEE | 464,000 | 0.2 | 3.8 | 481,600 | 0.2 |
| PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE | ADA | 416,800 | 0.2 | (14.0) | 358,300 | 0.1 |
| OCULAR HEALTH | PBD | 63,700 | * | (9.1) | 57,900 | * |

## TABLE E-5 (CONT.)

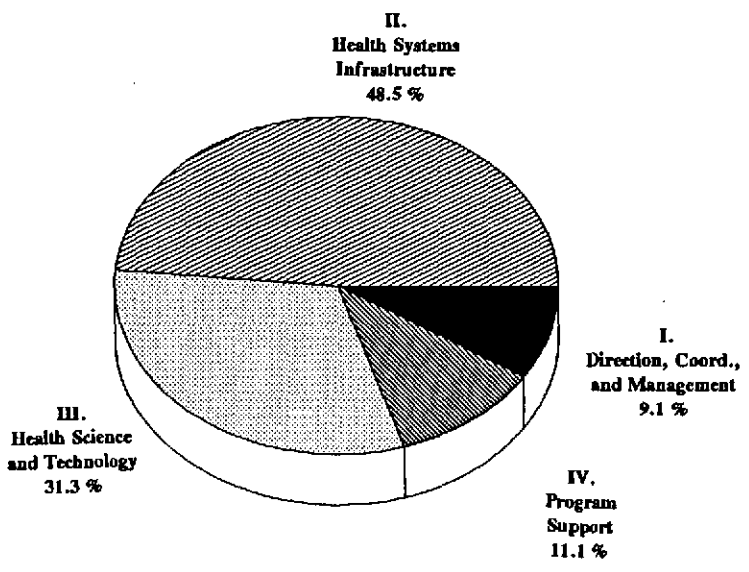
**PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS WITH PER CENT INCREASES/DECREASES (CONT.)**

| | PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | INCREASE/DECREASE 1994-1995 OVER 1992-1993 | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| | VETERINARY PUBLIC HEALTH | | 16,982,100 | 7.6 | 0.4 | 17,045,000 | 6.9 |
| | FOOD SAFETY | FOS | 2,132,300 | 1.0 | 31.6 | 2,807,000 | 1.1 |
| | FOOT-AND-MOUTH DISEASE | FMD | 8,586,100 | 3.8 | (2.8) | 8,341,700 | 3.4 |
| | ZOONOSES | ZNS | 6,263,700 | 2.8 | (5.9) | 5,896,300 | 2.4 |
| IV. | PROGRAM SUPPORT | | 24,905,300 | 11.1 | 7.5 | 26,765,100 | 11.0 |
| | ADMINISTRATION | | 24,905,300 | 11.1 | 7.5 | 26,765,100 | 11.0 |
| | BUDGET AND FINANCE | BFI | 7,649,400 | 3.4 | 4.3 | 7,978,600 | 3.3 |
| | GENERAL SERVICES AND HEADQUARTERS OPERATING EXPENSES | PGS | 12,208,900 | 5.4 | 7.4 | 13,106,700 | 5.4 |
| | PERSONNEL | PER | 3,513,400 | 1.6 | 14.6 | 4,025,300 | 1.6 |
| | PROCUREMENT | SUP | 1,533,600 | 0.7 | 7.9 | 1,654,500 | 0.7 |
| | GRAND TOTAL | | 224,067,000 | 100.0 | 9.0 | 244,260,000 | 100.0 |

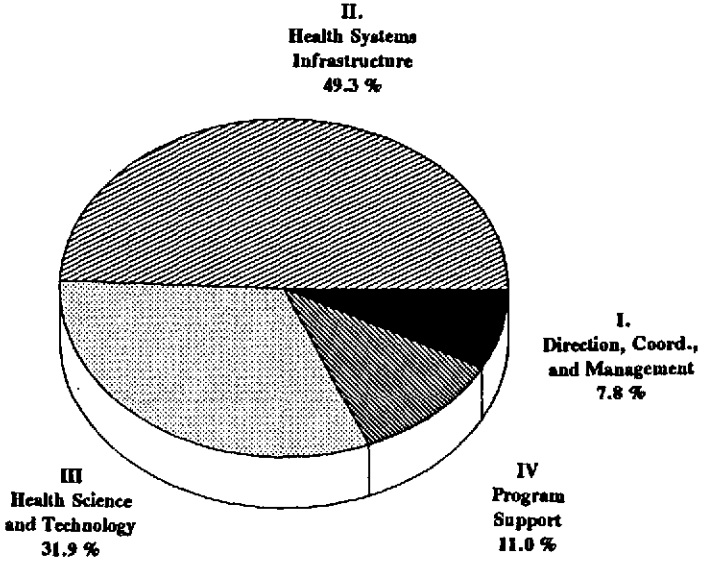
* LESS THAN .05 PER CENT

## GRAPH III

PAHO/WHO REGULAR PROGRAM BUDGET BY APPROPRIATION SECTION: PER CENT OF TOTAL



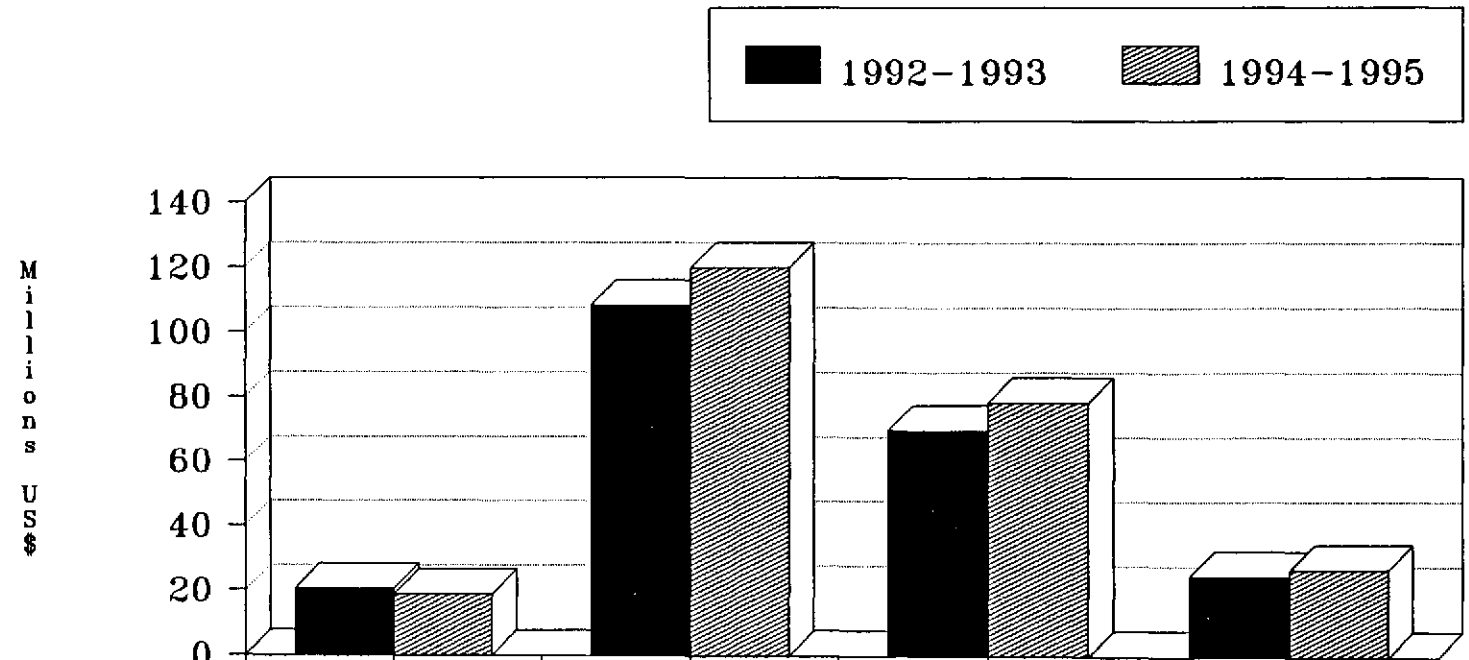

1992–1993




1994–1995

## GRAPH IV

PAHO/WHO REGULAR PROGRAM BUDGET BY APPROPRIATION SECTION: PER CENT INCREASES/DECREASES




| | I. Direction, Coord, Management | II. Health System Infrastructure | III. Health Science and Technology | IV. Program Support |
|---|---|---|---|---|
| | - 8.2 % | 10.6 % | 12.2 % | 7.5 % |
| 1992-1993 | 20.601 | 108.553 | 70.008 | 24.905 |
| 1994-1995 | 18.901 | 120.057 | 78.536 | 26.765 |

# TABLE F-1

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 152,576,000 | 282 | 384 | 20497 | 91,967,600 | 6,183,700 | 1536 | 3,060,000 | 10,970,800 | 7,844,100 | 2,161,800 | 30,388,000 |
| WHO - WR | 71,491,000 | 164 | 129 | 12240 | 45,278,800 | 2,506,600 | 1410 | 2,820,000 | 5,475,800 | 3,347,700 | 61,100 | 12,001,000 |
| TOTAL | 224,067,000 | 446 | 513 | 32737 | 137,246,400 | 8,690,300 | 2946 | 5,880,000 | 16,446,600 | 11,191,800 | 2,222,900 | 42,389,000 |
| % OF TOTAL | 100.0 | | | | 61.3 | 3.9 | | 2.6 | 7.3 | 5.0 | 1.0 | 18.9 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 164,466,000 | 270 | 384 | 19877 | 99,043,300 | 6,434,400 | 1385 | 2,770,000 | 12,541,200 | 8,056,000 | 2,758,400 | 32,862,700 |
| WHO - WR | 79,794,000 | 160 | 132 | 12883 | 49,906,900 | 2,885,600 | 1412 | 2,824,000 | 6,909,600 | 4,061,800 | 38,500 | 13,167,600 |
| TOTAL | 244,260,000 | 430 | 516 | 32760 | 148,950,200 | 9,320,000 | 2797 | 5,594,000 | 19,450,800 | 12,117,800 | 2,796,900 | 46,030,300 |
| % OF TOTAL | 100.0 | | | | 61.0 | 3.8 | | 2.3 | 8.0 | 5.0 | 1.1 | 18.8 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 180,357,000 | 270 | 384 | 19877 | 108,133,400 | 7,101,000 | 1385 | 2,770,000 | 13,968,700 | 8,971,600 | 3,018,800 | 36,393,500 |
| WHO - WR | 87,095,000 | 160 | 132 | 12883 | 54,011,000 | 3,198,600 | 1412 | 2,824,000 | 7,778,800 | 4,569,100 | 42,200 | 14,671,300 |
| TOTAL | 267,452,000 | 430 | 516 | 32760 | 162,144,400 | 10,299,600 | 2797 | 5,594,000 | 21,747,500 | 13,540,700 | 3,061,000 | 51,064,800 |
| % OF TOTAL | 100.0 | | | | 60.6 | 3.9 | | 2.1 | 8.1 | 5.1 | 1.1 | 19.1 |

## TABLE F-2

ANALYSIS OF BUDGETARY ELEMENTS - PAHO AND WHO REGULAR FUNDS

| BUDGET ELEMENTS | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | PER CENT INCREASE/ (DECREASE) | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL |
|---|---|---|---|---|---|
| PERSONNEL: | | | | | |
| POSTS | 120,469,700 | 53.8 | 9.1 | 131,405,200 | 53.9 |
| CONSULTANTS | 8,740,000 | 3.9 | 4.2 | 9,108,200 | 3.7 |
| LOCAL CONDITIONS STAFF | 1,231,500 | .6 | 2.3 | 1,259,700 | .5 |
| RETIREES' HEALTH INSURANCE | 3,650,000 | 1.6 | 8.2 | 3,949,300 | 1.6 |
| TEMPORARY ASSISTANCE | 3,155,200 | 1.4 | 2.3 | 3,227,800 | 1.3 |
| TOTAL, PERSONNEL | 137,246,400 | 61.3 | 8.5 | 148,950,200 | 61.0 |
| DUTY TRAVEL | 8,690,300 | 3.9 | 7.2 | 9,320,000 | 3.8 |
| FELLOWSHIPS | 5,880,000 | 2.6 | (4.9) | 5,594,000 | 2.3 |
| COURSES AND SEMINARS | 16,446,600 | 7.3 | 18.3 | 19,450,800 | 8.0 |
| SUPPLIES AND EQUIPMENT | 11,191,800 | 5.0 | 8.3 | 12,117,800 | 5.0 |
| GRANTS | 2,222,900 | 1.0 | 25.8 | 2,796,900 | 1.1 |
| OTHER: | | | | | |
| CONFERENCE SERVICES | 1,410,200 | .6 | 11.0 | 1,564,900 | .6 |
| CONTRACTUAL SERVICES | 17,016,000 | 7.6 | 10.2 | 18,759,700 | 7.7 |
| EXTERNAL AUDIT COSTS | 454,900 | .2 | 8.2 | 492,200 | .2 |
| GENERAL OPERATING EXPENSES | 17,439,400 | 7.8 | 9.1 | 19,022,100 | 7.8 |
| HOSPITALITY | 51,100 | .* | 1.8 | 52,000 | .* |
| INTERNAL AUDIT COSTS | 147,000 | .1 | 13.8 | 167,300 | .1 |
| REGIONAL DIRECTOR'S DEVELOPMENT PROGRAM | 2,945,200 | 1.3 | (8.8) | 2,686,300 | 1.1 |
| REPAYMENT OF TEXTBOOK LOANS | 216,200 | .1 | .0 | 216,200 | .1 |
| STAFF RELATIONS | 63,300 | .* | 8.2 | 68,500 | .* |
| TECHNICAL COOPERATION | 2,645,700 | 1.2 | 13.4 | 3,001,100 | 1.2 |
| TOTAL, OTHER | 42,389,000 | 18.9 | 8.6 | 46,030,300 | 18.8 |
| GRAND TOTAL | 224,067,000 | 100.0 | 9.0 | 244,260,000 | 100.0 |

* LESS THAN .05 PERCENT

# TABLE F-3

ALLOCATION BY OBJECT OF EXPENDITURE - EXTRABUDGETARY FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PA | 1,200,000 | 0 | 0 | 0 | 1,200,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PN | 13,000,000 | 0 | 0 | 0 | 13,000,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PM | 67,000 | 1 | 0 | 0 | 67,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PC | 3,244,100 | 3 | 0 | 233 | 1,966,700 | 87,200 | 0 | 0 | 31,600 | 801,200 | 0 | 357,400 |
| PJ | 2,340,900 | 0 | 0 | 149 | 551,800 | 422,700 | 0 | 0 | 235,300 | 200,900 | 12,000 | 918,200 |
| PH | 300,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 300,000 |
| PB | 1,926,200 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,926,200 |
| PD | 6,130,200 | 0 | 0 | 626 | 173,900 | 15,100 | 0 | 0 | 237,800 | 4,402,400 | 10,000 | 1,291,000 |
| PG | 96,343,600 | 29 | 57 | 20770 | 15,344,700 | 2,275,700 | 573 | 1,142,900 | 12,145,600 | 25,357,100 | 5,233,100 | 34,844,500 |
| PK | 761,500 | 0 | 0 | 482 | 139,900 | 83,000 | 0 | 0 | 168,200 | 74,200 | 216,200 | 80,000 |
| PL | 4,510,500 | 0 | 0 | 15 | 838,700 | 20,100 | 0 | 0 | 551,500 | 1,560,300 | 0 | 1,539,900 |
| PU | 13,800 | 0 | 0 | 19 | 8,400 | 3,000 | 0 | 0 | 0 | 2,400 | 0 | 0 |
| PX | 8,423,200 | 8 | 37 | 319 | 3,756,400 | 120,300 | 0 | 0 | 82,700 | 622,700 | 10,000 | 3,831,100 |
| DP | 1,096,400 | 0 | 0 | 0 | 256,900 | 37,200 | 0 | 0 | 447,300 | 316,300 | 0 | 38,700 |
| DR | 1,174,800 | 0 | 0 | 0 | 583,400 | 44,800 | 0 | 0 | 408,100 | 13,500 | 0 | 125,000 |
| FB | 1,365,600 | 16 | 0 | 0 | 1,164,400 | 59,400 | 0 | 0 | 0 | 0 | 0 | 141,800 |
| FD | 22,900 | 0 | 0 | 0 | 4,000 | 1,600 | 0 | 0 | 11,300 | 3,400 | 0 | 2,600 |
| FP | 6,797,800 | 0 | 0 | 295 | 1,882,200 | 285,100 | 0 | 341,500 | 1,541,700 | 1,269,000 | 103,000 | 1,375,300 |
| FX | 16,299,100 | 17 | 7 | 2996 | 4,045,000 | 621,400 | 7 | 12,600 | 1,907,000 | 3,289,500 | 202,100 | 6,221,500 |
| ST | 250,700 | 0 | 0 | 86 | 23,800 | 58,100 | 3 | 6,100 | 89,700 | 7,800 | 0 | 65,200 |
| VB | 30,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 26,500 | 0 | 0 | 3,500 |
| VC | 2,323,400 | 4 | 1 | 483 | 773,100 | 291,100 | 0 | 0 | 609,700 | 252,400 | 0 | 397,100 |
| VD | 6,280,400 | 2 | 0 | 2228 | 1,057,000 | 169,300 | 7 | 13,400 | 1,406,400 | 1,558,000 | 25,000 | 2,051,300 |
| VG | 3,600 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3,600 |
| VI | 727,500 | 2 | 0 | 472 | 481,300 | 61,900 | 0 | 0 | 3,300 | 1,000 | 0 | 180,000 |
| VL | 15,000 | 0 | 0 | 13 | 3,600 | 1,600 | 0 | 0 | 8,100 | 0 | 0 | 1,700 |
| VW | 76,600 | 0 | 0 | 32 | 8,900 | 6,600 | 0 | 0 | 42,300 | 4,000 | 0 | 14,800 |
| VY | 19,200 | 0 | 0 | 43 | 17,000 | 0 | 0 | 0 | 0 | 0 | 0 | 2,200 |
| AS | 4,228,700 | 4 | 25 | 1217 | 2,684,000 | 425,300 | 0 | 0 | 339,600 | 151,700 | 19,500 | 608,600 |
| EF | 215,300 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 215,300 |
| TOTAL | 179,188,000 | 86 | 127 | 30478 | 50,032,100 | 5,090,500 | 590 | 1,516,500 | 20,293,700 | 39,887,800 | 5,830,900 | 56,536,500 |
| % OF TOTAL | 100.0 | | | | 27.9 | 2.8 | | .8 | 11.3 | 22.3 | 3.3 | 31.6 |

## TABLE F-3 (CONT.)

ALLOCATION BY OBJECT OF EXPENDITURE - EXTRABUDGETARY FUNDS (CONT.)

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| **1994-1995** | | | | | | | | | | | | |
| PA | 1,200,000 | 0 | 0 | 0 | 1,200,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PN | 13,000,000 | 0 | 0 | 0 | 13,000,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PM | 70,000 | 1 | 0 | 0 | 70,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PC | 3,561,000 | 3 | 0 | 252 | 2,031,000 | 90,000 | 0 | 0 | 40,000 | 900,000 | 0 | 500,000 |
| PJ | 811,800 | 0 | 0 | 142 | 213,800 | 0 | 0 | 0 | 301,500 | 61,000 | 24,000 | 211,500 |
| PB | 1,400,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,400,000 |
| PG | 45,219,800 | 12 | 38 | 12015 | 9,090,200 | 960,400 | 40 | 80,000 | 6,615,700 | 10,273,400 | 550,000 | 17,650,100 |
| PK | 216,200 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 216,200 | 0 |
| PX | 4,432,200 | 8 | 37 | 180 | 4,238,200 | 80,000 | 0 | 0 | 64,000 | 10,000 | 0 | 40,000 |
| DP | 250,000 | 0 | 0 | 0 | 67,000 | 5,000 | 0 | 0 | 127,600 | 35,400 | 0 | 15,000 |
| DR | 311,800 | 0 | 0 | 0 | 115,500 | 18,000 | 0 | 0 | 120,000 | 6,500 | 0 | 51,800 |
| FB | 22,200 | 2 | 0 | 0 | 21,500 | 0 | 0 | 0 | 0 | 0 | 0 | 700 |
| FP | 2,097,200 | 0 | 0 | 60 | 701,600 | 145,400 | 0 | 12,000 | 687,800 | 198,500 | 0 | 351,900 |
| FX | 19,652,900 | 15 | 7 | 0 | 3,438,700 | 370,000 | 0 | 0 | 4,816,600 | 4,350,600 | 0 | 6,677,000 |
| VC | 2,498,000 | 3 | 1 | 540 | 722,000 | 300,000 | 0 | 0 | 730,000 | 292,200 | 0 | 453,800 |
| VD | 1,152,000 | 0 | 0 | 792 | 280,000 | 110,000 | 0 | 0 | 280,000 | 179,400 | 0 | 302,600 |
| VI | 228,300 | 2 | 0 | 0 | 182,000 | 20,000 | 0 | 0 | 0 | 0 | 0 | 26,300 |
| AS | 4,610,600 | 4 | 25 | 1313 | 2,956,300 | 435,000 | 0 | 0 | 367,300 | 166,400 | 21,500 | 664,100 |
| TOTAL | 100,734,000 | 50 | 108 | 15294 | 38,327,800 | 2,533,800 | 40 | 92,000 | 14,150,500 | 16,473,400 | 811,700 | 28,344,800 |
| % OF TOTAL | 100.0 | | | | 38.1 | 2.5 | | .1 | 14.0 | 16.4 | .8 | 28.1 |
| **1996-1997** | | | | | | | | | | | | |
| PA | 1,200,000 | 0 | 0 | 0 | 1,200,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PN | 13,000,000 | 0 | 0 | 0 | 13,000,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PC | 3,714,000 | 3 | 0 | 252 | 2,151,000 | 90,000 | 0 | 0 | 40,000 | 900,000 | 0 | 533,000 |
| PB | 1,500,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,500,000 |
| PG | 14,735,700 | 5 | 35 | 1211 | 4,091,800 | 90,000 | 15 | 30,000 | 556,700 | 4,127,100 | 0 | 5,840,100 |
| PK | 54,100 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 54,100 | 0 |
| PX | 4,596,200 | 8 | 37 | 0 | 4,596,200 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| FP | 8,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8,000 | 0 | 0 |
| AS | 4,987,000 | 4 | 25 | 1424 | 3,182,000 | 474,000 | 0 | 0 | 400,000 | 182,700 | 23,600 | 724,700 |
| TOTAL | 43,795,000 | 20 | 97 | 2887 | 28,221,000 | 654,000 | 15 | 30,000 | 996,700 | 5,217,800 | 77,700 | 8,597,800 |
| % OF TOTAL | 100.0 | | | | 64.4 | 1.5 | | .1 | 2.3 | 11.9 | .2 | 19.6 |

## I. DIRECTION, COORDINATION AND MANAGEMENT

| | |
|---|---|
| 1. Governing Bodies | Includes the following program: |
| **GOB** Governing Bodies | Activities related to the preparation and convening of meetings of the Organization's Governing Bodies (Pan American Sanitary Conference, Directing Council and Executive Committee); to such subcommittees as may be set up by the Governing Bodies; and to external audit. |
| 2. General Program Development and Management | Activities of coordination and management at Headquarters, comprising the following programs: |
| **EXM** Executive Management | Activities of the Offices of the Director/Deputy Director (D/DD); of the Chief of Administration (AM); and of two units under D/DD: Legal Affairs (DLA) and Internal Audit (IA). |
| **DGP** Regional Director's Development Program | Budgetary provisions for innovative technical cooperation programs which cannot be specifically determined at the time of the program budget approval. |
| **GPD** General Program Development | Activities of Analysis and Strategic Planning Coordination Unit (DAP); and the Program of Staff Development and Training (APL/SDT). |
| **COR** External Coordination for Health | Activities of a unit under D/DD: External Coordination (DEC), including collaboration with regional United Nations and inter-American systems, with other organizations and with multilateral and bilateral programs. |
| **ISS** Informatics Management | Activities of information support services for PAHO's management. |

PAHO CLASSIFIED LIST OF PROGRAMS WITH DESCRIPTION (Cont.)

## II. HEALTH SYSTEM INFRASTRUCTURE

| | |
|---|---|
| 3. Managerial Process for National Health Development | Technical and administrative management of technical cooperation at country level, performed by the PAHO/WHO Representatives and their basic administrative staff, and comprehensive programmatic interventions aimed at the strengthening of national health development in the Member Countries, comprising the following subprograms: |
| **MPN** Managerial Support for National Health Development | Promotion, initiation and establishment of permanent functional mechanisms for the application of the process of broad national health program development and training of national personnel. Includes activities of the Office of Assistant Director (AD), Country Representative Offices, Caribbean Program Coordination, and the Filed Office on the US-Mexico Border, as well as the activity of the Executive Secretariat for the Regional Plan for Investment in the Environment and Health (PIAS). |
| **AAN** Administrative Analysis | Preparation of studies, directives, and procedures on the administrative management of technical cooperation programs. Conduct systems development activities aimed at improving functionality and performance of the organization's administrative systems. |
| 4. Technical Cooperation among Countries | Includes the following subprograms: |
| **TCC** Technical Cooperation among Countries | Promotion and support of activities of technical cooperation among countries, which would serve as a catalyst in supporting the governments' efforts in identifying, planning and implementing mechanisms of intercountry cooperation at bilateral, subregional, regional and global levels. |
| 5. Health Situation and Trend Assessment | Includes the following subprogram: |
| **HST** Health Situation and Trend Assessment | Improving the capability for generating and utilizing knowledge related to: a) assessment of the health status of the population, its determinants and trends, in order to contribute to the definition of health priorities, policies and intervention strategies and b) evaluation of the impact of those policies, strategies, and interventions, so that they may be adjusted or redesigned as necessary. The above includes enhancement of the availability, quality and timeliness of suitable data and the promotion of their appropriate utilization. |

| | |
|---|---|
| 6. Health Policy Development | Includes the following programs: |
| **HDP** Health Policy Analysis and Development | Analysis of the political dimensions of health; identification of relevant entities in defining health policies; promotion of health goals in national and regional development agendas; analysis of institutional aspects in health policies; articulation of state services, Social Security, and the private sector in national health systems; strengthening of intersectoral action in the formulation and implementation of health policies; analysis of the constitution, organization, resources, and operation of the sector in order to orient its strategic-situational conduct of health policies and sectoral development projects; and participation of the health system in integrated programs to combat extreme poverty. |
| **HDE** Health Economics and Financing | Analysis and search for alternatives for sectoral financing; economic-financial management of the sector for greater equity and efficiency in its benefits; and study of the impact of the crisis on health, on the adjustment policies, and on the relationships between health and economy. |
| **HLE** Health Legislation | Implementation of the Documentation System on Health Legislation of Latin America and the Caribbean; cooperation for the analysis, development, and evaluation of health legislation in the countries; and support for PAHO/WHO programs for development of the legal aspects involved in the respective health policies. |
| **WHD** Women, Health and Development | Activities of promotion and support aimed at introducing gender considerations in the epidemiological analysis of the population, at applying of this approach to the formulation of health policies and programs, and at disseminating information and developing training and research programs on women, health and development. |
| **HBE** Promotion of Bioethics | Contribute to enhancing the quality of life of the region's populace by applying ethical principles to medical practice in general, biomedical research and health regulations. Particularly, to contribute to the development of knowledge in bioethics; to cooperate with other countries in the establishment of rules and regulations for bioethics-related issues. |

PAHO CLASSIFIED LIST OF PROGRAMS WITH DESCRIPTION (Cont.)

| | | |
|---|---|---|
| 7. | Organization of Health Services Based on Primary Health Care | General activities oriented towards achieving extension of coverage, increasing operating capacity and developing health services infrastructure through the following programs: |
| **DHS** | Health Services Development | Technical cooperation activities for the reorganization of the sector on the basis of the primary care strategy with a view to achieving equity, effectiveness, quality, and efficiency in the health services. Support for the processes of decentralization and local health system development, the intersectoral approach, and social participation. Incorporation within the network of services of all health care resources, including those of the public sector, social security, and nongovernmental and private organizations, as well as hospital services and their accreditation and quality assurance. Support for specific programs to address the needs of high-risk groups. Development of local strategic administration and support for health services research. |
| **EDV** | Essential Drugs and Vaccines | Formulation and implementation of national drug policies to ensure quantification of needs, procurement, production, distribution and management of essential drugs and vaccines, including assurance of regular supply at the primary health care level. Includes activities geared to development of national programs for monitoring and maintaining the quality, safety and efficacy of drugs. |
| **ORH** | Oral Health | Activities related to community prevention and control of oral diseases and to general promotion of oral health. |
| **DPP** | Disaster Preparedness | Activities related to disaster preparedness and emergency assistance, included in this program due to their obvious relationship with the organization of health services. |
| **CLR** | Clinical, Laboratory and Radiological Technology for Health Services | Activities concerned with the determination of standards for clinical, diagnostic and treatment methods (including surgical) appropriate for delivery through primary health care and the immediate supporting levels; and promotional activities in the field of health technology, including radiological and health laboratory techniques and dissemination of relevant information. |
| **HED** | Health Education and Community Participation | Activities related to the development and implementation of appropriate approaches aimed at promoting self-care, preventive measures and health practices in the population, as well as community participation in health and well-being. Includes development and utilization of simplified educational technology and materials. |
| **RHB** | Rehabilitation | Support for the countries in their development of national policies and programs for disability prevention and community-based rehabilitation which are integrated into the health services systems as part of primary care. |

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| 8. | Human Resources Development | Activities related to planning, education and training as well as utilization of human resources in health, carried out through the following programs: |
| **HRC** | Human Resources Training | Activities to coordinate the fellowship and textbooks program as well as the didactic and pedagogical development to ensure the continuing education of health services personnel. |
| **HRP** | Human Resources Planning and Policy | Promotion of the institutional development for personnel management with emphasis in the analysis of the labor market, formulation of human resources policies and advanced training in these fields. |
| **HRE** | Human Resources Education | Institutional and program development of education in the health professions with emphasis in medicine and nursing, promotion of leadership and advanced education in public health. |
| 9. | Health Information Support | One of the basic elements of PAHO's main policy on management of knowledge (fostering of knowledge, critical analysis and dissemination of information), including the following programs: |
| **HBP** | Official and Technical Publications | Production of publications and documents of the Organization. |
| **HBF** | Public Information | Activities related to the mobilization of public opinion in support of major health objectives, including utilization of mass communication techniques in the promulgation of basic tenets of health promotion. |
| **HBL** | Language Services | Activities related to simultaneous interpretation during executive, technical, and administrative meetings; and to translation of books, documents and other publications of the Organization. |
| **HBD** | Scientific and Technical Information Dissemination | Development and promotion of health bibliographic and documentation services, including libraries and regional document centers. |

PAHO CLASSIFIED LIST OF PROGRAMS WITH DESCRIPTION (Cont.)

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| 10. Research Promotion and Technology Development | Includes the following programs: |
| **RPD** Research Promotion and Development | An essential part of PAHO's main strategy of management of knowledge, comprising overall coordination of biomedical and health systems research, highlighting the functions of the regional Advisory committee on medical research, its subcommittees and working groups; strengthening of national health research capabilities; promoting biomedical, socioepidemiological and health systems research methodology; managing health research, including ethical aspects; providing research information support; and promoting national and international health research development mechanisms. |
| **HDT** Health Technology Policies and Development | Activities aimed at development of a conceptual framework and analytical, administrative and evaluating tools applied to technological development in health. |
| **RDV** Research and Development in the Field of Vaccines | Activities aimed at stimulating and supporting research on new vaccines, the organization of vaccines trials with the Member Countries, and the evaluation of the results of introducing new vaccines. |

## III. HEALTH SCIENCE AND TECHNOLOGY

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| 11. Food and Nutrition | Includes the following programs: |
| **FOD** Food | Activities of analysis and surveillance of the food situation and its impact on health; cooperation in food assistance programs; education; availability and consumption of foods. |
| **NUT** Nutrition | Activities related to prevention and control of malnutrition and development of nutrition and dietetic services in the community. |

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| 12. Environmental Health | Includes the following programs: |
| **CWS** Community Water Supply and Sanitation | Activities aimed at the implementation of national programs of drinking water supply and environmental health; promotion of policies, legislation and strategies to ensure that planning, assessment and implementation of development projects give full consideration to their impact on the ecology; development of methodologies for assessment of health and ecological impacts; and support mechanisms. |
| **RUD** Solid Wastes and Housing Hygiene | Support of development of activities regarding solid wastes (collection, transportation and disposal); promotion of these activities in relation to rural and urban development; and sanitary control of housing. |
| **CEH** Control of Environmental Health Hazards | Activities concerned with the formulation and implementation of national policies and programs for health protection of people against environmental hazards and assessment of possible adverse health effects from radiation hazards and chemicals in air, water, soil and food. |
| **OCH** Workers' Health | Promotion of workers' health, early detection and prevention of workers' health problems, and the preparation of technical guidelines. |
| 13. Maternal and Child Health | Includes the following programs: |
| **MCH** Growth, Development and Human Reproduction | Program planning and general activities in support of integral protection of the processes of human reproduction; growth and development of the child, including promotion of multisectoral policies; and development of appropriate services for women and children, including family planning activities. |
| **ADH** Adolescent Health | Activities geared to promote development of programs aimed at improving the physical and mental health of adolescents. |
| **ARI** Acute Respiratory Infections | Prevention and control of acute respiratory infections. |

PAHO CLASSIFIED LIST OF PROGRAMS WITH DESCRIPTION (Cont.)

13. Maternal and Child Health (Cont.)

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|---|---|---|
| **EPI** | Immunization | Activities related to the Expanded Program on Immunization. |
| **CDD** | Diarrheal Diseases | Activities related to diarrheal disease prevention and control, including actions against Cholera. |

14. Communicable Diseases — Includes the following programs:

| | | |
|---|---|---|
| **OCD** | General Communicable Disease Prevention and Control Activities | Communicable disease program planning and general activities, including administration of the International Health Regulations; activities related to prevention and control of other communicable diseases of major public health importance such as meningitis, plague, influenza, dengue and yellow fever. |
| **TDR** | Tropical Disease Research | Activities pertaining to and included in the special program only. |
| **TUB** | Tuberculosis | Prevention and control of tuberculosis. |
| **HIV** | Acquired Immunodeficiency Syndrome | Prevention and control of acquired immunodeficiency syndrome. |
| **VBC** | Vector-Borne Diseases | Control of vectors including the use of chemical pesticides and biological measures. |
| **MAL** | Malaria | Prevention and control of malaria. |
| **PDP** | Parasitic Diseases | Activities related to the prevention and control of schistosomiasis, helminthiasis, filariasis (including onchocerciasis), trypanosomiasis and leishmaniasis. |
| **LEP** | Leprosy | Control of leprosy. |
| **VDT** | Sexually Transmitted Diseases | Prevention and control of sexually transmitted diseases. |

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| 15. Health Promotion | Includes the following programs: |
| **NCD** Health Promotion and Prevention and Control of Noncommunicable Diseases | Activities related to support the development of health promotion policies and programs, involving group and individual interventions directed toward the modification of common risk factors, especially smoking, alcohol and drug consumption, poor dietary habits, sedentary life-styles, aggressive behavior, and other psychosocial factors. General activities of prevention and control of noncommunicable diseases, and strengthening the organization of health services to provide care for this group of pathologies. |
| **TOH** Tobacco or Health | Support to countries' actions aimed at reducing the incidence and prevalence of smoking, protecting the rights of nonsmokers, and decreasing diseases related to the use of tobacco. Promotion of societies and new generations that are tobacco-free. |
| **MND** Prevention and Treatment of Mental and Neurological Disorders | Promotion and development of plans, programs and standards for mental health, and prevention of mental and neurological disorders, with psychosocial determinants being taken into account. |
| **CAN** Cancer | Promotion and support for activities in cancer prevention and control, with emphasis on programs for the detection of cancer in women and the prevention of lung cancer. Strengthening of cancer registries in the countries, and of epidemiological research as well. Dissemination of specialized information on cancer prevention and management. |
| **APR** Accident Prevention | Expansion of knowledge about the epidemiology of accidents to help promote the establishment of intersectoral policies and programs for their prevention and control. Collection and dissemination of information on prevention techniques. |
| **HEE** Health of the Elderly | Promotion of better understanding of the normal and pathological aging processes to provide a basis for the establishment of comprehensive plans, policies and programs for this emerging social group. Promotion of training in gerontology and dissemination of current knowledge. |
| **ADA** Prevention and Control of Alcoholism and Drug Abuse | Promotional and technical advisory services on the formulation of national policies and programs for research on and prevention and treatment of the problems resulting from use of psychoactive substances. |
| **PBD** Ocular Health | Support for the development of national programs on blindness prevention and ocular health that are integrated into the national health systems. Emphasis on the control of cataracts, ocular traumas, glaucoma, and parasitic and infectious diseases. |
| **CVD** Cardiovascular Diseases | Support for the development of intervention programs at the individual and group level which cover the most important risk factors for cardiovascular diseases, with priority given to the detection and control of arterial hypertension. |

PAHO CLASSIFIED LIST OF PROGRAMS WITH DESCRIPTION (Cont.)

| | | |
|---|---|---|
| 16. Veterinary Public Health | | Includes the following programs: |
| **FOS** | Food Safety | Promotional and other activities for development of national policies and programs for ensuring food safety, including effects on health of food additives and pesticide residues in food. |
| **FMD** | Foot-and-Mouth Disease | Prevention and control of foot-and-mouth disease. |
| **ZNS** | Zoonoses | Prevention and control of the major zoonoses and related food-borne diseases. |

## IV. PROGRAM SUPPORT

| | | |
|---|---|---|
| 17. Administration | | Applies only to Headquarters and includes the following programs: |
| **BFI** | Budget and Finance | Budget, finance and accounting services. |
| **PGS** | General Services and Headquarters Operating Expenses | Conference, office and building services. |
| **PER** | Personnel | Personnel services. |
| **SUP** | Procurement | Procurement and related supply services. |

## ANALYSIS OF REAL AND COST INCREASES/DECREASES - PAHO/WHO REGULAR BUDGET BY PROGRAM

| PAHO PROGRAM CLASSIFICATION | 1992-1993 APPROPRIATION AMOUNT | 1992-1993 APPROPRIATION % OF TOTAL | REAL INCREASE/DECREASE AMOUNT | REAL INCREASE/DECREASE % | COST INCREASE/DECREASE AMOUNT | COST INCREASE/DECREASE % | TOTAL INCREASE/DECREASE AMOUNT | TOTAL INCREASE/DECREASE % | 1994-1995 PROPOSAL AMOUNT | 1994-1995 PROPOSAL % OF TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|
| DIRECTION, COORDINATION AND MANAGEMENT | 20,600,700 | 9.1 | (3,125,300) | (15.2) | 1,425,900 | 6.9 | (1,699,400) | (8.3) | 18,901,300 | 7.8 |
| 1. GOVERNING BODIES | 2,536,500 | 1.1 | 0 | 0.0 | 109,200 | 4.3 | 109,200 | 4.3 | 2,645,700 | 1.1 |
| 2. GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT | 18,064,200 | 8.0 | (3,125,300) | (17.3) | 1,316,700 | 7.3 | (1,808,600) | (10.0) | 16,255,600 | 6.7 |
| HEALTH SYSTEM INFRASTRUCTURE | 108,553,300 | 48.5 | (356,600) | (0.3) | 11,860,500 | 10.9 | 11,503,900 | 10.6 | 120,057,200 | 49.3 |
| 3. MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | 30,259,000 | 13.3 | 1,884,000 | 6.2 | 4,224,900 | 14.0 | 6,108,900 | 20.2 | 36,367,900 | 15.2 |
| 4. TECHNICAL COOPERATION AMONG COUNTRIES | 2,645,700 | 1.2 | 13,300 | 0.5 | 342,100 | 12.9 | 355,400 | 13.4 | 3,001,100 | 1.2 |
| 5. HEALTH SITUATION AND TREND ASSESSMENT | 10,581,900 | 4.7 | (1,639,700) | (15.5) | 1,067,500 | 10.1 | (572,200) | (5.4) | 10,009,700 | 4.1 |
| 6. HEALTH POLICY DEVELOPMENT | 6,318,100 | 2.8 | 680,000 | 10.8 | 599,900 | 9.5 | 1,279,900 | 20.3 | 7,598,000 | 3.1 |
| 7. HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | 30,541,300 | 13.7 | (947,600) | (3.1) | 2,848,900 | 9.3 | 1,901,100 | 6.2 | 32,442,400 | 13.3 |
| 8. HUMAN RESOURCES DEVELOPMENT | 13,308,400 | 6.0 | (779,700) | (5.9) | 1,237,100 | 9.3 | 457,400 | 3.4 | 13,765,800 | 5.6 |
| 9. HEALTH INFORMATION SUPPORT | 10,441,500 | 4.7 | 399,000 | 3.8 | 1,125,200 | 10.8 | 1,524,200 | 14.6 | 11,965,700 | 4.8 |
| 10. RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT | 4,457,400 | 2.1 | 34,300 | 0.8 | 414,900 | 9.3 | 449,200 | 10.1 | 4,906,600 | 2.0 |
| HEALTH SCIENCE AND TECHNOLOGY | 70,007,700 | 31.3 | 1,180,500 | 1.7 | 7,348,200 | 10.5 | 8,528,700 | 12.2 | 78,536,400 | 31.9 |
| 11. FOOD AND NUTRITION | 7,365,600 | 3.3 | (525,800) | (7.1) | 783,200 | 10.6 | 257,400 | 3.5 | 7,623,000 | 3.1 |
| 12. ENVIRONMENTAL HEALTH | 16,819,100 | 7.6 | 488,200 | 2.9 | 2,218,800 | 13.2 | 2,707,000 | 16.1 | 19,526,100 | 8.0 |
| 13. MATERNAL AND CHILD HEALTH | 10,041,000 | 4.4 | 1,140,900 | 11.4 | 1,095,000 | 10.9 | 2,235,900 | 22.3 | 12,276,900 | 5.0 |
| 14. COMMUNICABLE DISEASES | 12,350,800 | 5.6 | 987,100 | 8.0 | 1,322,600 | 10.7 | 2,309,700 | 18.7 | 14,660,500 | 6.0 |
| 15. HEALTH PROMOTION | 6,449,100 | 2.8 | 250,900 | 3.9 | 704,900 | 10.9 | 955,800 | 14.8 | 7,404,900 | 2.9 |
| 16. VETERINARY PUBLIC HEALTH | 16,982,100 | 7.6 | (1,160,800) | (6.8) | 1,223,700 | 7.2 | 62,900 | 0.4 | 17,045,000 | 6.9 |
| PROGRAM SUPPORT | 24,905,300 | 11.1 | (372,900) | (1.5) | 2,232,700 | 9.0 | 1,859,800 | 7.5 | 26,765,100 | 11.0 |
| 17. ADMINISTRATION | 24,905,300 | 11.1 | (372,900) | (1.5) | 2,232,700 | 9.0 | 1,859,800 | 7.5 | 26,765,100 | 11.0 |
| GRAND TOTAL | 224,067,000 | 100.0 | (2,674,300) | (1.2) | 22,867,300 | 10.2 | 20,193,000 | 9.0 | 244,260,000 | 100.0 |

## 1. GOVERNING BODIES

The Pan American Health Organization is Governed by the Pan American Sanitary Conference, which meets every four years. The Directing Council acts on behalf of the Conference in the intervening years. By agreement with the World Health Organization these Governing Bodies also serve as the Regional Committee of the World Health Organization for the Americas. In addition, the Executive Committee holds two regular meetings every year. Other subcommittees of these Bodies meet every year as appropriate. The category "Governing Bodies" covers the cost of scheduled meetings and support staff, as well as the cost of the external audit. The staff also serves other conferences, meetings and seminars as time allows.

PROGRAM BUDGET DISTRIBUTION BY LOCATION

| LOCATION | PAHO AND WHO REGULAR BUDGET 1992-1993 | 1994-1995 | 1996-1997 | EXTRABUDGETARY FUNDS 1992-1993 | 1994-1995 | 1996-1997 |
|---|---|---|---|---|---|---|
| GOVERNING BODIES | 2,536,500 | 2,645,700 | 2,870,200 | 19,000 | 0 | 0 |
| TOTAL | 2,536,500 | 2,645,700 | 2,870,200 | 19,000 | 0 | 0 |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL PROF. POSTS | PERSONNEL LOCAL POSTS | PERSONNEL CONS. DAYS | PERSONNEL AMOUNT | DUTY TRAVEL AMOUNT | FELLOWSHIPS MONTHS | FELLOWSHIPS AMOUNT | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 2,176,100 | 3 | 4 | 0 | 874,600 | 0 | 0 | 0 | 0 | 0 | 0 | 1,301,500 |
| WHO - WR | 360,400 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 360,400 |
| TOTAL | 2,536,500 | 3 | 4 | 0 | 874,600 | 0 | 0 | 0 | 0 | 0 | 0 | 1,661,900 |
| % OF TOTAL | 100.0 | | | | 34.5 | .0 | | .0 | .0 | .0 | .0 | 65.5 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 2,262,600 | 3 | 4 | 0 | 847,600 | 0 | 0 | 0 | 0 | 0 | 0 | 1,415,000 |
| WHO - WR | 383,100 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 383,100 |
| TOTAL | 2,645,700 | 3 | 4 | 0 | 847,600 | 0 | 0 | 0 | 0 | 0 | 0 | 1,798,100 |
| % OF TOTAL | 100.0 | | | | 32.0 | .0 | | .0 | .0 | .0 | .0 | 68.0 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 2,455,700 | 3 | 4 | 0 | 924,700 | 0 | 0 | 0 | 0 | 0 | 0 | 1,531,000 |
| WHO - WR | 414,500 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 414,500 |
| TOTAL | 2,870,200 | 3 | 4 | 0 | 924,700 | 0 | 0 | 0 | 0 | 0 | 0 | 1,945,500 |
| % OF TOTAL | 100.0 | | | | 32.2 | .0 | | .0 | .0 | .0 | .0 | 67.8 |

## HEALTH SITUATION ANALYSIS

1. The 1994-1995 Budget has been developed based on an analysis of the health situation, the strategies and policies of the Organization and the demands for technical cooperation of the countries.

2. The programs that constitute the technical cooperation of the Organization respond in part to the definition of health conditions being identified in the preparation of the document on Health Conditions in the Americas 1991-1994. They also reflect the implementation of the Strategic Orientations and Program Priorities of PAHO during the quadrennium 1991-1994 (SOPP).

3. Similarly they reflect the fact that the budget preparation has paralleled the development of the 9th General Program of Work of the World Health Organization.

4. The proposed budget has been designed to concentrate resources of the Organization within the policy framework set forth in the SOPP already adopted by the Member Countries. At the same time, it has been adjusted to reflect the changed conditions and circumstances since the adoption of the SOPP. In that regard, it is an attempt to marry continuity and change, assuring continuity in the fundamental strategic orientation of the Organization but producing the necessary changes in program required by the shifting circumstances affecting each Member Country.

5. Each program has and will continue to conduct its own examination of the health situation applicable to its own goals and objectives within the Organization's common pursuit of the goal of Health for All by the year 2000. The analysis of the health situation takes place therefore in the context of a constant dialogue with the countries in order to insure an accurate assessment of conditions, needs and priority requirements for technical cooperation and for external resource mobilization.

6. During the biennium, much of the work of the Organization will be dedicated to assisting the countries in undertaking this analysis.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

7. The "Managerial Strategy to Optimize the Use of PAHO/WHO Resources in Direct Support of the Countries" continues to offer operating mechanisms to enhance the efficiency and effectiveness of the Organization's technical cooperation. They will be even more essential during the forthcoming biennium given the limitations on quantity, quality and availability of needed resources.

8. The principal ethos of the strategy of cooperation emphasizes that the country must be the axis of the Organization's technical cooperation. Even the regional policies and perspectives are developed from an awareness of the status of health development in Member Countries and with a vision of helping to improve that status within each country and within the region as a whole.

9. In the context of the pursuit of more efficient use of resources, the Organization continues to utilize the subregional initiatives and other joint activities of Member Countries to achieve economies of scale and to benefit from an exchange of experiences.

10. One of the important operational strategies will continue to be the mobilization of external resources in support of national and regional program priorities. Increasing national awareness of the international context for the provision of technical assistance will be essential along with expanding the Organization's own contacts and knowledge of the decision making processes of the Inter-American, United Nations and bilateral assistance agencies.

11. At the same time, the utility of intersectoral coordination has been amply demonstrated not merely as a tool to enhance the role of the health sector but to achieve fundamental new views of the relationship between health and development.

12. Special initiatives in functional areas also continue to constitute an avenue for the concentration of resources and the targeting of priorities. The success of the polio eradication campaign has given rise to a series of other endeavors to target specific disease prevention and control objectives.

13. A comprehensive analysis of the health development situation during the prior biennium, based in part on the outbreak of cholera, produced a broad and comprehensive initiative to identify and measure the gaps in the health, water and sanitation infrastructure in the Americas and then to define, community by community, nation by nation, the actions needed to close those gaps. It is called the Plan for Regional Investment in Environment and Health (PIAS). Benefiting from past experience, the PIAS plan constitutes the most ambitious of these initiatives. Its breadth of purpose affects the full range of the health, water and sanitation infrastructure. It offers an opportunity to conceptualize the goal of full access to health and environmental protection, and to specify in operational terms how to reach that goal.

14. The management strategy encourages the creation of networks of technical excellence, linking research and strategic health development concerns and assuring information systems that provide both epidemiological surveillance and a managerial data base for decision making.

15. The need to link program and budget has meant intensifying the use of the PAHO system of planning, programming and evaluation (AMPES).

16. During the biennium 1994-1995, will see a continuation of the refinement of AMPES that has given rise to gradual modifications which have enhanced the system and succeeded in combining the programming and budgeting phases into single instruments that allocate resources and at the same time program activities in

terms of both biennial targets and annual and four-month operating programs of work. The development of automated systems for formulation and execution of the program budget, which will be part of the basis for an integrated information management system, will also be an important advance in the utility of the system.

17. Mechanisms for analysis of the regional and country-level situations as a basis for terms of the formulation of technical cooperation will continue to be strengthened and enhanced during the biennium and will be expressed both in the annual operating program cycles and in the biennial programming exercise. The inclusion of extra-budgetary projects within the AMPES has also improved its use as the single mechanism for management of the organization's technical cooperation. This process should be accompanied by supplementary efforts to develop the PAHO technical information system at both the regional and the country level, which will require joint action by the Bureau and the Member Countries.

18. The fundamental intention will be to have a mechanism which, as an integral part of the planning and programming process, will provide bases for the reorientation of actions to reflect the problems identified and for the formulation of recommendations.

19. From the preceding paragraphs it can be seen that the program area of General Program Development and Management encompasses the entire executive management process, from the formulation of policies through the evaluation of technical cooperation programs. Thus it includes the activities of the Offices of the Director and Deputy Director, the Assistant Director, the Chief of Administration, the supporting and coordinating units that answer to the executive levels of the Organization, and the Regional Director's Development Program. It is in this area of the Bureau's organizational structure that promotion and supervision of the General Policy of Technical Cooperation of PAHO will take place during the biennium. As a result, during this period the basic functions to be carried out by these executive offices, in keeping with the quadrennial priorities, will be leadership, overall management of the program, external relations, institutional development, legal affairs, regional analysis, strategic planning and programming, program monitoring and evaluation, personnel development, and information management.

20. PAHO's Executive Management provides overall policy direction to the Pan American Sanitary Bureau, as well as leadership and guidance to the Organization as a whole. This leadership includes the identification of transnational issues that PAHO Member Governments should address as an Organization, and the presentation of alternatives and guidelines for international and national actions to improve health development.

21. This category comprises five specific programs: Executive Management (EXM), Regional Director's Development Program (DGP), General Program Development (GPD), External Coordination for Health Development (COR), and Informatics Management (ISS), all of which correspond to units and/or activities of coordination and management at Headquarters. Following are the biennial targets and general lines of action for these programs.

## SPECIFIC PROGRAMS

### Executive management (EXM)

#### BIENNIAL TARGETS

22. To provide efficient and effective administrative support for both headquarters and field offices, including budget, finance, personnel, general services, information management, and procurement activities.

23. To improve institutional mechanisms in order to make the provision of legal services to the Director and the Secretariat more effective, and to extend these services as possible components of the technical cooperation activities carried out by the technical units, particularly in relation to local health systems, privatization of health services/industry, women and development, the reform of health services provided by social security systems, and issues such as bioethics.

24. To manage the Bureau, the Director and his immediate staff make normative decisions and foster dialogue and coordination within the staff.

#### LINES OF ACTION

25. The AM Program will respond to the program priorities established by the Governing Bodies and the Director by providing required administrative support to the programs established by the Headquarters technical units and country offices and by supervising the administrative support activities of the Organization.

26. Provision of legal services to the Director, the Governing Bodies, and PAHO offices. Coordination of legal services with WHO and other bi- and multilateral international agencies.

27. Provision of support for the analysis of legal and ethical issues relating to activities carried out by other programs in the Organization in such fields as AIDS, women and development, technology transfer, NGOs, mental health, and coordination of bioethic issues.

### Regional director's development program (DGP)

#### BIENNIAL TARGETS

28. To promote the development, particularly at the country level, of programs that promise to be innovative and effective within the context of the collective mandates that orient the work of the Organization.

29. To provide budgetary flexibility for the Director in the allocation of resources for the support of new approaches, concepts, or innovative technological developments that have the potential to contribute to attainment of the goal of Health for All.

30. To meet special needs that have a critical timing and for which sufficient funds were not foreseen in the Biennial Program Budget, including enabling the Director to respond to emergencies directly affecting health conditions in Member Countries; to promote the development of innovative programs, concepts or technologies, particularly at the national level, which advance the collective mandates of the Organization.

LINES OF ACTION

31. Strengthening of capabilities at the country level to develop innovative programs, with search for technical competence in specific areas. Provision of financial and technical support for new approaches and incipient programs and projects that are geared toward fostering management strategies that will enable attainment of the goal of Health for All by the year 2000.

General program development (GPD)

BIENNIAL TARGETS

32. To develop and implement management strategies for PAHO in accordance with the Strategic Orientations and Program Priorities of PAHO during the Quadrennium 1991-1994, and to direct the review, revision and implementation of the new SOPP, 1995-1998.

33. To carry out regional and country-level technical cooperation activities coherently and effectively within the framework of the SOPP and the General Strategy of PHC, with a view toward attainment of the goal of Heath for All by the year 2000.

34. To promote optimum utilization of the Organization's resources within the framework of short-, medium-, and long-term programs, taking into consideration the specific context of the Region and the changing international situation.

35. To implement the regional program and budget policy of PAHO/WHO.

36. To develop and carry out special initiatives and projects of the Bureau.

LINES OF ACTION

37. Development of studies and preparation of official PAHO documentation on PAHO general program development, policies, and priorities, as well as analyses and evaluations of technical cooperation and follow-up and implementation of the SOPP, in presentation thereof to the Governing Bodies and in the review and discussion of these matters in the Director's Advisory Committee.

38. Development, through ongoing internal and external consultation, of a process analysis of major regional and international trends in order to support actions being taken for the strategic planning of the institution. In addition, preparation of institutional development proposals on action policies for the Organization as well as management mechanisms for the Secretariat.

39. Continued development and enhancement of the AMPES system so that it will serve as a basic axis for management of the technical cooperation provided by the Bureau. For this purpose, an effort will be made to articulate the three subsystems related to the delivery of technical cooperation (analysis of the situation, planning and budgeting, and monitoring and evaluation). This line of action includes the development of automated systems for the formulation and implementation of short-term program and budget instruments.

40. Implementation of special projects aimed at strategically expanding PAHO participation in activities both within and outside the health sector as well as relations with other organizations.

41. Monitoring of qualitative and quantitative fulfillment of goals for the area as a whole and for the corresponding programs in terms of attainment of the overall goal of Health for All by the year 2000 as well as goals related to regional strategies and priorities.

External coordination for health and social development (COR)

BIENNIAL TARGETS

42. External Coordination for Health and Social Development is part of the Regional Director's Development Program. Through this project, efforts during 1994-1995 will continue to ensure and promote the presence and participatory role of PAHO within the international system in order to mobilize technical and financial external resources and promote and strengthen the Organization's external relations with other multilateral, bilateral and nongovernmental organizations.

LINES OF ACTION

43. Maintaining the Organization's direct channels of communication with the major bilateral and multilateral agencies.

44. Efforts will be directed toward the formulation of strategies for interagency collaboration and, when feasible, the establishment of interagency agreements. At the same time, actions will be taken to support the countries in strengthening their national capacity for external cooperation in health coordination, which should be based on sound national health planning and programming.

45. The responsibility of the Organization in the process of channeling external financing toward the reorganization of the health sector, as established in the Strategic Orientations and Program Priorities, requires constant

coordination with multilateral and bilateral agencies, which have approved and are implementing new sectoral strategies and approaches for their lending operations.

46. The External Financial and Technical Resource Mobilization Component organizes and coordinates the PAHO strategy for resource mobilization during the quadriennium, with concentration on activities to strengthen the capacity of PAHO technical units and the countries to prepare, present, and successfully negotiate proposals for external technical and financial support, both bi- and multilateral. As part of this effort, activities will be initiated to support the quadrennial program priorities of PAHO. Also, guidelines will be prepared, country and subregional training seminars will be conducted, and direct technical assistance will be provided to countries on a one-to-one basis.

47. Since the main purpose of this component is to channel external financing to Member Countries for their priority programs, initiatives will be taken to strengthen PAHO-donor relations. For this purpose, donors will be visited systematically; donor conferences and annual consultations will be organized; joint PAHO-donor missions will be carried out in the countries; information and project documentation, progress reports, and evaluations will be transmitted to donors; and negotiations will be conducted with donors.

48. The activities carried out under the Project Review Process during the period 1992-1993 will assist the Organization in meeting the challenge of increasing health sector efficiency through collaborative activities with countries of the Region.

49. The major line of action will be the improvement of human resources capability to conceptualize and formulate extrabudgetary projects in order to facilitate comprehensive review and eventual implementation.

50. The activities will be supported by an information resource network to permit coordination and technical cooperation in similar areas.

51. Implementation of an extrabudgetary monitoring and evaluation system.

52. The activities of the NGO Liaison extend the Organization's technical and resource mobilization role to NGOs working in health and development. This will be done by assisting the Country Representative in catalyzing a process of Government-NGO partnerships through the promotion of opportunities to discuss joint health care strategies and activities.

53. Identification of creative financing mechanisms for the funding of NGO activities that are consistent with Member Government priorities in health, and the strengthening of NGO and government capability to work together on improving their capacity to identify local as well as international resources.

54. Activities will also include assistance to the Organization's technical staff in the identification of appropriate NGOs to collaborate on the design, execution, and evaluation of projects.

Informatics management (ISS)

BIENNIAL TARGETS

55. To provide computer support consistent with the combined needs of the Organization. This support will consist of computer hardware of various sizes and capabilities, appropriate operating environments, the ability to support all necessary data exchanges, and user software consistent with the legitimate needs of the Organization.

56. To provide assistance in the definition of projects in the non-Administrative areas and to assist users in the development of Organization-wide data bases or in choosing appropriate means to develop specific applications.

LINES OF ACTION

57. Assistance will be provided in the development of survey methodologies, processing, and data interpretation for several ongoing projects at the request of the user researchers.

58. Database assistance will be provided for all administrative and non-administrative applications and all appropriate non-administrative data bases which are of common interest to the Organization will be developed.

59. All installed central data processing services will be supported as well as hardware and software maintenance for all installed centralized computer systems.

60. A common PAHO Local Area Network of sufficient capacity to meet the needs of the Organization will be provided. The LAN capabilities will include copies of commonly used software, necessary communications linkages, and storage for PAHO databases.

61. An application development staff capable of assisting the user community in meeting their computer processing requirements will be maintained. In addition, will develop selected computer applications which are of common interest to several areas of the Organization.

62. Continue to maintain the existing computerized Administrative applications until they have been replaced with new systems.

## 2. GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT (CONT.)

### PROGRAM BUDGET DISTRIBUTION BY LOCATION

| LOCATION | PAHO AND WHO REGULAR BUDGET 1992-1993 | 1994-1995 | 1996-1997 | EXTRABUDGETARY FUNDS 1992-1993 | 1994-1995 | 1996-1997 |
|---|---|---|---|---|---|---|
| DIRECT COOPERATION WITH COUNTRIES | 4,446,800 | 4,179,900 | 4,518,200 | 280,900 | 254,000 | 0 |
| REGIONAL PROGRAMS | 5,861,600 | 4,965,800 | 5,386,800 | 183,200 | 213,000 | 231,500 |
| TECHNICAL AND ADMINISTRATIVE DIRECTION | 7,755,800 | 7,109,900 | 7,684,900 | 328,900 | 485,700 | 614,100 |
| TOTAL | 18,064,200 | 16,255,600 | 17,589,900 | 793,000 | 952,700 | 845,600 |

### ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL PROF. POSTS | PERSONNEL LOCAL POSTS | PERSONNEL CONS. DAYS | PERSONNEL AMOUNT | DUTY TRAVEL AMOUNT | FELLOWSHIPS MONTHS | FELLOWSHIPS AMOUNT | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 15,521,500 | 34 | 30 | 1440 | 9,188,100 | 535,200 | 0 | 0 | 991,500 | 1,768,200 | 0 | 3,038,500 |
| WHO - WR | 2,542,700 | 7 | 4 | 0 | 1,756,500 | 131,300 | 0 | 0 | 341,600 | 97,300 | 0 | 216,000 |
| TOTAL | 18,064,200 | 41 | 34 | 1440 | 10,944,600 | 666,500 | 0 | 0 | 1,333,100 | 1,865,500 | 0 | 3,254,500 |
| % OF TOTAL | 100.0 | | | | 60.6 | 3.7 | | .0 | 7.4 | 10.3 | .0 | 18.0 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 14,219,000 | 28 | 24 | 1332 | 8,195,600 | 436,200 | 0 | 0 | 1,309,100 | 1,440,700 | 0 | 2,837,400 |
| WHO - WR | 2,036,600 | 5 | 4 | 0 | 1,612,300 | 135,800 | 0 | 0 | 0 | 125,200 | 0 | 163,300 |
| TOTAL | 16,255,600 | 33 | 28 | 1332 | 9,807,900 | 572,000 | 0 | 0 | 1,309,100 | 1,565,900 | 0 | 3,000,700 |
| % OF TOTAL | 100.0 | | | | 60.3 | 3.5 | | .0 | 8.1 | 9.6 | .0 | 18.5 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 15,385,400 | 28 | 24 | 1332 | 8,867,900 | 472,000 | 0 | 0 | 1,416,400 | 1,559,000 | 0 | 3,070,100 |
| WHO - WR | 2,204,500 | 5 | 4 | 0 | 1,745,400 | 147,000 | 0 | 0 | 0 | 135,500 | 0 | 176,600 |
| TOTAL | 17,589,900 | 33 | 28 | 1332 | 10,613,300 | 619,000 | 0 | 0 | 1,416,400 | 1,694,500 | 0 | 3,246,700 |
| % OF TOTAL | 100.0 | | | | 60.3 | 3.5 | | .0 | 8.1 | 9.6 | .0 | 18.5 |

## HEALTH SITUATION ANALYSIS

1. One of the basic tenets of the Organization is that a focus on the country is fundamental to the ultimate success of any program of technical cooperation. It is therefore important to ensure that the country locus of PAHO's activities is efficiently organized, managed and supervised. This will also contribute to efficient use of those national resources applied to health.

2. Almost all, if not all, countries need to improve the management of the health services, and more particularly their infrastructure. This implies paying attention to the organization of the human, financial, organizational and material resources available. The vast majority of these resources will be national in origin, but a not insignificant part will be from external sources. This implies a major effort in coordinating these various inputs to ensure complementarity and a cohesive program directed towards the national priorities for health development.

3. The health sector must not only be organized to coordinate the resources coming to the sector, but must be in a position to make effective links with other sectors. The managerial processes necessary for this kind of health development form an important part of PAHO's technical cooperation as offered through its country offices. Although considerable attention has been paid to the management of PAHO's technical cooperation all these years and there has been noticeable marked improvement, this is still an area that needs constant attention. There has been improvement in the physical facilities, in the area of data processing and in communications. There needs to be attention paid to the development of the Country Offices as an ongoing exercise so that the basic functions may be performed most efficiently. There is still undue heterogeneity in the appreciation of the essential functional approaches of technical cooperation and no clear guidelines for new staff of these managerial processes they need to master to deliver such technical cooperation.

Regional Investment Plan in Environment and Health (PIAS)

4. Recent experiences especially in relation to the epidemic of cholera has revealed the great deficiency that exists in basic environmental and health services. Emergency measures have been put in place to stem the epidemic and institute such actions as may prevent cholera becoming endemic in the Americas. PAHO/WHO in collaboration with its Member Governments and in response to a mandate from the I Ibero American Summit of Heads of State and Governments has developed a Regional Plan for Investment in the Environment and Health (PIAS). The Plan has been designed to facilitate the definition in each country of those investments that need to be made in the Environment and Health over the next 12 years. Its success will depend in part on the political commitment and will of Member Governments to direct the necessary resource flows into those sectors and it will also involve the close attention of all the programs of technical cooperation of PAHO/WHO especially at the country level.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

5. Although all parts of this program contribute to strengthening the managerial processes for national health development, there are different emphases and strategies. The Office of the Assistant Director, including the Country Program Analysts focus more on the overall coordination of the operational aspects related to the development, implementation, monitoring and evaluation of the technical cooperation programs at the field level. This is done through revision of reports and visits to the countries. Attention is also given to the development of schemes, simple instruments and policy guidelines to facilitate program development.

6. The Country Offices are directly responsible for those political, technical and administrative functions that underpin the delivery of the cooperation. Stress is placed on the understanding and proper utilization of the AMPES as the Organization's prime managerial tool. Efforts are made to use the AMPES and the discussions with national authorities about its application as an entry point for improving the national systems of planning and programming, and ensuring that due cognizance is taken of the operational implications of the SOPP and the PIAS.

Regional Investment Plan in Environment and Health (PIAS)

7. The process of implementing the Regional Plan for Investment in the Environment and Health (PIAS) is being supported, within PAHO, through the creation of the Executive Secretariat (DSI) and the Coordinating Group. The fundamental purpose for the establishment of these two mechanisms is to design, promote, and coordinate actions for the implementation of the PIAS. The functions of the Executive Secretariat are: to coordinate the implementation of the strategies established for the execution of the Regional Plan for Investment in the Environment and Health, both through the Secretariat's own actions and through actions carried out by the various units in the field and at Headquarters; to make provision for the establishment of the Fund for the Development of Preinvestment Activities and assume responsibility for its technical and administrative management; to foster ties with multilateral lending institutions with a view to forming a strategic alliance to promote implementation of the PIAS; and to oversee the necessary operational actions, both internal and external, in coordination with the appropriate units.

8. DSI's strategy of action within the Bureau will be to act as a catalyst, drawing on the resources and regular work of all the field and Headquarters units, in order to ensure maximum complementarity of functions and activities. DSI will not duplicate lines of action that are already being carried out by the various programs of the Organization but rather will endeavor to ensure coordination between them with a view to achieving the common objective of implementation of the PIAS.

9. PAHO will establish a "strategic alliance" with the principal multilateral and bilateral institutions that provide technical and financial cooperation, in particular the World Bank and IDB, in order to ensure the consonance of the specific approaches, methodologies, and actions taken with regard to investments in the environment and health. To this end, it will seek the joint participation of banks and agencies in the Preinvestment Fund, as well as joint action in preinvestment activities.

## SPECIFIC PROGRAMS

### Managerial process for national health development (MPN)

#### BIENNIAL TARGETS

10. To enhance the effective application of those managerial practices and operational procedures that are essential for maintenance and improvement in the national health services.

### Regional Investment Plan in Environment and Health (PIAS)

11. To ensure the implementation of the Regional Investment Plan in Environment and Health (PIAS).

#### LINES OF ACTION

12. The Organization will cooperate in the design of instruments that establish the process for identifying the national priorities, the priorities for technical cooperation and that part of the cooperation to be delivered by PAHO/WHO. In addition attention will be paid to the manner in which the instruments are used and assistance given to the Country Offices in terms of monitoring the execution of the accepted programs through reports and visits. The joint evaluation of the technical cooperation program will continue to be carried out in selected countries according to the established protocol. Every effort will be made to support the Country Offices in their process of development which must be an ongoing exercise designed to improve their capacities to deliver the cooperation as a part of the Organization's managerial process of national health development. Documentation Centers will be maintained to provide access to publications of PAHO/WHO and other international agencies; journals, books and other reference materials; national publications; and computerized data bases.

### Regional Investment Plan in Environment and Health (PIAS)

13. PAHO/WHO will seek to operate a Preinvestment Fund as support for the development of the Regional Plan, financing specific preinvestment operations in the countries. A strategic and operational alliance will be developed with banks and development agencies for the implementation of the Regional Plan. PAHO/WHO will support the countries through the development of appropriate instruments, sectorial analysis and methods for design, execution and evaluation of investment projects as part of their efforts to formulate and execute national plans for investment in the Environment and Health. Institutional development will be supported principally through the development of human resources appropriate for the fields indicated above.

### Administrative analysis (AAN)

#### BIENNIAL TARGETS

14. To provide administrative support to HQ and field offices in the design and development of administrative systems, organizational approaches to management functions and in the training of administrative staff.

#### LINES OF ACTION

15. Development of systems and methods of administrative organization, both at HQ and in the field for supporting the process of decentralization of program management to operational levels. This includes assistance in defining appropriate organizational approaches to management functions, and in formalizing policies and procedures to control administrative systems and subsystems.

PROGRAM BUDGET DISTRIBUTION BY LOCATION

| LOCATION | PAHO AND WHO REGULAR BUDGET 1992-1993 | 1994-1995 | 1996-1997 | EXTRABUDGETARY FUNDS 1992-1993 | 1994-1995 | 1996-1997 |
|---|---|---|---|---|---|---|
| DIRECT COOPERATION WITH COUNTRIES | 27,457,200 | 32,692,100 | 36,507,800 | 1,751,800 | 391,000 | 413,000 |
| REGIONAL PROGRAMS | 576,600 | 1,781,700 | 1,934,200 | 370,800 | 502,500 | 543,100 |
| TECHNICAL AND ADMINISTRATIVE DIRECTION | 2,225,200 | 1,894,100 | 2,053,000 | 97,600 | 0 | 0 |
| TOTAL | 30,259,000 | 36,367,900 | 40,495,000 | 2,220,200 | 893,500 | 956,100 |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL PROF. POSTS | PERSONNEL LOCAL POSTS | PERSONNEL CONS. DAYS | PERSONNEL AMOUNT | DUTY TRAVEL AMOUNT | FELLOWSHIPS MONTHS | FELLOWSHIPS AMOUNT | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 24,726,200 | 42 | 102 | 300 | 17,332,100 | 879,900 | 0 | 0 | 269,500 | 555,900 | 127,600 | 5,561,200 |
| WHO - WR | 5,532,800 | 4 | 32 | 250 | 3,230,800 | 23,200 | 0 | 0 | 27,000 | 175,400 | 0 | 2,076,400 |
| TOTAL | 30,259,000 | 46 | 134 | 550 | 20,562,900 | 903,100 | 0 | 0 | 296,500 | 731,300 | 127,600 | 7,637,600 |
| % OF TOTAL | 100.0 | | | | 68.0 | 3.0 | | .0 | 1.0 | 2.4 | .4 | 25.2 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 30,254,600 | 43 | 108 | 1311 | 20,288,600 | 1,134,100 | 75 | 150,000 | 518,000 | 765,800 | 545,300 | 6,852,800 |
| WHO - WR | 6,113,300 | 3 | 33 | 238 | 3,510,800 | 26,300 | 0 | 0 | 37,700 | 271,300 | 0 | 2,267,200 |
| TOTAL | 36,367,900 | 46 | 141 | 1549 | 23,799,400 | 1,160,400 | 75 | 150,000 | 555,700 | 1,037,100 | 545,300 | 9,120,000 |
| % OF TOTAL | 100.0 | | | | 65.4 | 3.2 | | .4 | 1.5 | 2.9 | 1.5 | 25.1 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 33,635,100 | 43 | 108 | 1311 | 22,430,700 | 1,267,000 | 75 | 150,000 | 567,500 | 861,200 | 617,100 | 7,741,600 |
| WHO - WR | 6,859,900 | 3 | 33 | 238 | 3,911,600 | 29,800 | 0 | 0 | 42,700 | 307,600 | 0 | 2,568,200 |
| TOTAL | 40,495,000 | 46 | 141 | 1549 | 26,342,300 | 1,296,800 | 75 | 150,000 | 610,200 | 1,168,800 | 617,100 | 10,309,800 |
| % OF TOTAL | 100.0 | | | | 65.0 | 3.2 | | .4 | 1.5 | 2.9 | 1.5 | 25.5 |

## 4. TECHNICAL COOPERATION AMONG COUNTRIES

### HEALTH SITUATION ANALYSIS

1. Subsequent to the major United Nations' Conference in Buenos Aires in 1978 there have been numerous declarations and resolutions related to technical cooperation among countries. The Regional Strategies for Health for All by the year 2000 and the Plan of Action for implementing those strategies emphasized this approach and several General Programs of Work stressed the need to consider technical cooperation among countries as a viable mechanism for satisfying national needs for technical cooperation.

2. PAHO/WHO has reviewed its practices and operating concepts recently and now emphasizes that cooperation should be stimulated and promoted among all countries regardless of their level of development.

3. The various modalities of TCC can be fitted into three basic categories: countries cooperating among themselves to address a common problem; one country cooperating with another to solve a problem in that country; and two countries cooperating in order to assist a third country.

4. As its name implies, TCC is an arrangement among countries and may use a framework of formal or informal agreements; however, national agencies and institutions may be the instruments or receptors of the cooperation.

5. Two fundamental principles that PAHO/WHO embraces are that the nature of the technical cooperation is the same, irrespective of whether it derives from an agency such as PAHO/WHO or from a cooperating country or countries and that the cooperation should take place as a part of ongoing activities rather than responding to day-to-day demands.

6. There is a perception that TCC has not realized its full potential in the Region due to several constraints. It is rare to find written government policies on TCC and TCC in health is often managed as a wider government concern for technical cooperation in general. Few Ministries of Health have designated focal points for TCC and there is usually no formal mechanism for identifying TCC requirements in health. There is not a good mechanism for disseminating information about TCC and attempts at establishing and maintaining catalogues of needs and resources have failed.

7. The most successful and permanent examples of TCC supported by PAHO/WHO have been the subregional centers. More recently the subregional health initiatives have come to be seen as excellent examples of TCC and they explicitly state that promotion of TCC is an objective.

8. Activities in relation to border health constitute another example of TCC and the most successful example is found in the U.S.-Mexico border area where PAHO/WHO has maintained an office for the past 50 years.

9. In 1991 PAHO/WHO, SELA (Latin American Economic System) and UNDP joined efforts to promote Project Convergence as an example of TCC. The objective of the project is to promote technological development in health in Latin America and the Caribbean through TCC. A series of subregional meetings and a regional meeting have been held to advance the development of subregional and regional projects.

### GLOBAL STRATEGY FOR TECHNICAL COOPERATION

10. Technical cooperation among countries is essentially a national activity and responsibility, but the Strategic Orientations and Program Priorities commit the Organization "to continue to promote with substance and vigor, the spirit of cooperation among countries so as to resolve common health problems jointly".

11. The essence of the global strategy will be to promote the concept and assist the countries in identifying technical cooperation needs that may be filled through TCC. As a part of this promotional strategy, PAHO/WHO will provide catalytic financial support to the activities designed to initiate or stimulate TCC.

12. PAHO/WHO will continue to support institutional arrangements such as the subregional centers that have proven to be valid instruments of TCC. The subregional initiatives and specific interagency agreements and arrangements that favor TCC will also be emphasized.

13. Central to the strategy will be the dissemination of information about the possibilities for TCC. Such information must be current and lead to the identification of problems and opportunities that favor TCC.

### SPECIFIC PROGRAMS

<u>Technical cooperation among countries (TCC)</u>

#### BIENNIAL TARGETS

14. To enhance the quantum and quality of technical cooperation among countries as an effective mechanism for partially satisfying the technical cooperation needs of the countries of the Americas.

LINES OF ACTION

15. Promote the concept and the opportunities for TCC among Member Countries. This will be done through PAHO/WHO Country Offices as a part of the dialogue with national authorities which leads to the identification of national priorities and the technical cooperation needed to address these priorities.

16. Provide catalytic support for TCC. This support can be used to fund critical activities within a TCC proposal.

17. Assist the national focal points for TCC in the Ministries of Health to contact and coordinate with appropriate entities in other countries.

18. Promote interaction and collaboration with other agencies and institutions that may support TCC.

19. Increase the general knowledge about TCC.

20. Ensure that TCC is evaluated in the same manner as the regular technical cooperation provided by PAHO/WHO.

## 4. TECHNICAL COOPERATION AMONG COUNTRIES (CONT.)

### PROGRAM BUDGET DISTRIBUTION BY LOCATION

| LOCATION | PAHO AND WHO REGULAR BUDGET | | | EXTRABUDGETARY FUNDS | | |
|---|---|---|---|---|---|---|
| | 1992-1993 | 1994-1995 | 1996-1997 | 1992-1993 | 1994-1995 | 1996-1997 |
| DIRECT COOPERATION WITH COUNTRIES | 2,645,700 | 3,001,100 | 3,388,000 | 1,699,900 | 113,000 | 0 |
| TOTAL | 2,645,700 | 3,001,100 | 3,388,000 | 1,699,900 | 113,000 | 0 |

### ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 2,645,700 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,645,700 |
| TOTAL | 2,645,700 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,645,700 |
| % OF TOTAL | 100.0 | | | | .0 | .0 | | .0 | .0 | .0 | .0 | 100.0 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 3,001,100 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3,001,100 |
| TOTAL | 3,001,100 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3,001,100 |
| % OF TOTAL | 100.0 | | | | .0 | .0 | | .0 | .0 | .0 | .0 | 100.0 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 3,388,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3,388,000 |
| TOTAL | 3,388,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3,388,000 |
| % OF TOTAL | 100.0 | | | | .0 | .0 | | .0 | .0 | .0 | .0 | 100.0 |

## HEALTH SITUATION ANALYSIS

1. Complex epidemiological patterns characterize the Region. Drop of fecundity, increase of life expectancy, aging of population, urbanization and industrialization, have changed the demographic patterns and have strong incidence in the epidemiological profiles and long term trends in mortality.

2. On the other hand, over approximately the last ten years, most of the countries in the Region have witnessed tremendous changes in their economy which have had an adverse effect on the living conditions of large segments of the populations. The burden of poverty has been sharply increased.

3. The lack of equity has been increasingly recognized as one of the most important factors against the possibilities of a sustained development.

4. Within the framework of extension of coverage and health for all by the year 2000, the Member Countries have committed themselves to programs that are most efficient, effective and equitable. While many countries have developed efforts for extending and restructuring their services reinforcing the local systems, most have limited capacity for strategic planning and programming, for assigning resources according to priorities of different population groups, and for evaluating the impact of interventions.

5. The proposal that the public health institutions of Member Countries have the responsibility to reduce inequalities between groups implies equitable provisions of accessible services and the identification of interventions most likely to improve the health situation and living conditions of the disadvantaged.

6. The application of appropriate epidemiological methods to understanding the health situation and its trends in the long and short terms, in order to improve program planning and evaluation, will clearly be important for all countries.

7. Improving the quality of information systems on mortality, morbidity and natality, and the adequate use of international classification of diseases is other important necessity for all countries.

8. Strengthening the capability of the Secretariat of PAHO for under standing these epidemiological changing profiles is basic to reinforcing the technical cooperation in the context of the complex relationship between Health and Development.

## ANALYSIS OF THE PROGRAMS

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

9. According to the SOPP for the PAHO for the Quadriennium 1991-94, one of the challenges for health and the transformation of the sector for reinforcing the development, is to improve the capacity for situation analysis and for identification of groups at high risk. Another is to concentrate resources in efficient interventions to diminish dangers and risks.

10. According to experience, the development of national capabilities in epidemiology, for supporting decision making process and reinforcing the development and equity, must be assumed as a whole process. It has to incorporate health situation analysis, surveillance of diseases, evaluation of impact and research capability, and the improvement of information systems. It will require comprehensive approaches from cooperation. Isolated and unilateral efforts are unlikely to be successful.

11. The recent reorganization of PAHO HQ structure stresses the importance of health situation analysis in the broader context of health in development.

12. The Program HDA in coordination with other programs and under the supervision of the Division of Health and Development (HDP) will promote activities in the Member Countries and the Secretariat aimed to strengthening the capacity to produce and utilize knowledge related to:

13. Evaluation and monitoring of the health situation of various sectors of the population, as well as determinants and trends, with a view to setting priorities and formulating policies on health and well-being and adequate strategies for intervention.

14. Evaluation of the impact of these policies and strategies of intervention, so that they can be adjusted or revised as necessary.

15. Additionally, the Program will promote activities in the Member Countries, in coordination with other agencies of United Nations, to strengthening the quality of the information systems on natality and mortality, and in coordination with other programs and the Country Representatives, to continuing the development of the Technical Information System and the Country Profiles. These efforts will incorporate the cooperations regarding the International Classification of Diseases.

16. Cooperation activities in the countries will be carried out mainly through the PAHO Country Representative Offices and, in particular, the country epidemiologist, with the support of the intercountry and regional personnel, and in coordination, when necessary, with CAREC and other Regional Centers and Collaborative Centers. These activities will be aimed at:

5. HEALTH SITUATION AND TREND ASSESSMENT (Cont.)

17. Strengthening of epidemiological practice in the health services and other governmental and non governmental organizations concerned with health and well-being. Special efforts will be devoted to reinforce the capability to analyze and monitor the health situation in relation to development plans and inequities according to living conditions of different sectors of the population, conduct epidemiological surveillance, and evaluate the impact of socioeconomic changes and health policies, strategies and services, as well as to promote the utilization thereof in decision-making processes.

18. Improvement of the collection, processing, and analysis of information on the health situation, including vital statistics and International Classification of Diseases related activities.

19. The promotion of epidemiological research and the dissemination of its results, including support for national scientific meetings on epidemiology.

20. The identification of needs for training in epidemiology and other disciplines related to health situation analysis. Formulation of training strategies and programs, including in service training, in coordination with other related Programs.

21. Intensification of the search for, and dissemination of, scientific and technical information on epidemiology, health situation, and living conditions produced in the countries, and improvement of access to, and exchange with, international sources and systems.

22. Cooperation activities at the regional level will be carried out mainly by staff from the Regional program, in coordination with other Programs and under supervision of the Division of Health and Development (HDP), and when necessary in coordination with Regional Centers and Collaborative Centers. They will be oriented toward:

23. Support of country and intercountry epidemiologists in the delivery of technical cooperation, including supervision, review, and adjustment of activities according to national needs and in regional and country priorities.

24. Preparation of reports and analytical studies on the health situation and its trends at the Regional, subregional, and country level, including Health Conditions in the Americas, Health Statistics from the Americas, the chapter on health situation of the Annual Report of the Director.

25. Development, revision and dissemination of concepts, methods, and techniques related to:

26. The study of health situation, with emphasis on short-term trends, based on variations in the living conditions of different sectors of the population.

27. The study of long-term trends in the health situation of populations and its relationship to demographic, environmental, socioeconomic and other structural changes.

28. Epidemiological surveillance systems for communicable and non communicable diseases and other health problems.

29. Capture and dissemination of scientific and technical information, with continued production and distribution of PAHOś Epidemiological Bulletin; technical reports, publications, bibliographies, and other reference materials on epidemiology and health statistics.

30. Development of the Technical Information System (TIS), in coordination with other Regional Programs.

31. Promote and support research on health situation and its trends, related to inequities in living conditions in different population groups and geographical areas.

32. Define strategies in coordination with the Regional Program on Human Resources Development, for training in epidemiology and public health, both at in-service and academic levels.

33. Define strategies and actions in coordination with other Health and Development Division programs, and the Division of Health Systems and Services, for strengthening the use of epidemiology in the formulation of health policies and in the management of health services.

34. Cooperate, jointly with other Regional Programs and other United Nations agencies, for improving the quality and completeness of the data and the vital statistics systems in the countries, and coordinate activities related to ICD implementation.

35. Maintenance and strengthening, in coordination with the Division of Prevention and Control of Communicable Diseases and WHO, of mechanisms for international epidemiological surveillance in the Region.

## SPECIFIC PROGRAMS

### Health situation and trend assessment (HST)

### BIENNIAL TARGETS

36. The activities of the Program will contribute to the achievement of an increased capability by the countries and the Secretariat to generate, disseminate and utilize information leading to the assessment of the health situation and trends, including that of different population groups, therefore contributing to:

37. the identification of health priorities, in terms of problems and population groups.

38. the improvement of the use of epidemiology in the definition of policies;

39. the monitoring of changes in health situation and living conditions; and

40. the evaluation of impact of health services and of extrasectoral policies and actions on health.

LINES OF ACTION

41. According to the described situation and for achieving the proposed targets, the main lines of action of the program will be:

42. To cooperate for improving the capacity of the Member Countries for evaluating and monitoring the health situation in different groups of population, for evaluating the impact of changes of living conditions and of the health policies. To reinforce the use of epidemiology in the health services.

43. To promote a reinforcement of the capability on health situation analysis in the Secretariat.

44. To strengthen the national capabilities for research in epidemiology and public health, and for the production, dissemination and access to scientific and technical information on epidemiology and health situation analysis.

45. To strengthen the information systems on vital statistics in Member Countries and the TIS in the Secretariat.

46. To prepare regional reports on health situation analysis, including Health Conditions in the Americas, Health Statistics from the Americas, the chapter on health situation of the Director's Annual Report.

47. To publish and distribute PAHOś Epidemiological Bulletin.

## 5. HEALTH SITUATION AND TREND ASSESSMENT (CONT.)

### PROGRAM BUDGET DISTRIBUTION BY LOCATION

| LOCATION | PAHO AND WHO REGULAR BUDGET 1992-1993 | PAHO AND WHO REGULAR BUDGET 1994-1995 | PAHO AND WHO REGULAR BUDGET 1996-1997 | EXTRABUDGETARY FUNDS 1992-1993 | EXTRABUDGETARY FUNDS 1994-1995 | EXTRABUDGETARY FUNDS 1996-1997 |
|---|---|---|---|---|---|---|
| DIRECT COOPERATION WITH COUNTRIES | 6,473,200 | 7,242,200 | 7,903,900 | 5,000 | 0 | 0 |
| REGIONAL PROGRAMS | 2,889,500 | 2,767,500 | 3,002,800 | 0 | 0 | 0 |
| CENTERS | 1,219,200 | 0 | 0 | 5,645,100 | 0 | 0 |
| TOTAL | 10,581,900 | 10,009,700 | 10,906,700 | 5,650,100 | 0 | 0 |

### ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL PROF. POSTS | PERSONNEL LOCAL POSTS | PERSONNEL CONS. DAYS | PERSONNEL AMOUNT | DUTY TRAVEL AMOUNT | FELLOWSHIPS MONTHS | FELLOWSHIPS AMOUNT | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 4,381,700 | 12 | 9 | 915 | 3,182,900 | 246,400 | 48 | 96,000 | 290,800 | 228,800 | 15,800 | 321,000 |
| WHO - WR | 6,200,200 | 18 | 5 | 850 | 4,173,900 | 292,600 | 120 | 240,000 | 601,600 | 364,400 | 0 | 527,700 |
| TOTAL | 10,581,900 | 30 | 14 | 1765 | 7,356,800 | 539,000 | 168 | 336,000 | 892,400 | 593,200 | 15,800 | 848,700 |
| % OF TOTAL | 100.0 | | | | 69.6 | 5.1 | | 3.2 | 8.4 | 5.6 | .1 | 8.0 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 3,058,000 | 5 | 10 | 890 | 2,094,300 | 126,300 | 29 | 58,000 | 312,400 | 204,000 | 15,400 | 247,600 |
| WHO - WR | 6,951,700 | 19 | 3 | 1044 | 4,684,200 | 280,300 | 77 | 154,000 | 768,900 | 383,600 | 0 | 680,700 |
| TOTAL | 10,009,700 | 24 | 13 | 1934 | 6,778,500 | 406,600 | 106 | 212,000 | 1,081,300 | 587,600 | 15,400 | 928,300 |
| % OF TOTAL | 100.0 | | | | 67.6 | 4.1 | | 2.1 | 10.8 | 5.9 | .2 | 9.3 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 3,333,800 | 5 | 10 | 890 | 2,271,700 | 138,600 | 29 | 58,000 | 348,700 | 224,600 | 17,500 | 274,700 |
| WHO - WR | 7,572,900 | 19 | 3 | 1044 | 5,041,900 | 307,300 | 77 | 154,000 | 869,600 | 434,800 | 0 | 765,300 |
| TOTAL | 10,906,700 | 24 | 13 | 1934 | 7,313,600 | 445,900 | 106 | 212,000 | 1,218,300 | 659,400 | 17,500 | 1,040,000 |
| % OF TOTAL | 100.0 | | | | 67.1 | 4.1 | | 1.9 | 11.2 | 6.0 | .2 | 9.5 |

## HEALTH SITUATION ANALYSIS

1. The Eighth General Program of Work of WHO for 1990-1995 recognizes that attainment of health objectives depends to a great extent on policies originating in other sectors of development, particularly those that have an impact on the living conditions of the population. The Strategic Orientations and Program Priorities for the Pan American Health Organization during the Quadrennium 1990-1994 (SOPPs) emphasizes the need for giving more consideration to health in the political, economic, and social agendas of the Member Countries in order to reduce the inequalities between social groups as regards health and access to health services. In specific terms, the Strategic Orientations emphasize the promotional and political role of health in furthering economic development, which, in turn, points to the need for assigning priority to the process of "health advocacy" among heads of state, governing councils, legislatures, and civil society in the Member Countries. In addition, they provide a role for health in promoting regional and subregional integration, as well as cooperation between countries. They also promote strengthening the health sector's capacity for analysis and economic-financial management of its resources as a means of rendering its policies more equitable and less costly to finance. Finally, they recommend expanding coverage and extending the benefits provided by Social Security institutions by improving their coordination with the Ministries of Health.

2. Since the early 1990s the countries of Latin America and the Caribbean have evolved in a manner that may generally be considered more advantageous for the development of their health policies than had been possible previously. First of all, the economic crisis that had affected most of the countries since the previous decade has been attenuated, although the rate of growth that has been attained is still modest in comparison with the situation in the Region prior to the crisis. At the same time, advances were made in the direction of restoring democracy to the Region, in spite of some setbacks that did not, however, succeed in reversing the trend observed during the second half of the 1980s. Obviously the social deterioration caused by the crisis and the structural adjustment policies adopted recently by many governments continue to affect low-income groups and to increase the inequities in many areas, including health. However, both in the countries themselves and at the international level, a climate more favorable for the promotion of social demands appears to be forming as part of the strategies for regional development and of the formulation of new mechanisms in order to satisfy such demands.

3. In order to be able to assign priority to health as part of the goals of socioeconomic development in the context of the consolidation of democracy that is currently taking place in the countries of the Americas, a minimum consensus must be arrived at between often divergent interest groups, such as the producers of health goods and services, community organizations, labor unions, businesses, legislatures, and other governmental entities. The next biennium may be very favorable for proposing changes in the health area, since in almost half the countries in the Region new governments will be assuming power by means of democratic elections and a marked trend has emerged toward strengthening integration processes at the subregional level.

4. New operational modalities must also be sought for the alliance between the public and private health sectors in order to maximize the results that can be achieved with the resources that the Region's societies and governments are prepared to allocate to satisfy the growing health needs of the population. In this connection, the role that the Social Security institutions can play in expanding the coverage of the national health systems in coordination with the Ministries of Health is of particular importance. In like manner, consideration should be given to service delivery systems sponsored by companies, nongovernmental organizations, and community groups, which will play an increasing role in the Region.

5. It is also necessary to strengthen the ability of the countries to analyze and formulate health policies and projects, since the intersectoral nature of health problems makes it imperative for them to be consistent with national social development strategies. Efforts in this direction should also take into account the rapidity and nature of the external factors that influence the sector, the multiplicity of institutions that make up the sector, the frequent rotation of the authorities and ministerial governing bodies, the accelerated technological innovation of the services, and the medium-term sustainability of the goals that are being pursued.

6. The search for greater equity and efficiency in the national health systems assumes special importance in redefining the roles of the State and the civil society in the development process. For this purpose it is essential to increase the regulatory capacity of the State through sectoral legislation, which has not kept up with the rapid changes that are taking place as far as controlling the risks and alternatives for health care is concerned or with regard to the forms of citizen participation in most of the countries.

7. The expansion of investment and spending on health in order to reduce the existing coverage deficits should be financed through new mechanisms and new sources of public and private resources, accompanied at the same time by greater efficiency in the economic and financial management of the health sector. In the same manner consideration should be given to the economic contributions of the health sector toward the generation of employment, technological innovation, conversion of production, the balance of payments and regional integration, and the search for a more favorable allocation of resources to the sector.

8. With regard to the situation of women in health and development, the results of research over the past decade have emphasized the differential risks of becoming ill and dying to which the sexes are exposed, which particularly affect women. A significant portion of the origin of some differentials derives from the endogenous and biological factors associated with the reproductive function. Others no less important, and even on occasion decisive, derive from exogenous social factors associated with the social construct of gender.

9. Exogenous factors influence health through two mechanisms: At the microlevel they exert their effect during the socialization process by means of individual internalization of cultural paradigms of femininity and masculinity that promote attitudes and behavior that result in differential risk for the physical and mental integrity of men and women. At the macrolevel, gender-based determinants act through the division of labor by sex, practiced, on the one hand, by the various economic, religious, family, health, educational, and legal institutions; and, on the other, through the differential assessment of such activities in terms of prestige and remuneration, making it appear that the inferior condition of women is a "natural" phenomenon, legalized, moreover, by law and custom.

10. Examination of the most recent information available demonstrated how a series of conditions with negative impact for women's health may be aggravated by social factors related to the social construct of gender and to the division of labor by sex--conditions, which because of their prevalence, include the following:

11. The greater social value given to the productive activities carried out by men as compared with those carried out by women has led to a situation in which from infancy onward priority is given to males over females as regards the distribution of food. This kind of differential treatment appears to be associated with the female mortality characteristic of certain countries in the Region. Anemia in adolescents and young women has been considered to be the most important health problem, one that affects physical and intellectual productive capacity, brings about chronic fatigue, and makes the body vulnerable to infection.

12. The complications of pregnancy, delivery, and the puerperium continue among the five leading causes of death of women of childbearing age in the Region. This phenomenon is an extreme manifestation of sex inequities with regard to opportunities for survival, which derive not only from biological differences but are also closely associated with the value and priority that various societies assign to the reproductive function and, thereby, with the inferior legal and social status of women.

13. The increase in the prevalence of AIDS among heterosexuals, particularly in the countries of lesser economic and social development, suggests the presence of factors related to sexual behavior.

14. Physical abuse and the various manifestations of violence against women, both in and outside the home, has at the present time become endemic, cutting across the borders of countries, cultures, and social classes.

15. Although progress has been achieved in describing the differential risks and effects for the sexes with regard to living conditions, disease, and death, there is an evident lack of knowledge and of conceptual and methodological development that would make it possible to demonstrate how the role or influence of the social construct of gender is a determining factor in the concrete manifestations of health and disease among the population. Accordingly, it may be seen that health programs for health promotion and disease prevention and control assign special importance to women's traditional reproductive role, both biologically and socially, but undermine their development as individuals and citizens and as a vital part of human development under more equitable conditions.

16. In addition, and as an extension of the division of labor by sex, women continue to be assigned a fundamental role in health care, not only with regard to family members, but also at the community and social levels. Taking full advantage of their natural ability to be leaders in health so as to favor their identity, their self-esteem, and their control over their own bodies and the available resources could become one of the most important contributions of women to human development and to the health of the population.

17. As far as bioethics is concerned, medicine and health are social activities with profound ethical consequences. As science and technology increase their ability to intervene in processes that regulate or alter life, there is also an increased need to subordinate their use to ethical considerations. New knowledge and techniques will inevitably be applied in the modern world as the population strives to enhance its health and physical well-being. Bioethics (defined by the International Association of Bioethics in 1992 as the study of ethical, social, and legal issues related to health care and the biological sciences) is a new technical area concerned not only with ethical problems in the areas of clinical and scientific medicine but also with social and economic issues, especially the planning and provision of health care, the allocation of resources, animal welfare, and environmental concerns. It integrates various related disciplines and professions which, alone, do not possess the resources necessary for dealing with the political, economic, social, biomedical, and legal dilemmas encompassed by bioethics.

18. Bioethics is a social and cultural phenomenon, about which the population is informed through the communications media and which has to do with a variety of issues, including: the doctor-patient relationship, human reproduction, genetic research, transplants, AIDS, the processes of death and dying, access to the health services, health financing, and the allocation of health resources. The theory and practice of bioethics is a field in which medicine, law, philosophy, theology, the social sciences, and the related health professions can contribute their knowledge and experience.

19. The regional situation with regard to bioethics is one of profound inequality between North America--notably the United States and Canada--and the rest of the countries of the Region in terms of the discussion and proposal of solutions to the common problems and dilemmas posed by scientific-technological progress in terms of ethics. There is a considerable lack of resources, information, and opportunities for the development of a Latin American and Caribbean bioethics consistent with the social, economic, and cultural realties of the countries. This results in acritical acceptance of reasoning and options that are not always compatible with the reality of the countries and that affect the form and content of health care and the practice of medicine and public health in general.

GLOBAL STRATEGY FOR TECHNICAL COOPERATION

20. The Program on Health Policy Development implements the strategic orientations during the quadrennium 1991-1994 relative to Health in Development and to incorporation of the potential of Social Security. In addition, it provides a response to two of the program priorities, Sector Analysis and Sectoral Financing. Given the content of the subjects involved in its field of action, the Program will identify institutions specializing in the socioeconomic and political dimensions of development that can support the formulation, implementation, monitoring, and evaluation of the national health policies of the Member Countries. In the particular case of cooperation with the Social Security institutions, support will be provided by the Director's Advisory Committee on Health and Social Security. Special emphasis will be placed on support for the PAHO/WHO Representative Offices and other Headquarters programs and divisions in applying the aforementioned strategies and priorities. Action in the countries will in all cases endeavor to involve not only the authorities of the health sector, but also the authorities of other sectors of the government, the legislatures, and the representatives of the civil society, whose participation is necessary for ensuring achievement of the Program's goals.

21. With regard to women in health and development, the Organization hopes to improve the status of women in the Region and to overcome the "discriminatory barriers" that affect their development as persons, their living conditions, and their health. This demands recognizing that differences based on sex are generating inequities that are compromising the health conditions of the population as a whole.

22. Recognition of this problem on the part of the Member Countries of the Organization and the implementation of policies, programs, and health services aimed at reducing the social and gender inequities of women are the core objective of technical cooperation in Women, Health, and Development for the biennium 1993-1994.

23. In order to make the strategic orientation on the incorporation of Women in Health and Development viable, the Regional WHO Programs will direct their efforts toward achieving the following specific objectives:

24. To strengthen national abilities to formulate, carry out, and evaluate policies, programs, and health projects with a gender-based perspective, in addition to facilitating the design of policies to promote and protect the health of women that take into account their gender, class, ethnic origin, social function, and age.

25. To promote the enactment of laws or legal reforms in order to eliminate de jure discrimination against woman and to provide strategies for the exercise of their right to health.

26. To promote the design and implementation of alternative models for health and comprehensive care services for women that take into account both their biological functions and those that are assigned them socially--functions of gender--in the different stages of life.

27. To improve and expand awareness of gender gaps in health, their impact on the health conditions of women, and their relation to the development process.

28. To support the strategies for mobilizing national and international resources and forming socially organized groups to defend the cause of women's health in the framework of the development process.

29. The following will be adopted as strategic technical cooperation approaches to Women, Health, and Development:

30. Mobilization of political, institutional, human, and organizational resources that will promote the formation of exchange and cooperation networks for the identification and formulation of technical cooperation projects, the management of external resources, interprogram and interagency complementation and coordination, and coordination with governmental and nongovernmental organizations.

31. Dissemination of information on issues relating to women, gender, and health and development by organizing and supporting the publication and dissemination of scientific and technical materials on the subject.

32. Support for the formulation and evaluation of laws, policies, programs, and comprehensive care models for women in the framework of both public and health policies.

33. Training and development of human resources in the areas of gender, women, health, and development through support for the holding of courses, seminars, and workshops, as well as the introduction of this discipline into undergraduate and graduate curricula.

34. Promotion and development of scientific research on women's health issues from a gender perspective and with linkage to the development process, with special emphasis on the promotion of multicenter and action-oriented research at the local level.

35. Direct technical advisory services that respond to the concrete demands for support of national, subregional, and regional initiatives.

36. With regard to bioethics, the Organization's cooperation activities will be framed in SOPPs with regard to:

37. Health in development, by promoting thought and action in the area of health, furthering understanding of the interdependence between health and the process of sustained human development, and contributing to the importance of the positive value of health in the development process.

38. Reorganization of the health sector, and focusing of actions on high-risk groups by promoting the discussion of macroethical considerations related to the health services and their accessibility, organization, and decentralization; the use of health resources; and the ethics of care models and priorities.

39. Health promotion, by emphasizing the social justice and equity inherent in renewing the concept of health promotion (Letter of Ottawa, 1986, and Declaration of Bogotá, 1992) and the quality of life as it relates to human rights approached from the standpoint of bioethics.

40. Mass communication in health, by extending bioethical information and education to the entire population and contributing to an informed public that is aware of the value of individual and collective health.

41. Integration of women, by specifically including gender-based considerations in the debate, in addition to bioethical options in concrete situations.

42. Management of knowledge, by pursuing the generation and management of conceptual and applied knowledge of scientific-technological progress and its ethical and social consequences.

43. Mobilization of resources, since planning for society as a whole makes it possible to promote health in the broad framework of bioethical discussion, which includes political will, the potential of public institutional and private resources in the countries, concerted action between multilateral technical and financial cooperation entities in bioethical subjects, and consideration of the bioethical variable in health development projects. .

44. Cooperation between countries, by referring to health problems and ethical challenges common to many countries in the Region in the management of health.

## SPECIFIC PROGRAMS

### Health Policy Analysis and Development (HDP)

#### BIENNIAL TARGETS

45. To achieve greater consensus with respect to health priorities, in addition to a more privileged position among the development goals in each country and in the Region.

46. To improve coordination between governmental agencies, Social Security institutions, community organizations, and the private sector in the production of health goods and services.

47. To increase the countries' ability to analyze the health sector and to formulate, implement, monitor, and evaluate health policies and projects.

#### LINES OF ACTION

48. Political Development in the Area of Health: analysis of the political dimensions of health; mobilization of other relevant actors for the promotion of health policies, such as legislatures, labor unions, and other social organizations; and promotion of health targets in national and regional development agendas.

49. Organization and Interinstitutional Action in the Area of Health: support for the development of Social Security institutions in order to expand coverage of their health programs in coordination with State services and the private sector; to function as the secretariat for the Advisory Committee on Social Security.

50. Sector Analysis and Sectoral Planning: sectoral analysis in order to orient the leadership and transformation of the health sector; planning and analysis of policies, as well as sectoral development projects; promotion of the participation of the health sector in integrated programs to combat poverty.

### Health Economics and Financing (HDE)

#### BIENNIAL TARGETS

51. To increase national capacity to monitor the impact on health of macroeconomic and development policies, and to improve equity and efficiency in the economic-financial management of the health sector.

#### LINES OF ACTION

52. Monitoring of the impact on health of macroeconomic and development policies; analysis of the economic dimensions of the production and consumption of health goods and services; analysis and formulation of alternatives for sectoral financing; and economic-financial management in order to increase equity and efficiency in the health sector.

### Health Legislation (HLE)

#### BIENNIAL TARGETS

53. To develop national legislation that permits effective exercise of the rights and responsibilities of the citizens, the State, and private institutions with regard to health.

LINES OF ACTION

54. Support for national authorities and legislatures in the analysis, development, and evaluation of health legislation of the countries at the national, subregional, and regional levels; support for other programs and divisions in developing the legal aspects of pertinent health policies; and maintenance and updating of the LEYES data base and other information mechanisms concerning health legislation.

Women, Health, and Development (WHD)

BIENNIAL TARGETS

55. To assist in improving the health conditions of the population as a whole through incorporation of a gender-based approach to policies and programs for health promotion and health care.

LINES OF ACTION

56. Strengthening of regional leadership in Women, Health, and Development.

57. Strengthening of leadership to facilitate implementation of the strategic orientation on Women, Health, and Development. For this purpose the sensitization and training of the professional personnel of the Secretariat will be promoted in the gender perspective; support will be given to the processes of law and the creation of gender awareness as regards health; and information will be disseminated and special efforts will be concentrated on promoting and support research on Female-Friendly Services.

58. Impetus and strengthening of the subregional initiatives on Women, Health, and Development.

59. The Central American Initiative will continue to be promoted, particularly Phase II of the Subregional Project "Comprehensive Health of Women," in accordance with the targets proposed for the next two years. Support will also be provided to execution of the Subregional Project on Health and Development of Indigenous Women and Central American ethnic groups.

60. Support will be given to the development and gradual expansion of the Caribbean initiative by launching a preliminary phase to strengthen the Focal Points on WHD in the countries in the subregion through a training program and informational materials to support its functions.

61. The formulation and management of resources will be initiated for a project on Communication and Promotion of the Health of Women in the Andean Area.

Promotion of Bioethics (HBE)

BIENNIAL TARGETS

62. Promotion and dissemination of bioethics as an area of study, research, and regional cooperation.

63. Promotion of pluralistic bioethical and objective discussion.

64. Human resources education in bioethics at the regional level.

65. Establishment of Committees on Clinical Ethics and training of their members in health care services.

66. Establishment of Committees for Review of Biomedical Research and training of their members.

67. Training of members of professional organizations (physicians, nurses, psychologists, judges).

68. Coordination of bioethical studies and research.

69. Development of a regional bioethical information system.

LINES OF ACTION

70. Identification of and cooperation and coordination with entities and people interested in bioethics in order to form a network of national bioethical nuclei to exchange information and experiences and to constitute national resources for carrying out activities in the countries.

71. Development of Committees on Clinical Ethics and Review of Biomedical Research.

72. Training of members of Ethics Committees.

73. Development of academic and applied training in bioethics.

74. Informed discussion of bioethical subjects that affect the health of populations and that are potential subjects for policy decisions.

75. Development of a regional system of bioethical information.

## 6. HEALTH POLICY DEVELOPMENT (CONT.)

### PROGRAM BUDGET DISTRIBUTION BY LOCATION

| LOCATION | PAHO AND WHO REGULAR BUDGET 1992-1993 | 1994-1995 | 1996-1997 | EXTRABUDGETARY FUNDS 1992-1993 | 1994-1995 | 1996-1997 |
|---|---|---|---|---|---|---|
| DIRECT COOPERATION WITH COUNTRIES | 3,726,800 | 4,508,500 | 4,902,900 | 985,500 | 1,361,500 | 0 |
| REGIONAL PROGRAMS | 2,591,300 | 3,089,500 | 3,361,100 | 0 | 0 | 0 |
| TOTAL | 6,318,100 | 7,598,000 | 8,264,000 | 985,500 | 1,361,500 | 0 |

### ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL PROF. POSTS | PERSONNEL LOCAL POSTS | PERSONNEL CONS. DAYS | PERSONNEL AMOUNT | DUTY TRAVEL AMOUNT | FELLOWSHIPS MONTHS | FELLOWSHIPS AMOUNT | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 5,744,000 | 11 | 8 | 1685 | 3,292,500 | 520,300 | 6 | 12,000 | 744,300 | 91,300 | 47,800 | 1,035,800 |
| WHO - WR | 574,100 | 1 | 0 | 290 | 273,600 | 14,200 | 20 | 40,000 | 61,500 | 41,800 | 0 | 143,000 |
| TOTAL | 6,318,100 | 12 | 8 | 1975 | 3,566,100 | 534,500 | 26 | 52,000 | 805,800 | 133,100 | 47,800 | 1,178,800 |
| % OF TOTAL | 100.0 | | | | 56.3 | 8.5 | | .8 | 12.8 | 2.1 | .8 | 18.7 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 6,745,500 | 10 | 9 | 1195 | 3,415,800 | 491,100 | 7 | 14,000 | 1,002,600 | 257,700 | 119,700 | 1,444,600 |
| WHO - WR | 852,500 | 1 | 2 | 130 | 493,000 | 7,900 | 20 | 40,000 | 132,500 | 73,400 | 0 | 105,700 |
| TOTAL | 7,598,000 | 11 | 11 | 1325 | 3,908,800 | 499,000 | 27 | 54,000 | 1,135,100 | 331,100 | 119,700 | 1,550,300 |
| % OF TOTAL | 100.0 | | | | 51.4 | 6.6 | | .7 | 14.9 | 4.4 | 1.6 | 20.4 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 7,327,800 | 10 | 9 | 1195 | 3,683,200 | 531,600 | 7 | 14,000 | 1,094,500 | 281,200 | 132,400 | 1,590,900 |
| WHO - WR | 936,200 | 1 | 2 | 130 | 533,900 | 9,000 | 20 | 40,000 | 150,200 | 83,200 | 0 | 119,900 |
| TOTAL | 8,264,000 | 11 | 11 | 1325 | 4,217,100 | 540,600 | 27 | 54,000 | 1,244,700 | 364,400 | 132,400 | 1,710,800 |
| % OF TOTAL | 100.0 | | | | 51.0 | 6.5 | | .7 | 15.1 | 4.4 | 1.6 | 20.7 |

## HEALTH SITUATION ANALYSIS

1. The health services systems continue to be affected by the severe economic crisis that has engulfed most of the countries in the Region. The general picture, however, is being influenced by the new socioeconomic trends that are emerging in some national contexts. In some specific cases and countries, application of the models of structural adjustment has resulted in a certain measure of financial stability, control of inflation, and even positive growth of the economy. However, this positive economic situation has not succeeded in resolving the basic needs of the population, which continues to suffer from high rates of unemployment and an increase in poverty levels.

2. The structural adjustments, in demanding reorganization of the economy, have resulted in a shortage of adequate financing for national, provincial, and municipal health systems, not only because of the restrictions imposed on State budgets, but also because of the financial problems that must be faced by the social security systems. This situation also prevails in the private sector, where limitations may be observed in the capacity of the great majority of the population to pay for growing health care costs.

3. Furthermore--and this may be viewed as a positive trend--the exercise of democratic political systems has led to greater social participation by virtue of the introduction of reforms in State structures and the further progress made in the decentralization efforts that are already under way. This situation requires that the population have access to and become involved in health education programs, and that it participate more actively in the decisions that affect the development of local health services.

4. These democratic movements now provide a voice for previously neglected population sectors, as is the case of the indigenous peoples, who are now demanding greater and more equitable participation in development activities.

5. The population's access to the health services continues to be conditioned by income levels. Those with higher incomes have access to health services of high complexity, and this, in turn is orienting the health sector toward disjointed growth of its installed capacity and encouraging the use of technologies that are not always cost-effective.

6. Populations with medium or medium-low incomes are faced with a twofold problem: on the one hand, the financial limitations of the social security systems, which are restricting their coverage capacity, and on the other, the increase in health care costs, which impedes access to the services. In many cases, these populations are forced to request services from the public sector, thereby increasing the demand for services from State-run establishments and making their limitations even more obvious.

7. Finally, populations with the lowest incomes who live in poverty or even extreme poverty depend exclusively on the health care provided by the State. As mentioned previously, these services are wrestling with serious financing problems at the present time.

8. The short-term solutions adopted by some countries consist of requiring a financial payment from the patients when they receive the services or a contribution in kind in the form of essential supplies in order to gain access to the care provided by public establishments. Such solutions, in addition to constituting an economic obstacle to accessibility, do not succeed in resolving the financial problems of the sector.

9. It may be stated, then, that despite the efforts made by the countries and the economic improvement that some of them have demonstrated, the general inequity as regards the accessibility of quality health services continues to increase. It is estimated that a total of 160 million people lack proper access to the health services.

10. In addition, the recent epidemics of AIDS and cholera have meant new demands on the health services of the Region. Although in both cases, the response capacity and solidarity of the health services have been demonstrated, it is also true that the problems existing with regard to financing, accessibility, and installed capacity have also come under scrutiny.

11. There is also agreement on the important role of the Region's health services in the face of such challenges as increasing immunization coverage, eradicating the wild polio virus, and controlling other communicable diseases. In order to promote the active and committed participation on the part of the population and the health institutions, trained personnel are needed to enlist support for and contribute to developing and evaluating these processes.

12. The relative increase in private health services in relation to the health services as a whole, both with regard to financing systems and installed capacity, also represents a new challenge in achieving better articulation of these services with the rest of the health resources for the purpose of enhancing social effectiveness. Changes in the structure of the State and the processes of decentralization, democratization, and social participation are political and social trends that affect organization of the health services.

13. In rural areas problems of access to the health services may be associated with geographic inaccessibility; but they are also evident in the large urban centers, especially among the marginalized population, whose access to the services is hindered by financial and cultural considerations.

14. The critical situation and the new trends and emerging demands require further study in order to arrive at in-depth solutions. Such solutions are related not only to financing mechanisms and the development of social security, but also have to do with adequate organization of the services systems and the existence of an appropriate balance between State and private resources aimed at establishing a complementary relationship between them and thereby achieving equity with quality and social effectiveness.

15. In this context the Organization and the member countries are developing the Regional Plan for Investment in the Environment and Health (PIAS) for the purpose of providing the health sector with an overall framework of equitable development for the decade.

7. ORGANIZATION OF HEALTH SERVICES BASED ON PRIMARY CARE (Cont.)

16. This proposal has, in turn, been incorporated into the processes of democratization and social participation, which has in all the countries resulted in political decisions and strategic programs aimed at decentralization and the development of local health systems.

17. In the study carried out by the Organization in 1990 on reorganization of the health sector, it was found that 94% of the countries were formulating and implementing national policies to decentralize the State. A second study, carried out in 1992, showed that this trend was continuing and accelerating in all the countries in the Region. The decentralization and development of local health systems is a social process that is under way in all the countries at the national level, in the provincial states, and in the municipalities.

18. Thus, the processes of decentralization and development of the local health systems are becoming the driving force not only for the changes that are taking place in the entire health sector, but also for the support that is being given to institutional development at the local level. This means, in many cases, that the municipalities are taking a comprehensive approach to the development of health that emphasizes health promotion and preventive care. The results obtained in controlling certain diseases are an example of the potential for local management processes that are supported by national policies.

19. In other cases, the development of local health systems in population and territorial terms refers to ethnic groupings, which include the elements of culture and traditional practices. Analysis of the situation of indigenous peoples, their health, and well-being indicates that efforts must be increased to identify and respond to their needs as vulnerable populations.

20. The strategy of local health systems at the municipal level supports the movement known as "Healthy Municipalities" as a means of change, not only in the transfer of decision-making and responsibility at the local level, but change in the current health development models.

21. Two generalized trends may be distinguished in reorganizing the health sector in the Region. On the one hand, there are the concrete experiences of countries that are reorganizing their entire health structures in the direction of decentralization and local development in the form of local health systems as part of development of the entire territory of a country. In other countries, efforts are being focused on provincial or municipal development, in which the local health systems are the driving force. In both cases these processes envisage equity, quality, efficiency, and participation as the fundamental objectives of reorganization of the sector.

22. This expression of change in the health sector is framed within the economic structural reforms being undertaken by the countries in the Region. The health services system, as a component of the social sector and as an integral part of society, influences and is influenced by the changes taking place in the structures.

23. The major thrust of the Strategic Orientations and Program Priorities for 1986-1990 in reorganizing the sector was the decentralization and development of local health systems. This reorganization proposal continues to serve as the guideline for the Strategic Orientations and Program Priorities for 1991-1994 and for the policies contained in the Ninth General Program of Work of WHO for the period 1996-2001.

24. The operational aspects of the health services, in addition to problems of financing, organization, administration, and maintenance of the physical infrastructure, are matters of great concern to the countries. This concern is evident with regard to the role of the Ministries of Health, not only in managing health matters, given the diversity of public and private health care providers and the processes of decentralization, but also in administering and managing care establishments (public and private hospitals, health centers, clinics, sanatoriums, etc.).

25. In both cases there is growing interest in making further studies and seeking solutions for reorganizing the Ministries of Health, administering hospitals and decentralizing State establishments, and setting up networks of private services and selecting and incorporating technologies.

26. Financial cooperation agencies, international lending agencies, and bilateral aid institutions have demonstrated growing interest in supporting local development in the framework of the proposal for local health systems.

27. A priority subject for enhancing the health services is the development of human resources and health teams by means of training and refresher courses. The countries in the Region are continuing to analyze these needs in terms of current political and social processes.

28. The regional situation should also be observed in the specific areas that affect health services development. Among these are the organization of public hospitals; the development of information; health services research; the economics and financing of health; the quality and efficiency of health care; nursing; drugs; laboratories; radiology; rehabilitation; oral health; and the safe and efficient operation and maintenance of health installations and equipment.

29. In the area of hospital organization and administration the countries are placing particular emphasis on increasing the equity, quality, and efficiency of the hospital establishments and on the role public hospitals should play in consideration of the crisis, reform of the State, and the processes of decentralization. With an installed capacity of approximately 50% of the total resources, the hospitals are being analyzed with the aim of incorporating them actively into the process of change in the sector.

30. The interest in obtaining systematized knowledge of current experiences; creating decentralized units; setting up self-managing hospitals; and carrying out

studies on equity, quality, costs, and safety is increasing the need for expanding research on the health services with the aim of promoting decision-making at the overall system level and at the operational level.

31. The physical infrastructure of the health services, represented by their buildings and equipment, is in an advanced state of deterioration and physical and technological obsolescence. This situation is further complicated by the lack of adequate conservation and maintenance programs to ensure their operation and functioning, combined with the absolute need to permanently incorporate new technologies into the health services.

32. The countries have recognized the importance for health education programs of achieving greater participation of the population in health promotion. At the present time the shortage of properly trained personnel prevents the local health services from carrying out promotion and prevention actions jointly with the population and other institutions. Social participation in the development of local health systems and services requires the management of knowledge and new technologies that will make it possible to make headway in implementing a more integrative and participatory model for health promotion. This requires training and motivating personnel in the area of health participation and education and inspiring them to engender concerted action, negotiate and mobilize resources, promote the participation of the population in decision-making, and maintaining continuity in the actions undertaken. The projection of health education with a broad basis of social participation demands a permanent process of research-action-evaluation that permits the exchange and enhancement of experiences at the local and regional levels.

33. The shortage of nursing personnel in the countries affects the quality of health care and limits the potential of nursing for organizing services and providing care for the community. Working conditions are deficient, pay is low, and there is a lack of policies for professional advancement and few possibilities for increasing recognition of the role of nursing personnel and improving their living conditions. Community participation in the health services demands changes in the education, practice and attitudes of nursing personnel and health teams. The application of new technologies in health care requires analysis and decision-making on the part of nursing personnel in order to guarantee that they are duly and appropriately utilized. The new roles and models of health care require changes in health care modalities, decision-making capacity, and leadership to bring about change and to make effective use of power in the social and political context.

34. The availability of drugs of recognized safety, effectiveness, and quality has been directly affected by the economic adjustment processes under way throughout the Region, the trends toward internationalization of markets, and the elimination of barriers to trade. The strategies of the economic sector to increase the supply of drugs as a means of lowering costs has led to policies aimed at reducing bureaucracy and regulation in order to simplify and reformulate procedures and standards for the approval and registry of pharmaceutical products. There is a real concern that these processes are taking place in an economic context that fails to include sufficient participation of the health sector. This may lead to decisions that can adversely affect the health of the population as a result of placing on the market products whose quality and appropriateness have not been fully evaluated. The governments are emphasizing the regulation and control of drugs, in addition to defining priorities for the formulation of efficient policies and programs that are truly able to monitor the quality and uses of these critical supplies throughout the production and marketing chain. In view of the trends toward the internationalization and integration of markets, it is obvious that the drug problem will continue to be a concern of the governments that will demand constant attention on the part of the authorities. The identification of basic drug needs, the adoption of policies for generic drugs, and recognition of the registries of other countries constitute national responses for increasing the availability of drugs and for diminishing the lack of access of significant sectors of the population to priority drugs.

35. The active participation of pharmacists in health teams as advisors for the prescription and use of drugs is being considered by the countries, essentially through the development of pharmaceutical services in both public and private hospitals and as part of the reorganization of the sector at the local level. In similar manner, the schools of pharmacy in many countries in the Region are updating their curricula in order to train pharmacy professionals in the social, health, and clinical aspects of drugs and to effectively integrate pharmacists into health teams.

36. While the technologies emerging in the laboratories make it possible to carry out rapid and simple analyses, the costs of importing reagents, combined with the administrative deficiencies of the laboratories, continue to obstruct optimum use of the support that the laboratories could provide to primary health care programs. For the most part, laboratories at the local level continue to work with antiquated equipment, shortages of quality reagents, and insufficiently trained personnel. The development of laboratory clinical services is not uniform throughout the health systems and tends to favor urban hospitals and the principal referral centers to the detriment of the support needed for local laboratory services. In decentralizing the services it is important to monitor the reliability and timeliness of laboratory results. It is hoped that the use of an external strategy to evaluate the quality of the results will make it possible to implement national quality assurance programs so that each laboratory will have its own internal quality controls. The progress achieved in biotechnology, genetic engineering, bioengineering, molecular chemistry, filtration processes, electronic instruments for detection and analysis, and data processing is creating new profiles as regards the personnel needed for laboratory work. In addition, the costs of equipment and materials are having repercussions on health expenditures, and consequently the efficiency of laboratory use in the health programs must be studied and reviewed.

37. Diagnostic radiology and radiotherapeutics in the United States and Canada have continued to expand with the inclusion of new technologies, such as magnetic resonance, and emphasis has been placed on quality control and protecting users from radiation. In Latin America and the Caribbean, on the contrary, the services have deteriorated significantly, not only because obsolete equipment has not been replaced, but also because of the shortage of adequately trained and periodically updated human resources and the lack of maintenance programs, especially with respect to spare part replacement. The few resources available continue to be concentrated in urban hospitals, where the services provided are inadequate due to the absence of quality control programs and the poor working conditions of the personnel as far as protection from radiation is concerned. The lack of leadership of the Ministries of Health in the planning of services has created a gap that the private services are attempting to bridge; however, given the high costs of radiological equipment, private health plans have also increased the price of their services, so that coverage of the population has actually diminished instead of increasing. In addition, since national legislation and

regulation of radiological protection is deficient, private and public services are not constrained to adhering to basic radiation protection standards. The most serious danger lies in radioactive waste materials, especially in the case of no longer used sources of teletherapy and brachytherapy which endanger the safety of the population.

38. The inequities existing in the accessibility of the health services for disabled persons have increased, even though there has been greater awareness of the problem of disability.

39. The change that the health sector is undergoing through decentralization and economic reform is permitting the inclusion of rehabilitation in local planning and in the operation of the local health systems, in addition to the development of a network of national services.

40. The countries recognize that the prevention and detection of dental disease and the need for improving the oral health of the population must be priority targets of the health programs. The growing implementation of preventive measures to combat caries, combined with improved education and good oral hygiene practices, has had an impact on the incidence and severity of these diseases.

41. In this regard, it should be pointed out that considerable progress has been achieved through the implementation of water and salt fluoridation programs as large-scale measures to prevent dental caries.

42. Nevertheless, high prevalence of these diseases persists in the countries of the Region. The two principal oral health problems continue to be caries and periodontal disease. Although commitment to assign priority to children's health is emphasized in almost all the programs, carrying out effective programs against the oral diseases prevalent in this age group has been impeded by the permanent population growth experienced by the countries in the Region.

43. The factors that affect oral health are related not only to the causative agencies of oral cavity diseases, inasmuch as the economic crisis has reduced the availability of financial resources for the execution of many specific programs, and therefore less money is available for procuring the equipment needed to maintain oral health.

44. Reference must be made to the impact of HIV infection on the practice of dentistry, which has resulted in an urgent need to improve the control of infections and protect the health workers.

45. The overall increase in the number of professional dentists in many countries in the Region has not been accompanied by a commensurate increase in dental services within the framework of institutional programs, and consequently problems of access of the population to this type of service continue to exist. It should also be pointed out that in many cases problems exist that involve the distribution of professional dental personnel and the availability of laboratory and equipment maintenance technicians.

46. Significant strides in disaster preparedness and management have been made througout Latin America and the Caribbean in the last years. However, the Region's vulnerability to both natural and potential man-made disasters remains. Social and economic factors, the urban population growth and settlements in vulnerable areas constitute additional risks.

47. While most countries have now established Preparedness Departments in their Ministries of Health with trained competent staff, many of these departments are still without permanent funding, especially in those countries undergoing the most serious economic problems.

48. Positive strides have been made in intercountry technical cooperation and resource sharing, human and material. The initiatives in integrating preparedness issues into the curricula of health science faculties and schools of engineering in universities is succeding, and a series of regional and country training workshops for foreign affairs and diplomatic personnel have led to continued requests for more of this type of training.

49. Too often, natural disasters are ignored in the planning and design of hospitals and related facilities--even in areas where the risks are well known. These facilities must be able to withstand the impact of earthquakes, hurricanes, and other disasters and not themselves pose an added threat to their occupants. But several factors impede this. Structurally, many hospitals in Latin America are old; some date from Spanish colonial times. Others are contemporary, modern facilities but the lax application of anti seismic building codes may make their ability to withstand earthquakes, both structurally and non-structurally, questionable.

50. The natural hazards that threaten Latin America and the Caribbean, and the special vulnerability of the health sector to disaster situations, justifies specific prevention and mitigation actions.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

51. The Division's global strategy of cooperation is based on the strategic orientations formulated for the quadrennium, especially those referring to the reorganization of the health sector in order to achieve equity, quality, efficiency, and social participation. Support will be given to the essential components for developing and strengthening the local health systems and the processes of decentralization; providing leadership in health from the central levels; incorporating the potential of the social security institutions, and channeling external financing toward reorganization of the health sector. In addition, strategic orientation of reorganization of the sector will garner support for developing the Plan for Investment in the Environment and Health (PIAS), promoting health and development strategies, focusing actions on high-risk groups, health promotion, the use of mass communication for health, integration of women into health and development, management of knowledge, mobilization of resources, and cooperation between countries. In addition, taking into account the policy guidelines of the Ninth General Program of Work of WHO, the Division will base its activities on a policy aimed at ensuring equitable access to the health services.

52. As part of the strategic orientation for the reorganization of the health sector, support will be provided to program priorities directed toward the

development of health services infrastructure, especially as regards development of the role of the Ministries of Health; management of the local health systems and local strategic administration; analysis of the sector; sectoral financing; technological development; and in-service training of human resources.

53. Among the important elements in this program priority are integration of the programs, social participation in managing the local health systems, and the development of health services research as it pertains to equity, quality, efficiency, and social participation.

54. In addition, the countries will be assisted in reducing and palliating the impacts on health derived from natural and man-made disasters. This refers not only to reducing the toll in human lives and injuries, but also reducing the economic impact of such disasters on health and on the health services infrastructure.

## SPECIFIC PROGRAMS

### Organization of the health services based on primary care (DHS)

#### BIENNIAL TARGETS

55. To promote and develop transformation of the national health systems on the basis of the need to contribute to social equity in view of the structural adjustments under way and to support the countries in formulating and implementing the Plan for Investment in the Environment and Health (PIAS) and maintaining relations with financial bilateral support institutions.

56. To endorse reorientation of the processes of leadership and management of the health sector by defining the role of the Ministries of Health in the context of reform of the State, decentralization, and the need for ensuring equity in health.

57. To support the study of, and proposals for, alternative mechanisms for financing health, together with the role of State and social security funds, as well as that of direct contributions.

58. To incorporate the health sector into local and regional socioeconomic development processes, democratization, and social participation based on decentralization and the development of local health systems and primary health care as a means of achieving the target of "Health for All by the Year 2000."

59. To develop strategies and instruments in order to program, carry out, and evaluate the identification of population groups with the greatest needs and at greatest risk, and to grant resources comprehensively to provide for priority health problems as far as promotion, prevention, recovery, and rehabilitation are concerned, and in order to incorporate the population in decision-making and leadership at the local level.

60. To incorporate the development of strategic administrative instruments, including information systems, into the local health systems as agents for the development of comprehensive health at the local level, community-based rehabilitation, and specific services such as immunization coverage, the control and eradication of diseases, control of cholera and treatment of AIDS, maternal and child care, the health of adults and the elderly, workers' health and the health of other special groups, preventive and curative oral health care, emergency care, and urban health care services.

61. To facilitate the development of public and private health service delivery institutions through collaborative work with the appropriate representative agencies. This means providing support for the development of public hospitals as part of State reform processes and supporting private hospitals and services in an interrelated care network for the purpose of achieving optimum use of installed capacity.

62. To emphasize the development of nursing and hospital maintenance services as critical areas within the needs of the sector.

63. To continue to support the development of health services research and studies on equity, quality, and efficiency in the local health systems.

64. To support the in-service training of health personnel in coordination with human resource development agencies, public health training and higher education institutions, universities, and other training centers.

65. To continue to support the countries in organizing their engineering and maintenance systems, emphasizing strengthening of their operating capacity at the local level in coordination with all the health programs.

#### LINES OF ACTION

66. To support the countries in order to promote national reorganization of the health care system and to formulate the Plan for Investment in the Environment and Health (PIAS) as a means for promoting interprogram, interinstitutional, and interdisciplinary coordination and social participation on the basis of development and decentralization of health systems and the development of local health systems, relating health with other sectors of development in order to achieve equity, quality, and efficiency.

67. To manage knowledge for reorganization of health systems and development of local health systems, promoting research on health systems and services.

68. To promote the interprogram, interdisciplinary, and interinstitutional approach for the purpose of incorporating into the development of local health systems the health programs and strategies of health promotion in development,

social participation, community-based rehabilitation, and oral health through the development of strategic administration, reinforcement of the analysis capacity at the local level, and the development of information systems.

69. To support the local levels, the municipalities, and other decentralized State entities for the purpose of promoting a comprehensive approach to health promotion and the constitution of healthy communities.

70. To promote the incorporation of specific programs and projects into development of the health services, especially with regard to clinical technology, drugs, laboratories, radiology, and oral health.

Essential drugs and vaccines (EDV)

BIENNIAL TARGETS

71. To promote and monitor the policies on generic and essential drugs adopted by the countries.

72. To support the systematization and automation of the registry of drugs in six countries.

73. To reorient the education of pharmacists in order to integrate them into health teams by providing support for curriculum reform and monitoring of the recommendations made by the II Pan American Conference on Pharmacy Education.

74. To implement hospital pharmaceutical services in seven countries, emphasizing single-dose distribution systems and information services on drugs in order to improve the quality of hospital care.

75. To design and establish pharmaceutical services in local health systems in seven countries in order to increase the availability of drugs and promote their rational use.

76. To promote and coordinate studies on drug use in six countries based on a common protocol.

77. To prepare and disseminate pharmacological information bulletins and technical publications on pharmaceutical policy, quality control, good manufacturing practices, and pharmaceutical education.

LINES OF ACTION

78. To implement and monitor national drug policies and programs, emphasizing essential and generic drugs.

79. To support the regulation of pharmaceutical products in order to ensure their safety, effectiveness, and quality, in addition to strengthening systems to facilitate the registry, quality control, and surveillance of drugs.

80. To cooperate in the training of the human resources required to improve the availability and use of drugs.

81. To promote development of pharmaceutical services at the hospital level and in the context of local health systems.

Oral health (ORH)

BIENNIAL TARGETS

82. To incorporate dental health into local health systems in the countries on the basis of previously established theoretical-methodological and technical-administrative guidelines.

83. To support the establishment of a preventive infrastructure in the countries for the control of prevalent oral processes (caries and periodontal disease).

LINES OF ACTION

84. To support the mass prevention of caries through salt fluoridation.

85. To cooperate in developing a Latin American plan of action for the dental services and study of dentistry, prioritizing the production of knowledge and services, and the development of human resources.

86. To set up scientific and technical networks in specific tasks related to: information, prevention, technology, continuing education, oral pathology, maintenance, biological materials, and education-service.

Disaster preparedness (DPP)

BIENNIAL TARGETS

87. To strengthen national institutions and programs related to disaster preparedness and develop the capacity of the Regions's human resources to be prepared for and respond to disasters.

88. To promote technical cooperation among countries and subregions and coordinate regional disaster preparedness activities within the context of the International Decade for Natural Disaster Reduction and as part of the framework of collaboration with the United Nations Department of Humanitarian Affairs.

LINES OF ACTION

89. Continue promoting technical cooperation in disaster preparedness and give increasing priority to the fields of disaster prevention and mitigation to prevent and reduce the effects of all types of disasters -- natural disasters and technological accidents --on physical facilities. Technical support will be given to training activities at the national and regional level in disaster management

and the production and dissemination of specialized training material, broadening the scope from health sector preparedness to include mitigation of damages to health care facilities and infrastructure.

90. In the aftermath of disasters, assist stricken countries to assess health sector needs and coordinate and manage international disaster relief, in particular incoming relief supplies.

Clinical, Laboratory and Radiological Technology for Health Services (CLR)

BIENNIAL TARGETS

91. To improve the laboratory and blood transfusion services in support of National health programs, particularly in the local health care systems through: a) improved management procedures, including organization, personnel development, workload and staff requirements, cost studies, inventory control, etc.; b) quality assurance programs to ensure reliable results through the use of standardized procedures, proper utilization of quality reagents, proper equipment preventive maintenance, and implementation of internal laboratory quality controls, and participation in external assessment schemes.

92. To maintain an information exchange in promoting new technologies as they become available and appropriate for the health care system. These emerging technologies exist in the area of biotechnology with improved detection systems, along with computer assisted analysis and reporting. Particular attention to less invasive procedures for specimen obtention as applicable to the primary health laboratory.

93. To improve the biosafety policies and measures in the public health laboratory, and to promote laboratory support in the nosocomial infections control programs. Particular attention to studies in antimicrobial susceptibility testing.

94. Increase the coverage of diagnostic imaging, radiation therapy, nuclear medicine and radiation safety services --especially in the local health system-- thorugh the promotion of appropriate technology and qualified staff.

95. Improve the quality of existing services through comprehensive quality assurance programs that:

95.1 In diagnostic imaging services ensure optimum image quality at miminum radiation dose.

95.2 In radiotherapy services deliver accurate radiation doses to the volumes of interest.

LINES OF ACTION

96. To maintain information for situation analysis of quality laboratory services for primary health care at the local health system.

97. To assist the countries of the Region in their efforts to develop laboratory improvement projects, including activities in reorganization, management and utilization studies.

98. To maintain international external quality assessment schemes with national or reference laboratories and the WHO Collaborating Centers.

99. To support laboratories in the Region to implement quality assurance and biosafety programs.

100. To assist the National and Reference laboratories improve their technology in support of specific disease control programs such as HIV, STD, Cholera, diarrheal diseases, TB, Chagas, Blood Transmitted Diseases, etc.

101. To provide consultation in field evaluations studies, operational research and training support for subregional and national laboratory program activities.

102. To continue and expand inter and intraprogrammatic activities within and outside PAHO/WHO, especially with other UN organizations and NGOs.

103. To continue the assessment of policies and resources for diagnostic and therapeutic radiology services and radiation protection programs in the Region; promoting and assessing the use of appropriate technology such as the BRS, and developing legislation, regulations and guidelines for radiological protection.

104. To provide direct technical cooperation in the areas of diagnostic imaging, radiation therapy and nuclear medicine by: assisting governments in planning medical imaging and radiation treatment facilities that provide nation - wide coverage; advising on appropriate equipment and personnel for these facilities; enhancing training; establishing quality assurance programs and promoting the role of medical physicists.

105. To provide direct technical cooperation in radiation protection by supporting national and regional radiation protection programs; supporting radiological emergency preparedness training, and providing assistance in case of radiation accidents.

106. To prepare publications regarding the uses of ionizing and non-ioning radiation in medicine and their safety.

Health education and community participation (HED)

BIENNIAL TARGETS

107. To promote social participation in the development of health systems as a component of Local Strategic Administration in the local health systems as part of the reorganization of the sector, decentralization, and the search for equity.

108. To strengthen health education, incorporating participatory methodology for analysis, planning, execution, and evaluation so as to promote participation of the population in the decisions that affect its health and the development of its local health systems.

109. To make progress in promoting and protecting health and development through the evaluation of experiences, action-oriented research, and the updating of knowledge and technologies of health education and social participation.

LINES OF ACTION

110. To compile, analyze, and disseminate the social participation and health education experiences that have resulted from local strategic administration, and emphasize the development of the local health systems.

111. To develop and implement action-oriented research projects in support of national and subregional initiatives related to social participation and health education.

112. To produce and evaluate implementation instruments and methodologies in order to promote social participation and improve health education actions as part of the development of local health systems.

113. To promote the mobilization of resources and technical cooperation between countries in the areas of social participation and health education, including the NGOs, the social security institutions, the Ministries, and the Nuniversities.

Rehabilitation (RHB)

BIENNIAL TARGETS

114. To incorporate the concept of community-based rehabilitation into comprehensive development of the health systems.

LINES OF ACTION

115. To incorporate the strategy of community-based rehabilitation into the development of care systems.

## PROGRAM BUDGET DISTRIBUTION BY LOCATION

| LOCATION | PAHO AND WHO REGULAR BUDGET 1992-1993 | 1994-1995 | 1996-1997 | EXTRABUDGETARY FUNDS 1992-1993 | 1994-1995 | 1996-1997 |
|---|---|---|---|---|---|---|
| DIRECT COOPERATION WITH COUNTRIES | 25,980,600 | 27,267,800 | 29,718,500 | 41,425,300 | 9,927,900 | 0 |
| REGIONAL PROGRAMS | 4,560,700 | 5,174,600 | 5,619,200 | 811,700 | 126,000 | 137,000 |
| TOTAL | 30,541,300 | 32,442,400 | 35,337,700 | 42,237,000 | 10,053,900 | 137,000 |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL PROF. POSTS | PERSONNEL LOCAL POSTS | PERSONNEL CONS. DAYS | PERSONNEL AMOUNT | DUTY TRAVEL AMOUNT | FELLOWSHIPS MONTHS | FELLOWSHIPS AMOUNT | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 15,245,300 | 24 | 12 | 5175 | 6,709,500 | 803,100 | 536 | 1,060,000 | 2,819,700 | 1,252,600 | 91,400 | 2,509,000 |
| WHO - WR | 15,296,000 | 37 | 17 | 3990 | 9,511,900 | 538,800 | 653 | 1,306,000 | 1,344,100 | 825,900 | 0 | 1,769,300 |
| TOTAL | 30,541,300 | 61 | 29 | 9165 | 16,221,400 | 1,341,900 | 1189 | 2,366,000 | 4,163,800 | 2,078,500 | 91,400 | 4,278,300 |
| % OF TOTAL | 100.0 | | | | 53.2 | 4.4 | | 7.7 | 13.6 | 6.8 | .3 | 14.0 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 14,717,000 | 21 | 13 | 5384 | 7,197,700 | 858,500 | 430 | 860,000 | 2,425,700 | 1,146,100 | 76,300 | 2,152,700 |
| WHO - WR | 17,725,400 | 35 | 18 | 4345 | 10,180,700 | 632,900 | 594 | 1,188,000 | 2,207,000 | 1,032,700 | 0 | 2,484,100 |
| TOTAL | 32,442,400 | 56 | 31 | 9729 | 17,378,400 | 1,491,400 | 1024 | 2,048,000 | 4,632,700 | 2,178,800 | 76,300 | 4,636,800 |
| % OF TOTAL | 100.0 | | | | 53.6 | 4.6 | | 6.3 | 14.3 | 6.7 | .2 | 14.3 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 15,999,700 | 21 | 13 | 5384 | 7,727,100 | 940,800 | 430 | 860,000 | 2,706,800 | 1,287,500 | 86,500 | 2,391,000 |
| WHO - WR | 19,338,000 | 35 | 18 | 4345 | 10,952,000 | 715,100 | 594 | 1,188,000 | 2,498,700 | 1,170,100 | 0 | 2,814,100 |
| TOTAL | 35,337,700 | 56 | 31 | 9729 | 18,679,100 | 1,655,900 | 1024 | 2,048,000 | 5,205,500 | 2,457,600 | 86,500 | 5,205,100 |
| % OF TOTAL | 100.0 | | | | 52.9 | 4.7 | | 5.8 | 14.7 | 7.0 | .2 | 14.7 |

## HEALTH SITUATION ANALYSIS

1. The critical economic situation of the Region and the subsequent introduction of adjustment policies have led to the stagnation of social policies and to considerable deterioration in health services. To this can be added the limitations in access to basic items such as housing, food, education, recreation, and safety, among others. On the whole, this situation requires considerable extra- and intra-sectoral linkage and coordination and a better understanding of the international dimension of health in order to promote and protect health.

2. In the specific field of human resources, the critical factors at work in the fields of education, labor economics, and scientific and technological development must be taken into account.

3. Segmentation in the health services market and segmentation in the educational market reinforce each other and have major repercussions in the field of human resources. The professionals who are trained in the schools with the greatest technological development are distinguished from those who come from poorer centers that limit themselves to serving low-income groups. The latter gradually lose prestige and are sometimes forced to seek other occupations. Thus, professionals from the peripheral countries take exhausting, dangerous, or unhealthful jobs in central countries, creating migratory movements in areas that were not seen in the past.

## SCIENCE AND TECHNOLOGY

4. Technologies meant mainly for the upper-income segments of the population are being rapidly incorporated into health practices. The traditional model of a practice, based on the single, autonomous worker, is being left behind. The roles of health workers are being redefined, and this has a direct effect on relations with the people they serve, since the response to their needs is also fragmented and institutionalized. Technological production is concentrated in the central countries, which increases the dependency of the other countries on them.

5. Contemporary technological development has increased the capacity to solve health problems; but at the same time, it requires new skills in institutional management and the organization of health care is subordinated to this development.

6. The rationale and logic of the bionatural disciplines are emerging as the predominant model at the expense of the recognition of the need for more collective and integrating approaches.

## THE LABOR MARKET

7. A reduction in the rates of increase in the supply of professionals can be seen, and this will be reflected in several years in the number of health care professionals per capita. In some categories an absolute reduction in the number of professionals has already been observed. Fewer people are pursuing studies in the field of health, and they are remaining for shorter periods in the sector; there is also an ongoing feminization of the work force, influenced by the laws of the market, adjustment policies, or low expectations of social status for health workers. Academic "mortality" is on the rise in certain countries, reaching losses of up to 80% of total admissions into health careers.

8. Personnel are also poorly distributed, with unemployment and underemployment in urban regions, while at the same time rural areas continue to have vacancies, which represents a waste of the social investments that are being made to train health care providers.

9. The trend toward specialization and ultra-specialization has increased, with the resulting deterioration in the social esteem and recognition of professionals who have a more general orientation. The ability to resolve specific problems is rewarded, to the detriment of an overview of the health status of the individual and society.

10. The democratization that is occurring in the countries of the Region has led to different modes of association among health workers and to a collective struggle against the devaluation of their work, resulting in frequent strikes, failure to appear for work as a means of leverage, and other reactions that merely serve to strengthen the view that the health sector--especially the public sector--is inefficient and unproductive, which is a disincentive to investment in it. This generates a vicious circle in which it is difficult to identify cause and effect.

## HUMAN RESOURCES POLICIES

11. The countries' capacity to formulate policies is very weak, given that most of them do not currently have information on the number of health professionals, the installed capacity for training them, and the conditions of professional practice. Hence, the activities of human resources offices are reduced to strictly institution and administrative functions: monitoring incomes, transfers, retirements.

12. Correcting human resources problems is arduous and complex, and it generally cannot be accomplished within the term of office of sector leaders. As a result, it is usually decided to take ad-hoc, short-term action that will have an impact on current circumstances. Knowledge about human resources in the field of health is fragmented, in disciplines and in areas of knowledge. A holistic approach would be more useful in maximizing the ability to explain and intervene in the field.

13. The State is renouncing its innate prerogative to regulate the work force, which is being abandoned and left to be governed by the marketplace, which is notoriously imperfect.

HUMAN RESOURCES TRAINING

14. Most of the institutions responsible for training the health workers of the Region are in precarious condition as a result of the crisis. The instructors are poorly aid, which often obliges them to seek more than one job. The activities of education and research are influenced by interests outside the training process, which threatens the traditional concept of university autonomy.

15. Innovative experiences, such as teaching-service integration, are usually peripheral to the corpus of advanced training and use the community merely as a laboratory. Highly sophisticated care environments remain the core of medical education. An educational model committed to the population, its organization, and its development has not emerged from prior experiences.

16. Educational processes are becoming steadily less scientific in nature as a result of weak methodologies and the lack of access to new knowledge as it is being produced. This impacts negatively on the generation and transmission of new knowledge about the major contemporary contextual challenges that are relevant to a comprehensive approach to health.

17. Programs for training in public health have increased in the Region, but concerns have arisen about the quality of the educational process. Traditional schemes have been perpetuated-placing emphasis on management at the institutional level-with practically no incorporation of epidemiology, despite all its potential, or of new disciplines, including those in the social, economic, and political spheres, that are necessary for a truly intersectoral approach. Training efforts that place greater emphasis on research (at the master's or doctorate level), curriculum updating, and decentralized teaching have recently begun to appear.

IN-SERVICE DEVELOPMENT OF HUMAN RESOURCES

18. The workers who are currently providing services must develop different skills as part of the decentralization process, so that they can implement the corresponding sectoral proposals. Continuing education emerges as an opportunity to identify and make up for significant deficiencies, for example in the areas of community participation, local management, intersectoral negotiation, advocacy, and health promotion.

19. Continuing education experiences in the Region should involve a wide range of participants, such as teaching and training institutes and professional associations, as well as organizational units within the Ministries of Health themselves. By and large, these experiences have been limited in terms of their coverage of workers in the sector and have been characterized by their orientation toward professional categories, the individual approach, and the lack of linkage between the different actors.

20. The structuring of work in health care delivery institutions leaves little room for worker participation in identifying the problems relative to the effectiveness and quality of the services offered and in seeking creative solutions. The predominant organizational culture is normative and rigid. This situation, in addition to adversely affecting the quality of care, aggravates the dissatisfaction of workers in the sector.

21. Fellowships have been an important mechanism for developing human resources, mainly to cover technical and scientific areas in both academic training and refresher training for in-service workers. However, in most of the countries a very limited capacity to identify needs and define training priorities has been observed. Few countries have established multi-institutional bodies or commissions to carry out these functions, and as a result they are assumed by the many different sources of financing, in keeping with their own particular objectives and interests.

GLOBAL STRATEGY FOR TECHNICAL COOPERATION

22. In a scenario of profound and rapid changes as described above, the primary characteristic of cooperation for the development human resources in the field of health should be the capacity to react flexibly in response to changing circumstances and, ideally, to anticipate--based on a forward-looking approach--the evolution of phenomena and processes in the field, as well as to secure the broad participation of all the parties concerned through, inter alia, linkage with all the programs of PAHO itself.

23. In order to increase the impact of the program's activities of cooperation, national needs in this field will be taken into account to a greater degree than in the past, bearing in mind the challenges indicated in the Strategic Orientations and Program Priorities (SOPPs) approved by the Governing Bodies of the Organization. To this end, special importance will be attached to three processes that are central to the development of human resources in the countries: the formulation of policies, the reorientation of regular training, and in-service training. Activities will be sought that will bridge gaps between country and other programs and Regional programs in this field, and procurement of the corresponding resources will be supported, for example under the Regional Plan for Investment in the Environment and Health (PIAS).

24. With a view towards giving greater visibility to the problems involved in formulating policies and planning for the development of human resources, their conceptualization, training, utilization, and strategic management, the efforts to train leaders in the field will continue. In this context, attempts will be made to improve knowledge about sectoral realities by strengthening the mechanisms for recording, gathering, and analyzing available information and by spurring the production of new knowledge, with incentives for research.

25. The process of professional education will be questioned terms of its appropriateness to actual health conditions in the countries, and the search for a new social commitment that salvages its institutional mission and lends it renewed legitimacy will be promoted. Moreover, a more appropriate ranking of training levels will be sought, and efforts will be made to define policies that will channel specialization in a balanced manner, in strict relation to the process of evaluating technologies that are incorporated into the different disciplines.

26. In the context of the strategic orientation of health in development, efforts will be aimed at carrying out an in-depth analysis and developing the theory and practice of public health, thus contributing to a real transformation of advanced training in this field with a view to the promotion of leadership on a national intersectoral and international basis.

27. A complementary strategy in the area of guiding the management of knowledge will be the effort toward increasing the scientific capabilities of the players involved and creating a biomedical and social scientific model that designs and lays the groundwork for a new educational paradigm, consolidating integration, with a commitment to service and to the population.

28. Special consideration will be given to the needs of training human resources in the context of decentralizing health services, by promoting continuing education, the core of which will be the very work being done by the personnel who are already in service, tailored in each instance to the realities of each region.

29. In the implementation of the aforementioned strategies, special attention will be given to making better use of the fellowships that the Organization awards, seeing to it that their utilization is programmed within the context of the policies of personnel development and continuing education for in-service personnel. Priority will be given to training at advanced levels in those fields that are not sufficiently developed in the country itself.

30. Emphasis will also be placed on promoting the textbooks program in close coordination with the promotion of continuing education, fostering the incorporation of books and manuals produced in the countries themselves or the exchange of such materials in an intercountry effort.

31. The aforementioned strategies will be applied at the Regional level, through the subregional initiatives, and at the country level, with special emphasis on the mobilization of resources and on the possibility of cooperation between countries, with support for joint activities designed to respond to the problems detected. In addition, an attempt will be made to support the lines of action of the PIAS.

## SPECIFIC PROGRAMS

### Human resources training (HRC)

#### BIENNIAL TARGETS

32. Achieving a presence and identity for the area of human resources at the country level and promoting a better integration of the different lines of work that affect the processes of human resources development.

33. Participation of the university in the formulation of directives for reorienting the development of health personnel in relation to Health for All by the year 2000.

34. Strengthening the strategies of human resources development in the context of the subregional initiatives, directly in the countries involved and indirectly through the other specific programs of the Organization.

35. Strengthening the linkage between the Expanded Textbooks Program and the fellowships program of the Organization by promoting their reorientation so that they become instruments of support for the training of health services personnel.

36. Dissemination of the achievements in the field of health manpower, as well as support for the scientific updating of academic and service institutions.

37. Giving already employed workers opportunities to pursue ongoing training.

#### LINES OF ACTION

38. Incentives for extensive communication between the groups responsible for human resources in the countries, thus facilitating the exchange of information.

39. Promoting the participation of interdisciplinary university groups in the Health for All by the year 2000 effort.

40. Support for the subregional initiatives to coordinate actions in the field of human resources with the other strategies in progress.

41. Integrating the utilization of fellowships and the textbooks program into the training of in-service personnel.

42. Regular publication of Educación Médica y Salud and of the human resources development series and acquisition of selected scientific journals for the Organization and national institutions.

43. Training of local teams to implement innovative educational approaches.

44. Monitoring and reassessment of the educational approaches that are being used at the level of the services.

Human resources planning and policy (HRP)

BIENNIAL TARGETS

45. Development of holistic knowledge in the field of human resources at the level of both academic institutions and among policy-makers, so that the former can deepen their analyses and the latter can play an active role in subsector regulation.

46. Promoting intersectoral consensus-building at the country level to enable policies of health human resources development to be formulated.

47. Innovative expansion of the capacity to manage the flexible utilization of the work force in the health sector, in an effort to increase productivity and improve the quality of the services provided.

48. Institutional and programmatic strengthening of the human resources units in the Ministries of Health, social security institutions, and unions.

LINES OF ACTION

49. Enhanced application of the strategic approach as a support for the formulation of policies and human resources planning in the countries.

50. Support for the advanced training of a critical mass of professionals from the academic and services sectors with a holistic knowledge of the field of human resources, who can reproduce this training in their countries and regions.

51. Review of the human resources content in graduate studies in public health and social medicine.

52. Support for the efforts to develop information systems on human resources for the optimum formulation of policies and production of knowledge.

53. Support for the training of specialized personnel in the field of human resources, at the Regional and country level.

54. Promotion of pluri-institutional forums to debate and build consensus on policies and programs of human resources development.

Human resources education (HRE)

BIENNIAL TARGETS

55. Reorientation of the basic training of health professionals so as to balance their social visibility and the standards for the quality of the care that they must provide.

56. Post-graduate training for enough professionals to meet the demand for services, in the context of the same social commitment.

57. Transformation of advanced training in this field, with emphasis on promoting leadership at the intersectoral level, based on the expansion of analysis and the development of the theory and practice of public health.

58. Training for a growing number of professionals with experience in the field of international health and promoting this same development at the level of the countries.

LINES OF ACTION

59. Promoting a reorientation of basic training, with the incorporation of the social aspects of health in appropriate coordination with biological knowledge, especially in medicine and nursing.

60. Participation of schools in the process of technological evaluation and in the development of specialized training.

61. Incentives for the discussion and development of the theory and practice of public health and support for the efforts to reorient advanced training in this field.

62. Continuation of the Training Program in International Health at the Regional level within the Organization.

63. Promoting the development of international health programs in graduate-level teaching institutions at the country level.

## 8. HUMAN RESOURCES DEVELOPMENT (CONT.)

### PROGRAM BUDGET DISTRIBUTION BY LOCATION

| LOCATION | PAHO AND WHO REGULAR BUDGET 1992-1993 | 1994-1995 | 1996-1997 | EXTRABUDGETARY FUNDS 1992-1993 | 1994-1995 | 1996-1997 |
|---|---|---|---|---|---|---|
| DIRECT COOPERATION WITH COUNTRIES | 9,360,800 | 9,844,400 | 10,682,900 | 1,700,300 | 2,663,400 | 260,000 |
| REGIONAL PROGRAMS | 3,947,600 | 3,921,400 | 4,276,400 | 0 | 0 | 0 |
| TOTAL | 13,308,400 | 13,765,800 | 14,959,300 | 1,700,300 | 2,663,400 | 260,000 |

### ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL PROF. POSTS | PERSONNEL LOCAL POSTS | PERSONNEL CONS. DAYS | PERSONNEL AMOUNT | DUTY TRAVEL AMOUNT | FELLOWSHIPS MONTHS | FELLOWSHIPS AMOUNT | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 8,997,200 | 15 | 20 | 1240 | 5,027,200 | 388,500 | 218 | 436,000 | 1,328,200 | 349,900 | 0 | 1,467,400 |
| WHO - WR | 4,311,200 | 4 | 8 | 1350 | 1,729,700 | 183,700 | 315 | 630,000 | 855,800 | 357,700 | 0 | 554,300 |
| TOTAL | 13,308,400 | 19 | 28 | 2590 | 6,756,900 | 572,200 | 533 | 1,066,000 | 2,184,000 | 707,600 | 0 | 2,021,700 |
| % OF TOTAL | 100.0 | | | | 50.8 | 4.3 | | 8.0 | 16.4 | 5.3 | .0 | 15.2 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 8,435,200 | 13 | 21 | 698 | 5,166,800 | 370,400 | 168 | 336,000 | 890,800 | 300,800 | 0 | 1,370,400 |
| WHO - WR | 5,330,600 | 4 | 8 | 1447 | 1,991,900 | 276,300 | 427 | 854,000 | 1,287,000 | 351,800 | 0 | 569,600 |
| TOTAL | 13,765,800 | 17 | 29 | 2145 | 7,158,700 | 646,700 | 595 | 1,190,000 | 2,177,800 | 652,600 | 0 | 1,940,000 |
| % OF TOTAL | 100.0 | | | | 52.1 | 4.7 | | 8.6 | 15.8 | 4.7 | .0 | 14.1 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 9,192,900 | 13 | 21 | 698 | 5,634,100 | 406,100 | 168 | 336,000 | 988,700 | 338,300 | 0 | 1,489,700 |
| WHO - WR | 5,766,400 | 4 | 8 | 1447 | 2,141,700 | 301,500 | 427 | 854,000 | 1,432,900 | 395,900 | 0 | 640,400 |
| TOTAL | 14,959,300 | 17 | 29 | 2145 | 7,775,800 | 707,600 | 595 | 1,190,000 | 2,421,600 | 734,200 | 0 | 2,130,100 |
| % OF TOTAL | 100.0 | | | | 52.0 | 4.7 | | 8.0 | 16.2 | 4.9 | .0 | 14.2 |

## HEALTH SITUATION ANALYSIS

1. From the mid-nineteenth century on, biomedical knowledge has grown exponentially, and that knowledge has been utilized in technology and health practice, allowing for significant gains in the general public health. Much of the improvement in people's health status in the Region has come since World War II, as the result of interventions based on science and the transfer of knowledge. Scientific and technical advances in health and medicine in the past three decades only serve as harbingers of what is to come in the twenty-first century. By the year 2000 science and technology as they relate to health and health services will be venturing into uncharted territory.

2. In line with the countries' primary health care commitment to improve people's health and welfare and the quality of their lives, health and biomedical communicators will play a major role in transmitting the significance of these advances to health workers at large--thereby contributing to improving people's health conditions and to transforming countries' health systems. It follows that the generation, production, and dissemination of knowledge related to scientific and technological advances in health are crucial to all levels of workers and throughout the health care sector.

3. Health practitioners in countries of the Region --across the geographic, political, and socioeconomic spectrum-- need information that is validated, useful, and relevant to their local needs, be it in the form of books, periodicals, or documents, in printed or electronic media. The public sector grasps the strategic importance of information in manpower training, in part as a means to reduce dependency on the developed world. At the same time, to solve health problems directly related to people's habits and lifestyle, it will be necessary to reach beyond academic centers and officialdom to health service consumers and the community at large. That outreach will require development of the tools and products of social communication. Certainly the success of priority health campaigns will depend on their ability to enlist the consumers of health services and the community, which in turn will require the application of social communication approaches and techniques.

4. Poor access to scientific literature is one of the biggest problems health researchers face. The decade past witnessed an increasing difficulty on the part of institutions, students, and researchers in gaining access to biomedical literature produced abroad, due to the rising costs of books and journals in relation to dwindling local resources. By contrast, the developed world has been experiencing a powerful information explosion, printed as well as electronic. Consequently, the gap in technical and scientific knowledge has widened from day to day. Health libraries throughout the Americas have suffered declines in funding, a situation that has forced them to reduce their already modest collections and services. Access problems related to reduced funding are complicated in many countries by the major obstacles of inefficient distribution and circulation of health literature, many of which relate to national customs and postal systems, the lack of networks of bookstores and sales agents, and the poor penetration of books into areas outside the big metropolises of the Region. Delays and bottlenecks in the delivery of material is another problem. One result of these conditions is the inadequate and slowed flow of critical information, which can lead to the duplication of research. To the extent that information access is improved in these countries, the productivity and quality of research can be expected to follow suit.

5. The countries' independent research bases are directly linked to the publication of original scholarship, as publishing is merely a latter stage of a continuum. Despite the apparent easing of the economic crisis in much of the Region, health researchers in the Americas continue to face funding problems, since governments must use the resources they have to meet their citizens' basic needs, leaving little available to expend on long-term research. One measure of the magnitude of quality information being produced in the Region is the list of journals indexed in the Index Medicus of the United States National Library of Medicine, inclusion in which is generally considered to be an indication of a journal's quality standards. The 1992 edition of the Index showed that, of over 3,000 titles worldwide, 47 pertained to journals produced in Latin America and the Caribbean (Argentina 7, Brazil 15, Chile 5, Costa Rica 1, Cuba 1, Jamaica 1, Mexico 11, Panama 1, Peru 1, Uruguay 1, and Venezuela 3).

6. In the Americas, the financial resources devoted to publishing are extraordinarily small—one reason why publishing in most countries, with a few notable exceptions, is such a fragile enterprise. Some countries have virtually no publishing industry, and must depend on external sources for expensive imported publications. Others are coursing through a transitional period characterized by the modernization of printing plants, explosion of electronic media, the emergence of technologies, an increase in literacy and an enhanced appreciation of the power of information to change behavior and influence the development of the health sector. Growing entrepreneurship and increasing availability of capital, so critically scarce during the economic crisis of the 1980s, can be expected to trigger a boom in health and biomedical publishing in the countries. In such a scenario, it will be important to promote the production of indigenous medical literature, as it can be more greatly relevant to local health situations, is generally presented in a more appropriate style and language, and can be made available at affordable prices.

7. In the next few years, the demand for health information will mushroom. Changes underway in the countries of the Americas will directly affect the generation, utilization, and dissemination of health information in the Region. Among those changes are growth in the gross domestic product in most countries, a tendency toward free trade agreements, including agreements on intellectual

property rights, and other arrangements aimed at solving monetary problems and removing government restrictions that impede the free flow of books and journals among countries, the gradual falling of illiteracy rates, and demographic bulges projected for many of the countries. In the years to come, these factors will make the demand and need for health information even greater.

8. In addition, with respect to mass media, there is a rising consciousness on the part of mass media owners and managers that they have a social responsibility to help provide access to health information. This 'consciousness' is helped in its development by audience surveys which constantly rank health among the top three or four areas of prime interest. Also, journalists and schools of journalism are increasingly interested in health matters and, more and more, recognize the need to train people in reporting on health issues. Some schools have or are developing special curricula in this area and a network of journalists interested in health matters is slowly developing throughout the region. However, even though health sector officials in most countries are now slowly accepting the fact that greater investment in information activities is not only necessary but cost effective, budgets in ministries are far from catching up with this reality. Consequently, Ministries of Health are increasingly turning to PAHO for communications expertise, for coordination and support for information programs and campaigns and for financial resources to mount them.

9. In response, DPI has seen its country - level and sub-regional activities rise constantly and substantially over the last few years. An integral part of this situation is the growing demand for training, equipment, and technical collaboration from the communications offices of the Ministries themselves, and in some cases from the PWRs who are realizing the importance of expertise in information and establishing press offices to work with the national authorities. Nevertheless, there is still a long way to go, since in modern societies health communications activities compete on the open market with commercial messages of all sorts, including health-damaging products such as tobacco and liquor, and to compete effectively health sector information efforts require a degree of expertise and financing not yet common in most countries. This situation is changing, albeit too slowly, and one of the principal regional targets for technical cooperation that need to be addressed in the next biennium is to ensure that the countries have available professional level expertise and adequate financing to carry out professional communications campaigns for short-term goals, such as immunization efforts, and for long-term goals of improving health status.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

10. The Organization considers the management of knowledge a strategic orientation, the purpose of which is to generate, produce, and disseminate scientific and technical information that is validated, useful, and appropriate for health workers throughout the Americas. The PAHO Publications Program coordinates with other technical programs the publishing of a broad range of information to enable the Organization and the members countries to deal with social and health issues of critical regional interest. Toward that end, the Program contributes to a better understanding and implementation of PAHO's other strategic orientations and program priorities. It performs a unique service by publishing information that no other public or private entity could, or would, for whatever reason --lack of market potential, differing institutional commitments and priorities, or inadequate production and distribution resources.

11. The Organization has the capability, unequalled by other institutions, to marshal national and international forces to gather, analyze, edit, and produce information related to health and the health sector of a broad scientific and technical nature. As examples, no other body would be able to produce the "Health Conditions in the Americas" series nor does any other produce a monthly journal, the "Boletín de la Oficina Sanitaria Panamericana" and its quarterly counterpart the "Bulletin of the Pan American Health Organization", that bring together such a diversity of health research experiences from throughout the Western Hemisphere. Reaching over 25,000 health workers in the Region, the "Boletín", the "Bulletin", and PAHO's other main journal, "Educación Médica y Salud" are important tools for the dissemination of biomedical information. They make links between subjects that more specialized journals might not envision. They serve as vehicles for postgraduate educators, while connecting other readers to social, humanitarian, and ethical issues that might not appear in more strictly technical publications. While the journals will continue to publish the results of original research, in the future they will include much more generally educational and review (state-of-the-art) material. Through the journals, moreover, PAHO makes a special contribution to maintaining the currency of health workers in the Region, many of whom do not read English, by making information available in Spanish and Portuguese.

12. In that context, the selection of information to be published—through the use of peer review and editorial boards—is critical to assuring that scarce resources will be used to do the most good, i.e., provide validated and useful information hemisphere-wide. Selection entails not just the approval of manuscripts from the point of view of validity but the determination as to whether or not they are appropriate to meet the needs and do not duplicate existing publications.

13. An international organization such as PAHO has a particularly critical role to play given the difficulties of publishing in Latin America—problems related to distribution, prices, availability of paper or its prohibitive expense, stiff competition from imported books, lack of adequate marketing and distribution facilities, constraints of copyright, inability to produce on a large scale that would make books more widely affordable, and the shortage of trained personnel. In light of these difficulties, the Organization will enter into copublishing arrangements, based on cooperation with other institutions under varying contractual guises, as an optimal means of pooling resources to serve health readerships, to satisfy the demand for more and a wider array of books, and to reduce costs. In addition, since effective distribution determines the relative

success of the Organization's publishing activity, PAHO will strive to improve its means and mechanisms of information dissemination, so that its products get to those who need them opportunely. Efforts will target the establishment of national focal points and the elaboration of a distribution and sales policy.

14. At the same time, as publishing technology extends its reach to, and reduces its costs for, developing countries in the Region, PAHO has a role to play in strengthening national capabilities in the areas of researching, writing, publishing, and understanding health literature. Obviously, different countries are at different stages in their development of a publishing capability, and PAHO should respond appropriately to their varying needs.

15. Finally, the importance of promoting the use and availability of health and biomedical information among PAHO technical staff, as a necessary tool of their continuing education, is crucial to assuring their ongoing professional competence and the excellence of their service to the countries. The effectiveness of the Organization's technical cooperation, decision-making, and problem-solving hinges on constant support from the professional literature—in both printed and electronic form. If collective use is made of health literature, it can have a tangible impact on health policies, strategies, and programs. As the linchpin in the Organization's internal bibliographic information system, the Headquarters Library will have as it main functions to improve the situation in regard to health information support and to promote the literature awareness of the Organization's staff through proactive programs of selective dissemination of information, streamlined reference services, and staff training targeting user education and user guidance about access to a wide array of literature sources—techniques of bibliographic searching and utilization of information, including computer databases.

16. Given the power of knowledge to contribute significantly to improving health status and to developing health services, the Organization is committed to the production and dissemination of knowledge--the critical resource not just in the health sector but in society as a whole.

17. In the area of mass communication, the Office of Information and Public Affairs strategy will be based on the health promotion and social communications strategies outlined in the SOPP, and carried out in direct cooperation with Ministries of Health through the PWRs, with technical units at PAHO HQ, and with print and broadcast journalists throughout the Hemisphere. The strategy encompasses all aspects of information and communications, as described in the SOPP, and makes maximum use of the most modern available technology to bring information to those who most need it. The SOPP, in the section on the strategy of using social communication, states, "It is essential to include as many of the inhabitants of the countries of the Hemisphere as possible among the informational and educational efforts regarding health. It is crucial that the mass communications media, the content of basic education, and community discussions, feature important health information."

18. The fundamental goals of this strategic orientation, cite "to guarantee the existence of an increasingly informed public that will play a decisive role in the battle for health, and to reach the audiences of health workers and social and political leaders to promote their support for the improvement or transformation of national health systems." And, of most relevance to DPI's strategy of global cooperation, the program priorities document states, "For this reason, more use must be made of the mass media and technological innovations to disseminate useful health information to the general public and specialized groups."

19. Thus, the fundamental elements of DPI's global strategy include making greater use of the mass media both from the Washington headquarters, and increasingly, through the PWR's and the Centers in the countries. To be successful, the strategy must ensure that every PWR and Center has an active press officer who, in collaboration with national authorities and under the technical guidance of DPI, works to disseminate crucial health information through the mass media and other resources in the countries. In addition, the strategy must make use of technological innovations such as videoteleconferencing, satellite transmission, electronic bulletin boards, electronic networks, and others to disseminate information efficiently and quickly.

20. DPI's strategy also plays an important role in health promotion, one of the nine strategic orientations in the SOPP outlined as essential to foment substantial progress in the recovery and modernization of the health sector in the countries of the Hemisphere and which also must help generate more efficient, effective, and equitable responses to the health needs of the peoples of the Americas. With health promotion now viewed as more than dissemination of information and health education, to encompass education, information, social communication, legislation, policy making, organization, population involvement, and reorientation of health services, the role of DPI is crucial in attaining the objectives of changing environmental conditions, collective lifestyles, and behavioral patterns which are harmful to health; of implementing health programs aimed at fighting health risks, and of "developing a feeling of shared responsibility for health services," i.e. promoting community participation and decentralization. DPI's active involvement in this aspect of health promotion is an important factor if the policy and strategic orientation are to be effective, and part of the global strategy of coordination must include close working collaboration between DPI and other units in the Organization, in this field, to avoid duplication of efforts and ineffective, limited actions which might be initiated by units with little experience.

21. DPI will also work directly with PWRs, schools of journalism and journalists to develop adequate curricula as well as strengthen and expand the growing network of journalists reporting on health matters and issues by providing ready access to PAHO's information resources and support materials including publications, information sheets, press releases, photographs, graphic material and video footage.

22. Finally, in cooperation with other units in the Organization, DPI will develop video materials and source video programs and footage throughout the region in order to strengthen continuing education efforts for health personnel and to help provide needed information of use to the general public.

*SPECIFIC PROGRAMS*

Official and technical publications (HBP)

BIENNIAL TARGETS

23. The Publications Program, in partnership with other technical programs and divisions, will bolster the Organization's pursuit of strategic orientations and program priorities by selecting, editing, translating, producing, and disseminating information that is critical to health workers in the Region. The focus will be on what information there is; what areas of information are needed or in demand; what information should be developed, how, and in what form; how to get that information to target audiences/readerships; and how to strengthen national publishing activities.

24. The Distribution and Sales Unit has as its purpose to assure that the right publications get to the right people in time for them to be of use. Toward that end, the promotion of PAHO publications seeks out organizational opportunities consistent with PAHO/WHO's management-of-knowledge mission; identifies the specific target readership for new and existing publications, and ensures that a publication reaches those readerships, either through free distribution or through effective promotion.

LINES OF ACTION

25. Issuance of Official Documents: Annual and Quadrennial Reports of the Director (English and Spanish); Final Reports of Governing Body Meetings.

26. Issuance of periodicals: Boletín de la Oficina Sanitaria Panamericana (24 issues), Bulletin of the Pan American Health Organization (8 issues), Educación Médica y Salud (8 issues).

27. Issuance of Scientific & Technical Publications (40-50 titles); Communicating for Health Publications (10 titles).

28. Participation in meetings of the Governing Bodies (six editors/12 man weeks per year); and technical cooperation in biomedical writing through seminars in 6-8 countries.

29. Full implementation of the new, PC-LAN based, mailing list system and promotion of its use by Headquarters-based technical programs, PWRs and PAHO Centers. Inventory control and order processing components will be developed in 1993.

30. Implementation of a new policy on the distribution and sales of PAHO publications.

31. Expansion of the distribution lists for PAHO's two principal journals: "Boletín de la OPS" and "Bulletin of PAHO", and identification of new target readerships to expand the distribution of Scientific Publications, Technical Papers, and Official Documents.

32. Reprinting of publications as needed.

Public information (HBF)

BIENNIAL TARGETS

33. Establish an active network of journalists in each country throughout Latin America and the Caribbean.

34. Improve PAHO's regional information program to respond to the needs of the countries and the technical units, in collaboration with the PAHO/WHO Representatives and Centers.

35. Provide 60 minutes per week of educational and information material on video for use in continuing education for health personnel.

36. Provide 30 minutes of general public information material on health related matters and issues.

LINES OF ACTION

37. Work through the PWRs and pertinent Ministries to identify and work with interested journalists.

38. Provide direct access to pertinent PAHO publications and reports.

39. Issue bi-weekly backgrounders and information sheets on health issues and matters.

40. Provide access to an electronic BBS service.

41. Provide direct, professional support to social communications projects in the countries, to help create better health conditions.

42. Identify existing materials in Latin America and the Caribbean.

43. Identify Universities with adequate video facilities to work with in co-productions.

44. Identify interested producers and work together with Universities on co-production.

45. Work with the Asociación de Television Educative Iberoamericana to help disseminate programs throughout Latin America.

46. Identify and work with a similar partner to the Association in the English speaking Caribbean.

47. Identify other potential outlets for dissemination.

48. Help establish a network of television stations with which to work on content and distribution.

49. In cooperation with PWRs, Ministries and technical units, establish priority areas of interest.

50. Identify interested producers and funding partners.

51. Develop a weekly program initially in Spanish and eventually in English.

52. Work with the Asociación de Television Educativa Iberoamericana to help disseminate programs.

53. Identify and work with a similar partner in the English speaking Caribbean.

Language services (HBL)

BIENNIAL TARGETS

54. PAHO will continue cooperating in the exchange of validated scientific-technical health information among institutions in their languages. This will include both printed information in various forms, and oral exchange in different types of meetings dealing with policy and program matters, as well as scientific-technical subjects.

LINES OF ACTION

55. Activities in Language Services include translation and interpretation in the four official languages of the Organization as well as the operation and development of ENGSPAN and SPANAM in their PC versions.

Scientific and technical information dissemination (HBD)

BIENNIAL TARGETS

56. The PAHO HQ Library will continue coordinating efforts and resources to assure the health literature awareness of PAHO staff and to strengthen the development of an efficient bibliographic information system for the whole Organization including the preservation of the institutional memory. Its focus will be on:

57. Promoting reference services and the selective dissemination of information needed to sustain and enhance the technical competence of PAHO staff.

58. Efficient sharing of resources to avoid duplication of efforts, to assure proper indexing, and to lower costs.

59. Maximum utilization of its own resources and of those available from other information services and databases mainly in WHO, in the USA, and in the Region, by applying the latest technology available such as CD-ROM, full-text retrieval, etc.

60. Collaborating with all Technical Programs, BIREME, WHO, NLM, and other international organizations, especially those within the UN system.

LINES OF ACTION

61. To provide all PAHO professional staff ready access to current knowledge in their fields of competence and responsibility.

62. To offer a PAHO technical memory database as complete as possible with the full participation of all components of the internal PAHO/WHO Bibliographic Information System who will continue sharing the work of selecting, analyzing, processing and inputting information about their own documents and those considered essential for their daily work (not included in other databases) following standard procedures to facilitate its retrieval. Assurance of the quality control of the indexing process will continue to be coordinated by the PAHO HQ Library.

63. To continue coordinating the processing of bibliographic information with PAHO programs at HQ to ensure the following of a common methodology and the development of compatible bibliographic information databases, to advise in the search for the best possible solutions to their information problems, and to provide training. Collaboration and cooperation with BIREME will be strengthened so that maximum return can be gained from the Organization's investment of scarce and valuable resources in this area. Strong contacts with WHO and other national and international organizations will likewise be maintained and further developed.

## PROGRAM BUDGET DISTRIBUTION BY LOCATION

| LOCATION | PAHO AND WHO REGULAR BUDGET 1992-1993 | 1994-1995 | 1996-1997 | EXTRABUDGETARY FUNDS 1992-1993 | 1994-1995 | 1996-1997 |
|---|---|---|---|---|---|---|
| DIRECT COOPERATION WITH COUNTRIES | 396,400 | 856,800 | 965,700 | 420,200 | 0 | 0 |
| REGIONAL PROGRAMS | 9,016,000 | 9,678,700 | 10,525,800 | 455,700 | 148,700 | 159,000 |
| CENTERS | 1,029,100 | 1,430,200 | 1,575,000 | 1,298,900 | 900,000 | 900,000 |
| TOTAL | 10,441,500 | 11,965,700 | 13,067,500 | 2,174,800 | 1,048,700 | 1,059,000 |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL PROF. POSTS | PERSONNEL LOCAL POSTS | PERSONNEL CONS. DAYS | PERSONNEL AMOUNT | DUTY TRAVEL AMOUNT | FELLOWSHIPS MONTHS | FELLOWSHIPS AMOUNT | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| **1992-1993** | | | | | | | | | | | | |
| PAHO - PR | 7,088,000 | 19 | 24 | 95 | 5,330,700 | 201,000 | 12 | 24,000 | 144,600 | 311,500 | 0 | 1,076,200 |
| WHO - WR | 3,353,500 | 11 | 6 | 30 | 2,424,900 | 2,200 | 0 | 0 | 16,000 | 170,400 | 0 | 740,000 |
| TOTAL | 10,441,500 | 30 | 30 | 125 | 7,755,600 | 203,200 | 12 | 24,000 | 160,600 | 481,900 | 0 | 1,816,200 |
| % OF TOTAL | 100.0 | | | | 74.4 | 1.9 | | .2 | 1.5 | 4.6 | .0 | 17.4 |
| **1994-1995** | | | | | | | | | | | | |
| PAHO - PR | 7,852,200 | 17 | 25 | 110 | 5,710,300 | 213,400 | 15 | 30,000 | 550,900 | 390,700 | 0 | 956,900 |
| WHO - WR | 4,113,500 | 12 | 6 | 34 | 2,813,400 | 16,500 | 0 | 0 | 18,300 | 184,200 | 0 | 1,081,100 |
| TOTAL | 11,965,700 | 29 | 31 | 144 | 8,523,700 | 229,900 | 15 | 30,000 | 569,200 | 574,900 | 0 | 2,038,000 |
| % OF TOTAL | 100.0 | | | | 71.2 | 1.9 | | .3 | 4.8 | 4.8 | .0 | 17.0 |
| **1996-1997** | | | | | | | | | | | | |
| PAHO - PR | 8,604,900 | 17 | 25 | 110 | 6,227,800 | 234,700 | 15 | 30,000 | 624,800 | 435,100 | 0 | 1,052,500 |
| WHO - WR | 4,462,600 | 12 | 6 | 34 | 3,056,000 | 17,900 | 0 | 0 | 19,700 | 199,200 | 0 | 1,169,800 |
| TOTAL | 13,067,500 | 29 | 31 | 144 | 9,283,800 | 252,600 | 15 | 30,000 | 644,500 | 634,300 | 0 | 2,222,300 |
| % OF TOTAL | 100.0 | | | | 71.1 | 1.9 | | .2 | 4.9 | 4.9 | .0 | 17.0 |

## HEALTH SITUATION ANALYSIS

1. The radical transformations in the dynamics of development at the world level, largely as the result of the new advances in science and technology, on the one hand, and the economic, political and social changes in Latin America in recent years, on the other hand, have created a new context to orient science and technology policies in the Region. The development models prevailing up to the mid-1980s created a scenario that was not very encouraging for the development of science and technology, at the same time that imports in protected markets could be substituted and indeed were substituted, by importing knowledge and previously developed technologies, some of which were already obsolete, without any concern for maintaining competitive levels. The opening of markets, the transformations of the State, the reduction in the importance of cheap raw materials and labor, to cite only a few elements, mean that a new role for science and technology must be recognized in the dynamics of development and, consequently, there is a need for defining policies based on that new context.

2. Besides the challenges that are common to science and technology in general, there are other challenges in the health sector, such as the demands for knowledge arising from the particular way in which the processes of demographic and epidemiologic transition are occurring and the changes in the organization of health care. These demands are being placed upon a scientific community with little capacity to meet them, owing to its quantitative, theoretical, methodological and organizational limitations.

3. Besides organizational problems such as weakness in the production, distribution, and use of knowledge and the vulnerability caused by the fact that the State is traditionally the main or only financing and executing agent of research, scientific production in Latin America is limited, concentrated in a few countries, and, with rare exceptions, of unsatisfactory quality. In 1984 Latin America contributed only 1.14% of the articles recorded in the database of the Institute for Scientific Information (ISI) and only 0.6% of the bibliographic references, a level below that of countries such as Belgium or Israel. In addition to being limited and not very well known, this production is also quite concentrated, since between 1973-1984, barely five countries (Argentina, Brazil, Chile, Mexico and Venezuela) accounted for nearly 90% of all publications. This concentration became even more pronounced during the period, since in 1973 those five countries accounted for 87% and in 1984 91.3%.

4. These general characteristics are duplicated at the level of health research, including the concentration in a handful of countries. In a study carried out with PAHO support in six countries (Argentina, Brazil, Chile, Cuba, Mexico and Venezuela) on the characteristics of projects in progress (87-89) and scientific production (72-89) in the field of health the following characteristics were noted: the marked prevalence of the individual approach to problems (biomedical and clinical), as opposed to their study at the population level (more than 80% of the projects in progress are in the first category); the low level of development of research into technological innovation (between 5% and 6% of the projects); and the predominance of work in the medical and biological sciences (more than 90% of the projects in progress), with little participation by the social sciences and engineering, which is explained by the fact that most of the investigators are doctors or biologists.

5. Given the weaknesses noted in the situation of science and technology in general and health science and technology in particular, it is very difficult to spell out what is actually happening in these fields. There are several reasons for this, including the scope and rapidity of the changes that have occurred in the last two or three years, particularly in those sectors where the presence of the State is or was relevant; the fact that the existing scientific and technical information systems do not allow for monitoring that is sensitive to short-term changes; and the diversity of situations in the various countries. In some of them there has clearly been a rapid deterioration in the institutions and the working conditions of investigators, with a sharp increase in the "brain drain", both externally to other countries and internally to other activities of greater prestige or earning power. In other countries, however, there would seem to be indications of the appearance of greater diversity in sources and mechanisms for financing science and technology activities, such as for example the growth of consortia of universities and companies and a greater diversification of subjects and types of health research. The proliferation in some countries of nongovernmental organizations (NGOs), which are often of high scientific caliber and have strong ties abroad, seems to be another recent and significant phenomenon.

6. Knowledge of the process of development of health technology in the Region has been increasing gradually as a result of studies carried out in several countries on various aspects of that process, such as the characteristics of the productive sector and of the imports of health equipment and materials, as well as aspects of the dissemination, installation, utilization, maintenance, and coverage of the technology. Progress has also been made in knowledge of the instruments of technology policy, the regulatory instruments in particular.

7. These policy studies corroborate the existence, on the one hand, of significant installed capacity for developing and producing various technologies and, on the other hand, serious imbalances. Among the most significant ones are the imbalance between the needs and demands of the population and the geographical and systemic distribution of the technology, where serious inequities are apparent. Added to this inequity are various factors that lead to low effectiveness, such as poor allocation, deficient utilization, and frequent lack of basic care technologies. Wastefulness stemming from inappropriate investments, procurement, and facilities is a third large category of problems that persist. Problems are noted in the productive sector in the areas of marketing, certification of products, regulation and quality assurance, along with low investments in technological innovation. The gap between the productive sector and the academic sector limits the innovative dynamism that could result from associations between these sectors.

8. This mix of problems and opportunities presents a unique challenge for the implementation of a policy of health technology development, within the broader framework of a national science and technology policy. This challenge is beginning to be a matter of concern both within the health sector and at the more general level of national planning. Some promising efforts are also under way aimed at linking the public and private sectors and academia and industry and, in another dimension, advances have been noted in cooperation between countries in this field.

9. Few countries of the Region have the scientific and technological capacity for producing and controlling the biologicals that their people need. Efforts are being carried out in some of them with a view to achieving self-sufficiency in biologicals and promising results have been achieved. In the last few years those efforts have been impaired by the high cost of the investments required to operate and modernize the infrastructure. Indeed, the lack of linkage between production and dynamic development of the science and technology system is creating obsolescence in processes and products and consequently a loss of competitiveness and quality.

10. The tremendous scientific and technological advances achieved in areas such as molecular biology, immunochemistry, genetic engineering, microbiology and production processes have led to the development of new products and new quality and performance standards. These advances made it possible in 1990, at the World Summit for Children, to launch the Child Vaccine Initiative (CVI). Through this initiative, the world's scientific community is called upon to increase the spectrum of diseases that can be prevented by vaccination, improve the quality of existing vaccines, and reduce the costs of vaccination. Although most of the capability to respond to this call is in the developed countries, it is possible that, by strengthening their scientific and technological capacity, the developing countries could participate actively in the CVI.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

11. PAHO's general strategy for cooperation for the biennium 1994-1995 in the field of health science and technology is based on some of the new general policy guidelines for science and technology that are being developed in the Region. These include:

12. The concept of mastery of science and technology as the fulcrum of these policies, i.e., the development of the capacity to access and master knowledge wherever it may be found, overcoming the false dilemma of native knowledge versus imported knowledge;

13. Technical cooperation among countries as an element of regional integration for the development of knowledge and technologies of common interest;

14. The organization of an institutional science and technology system that will allow and promote the free flow of knowledge between the institutions producing and using it;

15. A new role for the State from the role of main executing and financing agent for research to a role that takes advantage of the State's ability to call upon the various actors to mobilize resources and promote consensus with regard to the paths to be followed.

16. It has been sought to define cooperation strategies that are consistent with these new general policies on science and technology, adding specific features relating to the health sector, which include:

17. Integration of technical and scientific development in health into the overall development of the societies of the Region (Health in Development);

18. Promotion of technical cooperation among countries as a way of strengthening their ability to access and develop the health knowhow and technologies that they need (TCDC);

19. Integration between the processes of production, distribution, and utilization of knowledge so that health research will address more adequately the challenges posed by the health situation (management of knowledge).

## SPECIFIC PROGRAMS

### Research promotion and development (RPD)

#### BIENNIAL TARGETS

20. Strengthening of the processes of organizing scientific activity in health;

21. Strengthening the health science and technology infrastructure;

22. Strengthening and coordinating the technical cooperation of the various units of PAHO/WHO in the area of health science and technology.

#### LINES OF ACTION

23. Monitoring and analyzing the health research situation;

24. Strengthening the national agencies engaged in defining policies and managing health science and technology;

25. Training of researchers in priority areas;

26. Dissemination of scientific and technical information;

27. Support for the preparation of research projects in priority areas;

28. Financial support for research projects in priority areas;

29. Mobilization of national resources, including the designation of Cooperating Centers;

30. Strengthening the mechanisms of coordination of cooperation activities in health research of PAHO/WHO and its advisory bodies, particularly the Advisory Committee on Health Research (ACHR), the Advisory Subcommittee on Biotechnology, the Advisory Subcommittee on Research on Health Systems and Services, the Internal Advisory Committee on Research (IACR), and the Ethics Committee.

Health technology policies and development (HDT)

BIENNIAL TARGETS

31. Promote the execution the projects of technical cooperation among countries for health technology development negotiated under Project CONVERGENCE.

32. Develop mechanisms of technical cooperation among countries to prepare and execute the health technology development projects negotiated under Project CONVERGENCE.

33. Strengthen the joint leadership capacity of the countries to coordinate the processes of technological development and to harmonize the instruments of pertinent policies aimed at gradual regional integration.

LINES OF ACTION

34. Promote the execution of TCDC projects for health technology development in the areas of: vaccines for human use; medical devices; medicinal plants; ortheses, prostheses and rehabilitation; biologicals; blood products; oral health technology; workers' health technology; environmental health technology; and other projects.

35. Develop the TCDC mechanisms for health technology development, aimed at facilitating: interrelationships, exchange of information and negotiations between institutions; marketing and development of productive capacity; research, development and technological innovation; design and execution of TCDC projects and mobilization of national and international resources; interagency coordination.

36. Strengthen joint leadership by: promoting consortiums, associations and networks for cooperation between institutions of various countries; promoting activities for the evaluation of technology and quality management processes; supporting training in strategic planning and technological management; strengthening the processes of analysis of technology policies and health technology planning and forecasting.

Research and development in the field of vaccines (RDV)

BIENNIAL TARGETS

37. Strengthening the science and technology capacity in the countries of the Region for the development of vaccines through the implementation of the Regional System for Vaccines (SIREVA).

38. Strengthening the capacity for quality control of vaccines in the existing laboratories in the Region.

39. Improvement of the vaccine production processes in the existing laboratories through the application of good manufacturing practices (GMP).

LINES OF ACTION

40. Implementation of SIREVA

41. Training in GMP of the staff of the laboratories producing biologicals.

42. Training of personnel in techniques and processes of quality control.

## PROGRAM BUDGET DISTRIBUTION BY LOCATION

| LOCATION | PAHO AND WHO REGULAR BUDGET 1992-1993 | 1994-1995 | 1996-1997 | EXTRABUDGETARY FUNDS 1992-1993 | 1994-1995 | 1996-1997 |
|---|---|---|---|---|---|---|
| DIRECT COOPERATION WITH COUNTRIES | 2,990,000 | 3,202,400 | 3,448,000 | 2,677,400 | 0 | 0 |
| REGIONAL PROGRAMS | 1,467,400 | 1,704,200 | 1,849,700 | 56,000 | 60,000 | 64,500 |
| TOTAL | 4,457,400 | 4,906,600 | 5,297,700 | 2,733,400 | 60,000 | 64,500 |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL PROF. POSTS | PERSONNEL LOCAL POSTS | PERSONNEL CONS. DAYS | PERSONNEL AMOUNT | DUTY TRAVEL AMOUNT | FELLOWSHIPS MONTHS | FELLOWSHIPS AMOUNT | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 3,916,300 | 5 | 3 | 1115 | 1,537,700 | 166,200 | 5 | 10,000 | 242,900 | 73,600 | 1,693,600 | 192,300 |
| WHO - WR | 541,100 | 1 | 1 | 95 | 273,200 | 5,800 | 15 | 30,000 | 87,000 | 74,300 | 0 | 70,800 |
| TOTAL | 4,457,400 | 6 | 4 | 1210 | 1,810,900 | 172,000 | 20 | 40,000 | 329,900 | 147,900 | 1,693,600 | 263,100 |
| % OF TOTAL | 100.0 | | | | 40.6 | 3.9 | | .9 | 7.4 | 3.3 | 38.0 | 5.9 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 4,211,100 | 5 | 3 | 1173 | 1,784,700 | 179,800 | 5 | 10,000 | 248,300 | 58,700 | 1,691,300 | 238,300 |
| WHO - WR | 695,500 | 2 | 1 | 54 | 522,100 | 0 | 15 | 30,000 | 87,100 | 33,200 | 0 | 23,100 |
| TOTAL | 4,906,600 | 7 | 4 | 1227 | 2,306,800 | 179,800 | 20 | 40,000 | 335,400 | 91,900 | 1,691,300 | 261,400 |
| % OF TOTAL | 100.0 | | | | 47.0 | 3.7 | | .8 | 6.8 | 1.9 | 34.5 | 5.3 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 4,538,800 | 5 | 3 | 1173 | 1,908,200 | 194,600 | 5 | 10,000 | 271,800 | 64,000 | 1,829,500 | 260,700 |
| WHO - WR | 758,900 | 2 | 1 | 54 | 566,300 | 0 | 15 | 30,000 | 98,800 | 37,600 | 0 | 26,200 |
| TOTAL | 5,297,700 | 7 | 4 | 1227 | 2,474,500 | 194,600 | 20 | 40,000 | 370,600 | 101,600 | 1,829,500 | 286,900 |
| % OF TOTAL | 100.0 | | | | 46.7 | 3.7 | | .8 | 7.0 | 1.9 | 34.5 | 5.4 |

## HEALTH SITUATION ANALYSIS

### Demography

1. Existing information shows that the nutritional situation in the Americas is undergoing change. On one hand, there has been a well-defined decline in protein-energy malnutrition in certain countries, although it has remained stationary in others. Despite this apparent overall reduction, there remain foci of poverty and social marginality in which the prevalence of malnutrition continues to be two or three times higher than national averages.

2. Low birthweight, a retrospective indicator of pregnant women's nutritional status and a predictor, up to a certain point, of the future nutritional status and development of children, varies widely, from 16.6% in Guyana and 15.0% in Haiti and Ecuador to 5.7% in Chile and Costa Rica.

3. The prevalence of overall malnutrition in the Region (weight for age more than two standard deviations below the reference standard adopted by WHO for children under age 5) varies notably from around 2% in certain countries of the English-speaking Caribbean and Costa Rica to 38.5% in another Central American country. According to projections of the under-age-5 population in the Region, it is estimated that approximately 12% of the children in that age group are undernourished, which means that more than 7 million children in Latin America and the Caribbean suffer from moderate or severe malnutrition.

4. On the other hand, while the prevalence of chronic malnutrition (low height-for-age) is two or three times more than overall malnutrition, acute malnutrition (low weight-for-height) has generally very moderate rates.

5. An increase has been observed in the prevalence of overweight and obesity, which is not just limited to the society's affluent classes; in fact, it is greater in the lower-middle and low economic classes, and it is more marked among women. Concomitantly, there has been an increase in mortality and possibly in the incidence of some chronic diseases related to diet and nutrition, such as some cardiovascular diseases and types of cancer.

6. Recently, the importance of "hidden malnutrition" in the development and well-being of the population is becoming increasingly recognized. Deficiencies of certain micronutrients (iron, iodine, and vitamin A) are now known to play a more important role than was believed, even in conditions of moderate deficiency. The effects of iodine deficiency disorders in countries where this deficiency has persisted for years as an endemic problem (Bolivia, Ecuador, and Peru) are well known, and the disorders have been found in geographical areas in other countries where the situation was controlled. The latter is due mainly to noncompliance with legislation regulating the use of iodine-enriched salt.

7. While there are few reported cases of clinical symptoms of vitamin A deficiency, there is evidence of moderate deficiency, which has implications for resistance to diarrheal and respiratory diseases and may contribute to infant mortality in the poorest countries of the Region.

8. Iron deficiency anemia is a serious problem in all the countries of the Region. It is estimated that around 60% of pregnant women suffer iron deficiency anemia. Although there are programs for supplementation with iron compounds in almost all the countries, their effectiveness is doubtful.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

9 In general, the global strategy for technical cooperation of the Food and Nutrition Program is directed toward collaborating with governments in the identification, adaptation, development, application, and evaluation of appropriate methods to promote, achieve, and maintain an optimum nutritional status in the entire population of the Region.

10. Within this broad global strategy there are a series of components closely related to the strategic orientations of PAHO for the period 1993-1994. These are:

11. To encourage countries to include three criteria for the implementation of their plans: incorporation of nutritional objectives in policies and in the national and sectoral development plans; interventions related to nutrition in various sectors; development of community action for nutritional improvement.

12. To cooperate in the formulation and development or reinforcement of a suitable and realistic national nutrition plan in each country.

13. To support the development and strengthening of the Food and Nutrition Surveillance Systems (FNSS).

14. To support the strengthening of national technical capability to formulate, carry out, and evaluate programs designed to improve the availability of food, adequate intake, and biological utilization.

15. To review food and nutrition curricula in health science schools.

16. To promote dietary habits that will help to prevent chronic noncommunicable diseases.

17. To give technical support to programs directed toward reducing protein-energy malnutrition, such as hospital treatment of severe malnutrition and community-based treatment of moderate malnutrition.

18. To control deficiencies of iron, iodine, and vitamin A through multisectoral strategies that include food enrichment, specific supplements, and an increase in the availability of appropriate food.

19. To promote the strengthening of food and nutrition institutional services and the dietary management of obesity, diabetes, and cardiovascular diseases.

20. To support institutional and operational strengthening directed toward the formulation of policies and strategies that will focus interventions in the area of nutrition and food security on high-risk groups and the poorest sectors of society.

Food (FOO)

BIENNIAL TARGETS

21. To strengthen communication and education in food and nutrition through 1) personnel training, 2) in-service education of personnel, 3) community education, and 4) preparation of educational teaching material.

22. To compile and use information on those factors that condition community knowledge, attitudes, and practices concerning food and nutrition, including community participation as an indispensable component of both the planning and execution of programs.

23. To establish coordinating mechanisms in order to promote and integrate activities to combat micronutrient deficiencies (iron, iodine, and vitamin A) and strengthen the countries' capacity to attain the target of eliminating iodine deficiency disorders and hypovitaminosis A by the year 2000.

24. To promote the targeting of food distribution programs on the most vulnerable groups.

LINES OF ACTION

25. Support for the processes of planning, education, training, and utilization of human resources in food and nutrition.

26. Development of research and training activities for personnel at the local level.

ANALYSIS OF THE PROGRAMS

27. Formulation and implementation of strategies for the control of iodine deficiency disorders.

28. Support for the integration of national plans to combat micronutrient deficiencies.

29. Promotion of the formulation and execution of policies, plans, and programs for food distribution, ensuring the participation of diverse sectors in all stages, from program conception to execution and evaluation.

Nutrition (NUT)

BIENNIAL TARGETS

30. To support the development of national food and nutrition plans with a multisectoral scope and community participation.

31. To strengthen food and nutrition surveillance and promote its use in planning and programming in the countries.

32. To formulate criteria for the preparation of dietary guidelines for children under age 5.

33. To promote the use of indicators for monitoring pregnant women's nutritional status.

34. To promote and support operational research projects on diet and physical exercise in chronic non-communicable disease prevention.

35. To strengthen communication and education in food and nutrition through 1) personnel training, 2) in-service education of personnel, 3) community education, and 4) preparation of educational teaching material.

36. To compile and use information on those factors that condition community knowledge, attitudes, and practices concerning food and nutrition, including community participation as an indispensable component of both the planning and execution of programs.

37. To establish coordinating mechanisms in order to promote and integrate activities to combat micronutrient deficiency (iron, iodine, and vitamin A) and strengthen the countries' capacity to reach the target of eliminating iodine deficiency disorders and hypovitaminosis A by the year 2000.

38. To promote the targeting of food distribution program on the most vulnerable groups.

LINES OF ACTION

39. Expansion and continuous updating of the HPN data base, and regular dissemination of information to the entire Region. Manpower training in food and nutrition surveillance, with emphasis on information management for planning, programming, and evaluation.

40. Technical cooperation to the countries to strengthen food and nutrition surveillance systems.

41. Development of sentinel sites in order to supplement information received by regular areas.

42. Development of research to evaluate and program forecasting models in countries that require it.

43. Formulation and dissemination of food and nutrition guidelines for children under age 5.

44. Standardization of the evaluation of pregnant women's nutritional status.

45. Promotion of breast-feeding and the International Code of Marketing of Breast-milk Substitutes.

46. Evaluation of the current situation and the diet-related risk factors for non-communicable chronic diseases.

47. To propose and evaluate interventions relating to dietary measures and physical exercise in order to prevent NCDs.

48. Support for the processes of planning, education, training, and utilization of human resources in food and nutrition.

49. Development of research and training activities for personnel at the local level.

50. Formulation and implementation of strategies for the control of iodine deficiency disorders, hypovitaminosis A, and iron deficiency anemia.

51. Support for the integration of national plans to combat micronutrient deficiencies.

52. Promotion of the formulation and execution of policies, plans, and programs of food distribution, ensuring the participation of diverse sectors in all stages, from program conception to execution and evaluation.

PROGRAM BUDGET DISTRIBUTION BY LOCATION

| LOCATION | PAHO AND WHO REGULAR BUDGET 1992-1993 | 1994-1995 | 1996-1997 | EXTRABUDGETARY FUNDS 1992-1993 | 1994-1995 | 1996-1997 |
|---|---|---|---|---|---|---|
| DIRECT COOPERATION WITH COUNTRIES | 1,409,100 | 1,415,000 | 1,547,300 | 501,400 | 0 | 0 |
| REGIONAL PROGRAMS | 808,200 | 853,800 | 926,800 | 55,200 | 70,500 | 77,400 |
| CENTERS | 5,148,300 | 5,354,200 | 5,953,400 | 15,250,800 | 14,809,000 | 14,795,000 |
| TOTAL | 7,365,600 | 7,623,000 | 8,427,500 | 15,807,400 | 14,879,500 | 14,872,400 |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL PROF. POSTS | PERSONNEL LOCAL POSTS | PERSONNEL CONS. DAYS | PERSONNEL AMOUNT | DUTY TRAVEL AMOUNT | FELLOWSHIPS MONTHS | FELLOWSHIPS AMOUNT | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 5,462,200 | 11 | 3 | 585 | 4,171,800 | 382,200 | 27 | 54,000 | 225,900 | 226,000 | 12,700 | 389,600 |
| WHO - WR | 1,903,400 | 5 | 3 | 320 | 1,417,400 | 45,800 | 2 | 4,000 | 100,700 | 37,800 | 0 | 297,700 |
| TOTAL | 7,365,600 | 16 | 6 | 905 | 5,589,200 | 428,000 | 29 | 58,000 | 326,600 | 263,800 | 12,700 | 687,300 |
| % OF TOTAL | 100.0 | | | | 75.9 | 5.8 | | .8 | 4.4 | 3.6 | .2 | 9.3 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 5,610,200 | 9 | 3 | 622 | 4,070,000 | 375,300 | 33 | 66,000 | 251,300 | 195,200 | 13,300 | 639,100 |
| WHO - WR | 2,012,800 | 4 | 3 | 356 | 1,406,300 | 48,500 | 8 | 16,000 | 93,300 | 42,700 | 0 | 406,000 |
| TOTAL | 7,623,000 | 13 | 6 | 978 | 5,476,300 | 423,800 | 41 | 82,000 | 344,600 | 237,900 | 13,300 | 1,045,100 |
| % OF TOTAL | 100.0 | | | | 71.8 | 5.6 | | 1.1 | 4.5 | 3.1 | .2 | 13.7 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 6,205,400 | 9 | 3 | 622 | 4,488,200 | 417,500 | 33 | 66,000 | 279,400 | 219,300 | 14,400 | 720,600 |
| WHO - WR | 2,222,100 | 4 | 3 | 356 | 1,536,500 | 55,000 | 8 | 16,000 | 105,800 | 48,300 | 0 | 460,500 |
| TOTAL | 8,427,500 | 13 | 6 | 978 | 6,024,700 | 472,500 | 41 | 82,000 | 385,200 | 267,600 | 14,400 | 1,181,100 |
| % OF TOTAL | 100.0 | | | | 71.4 | 5.6 | | 1.0 | 4.6 | 3.2 | .2 | 14.0 |

## HEALTH SITUATION ANALYSIS

1. The United Nations Conference on Environment and Development (UNCED), held in Brazil (June 1992), underscored unequivocally the direct relationship between the quality of the environment and the quality of human life. It was shown that the good health situation and the longevity found in the so-called "developed" countries are basically the product of good environmental conditions. The economic development model applied in the Region exploits natural resources for the purpose of creating wealth and security. This exploitation alters the characteristics of both the physical environment and the social environment, and the changes can be positive or negative, but they are rarely equitable.

2. Traditionally the least well-off population groups bear the greatest part of the burden of negative environmental impact. In addition, under the applied development model, the great majority of countries in the Region are in a very special situation in that they must deal with both environmental risks typical of a lack of development and risks that are a consequence of the pattern of consumption characteristic of the economically developed countries.

3. For the health sector of the Region's countries, UNCED represents an urgent call for the sectoral and institutional development that will make it possible for the sector to perform adequately its leadership and support functions for the achievement of sustained development for health. The broad scope of Agenda 21 and the other commitments undertaken during UNCED are important mandates for the health sector in all countries. In this sense, the public health authorities are considered part of the health sector, as are all institutions and all individuals involved in health promotion and in the prevention and treatment of disease. Accordingly, the sector includes all ministries of health, public and private institutions geared toward health-service-related teaching and research, volunteer and professional health workers, hospitals, pharmacies, and laboratories (private or governmental), and a series of other resources that contribute to health in various ways. It is expected that all of these components of the national health sectors, as well as the international communities that support national efforts, will make a substantial contribution to the achievement of the targets and the objectives enunciated in Rio.

4. To that end, it is fundamental that development projects and processes throughout the world be formulated or reoriented so that they are sustainable. In other words, satisfaction of the needs of the current generation through demands on the environment should not jeopardize satisfaction of the needs and quality of life of future generations. Thus, it is urgent that the health sector become an active participant in the process of decision-making on development projects and processes.

5. All of this represents essentially a new function for the health sector--a function for which, in general, it is not adequately prepared. It will be necessary for the specialized and general personnel of the health sector to support those responsible for the formulation of political, economic, and social plans so that they may make more appropriate decisions and become aware of the consequences of the various development options on health. Defending the position of "development for health" will become one of the principal functions of the health sector.

6. Health promotion and protection activities can become an integral part of economic development when they offer equitable access, inter alia, to water, housing, and food and when they promote education, minimize exposure to environmental health hazards, and promote the improvement of social conditions. This is one of UNCED's effects on the health sector. It is necessary to establish or strengthen health and environmental policies that follow a holistic approach to health problems and that are interrelated with other national sectors. Having common policies would also mean sharing strategies and principles for the promotion of socioeconomic development in the rural, periurban, and urban areas. In this context, decentralization and coordination become basic principles. This is another important consequence of UNCED for the health sector, and considerable effort is required to educate and train communities to solve health and environmental problems from the standpoint of prevention and correction.

7. A third consequence has to do with the participation of the health sector in the process of decision-making on alternative development proposals. In order to perform this function fully, the health sector will have to improve its ability to carry out epidemiological studies and surveillance of environmental health hazards, as well as to make forecasts and assessments of their repercussions on health.

8. The fundamental consequences mentioned above require an additional effort on the part of the health sector in the spheres of personnel training; furtherance of research; establishment of guidelines, standards, and laws; and dissemination of information.

9. Many countries of the Region continue to present a health profile in which diarrheal and parasitic diseases contribute significantly not only to morbidity but also to the mortality of the population in general, particularly among the most vulnerable groups such as children and the elderly. The cholera epidemic has revealed the precariousness of basic health conditions in the Region. It is estimated that as a consequence of the insubstantial investments made during the past decade, at this time there are 130 million people who do not have drinking water, mainly in the rural and marginalized urban areas. In addition, there are only a few public water supply systems that meet quality, quantity, and continuity requirements. Monitoring and quality control services are few and limited in scope. Only 49% of the population of the Region has access to wastewater disposal services. Moreover, less than 10% of the volume of wastewater receives any type of treatment before its final disposal. Consequently, approximately 40 million cubic meters of sewerage drain daily into the riverbeds and seas of the Region, and in Latin America more than 400,000 hectares of agricultural land are irrigated directly with untreated wastewater. There are few countries that currently have adequately developed water and sanitation sectors and institutions. This translates into inefficiencies and a lack of credibility vis-à-vis the population in general, as well as extensive waste and inefficient use of water.

10. In most countries of the Region, the problem of solid waste has become worse in recent years as a consequence of population growth in urban centers and in marginal urban areas. This situation is influenced by a generalized trend toward the decentralization of responsibilities to the municipal level, without the corresponding promotion of needed institutional and technical development. Solid waste from hospitals is handled in almost all the countries of the Region like common household waste. Hence, there is a whole series of problems and deficiencies in the processes of collection, treatment, and final disposal of waste.

11. Deficiencies in human settlements and housing conditions, mainly in the rural and urban fringe areas, contribute significantly to the prevalence of certain vector-borne diseases and acute respiratory infections. In addition, these deficiencies have a major influence on the degradation of the quality of family life. The intersectoral coordination required to be able to manage the health issues in housing is lacking in most of the governmental programs.

12. The environmental imbalances resulting from development processes and projects have increased the potential for an ever-increasing segment of the population to be exposed to a series of health risks of a physical and chemical nature. Growth and industrial diversification in the Region have given rise to an increase in the production of hazardous waste, which poses a risk to human health. Improperly handled and treated, this waste has been a source of water and air pollution, as well as a cause of technological accidents. This increasing use of potentially dangerous chemical substances in industry and at home poses a significant risk for the health, well-being, and property of the people. In most of the countries, there is not sufficient institutional, technological, and human capacity to handle these situations adequately at this time. The level of academic development and research is in general insufficient, which is the reason for the frequent importation of environmental quality standards from outside the countries and the application, without adaptation, of evaluation and monitoring methodologies. At this time, the current institutional, legal, and human resource capacities of the countries are in general insufficient for dealing with the most significant problems in both occupational and household environments. In this context, the nearly indiscriminate use of pesticides in industry and in households continues to be a very important problem, owing to the number of cases of acute poisoning and the delayed and chronic effects that occur in the population. The problem of urban air quality has also become increasingly serious in recent years. According to GEMS-Aire, in 1990, 6 cities of the Region were included among the 20 megacities of the world with serious air quality problems.

13. Generally speaking, the population has succeeded in significantly raising its level of knowledge about the relationship between environmental quality and the quality of life. In this sphere, mass communication has been very effective in all countries of the Region. For this reason, it is urged that the necessary knowledge and information be made available to communities and individuals so that they may participate in identifying and solving environmental problems. Community participation and the action of nongovernmental organizations are of fundamental importance for the implementation of environmental primary health care in the Region.

14. The Strategic Orientations and Program Priorities call for the improvement of programs for the protection and care of the health of workers, in both the formal and informal sectors, through improved coordination among the social groups and institutions concerned with this problem. This priority has been reiterated through Resolutions XIV of the XXIII Pan American Sanitary Conference and XXII of the XXXVI Meeting of the Directing Council of PAHO-WHO. The health of workers--especially young workers, working women, and informal-sector workers--deserves special attention considering their vulnerability in the face of changes in the structure and dynamics of labor markets. However, programs for the protection and maintenance of workers' health under Ministries of Health and Labor, social security institutions, and businesses are extremely fragmented. Moreover, these programs do not always take a preventive approach, and they often fail to cover precisely the categories of workers who most need their benefits. Accordingly, promotional efforts are needed in order to foster the expansion and strengthening of workers' health programs as an integral part of the efforts that are being made to place the Region in a competitive position in the changing world economy.

15. The working-age population in the Region makes up more than 50% of the total population. Workers are exposed to accidents, occupational illnesses, and other pathologies that may result in disability and premature death, with the ensuing consequences for production, well-being, and development. The suffering and costs, both direct and indirect, generated by these problems have led the countries to emphasize their prevention through control of work-related risk factors, health promotion, and other strategies geared toward the maintenance of well-being and productive capacity.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

16. UNCED and the movements to which it has given rise are contributing substantially to ensure that political and community leaders are increasingly aware that mere provision of access to appropriate medical technologies is not enough to counterbalance the negative effects of environmental degradation, and that good health will still be far out of reach for millions of people as long as the environments in which they live do not offer the minimum acceptable conditions for the promotion of life. HPE will seek to bolster these UNCED follow-up movements in order to take advantage, in support of the countries, of the resources and orientations they are generating at the regional and global levels. This strategy will be fully consistent with that proposed in the Ninth General Program of Work.

17. In addition, the strategy of HPE will be to facilitate and strengthen the ties that are necessary, at the national and local level, for the effective development of environmental health activities. In the Region actions with bearing on the physical environment and the social environment are being promoted by authorities in the areas of agriculture; industry and work; housing and public works; water and sanitation; education and communication; social welfare; energy generation and transportation; administration of natural resources; and, obviously, public health. For this reason, there will be cooperation with all these authorities, utilizing whenever possible coordination with other units of PAHO and with the appropriate Collaborating Centers. In terms of strengthening its internal capacities, the HPE Division will focus its regional support for the

countries on three major areas of specialization: The Pan American Center for Human Ecology and Health (ECO) will continue to concentrate its technical capability in the areas of forecasting, identification, and evaluation of environmental health hazards; the Pan American Center for Sanitary Engineering and Environmental Sciences (CEPIS) will continue its efforts to support the countries in the control of duly identified and assessed environmental risks; and the HPE/Washington technical group will continue to lend its support to the countries in matters of sectoral and institutional strengthening, as well as in the mobilization of resources. These three groups will mobilize, in a coordinated fashion, the capacities of the Collaborating Centers and of WHO/Geneva.

18. For the period 1994-1995 HPE proposes to support the countries through health and environmental actions in two major areas: basic sanitation (HES) and the environmental quality (HEQ).

19. In basic sanitation, the area of greatest concentration will continue to be drinking water quality, ranging from the protection of sources to household storage, proposed in the Five-year Plan for Water Quality. To that end, support will be intensified for the countries in the adoption of quality standards, as well as in the operationalization of systems for the monitoring and control of chemical and microbiological quality. The protection of sources will be accomplished through river basin management. For this purpose, associations will be sought with other regional agencies, mainly the OAS, ECLA, and UNEP, which will contribute specific capacities in their specialties. The efficient use of water will continue to be a matter of central concern. To that end, work will be carried out for the institutional development of agencies responsible for water supply. In addition, mechanisms and methodologies will be implemented which allow for the utilization of mass communication and community participation in the context of local health systems.

20. The promotion of coverage of water, sanitation, and urban sanitation services will be one of HPE's most important actions and one that is completely integrated into the framework of the Regional Plan for Investment in the Environment and Health. The execution of this plan will become the highest priority of the Division, requiring full installed capacity at the regional level and at the country level. To that end, the work of preparing and updating the sectoral and institutional analyses will be continued as will the identification, preparation, and execution of investment projects, both for physical works and for the development of institutions and their resources. The fundamental strategy in these efforts will be to promote alliances with the development banks and with bilateral and multilateral agencies that are committed to supporting the health sector through water and sanitation projects. During the biennium special attention will be given to the development and integration of water, sanitation, and solid waste projects in programs for social and economic development in marginal urban areas, rural areas, indigenous communities, and tourist areas. This will make it possible to focus actions on high-risk groups and integrate all segments of the community into primary environmental health care.

21. With regard to environmental quality, in accordance with Resolution XI of the XXIII Pan American Sanitary Conference, the Environmental Health Program will support the strengthening and development of national capacities in the areas of environmental epidemiology, information management, administration and development of human resources, intersectoral coordination, and mobilization of the communities in order to facilitate the formulation and application of policies and programs appropriate to the protection of human health from environmental risks. In addition, there will be close cooperation with the health agencies and agencies of national development to ensure that the population and the various sectors, especially the industrial sector, may better perceive and understand the health hazards caused by environmental deterioration. Special attention will be given to the quality of work environments, as a part of the process of follow-up to the 1992-1993 campaign for the promotion of workers' health. Mass communication should serve as an important tool in several actions in this field.

22. An important activity in the area of environmental quality will be to collaborate with the Member Countries in the fulfillment of the commitments they made with regard to health and environment under Agenda 21 at UNCED. PAHO/HPE will play an important catalytic role in promoting inter- and multi-country activities and in building a Regional consensus on issues of health and environment. Many of these activities will occur in the framework of the Regional Plan for Investment in the Environment and Health, and to that end, intensive action will be taken for the identification, formulation, and execution of projects for the control of environmental pollution.

23. Another important line of action for the Program will be to support government agencies and nongovernmental organizations in strengthening community participation in the identification and resolution of environmental problems. Whenever possible, this participation will occur in the framework of the local health systems and of the "Healthy Municipios" initiative, always in the spirit of primary environmental health care.

24. During the biennium, the Health and Environment Division will promote the education of human resources to assume leadership roles within the field of environmental health so that they can participate actively in decision-making on development programs and projects and ensure that health issues are taken into account. In addition, the Division will work hard to ensure that those concerned with environmental health in the countries make better use of the specialized information systems that already exist at the regional and world levels, contributing data and information and using them as a basis for managerial and policy decision-making processes.

## SPECIFIC PROJECTS

### Public water supply and sanitation services (CWS)

#### BIENNIAL TARGETS

25. To promote in each country of the Region the expansion of supply services and the rehabilitation of existing systems, within the framework of the Regional Plan for Investment in the Environment and Health, to which end the performance of sectoral studies and the identification and formulation of the corresponding projects will be promoted.

26. To promote in each country the strengthening of sectoral and institutional capacity for the management of water supply and sanitation systems.

27. To reduce the absolute number of people who do not yet have safe water supply and sanitation services, mobilizing for this purpose the local strategic administrative capacity.

28. To support all countries in the implementation of a program for ensuring the quality of water for human use, to which end the development of corresponding policies, plans, and standards will be promoted.

29. To promote in all countries the treatment and reuse of wastewater of household origin, including the establishment of demonstration and training centers.

30. To promote and support in all the countries of the Region the training of sanitary engineers and sanitation technicians, including the preparation and dissemination of the corresponding instructional materials.

31. To expand REPIDISCA to the countries of the English Caribbean, and to strengthen the capacity of the integrated centers in terms of human resources and equipment.

32. To promote the concepts and methodologies for the efficient use of water, including in this regard the standardization of materials and equipment.

LINES OF ACTION

33. To formulate and carry out a Five-year Plan for Drinking Water Quality that will include actions for the protection of sources; production and distribution; disinfection; monitoring and quality control; analytical control of the laboratories; and organization and maintenance of qualitative information systems.

34. To promote, support, and implement in all the countries the Regional Plan for investment in the Environment and Health supporting the specific activities necessary based on the situation of each country and building alliances with the development banks and with other agencies of external support.

35. To promote and carry out sectoral and institutional development projects in coordination with the appropriate authorities in the countries and with agencies of international cooperation.

36. To collect, adapt, and distribute technical-scientific information, utilizing electronic media as much as possible.

37. To promote and organize courses and programs for the training and education of specialized human resources, as well as the production of appropriate instructional materials.

38. To strengthen and intensify the utilization of the Collaborating Centers specializing in water and sanitation.

Solid wastes and housing hygiene (RUD)

BIENNIAL TARGETS

39. To promote the institutional and technological development of urban services for solid waste management, including the formulation of policies, plans, and standards at the central level and at the municipal level.

40. To promote and support the development of low-cost technologies for the management of solid waste in special urban areas.

41. In the context of the Regional Plan for Investment in the Environment and Health, to promote an increase in the amounts of financial investment in the urban and public sanitation sector.

42. To promote the incorporation of public health and environmental standards into programs and projects for the construction and refurbishing of urban and rural dwellings.

43. To promote and support the formulation of national policies, plans, and standards for the management of hospital waste and other types of solid waste requiring special handling.

LINES OF ACTION

44. To prepare and disseminate guidelines and methodologies for the formulation of national plans and policies on solid waste, including the participation of the private sector in services.

45. To promote technologies and methodologies for the management of hospital waste and other types of waste requiring special handling.

46. To promote and support the education and training of human resources for the proper sanitary handling of solid wastes and sanitation in dwellings.

47. To collect, to adapt, and disseminate technical-scientific information about solid waste and sanitation in dwellings.

Control of environmental health hazards (CEH)

BIENNIAL TARGETS

48. To promote in each country of the Region the actions entrusted to the health sector under the National Plans of Action for Sustainable Development, as commitments undertaken at UNCED, supporting for this purpose any intersectoral actions that may be required.

49. To strengthen the Environmental Health Departments of the Ministries of Health, so that they will have human resources and appropriate information for intersectoral action to protect human health from environmental and occupational hazards.

50. To adapt and transfer technologies and methodologies for the evaluation and control of environmental risks to human health.

51. To support the formulation of sectoral analyses and environmental profiles in all countries, using for this purpose the methodologies prepared in the framework of the Regional Plan for Investment in the Environment and Health.

52. To support the implementation and execution of programs for environmental protection within local health systems.

53. To promote the program on chemical safety as well as the program for prevention of and preparedness for chemical emergencies in the countries of the Region.

LINES OF ACTION

54. To support the formulation and execution of programs and institutional and technological development projects by the environmental health units of the Ministries of Health, including laboratory analysis capacity and information management capacity.

55. To strengthen and intensify the use of the capacity of the Regional technical cooperation centers in specific and priority areas for environmental health management.

56. To promote technical cooperation among countries (TCC) in the priority areas of evaluation and control of environmental risk factors.

57. To support the strengthening of the mechanisms for human resources education at all levels, in addition to adapting and disseminating specialized technological knowledge, including, inter alia, epidemiology and environmental toxicology, environmental engineering, mass communication in environmental health, and environmental economics.

58. To promote the incorporation of environmental protection programs into local health systems and the utilization of mass communication to increase community participation in the identification and solution of environmental problems at the local level.

Worker's health (OCH)

BIENNIAL TARGETS

59. Promotion and support for the countries in the application of the program lines of action indicated in Resolutions CSP23.R14 and CD36.R22 on workers' health, through the planning, organization, and adaptation of occupational health programs and services in the framework of the National Plans for the Development of Workers' Health.

60. Fulfillment of the Plan of Action of the Initiative for the Development of Workers' Health, geared toward encouraging collective interest and political will with a view to vitalizing and extending the coverage of occupational health programs and services.

61. Cooperation with the countries in the review and updating of their workers' health policies, taking into account the formal and informal sectors, and giving priority to less protected, unprotected, more vulnerable, and high-risk groups of workers.

LINES OF ACTION

62. Development and strengthening of the national capacities for planning and management in workers' health, including the organization of responsibilities, the articulation of actions, the formulation of intersectoral and participatory national plans, the inclusion of occupational health in local health systems as a part of primary health care, and the fostering of mechanisms of cooperation that are conducive to the incorporation of existing potentials into programs of health, work, social security, trade associations, labor organizations, nongovernmental organizations, and the community.

63. Mobilization and optimization of internal and external resources in order to extend occupational health coverage to high-risk and underserved groups of workers, while favoring institutional strengthening and the development of human resources at all levels.

64. Dissemination of technical and scientific knowledge in order to facilitate generalized understanding and participation in the development of workers' health programs, including systematic knowledge of the risk and health profiles of workers for the identification of the highest-risk groups and the assessment of exposure and of programs and services, and the establishment of the interventions required.

## PROGRAM BUDGET DISTRIBUTION BY LOCATION

| LOCATION | PAHO AND WHO REGULAR BUDGET 1992-1993 | 1994-1995 | 1996-1997 | EXTRABUDGETARY FUNDS 1992-1993 | 1994-1995 | 1996-1997 |
|---|---|---|---|---|---|---|
| DIRECT COOPERATION WITH COUNTRIES | 9,883,500 | 11,404,400 | 12,437,600 | 4,011,600 | 3,694,200 | 58,700 |
| REGIONAL PROGRAMS | 2,501,800 | 2,662,800 | 2,888,600 | 184,000 | 167,500 | 181,400 |
| CENTERS | 4,433,800 | 5,458,900 | 6,042,200 | 2,142,100 | 1,306,200 | 1,230,700 |
| TOTAL | 16,819,100 | 19,526,100 | 21,368,400 | 6,337,700 | 5,167,900 | 1,470,800 |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL PROF. POSTS | PERSONNEL LOCAL POSTS | PERSONNEL CONS. DAYS | PERSONNEL AMOUNT | DUTY TRAVEL AMOUNT | FELLOWSHIPS MONTHS | FELLOWSHIPS AMOUNT | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 9,979,400 | 23 | 19 | 2975 | 6,626,300 | 488,700 | 278 | 556,000 | 1,055,800 | 551,900 | 13,300 | 687,400 |
| WHO - WR | 6,839,700 | 20 | 11 | 1090 | 5,024,500 | 267,900 | 68 | 136,000 | 411,800 | 306,900 | 0 | 692,600 |
| TOTAL | 16,819,100 | 43 | 30 | 4065 | 11,650,800 | 756,600 | 346 | 692,000 | 1,467,600 | 858,800 | 13,300 | 1,380,000 |
| % OF TOTAL | 100.0 | | | | 69.3 | 4.5 | | 4.1 | 8.7 | 5.1 | .1 | 8.2 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 11,982,400 | 25 | 18 | 2586 | 7,574,100 | 543,800 | 222 | 444,000 | 1,409,100 | 727,400 | 57,800 | 1,226,200 |
| WHO - WR | 7,543,700 | 20 | 11 | 962 | 5,696,200 | 318,300 | 60 | 120,000 | 308,000 | 322,100 | 0 | 779,100 |
| TOTAL | 19,526,100 | 45 | 29 | 3548 | 13,270,300 | 862,100 | 282 | 564,000 | 1,717,100 | 1,049,500 | 57,800 | 2,005,300 |
| % OF TOTAL | 100.0 | | | | 67.9 | 4.4 | | 2.9 | 8.8 | 5.4 | .3 | 10.3 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 13,106,200 | 25 | 18 | 2586 | 8,211,300 | 600,600 | 222 | 444,000 | 1,588,000 | 819,200 | 62,500 | 1,380,600 |
| WHO - WR | 8,262,200 | 20 | 11 | 962 | 6,183,300 | 360,900 | 60 | 120,000 | 349,300 | 365,300 | 0 | 883,400 |
| TOTAL | 21,368,400 | 45 | 29 | 3548 | 14,394,600 | 961,500 | 282 | 564,000 | 1,937,300 | 1,184,500 | 62,500 | 2,264,000 |
| % OF TOTAL | 100.0 | | | | 67.4 | 4.5 | | 2.6 | 9.1 | 5.5 | .3 | 10.6 |

## HEALTH SITUATION ANALYSIS

1. The status of Maternal and Child Health has not improved substantially over the last Biennium. Epidemiologic analysis of the health status of the population of the Americas shows that the most vulnerable groups continue to be women--especially those of childbearing age, children, and adolescents who are considered to be at greatest risk of becoming ill and dying.

2. By 1995, Latin America and the Caribbean will have a population estimated at 449 million inhabitants. The population growth rate in Latin America in the 1990s is 2.0% per year and in the Caribbean it is 1.5%, which determines that the times for doubling the populations are 30 and 46 years, respectively. There is an accelerated process of urbanization, which encompasses 76% of the total population.

3. The total fertility rate in Latin America and the Caribbean is around 3.5 in the early 1090s but still some countries such as Bolivia, Nicaragua, Guatemala, Honduras and Haiti continue to be over 4.8.

4. Women of reproductive age--from 15 to 49 years old, children, and adolescents constitute 70.6% of the population, more than 316.4 million inhabitants who form the target population of this program.

5. Maternal and child health problems are accentuated by rapid urban growth, particularly of the marginal sectors. It is estimated that 93 million Latin Americans in these areas are in poverty. Of the rural population of approximately 200 million, 70% live in conditions of poverty and 30% are destitute. At least 130 million people in Latin America and the Caribbean do not have access to health services and of them, 90 million are children and women of reproductive age.

6. Infant mortality is different in the three subregions of the Americas. For around 1990, Latin America has a rate of 55 per 1,000 live births; North America, 10 per 1,000 live births; and the English Caribbean, 21. Only three countries in Latin America have levels lower than the English Caribbean: Cuba, Costa Rica, and Chile. On the other hand, there are 10 Latin American countries with rates equal to or higher than 60 per 1,000; they register 55% of the births of the subregion. The decline in infant mortality observed occurred mainly in the postneonatal group. As a result, the relative proportion of deaths rose in the neonatal group; this has implications for strategies to reduce mortality in the coming years.

7. Diarrheal diseases constitute one of the most important health problems affecting the child population in Latin America and the Caribbean and are among the first five causes of death in infants under 1 year. In many countries, they are the highest ranking cause of death in children aged 1 to 4 years.

8. In children under 1 year, diarrheal disease mortality rates range from 0.5 per 100,000 live births in Canada to 967.3 per 100,000 live births in Nicaragua. The death rate in Nicaragua is almost 30 times higher than in the Bahamas (35.8 per 100,000 live births).

9. During the period 1960-1990, almost 5 million deaths from diarrhea occurred in children less than five years, amounting to 80% of all deaths from intestinal infections in all age groups and 7% of the deaths from all causes at all ages. For the countries of Latin America and the Caribbean, this data indicates that one out of every 14 deaths in the general population was from an intestinal infection in children less than 5 years.

10. During the 1980s, the annual reduction in mortality rates from diarrheal diseases among children less than 5 years were significant in some developing countries, such as, Chile (20.1%), Venezuela (16.8%), Ecuador (16.5%), and Uruguay (15.0%).

11. Where morbidity is concerned, the successful implementation of oral rehydration therapy (ORT) reduced hospitalization due to diarrhea, serious cases of dehydration, and hospital case-fatality rate in children less than 5 years.

12. The rate of access to oral rehydration salts (ORS) in 1991 reached 68% of the total population less than 5 years of age in the Region and the ORT use rate reached 54% for the same population. The Program has established Regional 1995 targets of 80% for ORS access rate and 50% for ORT use rate. By the end of 1991, 17 Member Countries had achieved an ORS access rate greater than 80% and 17 countries an ORT use rate greater than 50%.

13. Available data makes it possible to ascribe part of the decline in infant mortality due to the correct utilization of ORT and its use in prevention programs. It can be extrapolated that for 1990, with a reported regional ORT use rate of 50%, an estimated 75,500 deaths were averted.

14. The presence of cholera in the Region continued to create a challenge for the program. In 1992, cholera transmission was active in 20 countries reporting 318,003 cholera cases, 145,463 hospitalizations and 2,108 deaths. The recent cholera cases reported in Guyana in November 1992 prompted increased preparatory activities in the Caribbean countries.

15. Cholera is now endemic in the Region and countries in the Caribbean, can expect to be affected shortly. It is essential to maintain established emergency programs for cholera control through the National Cholera Control Commissions and monitor and refine national programs and polices.

16. The World Health Summit goals endorsed by PAHO and UNICEF will provide the framework for a comprehensive health strategy for diarrheal diseases/cholera control in the 1990s.

17. Acute respiratory infections (ARI), and pneumonia in particular, cause approximately 250,000 deaths annually among children under five. Those infections are the cause of 25% to 30% of all deaths in this age group in developing countries, in comparison with 10% to 15% in the industrialized countries; mortality due to pneumonia is particularly high in children under one year of age. ARIs are responsible, in addition, for 30% to 50% of the visits of children to medical care centers and 30% to 40% of the hospitalizations.

18. A considerable proportion of episodes of ARI are viral infections of limited duration, such as common colds and coughs. However, approximately one in every 50 episodes of ARI results in pneumonia and, without treatment, 10% to 20% of those cases will die. Most of the cases of children hospitalized with pneumonia acquired in the community are caused by two bacteria, Streptococcus pneumoniae and Haemophilus influenzae. It has been demonstrated that the timely recognition of the signs of pneumonia--by families as well as by health workers, antibiotic treatment, supportive measures, and shipment of the serious cases to a higher level of care can result in a considerable reduction of the mortality due to ARI. At present 20 countries carry out activities for control of ARI following the standards proposed by PAHO/WHO.

19. Morbidity and mortality due to the diseases preventable by vaccination follow a downward trend but continue to be a problem despite the availability of highly effective, easily administered vaccines.

20. The achievements of the Program for Eradication of Wild Poliovirus can be observed by the fact since August 1991 no case of paralytic poliomyelitis due to wild polio virus has been detected anywhere in the Region.

21. Measles and neonatal tetanus continue to be a serious problem in numerous countries but the areas of greatest risk of neonatal tetanus have been identified and now control measures are being developed. The behavior of measles in the Region is better understood and measures for its control are being developed with greater efficiency and effectiveness.

22. Between 1991 and 1992 coverage by vaccination of children under one year of age reached levels never before achieved: approximately 75% for all vaccines. There nevertheless remain large pockets of unvaccinated children. The problem of the high degree of drop outs between the first and subsequent doses in multiple vaccines and the missed opportunities for vaccination in the health establishments continue to be basic concerns of the program. All the countries have improved their systems of surveillance for the detection of the wild virus of poliomyelitis and the system is now being expanded to include other diseases preventable by vaccination.

23. For adolescents from 15 to 19 years of age, accidents appear first among the five leading causes of death, in 17 countries, suicides between second and fifth place in 13 countries, and homicides between second and fourth place in 14 countries. It should be pointed out that in two countries the complications of pregnancy, delivery, and the puerperium appeared among the 10 leading causes of death in women of this age group.In fact 16% of children are born to women between 15-19 years. The problem is greater in the Caribbean where 27% of births are births to adolescents.

24. Analysis of maternal mortality makes it possible to rank the countries of the Region at four different levels: the first group, with the lowest rates, includes the United States of America and Canada; the second, with moderate rates (between 21 and 49 per 100,000 live births), includes the Bahamas, Chile, Costa Rica, Cuba, Panama, and Uruguay; the third, with high rates (from 60 to 140), includes 10 countries; and the fourth, with very high rates (from 160 to 480 per 100,000 live births), comprises another 10 countries in Central America, the Andean area, and the Latin Caribbean.

25. For women of reproductive age (15 to 49 years) in 22 countries for which information is available, the complications of pregnancy, delivery, and the puerperium were among the ten leading causes of death, appearing in 11 countries as one of the first five. Accidents appeared ammong the first five causes of death for women in 21 countries, suicide in 15, and homicide in 16.

26. Despite improvements made to date, the coverage of prenatal care, is still inadequate in Latin America and the Caribbean as a whole. In only 65% of the 13 million estimated births did the mother receive some type of prenatal care; there were large variations by country.

27. The coverage of deliveries with institutional care or by professional personnel is 75%. In the Region 4.0 million births (28%) still do not have this type of care.

28. Contraception, according to the best available figures, is estimated to be used by 60% of sexually active women from 15 to 49 years in the countries where information is to be had and which represent 70% of the population of Latin America and the Caribbean. However special consideration must be given to differentials in contraceptive prevalence both at the country level and also within rural an urban areas and socioeconomic groups.

29. This level and the structure of infant, maternal, and adolescent mortality reflect the stages of demographic and epidemiological transition that coexist among countries and in their interiors with substantial variations.

30. In addition, the quality of the services is problematic and can be related to the availability of the resources necessary for prevention and for access to a level of care with adequate capacity to resolve this problem.

31. The overall level of the conditions of effectiveness of the maternal and child health services was recorded at 67%, and has not improved in the last two years, which indicates that the majority is still found in conditions considered to be less than satisfactory (80%). Principal deficiencies persist in the

managerial aspects of administration and programming and community participation. One frequently observed effect of the crises and the adjustments is a relative deterioration of the human resources in the services.

GLOBAL STRATEGY FOR TECHNICAL COOPERATION

32. The programming for maternal and child and adolescent health for the 1994-1995 biennium is set in a well-defined framework: the PAHO/WHO global strategy of health for all by the year 2000 and primary health care in the eighth WHO work program for 1990 to 1995, the strategic orientations and programming priorities of PAHO for 1991 to 1994, the recent mandates of the Governing Bodies, especially, the Regional Plan for Investment in the Environment and Health (XXXVI Directing Council Meeting).

33. This framework had been revised to make it consistent with the goals adopted at the U.N Summit for Children in 1990. Also, the 94-95 biennium will be the transition period for the changes needed to implement the 9th. WHO program of work.

34. In treating highly vulnerable population groups the program contributes substantively to the national development effort by protecting and increasing the investment in human resources that are necessary for future sustained development. This is especially true if such development is to favor the integration of women.

35. The regional maternal and child health program is guided by well-defined lines of action and strategies. It establishes a connection with the programming priorities and strategic orientations of the Organization for the quadrennium and the Regional Plan for Investment in the Environment and Health, among which the following are noted:

Concentration on high-risk groups and priority interventions:

36. All the actions of the program flow together along three main lines of work: a) health of women, emphasizing sexual and reproductive health and prevention of maternal mortality; b) child health with emphasis on surveillance, conservation and/or restoration of the normal processes of growth and development including breast-feeding, nutrition, and the categorical interventions required by the epidemiological profile of childhood in the countries of the region,such as perinatal care, immunizations,prevention and control of diarrheal diseases and acute respiratory infections; c) adolescent health with emphasis on the promotion of comprehensive health and prevention, with multisectoral participation, including that of adolescents. Lines of work will be continued in maternal, child and adolescents AIDS, abused children, and school health.

37. The program responds as a comprehensive technical whole. The division of the work that arises at the central level for reasons of specialization should not necessarily be applied at the local level where the consultants will have to prepare to act in a comprehensive fashion and develop complementary actions among the programs of the Organization that are especially focused on achieving the strengthening and development of local health systems, including among them social security and other agencies and institutions that work in health.

38. The program gives priority to action in those countries in which the problems are more serious and affect a greater number of people, either at the national level or in the interior of the countries, emphasizing the actions directed to the groups in most need (Population in extreme poverty, Indian Population, Women, Children, Adolescents and Workers).

39. It will place special emphasis on cooperation with those Member States that express their political will with the allocation, reassignment, or increase of their national resources, that favor international, interinstitutional, official, and nongovernmental coordination, and that, upon preparing their programs of technical cooperation with PAHO, assign resources to PAHO in their countries.

Lifestyles, promotion of health, and social communication:

40. The actions of the program will place emphasis on prevention and promoting the health of women, children, and adolescents. It will use social communications extensively, as well as school education and health education in cooperation with grass-roots organizations. The aim will be to achieve changes in behavior and lifestyles along with more positive attitudes toward health.

41. Special care will be given to integrating health care and reducing lost opportunities to ensure a better quality of care. It is foreseen that activities such as the detection of cervical and uterine cancer, sexually transmitted diseases and maternal, child and adolescent AIDS; diabetes, hypertension, and nutritional deficiencies will be included. Assessment of the characteristics of abused children and street children and their health will continue.

Mobilization of resources

42. Strengthening interagency coordination within the United Nations system, with bilateral cooperation agencies, development banks, governmental and nongovernmental agencies, universities, scientific societies, and especially the civilian society will continue to receive emphasis. The strategy to mobilize regular and extrabudgetary resources is vital for the program and the countries; if additional resources are not had, the viability of the different components will be jeopardized and it will not be possible to implement many of the actions programmed.

Management of knowledge: production, dissemination and incorporation

43. The promotion of the generation of scientific and technical knowledge and its dissemination will continue to be a priority. National groups and universities will be encouraged to make use of research subsidies, the Program on Human Reproduction, and regional, extrabudgetary, and country project funds. The possible range of research areas includes biomedical, epidemiologic, operational, and behavioral areas. The common denominator of research projects will be that they vitalize program and service development. Technologies and publications, and research produced by CLAP will be widely disseminated.

44. There will be continued development of the data bases at the regional level in the countries to allow better understanding of the state of health and its determinants, monitoring, and the evaluation of proposed interventions.

Strengthening and Development of the Local Health Systems

45. Local health systems and the inclusion of social security and other institutions and nongovernmental organizations strengthens the health sector's capacity to negotiate, coordinate, and manage action.

46. Local health systems promote institutional development, especially at local level, including local information systems and decentralized and participatory management models for Maternal and Child Health care.

Health and Development

47. Technical discussions with the Ministries of Health, parliaments and social security should lead to updating policies of promotion and protection of maternal and child health at the country level. The subject should be addressed by the Governing Bodies and in subregional meetings and initiatives, and emphasized to donors. It should be expressed in operating plans, programs, and standards developed by the maternal, child and adolescent health and other services, so that, in addition to coverage, there is quality and warmth in the care provided to the population. The technical normative aspects will be promoted so that they are applied nationally.

Adaptation of educational profiles, manpower development and educational technology:

48. Manpower development at all levels of a country's health infrastructure will continue to be important. Actions will be carried out to increase the participation of the universities, federations, and scientific societies, in national and international courses. Their cooperation will also be sought in training human resources, preparing teaching materials and evaluating them as to quantity, penetration, quality, and suitability to the needs of the countries. Such activities would favor national events over regional ones and foster local health systems.

49. Maternal and child health programs provide aa focus integrating services at different care levels. The technical content of these programs is shared with other priority areas of the Organization, such as: nutrition, lifestyles and risk factors, control of avoidable diseases, workers' health, dependence, and maternal and child, and adolescent AIDS.

50. Cholera activities and plans will continue to be coordinated with HST and IDB to emphasize the development and monitoring of national plans and include the dissemination of information, communication projects, research, mobilization of resources, and preparation of projects for long-term infrastructure development. Long-term projects will aim for rebuilding and strengthening of existing health, water and sanitation systems, extension of potable water and sanitation to the unserved and the provision of essential health services to 40% of the Region's population lacking such services.

## SPECIFIC PROGRAMS

Growth, development, and human reproduction (MCH)

### BIENNIAL TARGETS

51. To contribute to the development of national capacities to increase the coverage and quality of services for fertility regulation, pregnancy control, care at delivery and of the newborn, surveillance of the growth and development of children, and care of adolescents, using risk analysis and emphasizing neglected groups and the integration of activities through local health systems.

52. All the countries of the Region will have designed and implemented national plans and local family planning programs. The prevalence of use is expected to be at least 65% and there will be an increase in the availability and use of more modern methods with fewer secondary effects. Specific actions to reach males and convince them to participate more actively not only in family planning but in the care and education of their offspring.

53. All the countries of the Region will have designed and implemented national plans and local programs for the prevention and reduction of 30% of the 1990 ratios of maternal mortality among the target groups established in the regional plan. At least four strategies are being considered: establishment of surveillance committees on maternal mortality, strengthening hospital referral, improvement of perinatal care both in timing and quality, and training of traditional midwives as appropriate.

54. All the countries of the Region will, in order to facilitate action, have designed and implemented systems of epidemiological surveillance of maternal deaths, of monitoring and evaluation of the state of health of the population and analysis of its determinants, and of periodic evaluation of the conditions for the efficiency of services; models to estimate costs will be designed. The foregoing should improve the optimization of the utilization of the resources and of the process of decision-making.

55. All countries of the Region, will have prepared and be implementing plans and standards for the surveillance of the nutritional status of the children and their growth and development. Of the services 50% will be utilizing growth and development criteria and charts according to PAHO/WHO and UNICEF recommendations; and at least 35% of the countries will be utilizing validated instruments for evaluation of the psychosocial development of children and adolescents. Thus contributing to improve the health of children in the Americas trough the strengthening of both intra, intersectoral and social participation.

56. In all countries, the surveillance of the growth and development processes will be the flagship for facilitating comprehensive child and adolescent care,and for the strengthening local health systems.

57. By 1995 research and assessment of child abuse and the health status of street children will permit the identification of priority activities to be supported by the organization. The establishment of national networks of already existing research and action groups at the country level will be pursued.

58. 80% of the countries of the Region will have done at least one evaluation of the efficiency of their maternal and child services; and the testing and adoption of other quality assessment tools will be developed.

LINES OF ACTION

59. National plans, policies, and programs should be developed in local health systems in order to guarantee the possibility of providing information, education, and integrated family planning services to the entire population, to the individuals that demand them, and to those for whom they are medically indicated. Quality and the appropriate balance of modern contraceptive methods and cunseling activities will be emphasized geared to retain contraceptive users. Special emphasis will be given to activities aimed to increase male participation in family planning and in the care and education of their offspring. In addition, efforts will be made to make better use of demographic information in health planning and in programming local health systems.

60. Prenatal care will be carried out, by updating standards in accordance with the criteria recommended by CLAP, so that prenatal consultations are timely and thorough and guarantee quality services that make the detection of perinatal risks, and the inclusion of tetanus vaccination possible.

61. To promote adequate institutional care at delivery and/or clean delivery by trained lay midwives or professional medical or nursing personnel, trained in obstetrics. There should be improvement of intermediate sites of care and of referral hospitals to ensure risk-free delivery and timely attention to obstetric emergencies.

62. Control during the puerperium will be effected through observation during the 24 hours after delivery and examination 42 days afterwards in order to prevent the complications of puerperium. Preventive actions for the period between pregnancies and family life should be carried out.

63. Development of information systems and committees of maternal mortality that allow epidemiological surveillance of maternal deaths and monitoring of the maternal and child health situation and its determinants and the efficiency of the services.

64. Appropriate care of the newborn will be promoted extensively in order to prevent neonatal deaths.

65. Systematic surveillance of nutrition,growth and development status in children, whether in health and/or sick, will contribute to ensure timely interventions when deviations occur. Communities will be taught to organize themselves for surveillance activities.

66. Preparation of tables and criteria for evaluation of growth in children and the appropriate interventions and their distribution to services and communities.

67. Application of validity criteria to evaluate the development and use of schemes appropriate to the sociocultural reality in each every country.

68. Systematic evaluation of conditions of efficiency and quality of care assessment and implementation of the recommendations for improvement will be promoted.

69. Lines of action for increasing knowledge and activities toward the improvement of the health of abandoned, abused and street children will continue

to develop. Identification of advocacy, research and action groups is a priority and will enable the gathering of the existing experience and expertise to further develop this line of action.

70. Special emphasis and priority will be continued to be given to strengthening and making fully operative the interagency coordinating committee in which UNICEF, AID, WB, IDB, UNFPA participate, especially at the national level.

Adolescent Health (ADH)

BIENNIAL TARGETS

71. At the end of the biennium, all the countries of the Region will have established policies and plans and initiated the process of developing of programs for comprehensive health care for adolescents and young people with an eminently preventive and promotional approach and with effective social participation of the group and of the sectors involved in the health, well-being, and development of adolescents.

72. The countries will have the critical mass of multidisciplinary human resources from many professions necessary for the development of service and educational programs, nourished by effective and continuous mechanisms for dissemination of up-to-date information.

73. There should be regional and national networks of active groups that are developing service, educational, and research activities with a community approach and that serve to support the national initiatives for comprehensive health care of adolescents and young people.

LINES OF ACTION

74. Preparation of a plan for the development of the human resources--for implementation of health, educational, and training programs on adolescence and youth.

75. Strengthening of the health services to adapt them to the need for promotion and care of the health of adolescents and young people. This strengthening will include sensitization and mobilization of political will in order to incorporate adolescents and young people in the agenda of priority groups.

76. Strengthening of local, national, and regional networks of groups and institutions involved in caring for and promoting the general health of adolescents and young people.

Acute respiratory infections (ARI)

BIENNIAL TARGETS

77. Establishment of a program for control of ARI at the national level in at least ten countries of the Region that have infant mortality higher than 40 per 1,000.

78. In these countries 50% of the population will have regular access to drugs and 40% of the cases of pneumonia will be treated correctly.

79. In these countries 80% of the health workers that serve children will have received training in the management of cases of ARI.

LINES OF ACTION

80. To consolidate the updated PAHO/WHO guidelines for the diagnosis and treatment of ARI in all the countries of the Region, in the primary health care and hospital level.

81. To continue cooperation with the regional UNICEF office and USAID to implement ARI in their programs for cooperation, including the creation of national committees on interagency cooperation.

82. To promote epidemiological and clinical research and research on the health services, in the field of the acute infections.

83. To advise on the preparation of national operating plans for the control of ARI, including all the components, such as training, monitoring, supervision, and provision of supplies and drugs, in the context of comprehensive care for children.

84. To evaluate the progress in the country programs, using as indicators the number of health services with ARI activities programmed and standardized, the quality of the service, and the trend in mortality by cause in children under five years of age.

85. To promote, at the level of the local health services, the measurement and evaluation of the impact of the control measures.

86. To establish training units for the treatment of acute respiratory infections in hospitals and to train the technical team, medical and nursing students, and auxiliary personnel. To the extent possible these units will be established jointly with the CDD program.

87. To support the realization, at the national and departmental (state or provincial) levels, of courses on organization of the ARI program and on supervisory skills in ARI and the four-day clinical course.

88. To promote training activities with the professors in the departments of pediatrics of the schools of medicine and schools of nursing, to be developed jointly with CDD, for the introduction of ARI norms in the pediatric Chairs and nursing Schools.

89. to promote health education at the community level in family home care, including criteria for seeking additional care, trough communication methods that reach the families that do not bring their children to the health facilities.

Immunization (EPI)

BIENNIAL TARGETS

90. All the countries of the Region will provide immunization services for all the diseases included in the Expanded Program on Immunization (EPI) to all children under one year of age.

91. All the countries will have covered no fewer than 80% of the children under one year of age with polio, measles, and DPT vaccination and all women of child-bearing age in the areas with a high risk of neonatal tetanus in all the municipalities or equivalent geopolitical units with vaccination with tetanus toxoid.

92. All the countries will have systems of epidemiological surveillance that are capable of investigating all cases of flaccid paralysis and initiating control activities within the 48 hours after the report of possible cases, determining the actual magnitude of neonatal tetanus, and anticipating the outbreaks of measles so that control activities can be initiated.

93. All the countries of the Region will have initiated the process of certification of the interruption of the transmission of the wild virus of poliomyelitis.

94. All countries of the region will have determined the distribution of program resources in relation to high risk areas.

95. All the countries of the English Caribbean will have consolidated actions for eradication of measles by 1995.

96. All the countries of Latin America will have initiated actions to eliminate neonatal tetanus in the areas of risk and to control measles.

LINES OF ACTION

97. The principal line of action in this area will be the strengthening of vaccination through the regular health services, particularly those that are directed toward mothers and children. Special importance will be placed on the elimination of lost opportunities to vaccinate in these services. This approach will be implemented with the national vaccination days, or similar types of campaigns, that will be developed at least twice per year in those countries in which the health infrastructure does not reach the target population. In the presence of outbreaks of diseases for which there is immunization, sweeping operations will be developed in order to immunize all those in the areas at risk who are susceptible. The identification of the areas of low coverage will be carried out routinely, particularly coverage at the municipal or district level, so that when they are identified vaccination will begin immediately.

98. Epidemiological surveillance will be expanded and based on notification by all the health units of the absence of cases of diseases preventable by vaccination. Initially emphasis will be placed on the system currently in operation for epidemiological surveillance of poliomyelitis in order to include measles and neonatal tetanus. The criteria for a "case" will be defined specifically for every disease and guidelines will be prepared for reporting, investigating outbreaks, implementing control measures, and evaluating their impact. This line of action will be supported by a laboratory network for specific diagnoses.

Diarrheal Diseases (CDD)

BIENNIAL TARGETS

99. Toward the end of the biennium 1994-1995, all the countries of the Region will maintain operational national programs for the prevention and control of morbidity and mortality due to diarrheal diseases, based on the World Summit for Children strategies and goals. These programs should include the key areas as delineated in the previous section.

100. Reduce the number of deaths from diarrheal diseases in children less than 5 years to 50% of the mortality level observed in 1990 (year 2000 target) and reduce the number of diarrheal cases in children less than 5 years to 25% of the morbidity level observed in 1990.

101. Provide 80% of the population with access to a trained, continuously supplied provider of ORS, ensuring that 50% of the diarrheal cases in children less than five years receive increased amounts of ORT (ORS or a recommended home fluid), and continued feeding and that 80% of mothers can state the three rules of home case management (increase liquids, feeding and care seeking).

102. Ensure that 80% of the population which lives within a reasonable distance of a health facility or provider has a regular supply of ORS and antibiotics and practices correct case management principles.

103. Ensure that 70% of diarrhea cases treated at the home level are correctly treated with correct case management principles.

104. Provide training in CDD management to 100% of country program managers, provide CDD supervisory training to 80% of country personnel responsible for supervisory activities and provide "hand-on" training in diarrhea and cholera correct case management to 80% of health personnel responsible for treating these cases.

105. Ensure that 100% of medical, nursing and paramedical training institutions offer satisfactory training to their students including utilization of appropriate diarrheal diseases and cholera control training guidelines and associated materials.

106. Provide CDD training to selected personnel representing 20% of non-governmental organizations (NGOs) developing health activities and provide diarrheal diseases correct case management training to 20% of pharmacists and drug sellers.

107. All Member Countries will incorporate into their programs WHO/UNICEF indicators for assessing breast-feeding practices to establish common measures to assess breast-feeding practices and to evaluate the progress of promotional programs at the community level.

108. All Member Countries will maintain established national CDD/Cholera coordinating committees and preparation of national plans for prevention and control.

109. All Member Countries will strengthen systems for cholera and other diarrheal diseases surveillance and reporting, with the ability to confirm isolates of Vibrio cholerae in a national laboratory.

110. All Member Countries will strengthen comprehensive educational programs for teaching food safety and proper hygienic practices for street vendors and in households.

111. Proposals for long-term infrastructure development for water and sanitation systems for health services, based on eliminating cholera from the Region and reducing other diarrheal diseases will be developed and strengthened in all Member Countries.

LINES OF ACTION

112. Strengthening of international interagency coordination to enhance effective coordination and funding among all organizations and agencies for planning, training and education activities necessary to fulfill the goals established by the World Health Summit.

113. Improve awareness of diarrhea-related illness and deaths by promoting high level political commitment and leadership in the countries.

114. Strengthen national capabilities to develop, implement and monitor projects related to the prevention and control of CDD/Cholera.

115. Mobilize resources for CDD/Cholera activities from international donor agencies and funding institutions.

116. Strengthening of "district health systems" to improve district health management and integrate health activities.

117. Improvement of correct case management of diarrhea at the household and community levels by establishing Community Oral Rehydration and Sanitation Units (CORUS), including strengthening of education, social communication and ORS availability components.

118. Improvement of correct case management in the health facilities by establishing Diarrheal Training Units (DTU) and strengthening case management training in all public and private health sectors with special emphasis in the treatment of dysentery and persistent diarrheas.

119. Guarantee of self-reliance in the production, quality control and distribution of ORS.

120. Development and strengthening of information systems that permit monitoring and evaluation of program activities and progress towards achieving World Summit for Children goals.

121. Establishment of social mobilization through improved communication, education and training activities.

122. Improvement of breast-feeding practices by establishing Lactation Training Centers.

123. Promotion of measures to prevent diarrhea, including: exclusive breast-feeding during the first four to six months of life and continued breast-feeding during the first two years of life; improved weaning practices; use of clean water; hand-washing; proper use of latrines; proper disposal of children's feces; and immunization against measles.

13. MATERNAL AND CHILD HEALTH (Cont.)

124. Implementing the concept of "definition of high risk areas" to assist in identifying higher morbidity of neo-natal tetanus in specific geographical units of the country as defining high risk areas of disease, including diarrheal diseases.

125. Utilize community and non-governmental organizations and mass media for dissemination of CDD/Cholera technical information to all Member Countries.

126. Promote appropriate research on cholera vaccine, simplified and quicker diagnostic methods and intervention strategies and disseminate this information to Member Countries.

127. Develop plans for long-term projects to strengthen and extend infrastructure of health, water and sanitation systems.

PROGRAM BUDGET DISTRIBUTION BY LOCATION

| LOCATION | PAHO AND WHO REGULAR BUDGET 1992-1993 | 1994-1995 | 1996-1997 | EXTRABUDGETARY FUNDS 1992-1993 | 1994-1995 | 1996-1997 |
|---|---|---|---|---|---|---|
| DIRECT COOPERATION WITH COUNTRIES | 6,099,100 | 8,025,700 | 8,768,000 | 39,303,800 | 18,886,600 | 4,518,100 |
| REGIONAL PROGRAMS | 2,415,900 | 2,537,100 | 2,753,000 | 2,480,900 | 2,356,900 | 1,666,800 |
| CENTERS | 1,526,000 | 1,714,100 | 1,899,000 | 2,641,100 | 0 | 0 |
| TOTAL | 10,041,000 | 12,276,900 | 13,420,000 | 44,425,800 | 21,243,500 | 6,184,900 |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL PROF. POSTS | PERSONNEL LOCAL POSTS | PERSONNEL CONS. DAYS | PERSONNEL AMOUNT | DUTY TRAVEL AMOUNT | FELLOWSHIPS MONTHS | FELLOWSHIPS AMOUNT | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 5,775,700 | 8 | 4 | 1287 | 2,189,100 | 360,400 | 98 | 196,000 | 965,700 | 684,800 | 6,600 | 1,373,100 |
| WHO - WR | 4,265,300 | 14 | 3 | 880 | 3,291,500 | 182,000 | 44 | 88,000 | 379,000 | 165,500 | 0 | 159,300 |
| TOTAL | 10,041,000 | 22 | 7 | 2167 | 5,480,600 | 542,400 | 142 | 284,000 | 1,344,700 | 850,300 | 6,600 | 1,532,400 |
| % OF TOTAL | 100.0 | | | | 54.5 | 5.4 | | 2.8 | 13.4 | 8.5 | .1 | 15.3 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 7,230,400 | 9 | 4 | 1548 | 3,059,700 | 415,300 | 106 | 212,000 | 1,344,600 | 803,700 | 38,000 | 1,357,100 |
| WHO - WR | 5,046,500 | 15 | 3 | 845 | 3,804,400 | 193,200 | 37 | 74,000 | 501,300 | 264,800 | 0 | 208,800 |
| TOTAL | 12,276,900 | 24 | 7 | 2393 | 6,864,100 | 608,500 | 143 | 286,000 | 1,845,900 | 1,068,500 | 38,000 | 1,565,900 |
| % OF TOTAL | 100.0 | | | | 55.9 | 5.0 | | 2.3 | 15.0 | 8.7 | .3 | 12.8 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 7,946,600 | 9 | 4 | 1548 | 3,294,800 | 459,100 | 106 | 212,000 | 1,515,700 | 900,600 | 41,200 | 1,523,200 |
| WHO - WR | 5,473,400 | 15 | 3 | 845 | 4,090,600 | 212,900 | 37 | 74,000 | 563,400 | 297,900 | 0 | 234,600 |
| TOTAL | 13,420,000 | 24 | 7 | 2393 | 7,385,400 | 672,000 | 143 | 286,000 | 2,079,100 | 1,198,500 | 41,200 | 1,757,800 |
| % OF TOTAL | 100.0 | | | | 55.1 | 5.0 | | 2.1 | 15.5 | 8.9 | .3 | 13.1 |

## HEALTH SITUATION ANALYSIS

1. While chronic diseases and injuries are increasing in importance in all countries of the region, communicable diseases remain major causes of morbidity and mortality and place a burden on health services. The threat of epidemics of many infectious diseases remains unacceptably high.

2. The large majority of areas previously free of Aedes aegypti have been reinfected, with resultant increases in dengue, dengue hemorrhagic fever and the risk of yellow fever in South America, a threat which is heightened with the establishment of Aedes albopictus in Brazil and the United States. There are estimated to be over 6 million carriers of hepatitis B in the region, and the disease is endemic in many countries. Hepatitis C is recognized as an important cause of chronic hepatitis. Many viral infections, including rotaviruses, influenza and other respiratory viruses, place significant demands on the health services.

3. The incidence of confirmed malaria infections in the 21 countries with transmission increased from 5.1 per 1,000 inhabitants in 1990 to 6.8 per 1,000 in 1991. Trypanosoma cruzi infects 12 to 16 million persons in Central and South America, and transmission of this agent by blood transfusion is a common but preventible occurrence. Over 100,000 cases of leishmaniasis are estimated to occur annually, and visceral leishmaniasis has increased in young children in association with severe malnutrition.

4. Intestinal parasitic infection has increased in the last decade, and in the poorest countries more than half of preschool and school-age children are infected. Approximately 30 million persons in the region are at risk of schistosomiasis and 12 million are infected, many in association with hydroelectric and irrigation projects.

5. While onchocerciasis transmission occurs only in 6 countries of the region, 5.5 million persons are exposed and over 100,000 persons are infected and at risk of chronic eye and skin disease.

6. Leprosy remains endemic in most countries, with an estimated 350,000 cases, but over 85% of new cases and 70% of the prevalent disease occurs in one country. The disease is present throughout the entire territory of seven countries but infects over 1 per 10,000 persons in only circumscribed territories of five. Tuberculosis remains one of the most serious problems, with little or no decline in most countries and actual increases in some, in spite of improvements in BCG immunization programs and treatment regimens. The association with human immunodeficiency virus (HIV) infection and the appearance of multidrug resistance present serious challenges to the control of tuberculosis.

7. More than a quarter of AIDS cases officially reported worldwide have occurred in the Americas, but it is conservatively estimated that 2.5 million persons are infected with HIV in the region: 1 million in North America and 1.5 million in Latin America and the Caribbean. There is an increasing shift to heterosexual transmission, especially in Central America and the Caribbean, and infection of intravenous drug users is also more common. Transmission by blood is largely controlled but requires continuous effort and resources. Other sexually transmitted diseases (STDs) are extremely common throughout the region and contribute to the transmission of HIV. Diagnostic and treatment services for STDs are limited and underfunded in most countries.

8. Cholera appeared in this Hemisphere for the first time this century in Peru in January 1991. During that year it spread to 15 countries, producing 391,750 cases and 4,002 deaths. In 1992, 20 countries reported 351,416 cases and 2,391 deaths. While the spread of disease and the size of epidemics has been reduced as a result of widespread and intensive control measures, epidemics will continue to occur in many countries, and the disease has probably become endemic in some.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

9. The proposed program and budget for the control of communicable diseases during the biennium is closely linked to the Strategic Orientations and Program Priorities of the Organization.

10. The ability of populations to prevent and control communicable diseases is essential to their economic and social development and forms the basis for many international interventions in public health. Control of tropical diseases, such as malaria in areas experiencing large migrations of susceptible populations, and HIV infection, with its potentially profound effect on economically productive groups, will have a critical impact on development in the region. Focussing on and strengthening of local health systems is a basic strategy for nearly all projects and is receiving increased attention in control of malaria, tuberculosis and sexually transmitted diseases, among others. Because of the high incidence and prevalence of many communicable diseases and their wide geographic distribution, actions must be focussed on high risk groups, in order to maximize efficient use of resources. An example is the stratification of malaria interventions. Health promotion and the use of social communication are fundamental strategies for all prevention and control programs, ranging from prevention of cholera and diarrheal disease to elimination of leprosy. The risks experienced by women and their role in disease prevention are being recognized more clearly. Examples are the increasing risk of women throughout the Americas to HIV infection and their exposure to parasitic infections. The effective management of knowledge is fundamental to all prevention and control programs, since the collection and use of epidemiological data is essential to successful

intervention. A significant portion of the resources, both financial and human, for communicable disease control projects come from outside sources, and much of the technical expertise in the region is shared between countries.

11. Among PAHO's program priorities, the health of the environment is critical to prevention and control of cholera, other diarrheal diseases and most diseases transmitted by vectors. In turn, efforts to control vector borne diseases can have significant, sometimes deleterious, effects on the environment. The reduction of intestinal parasitic infections, especially hookworm, will have a direct impact on the nutrition of populations. Lifestyles and risk factors are critical in determining exposures to most communicable diseases, including HIV and other STDs. Practical methods are available for the control and/or elimination of nearly all communicable diseases, but in many cases, resurgences of diseases such as tuberculosis, STDs, malaria, dengue and cholera present critical challenges. Because of their greater exposure or lack of immunity, women and children may suffer a disproportionately high risk of some parasitic and foodborne diseases. Place and type of employment may put workers at higher risk of malaria and other vector-borne diseases, while the workplace may offer a focus for intervention in HIV infection and other communicable diseases.

12. Widespread participation in and successful implementation of the Regional Plan for Investment in Environment and Health will be essential for the control of communicable diseases and the elimination of some. The cholera epidemic was an immediate stimulus to the development of the plan, and the control and eventual elimination of this disease is intimately linked to it. Other diarrheal diseases and all vector-borne diseases are related to environmental quality. With increasing emphasis on integrating control of tropical diseases through the health services rather than vertical programs, adequate investment in the health services becomes a basic strategy to control, prevention and elimination of these ancient but persistent problems.

## SPECIFIC PROGRAMS

### General communicable disease prevention and control activities (OCD)

#### BIENNIAL TARGETS

13. To reduce the transmission of significant infectious diseases in the Region through well-structured programs that utilize integrated measures of prevention and control, including community participation.

14. To carry out special studies on intervention measures.

15. To strengthen the capacity of national laboratory networks to support epidemiological surveillance and the diagnosis of infectious, viral, and bacterial diseases.

#### LINES OF ACTION

16. To promote and support the development of integrated strategies for the control of epidemics.

17. To support the development and/or evaluation of vaccines for the viral, bacterial, rickettsial, and parasitic diseases of importance in the Region.

18. To foster the development of epidemiological studies on priority infectious diseases.

19. To promote the establishment of a regional laboratory network for the diagnosis of viral diseases and to strengthen its capacity for timely and effective diagnosis.

20. To strengthen or establish quality control systems for donated blood in order to detect infectious diseases transmitted through blood transfusions.

### Tropical disease research (TDR)

#### BIENNIAL TARGETS

21. To procure new methods and/or to improve the existing ones for the prevention, diagnosis, and treatment of tropical diseases.

22. To strengthen national capacity so that institutions in the Region are capable of carrying out research and training in research on the biomedical, epidemiological, and social aspects of tropical diseases.

#### LINES OF ACTION

23. To promote epidemiological studies aimed at improving knowledge about the factors that affect the transmission and control of tropical diseases.

24. To encourage research on diagnostic techniques, therapeutic procedures, and immunizing agents.

25. To support the evaluation of different intervention strategies for prevention and control.

26. To foster biomedical and social science training for research in tropical diseases.

27. To promote the strengthening of institutions that carry out research and training in malaria, leishmaniasis, and filariasis, especially bancroftian filariasis.

Tuberculosis (TUB)

BIENNIAL TARGETS

28. To establish the necessary conditions to increase the number of countries in which the efficient application of control measures will bring about a sustained and progressive reduction in tuberculosis and in the annual risk of infection and quickly lead to control of the disease.

LINES OF ACTION

29. To promote and support the incorporation of prevention and control activities into local health systems, achieving total integration of the program in all health units.

30. To support the enhancement of laboratory networks in order to improve quality control, information, and cooperation between the laboratory and medical care units.

31. To improve the reporting and information system on program activities.

32. To promote personnel training at all levels, for epidemiological analysis of TB and, at the operational level, for the health services that carry out prevention and control interventions.

33. To promote the mobilization of resources.

Acquired immunodeficiency syndrome (HIV)

BIENNIAL TARGETS

34. The following sixteen targets, to be achieved by the end of the 1994-1995 biennium, have been established for the Region of the Americas:

35. All countries of the Region will have medium term plans for the control and prevention of AIDS in full operation. At the end of the biennium all of the countries will be in the implementation stage of medium term plans of the second generation, stressing comprehensive strategies and activities for multisectoral collaboration and coordination.

36. Administrative and managerial capacity in all the national programs will be strengthened in order to enable the efficient and timely implementation of national strategic plans (medium term plans of first and second generation) and the timely preparation of planning documents and progress reports (e.g. APB, PIC, etc.).

37. Involvement of NGOs and the private sector in the planning, implementation and assessment of national AIDS programs will continue to be promoted and supported in all countries.

38. All the countries in the Region will have a fully developed system to obtain accurate and reliable data on the prevalence and trends of HIV infection and STD and to use this information in effective program planning.

39. Legal and policy instruments will be developed in at least one half of the countries to frame and support policies for integrating AIDS control activities into national health and development programs and to oppose discrimination and stigmatization.

40. Expansion of coverage and more effective, integrated control programs of other sexually transmitted diseases will be promoted in 20 countries, including strengthening of diagnostic and clinical management capacity.

41. All national programs will have fully developed, appropriate educational activities and behavioral interventions aimed at groups with high risk practices and behaviors: among in-and out-of school youth; among health workers, and among the general population. Formal mechanisms to assess the impact of those activities and interventions will be also fully developed in at least one half of the countries.

42. Culturally sensitive, explicit messages to counteract complacency and denial and to foster understanding and solidarity will be present in all information, education and communication (IEC) interventions in all countries on a periodic basis.

43. All national AIDS programs will have a fully developed strategy for the adequate and equitable care of HIV-infected people and AIDS patients, including active involvement of community members. In at least seven of the countries such a strategy will be fully operative by the end of the biennium.

44. All the countries will explicitly include activities aimed at reducing sexual transmission of HIV among women. At least ten national programs will incorporate such activities into a more comprehensive strategy of women's health and with a gender (societal role) perspective.

45. All national programs will promote the use of condoms, other barriers, virucides, and any other effective preventive practices in a culturally sensitive way, to reduce transmission of HIV and STDs among people whose behavior continues to put them at risk.

46. All countries will promote the rational use of blood and blood products. In addition, all blood banks, both public and private, will be providing safe blood and blood products through donor screening, self-deferral, testing and other techniques known to be effective in hemotherapy.

47. At least four subregional laboratories will be providing technical support and training to national laboratories to improve HIV diagnosis.

48. All the countries will strengthen their capacity for the identification and management of the more common opportunistic infections.

49. Appropriate operational research protocols will be developed and related research activities will be carried out in at least five countries.

50. Relevant technical and scientific information will be collected, collated and forwarded to all national AIDS programs on a regular basis. Documents produced by GPA/HQ will be translated and/or adapted within six months of their publication and sent to all national AIDS programs and/or other target groups (e.g. NGOs) as soon as Regional versions are ready.

LINES OF ACTION

51. PAHO will approach its collaboration with the countries of the Americas following ten lines of action. Specifically, PAHO will:

52. Support the development of the national capacity to plan, execute, monitor, and evaluate AIDS/HIV/STD prevention and control activities in all the countries of the Region.

53. Coordinate international and interagency initiatives and efforts to provide technical cooperation to Member Countries for AIDS/HIV/STD prevention and control.

54. Foster the commitment of Member Countries to ensure intersectoral participation from the government and nongovernmental organizations (NGOs) in the planning, implementation, and evaluation of national AIDS programs.

55. Conduct and support resource mobilization activities aimed at ensuring national and international (multilateral and bilateral), public, and private financial support for AIDS prevention efforts.

56. Foster the articulation of efforts with related health and social service programs (STD control, reproductive health, tuberculosis, etc.) to prevent and control AIDS and support community initiatives to lessen the socioeconomic impact of AIDS and the prevention of HIV infection.

57. Provide resources and assistance for the adequate identification of groups on which specific interventions should focus, including epidemiological surveillance and behavioral studies.

58. Promote and support interventions carried out at the local health systems level, encouraging, on the one hand, integration between programs/services and on the other, decentralization of activities and responsibilities, with special emphasis on long term delivery of medical and social services.

59. Support and reinforce the regional and national capacity for research, appropriate transfer of technology, and dissemination of technical and scientific information for the development of appropriate targeted interventions and approaches.

60. Facilitate the procurement of products necessary for the implementation of activities foreseen in the national AIDS plans (condoms, laboratory kits, reagents, etc.).

61. Promote the exchange of information and expertise within and outside the Region to facilitate efficient and timely implementation of national strategic plans.

Vector-borne diseases (VBC)

BIENNIAL TARGETS

62. To develop national plans of action in the most affected countries for the detection, epidemiological surveillance, and control of the vectors and viruses of dengue and yellow fever.

63. To reduce the populations of *Aedes aegypti* sufficiently to halt the transmission of dengue, through an intersectoral action program, using the mass media and effective community participation.

64. To incorporate guidelines for prevention and vector control in national development plans that entail investments in dam construction, irrigation works, and mining, as well as settlement programs in the Region.

65. To contribute to the continuity of conditions that will permit the maintenance of control measures for vector-borne parasitic diseases in the context of the primary health care strategy and through community participation.

66. To support programs for the elimination of the *I. infestans* in Southern Cone countries and the control of other triatomids in the other countries of the region where American trypanosomiasis exists.

LINES OF ACTION

67. To promote the implementation of integrated vector control measures (reduction and/or treatment of foci, biological control, sustainable community participation, environmental management, and in livestock and farming activities).

68. To support the preparation of proposals for development projects in their aspects of organization and environmental and social protection.

69. To encourage the inclusion of personnel training plans in national, bilateral, and multilateral development projects for the purpose of improving the efficiency of vector control programs.

70. To promote community participation in prevention and control actions.

Malaria (MAL)

BIENNIAL TARGETS

71. To adjust the structure of control programs and, in keeping with the primary care strategy, incorporate the activities of diagnosis, treatment, and intervention as part of local health services, taking into account the risk of transmission, in order to reduce the spread of malaria and prevent mortality.

72. To develop technical, managerial, operational, and epidemiological surveillance capabilities for maintaining and expanding malaria-free areas, and to reduce the endemic disease, or at least impede its recrudescence.

LINES OF ACTION

73. To promote and support epidemiological stratification as the method for evaluating the impact of programs on the epidemiological situation.

74. To encourage the utilization of bilateral and subregional agreements for technical cooperation between countries.

75. To foster and support the enhancement of the epidemiological information system adjusted to the national epidemiological information system.

76. To promote the monitoring and dissemination of experiences and research aimed at defining the minimum infrastructure and procedural needs to increase the response capacity at the local level of the general health services in order to reduce mortality and morbidity.

77. To foster study and systematization of mechanisms at the local level for promoting community and intersectoral participation in the solution of problems related to the prevention, treatment, and control of malaria.

Parasitic diseases (PDP)

BIENNIAL TARGETS

78. To develop and strengthen a multi-purpose laboratory network for the diagnosis and epidemiological surveillance of priority parasitic diseases in the Region.

79. To ensure that the countries most affected by parasitic zoonoses in the Region establish the legal grounds for compulsory notification and case-reporting in order to support information and epidemiological surveillance systems.

80. To establish unified theoretical and methodological criteria for implementing actions aimed at the elimination of onchocerciasis in at least three countries.

81. To produce guidelines on health education and the use of mass communication in a multisectoral approach in order to strengthen health promotion activities in support of control measures.

LINES OF ACTION

Soil-borne helminthiasis

82. To promote the development and application of methods for epidemiological stratification of helminthiasis, including the taeniasis/cysticercosis binomial.

83. To foster the creation and development of multipurpose parasitological and immunological laboratory networks in health services.

84. To promote the development of national programs of education and parasite elimination among school-age children.

85. To encourage the mobilization of resources for carrying out prevention and control actions through veterinary public health activities.

86. To promote the development of national and regional plans to train human resources to participate in control, research, and training on parasitic diseases.

Onchocerciasis

87. To promote the design, execution, and evaluation of a plan of action directed toward the elimination of onchocerciasis in selected countries.

88. To initiate actions for the determination of levels of endemicity in selected foci in order to strengthen a multinational and interagency plan for the elimination of onchocerciasis.

89. To participate in the monitoring of actions related to the donation of Ivermectin.

Leishmaniasis

90. To promote compulsory notification (establishment of legal grounds) in the countries most affected in the Region and the standardization of procedures of diagnosis, therapeutic management, and control.

91. To support the execution of control actions under the PHC strategy with optimum utilization of local health systems.

Leprosy (LEP)

BIENNIAL TARGETS

92. To incorporate prevention and control actions in health services in keeping with the primary health care strategy.

93. To train personnel from peripheral health services for the early detection of suspected cases, ensuring multidrug therapy for confirmed cases and care by professional personnel at the intermediate level for the prevention and treatment of disabilities and complications.

94. Short-term target (1994): Elimination of more than 80% of the cases through a full course of multidrug therapy (MDT) and successful treatment of more than 80% of new cases detected so that disabilities are avoided.

LINES OF ACTION

95. To promote the incorporation of prevention and control actions within general care services in keeping with the primary care strategy.

96. To improve epidemiological and operational information.

97. To support the use of multidrug therapy.

98. To promote personnel training at every level for early detection and treatment of cases and the prevention and treatment of disabilities.

Sexually transmitted diseases (VDT)

BIENNIAL TARGETS

99. For the 1994-1995 biennium, the following targets have been established:

100. At least 20 Member Countries will have in place a functioning surveillance system for the more common STD's.

101. By the end of the biennium, professionals of at least 75% of the countries would have undergone training in one or more of the following areas: epidemiological surveillance; laboratory methods; clinical management including patient education; and STD program management.

102. By the end of the biennium a proposal for the elimination of congenital syphilis as a public health problem would have been endorsed by PAHO's Governing Bodies and at least 10 countries will be fully participating in the initiative.

103. By the end of the biennium, all countries having a Medium Term Plan for AIDS prevention will include specific human and financial resources for the strengthening of STD control programs and activities at the national level.

LINES OF ACTION

104. Because of limited human and financial resources, PAHO will seek and secure support from other technical and funding agencies, including its continuing collaboration with the Latin American Union Against Sexually Transmitted Diseases and AIDS (ULACETS), CDC, USAID, CIDA, and others. The main approaches will be in the areas of training; dissemination of guidelines and technical and scientific information; establishment of STD surveillance systems; promotion and support of STD-specific research; and direct technical collaboration, especially in the areas of program evaluation and STD program administration and management.

## 14. COMMUNICABLE DISEASES (CONT.)

### PROGRAM BUDGET DISTRIBUTION BY LOCATION

| LOCATION | PAHO AND WHO REGULAR BUDGET 1992-1993 | 1994-1995 | 1996-1997 | EXTRABUDGETARY FUNDS 1992-1993 | 1994-1995 | 1996-1997 |
|---|---|---|---|---|---|---|
| DIRECT COOPERATION WITH COUNTRIES | 10,339,200 | 10,993,900 | 11,995,900 | 26,160,700 | 21,015,100 | 0 |
| REGIONAL PROGRAMS | 2,011,600 | 2,371,800 | 2,581,100 | 2,505,800 | 2,486,700 | 82,900 |
| CENTERS | 0 | 1,294,800 | 1,407,800 | 3,929,200 | 4,922,700 | 3,714,000 |
| TOTAL | 12,350,800 | 14,660,500 | 15,984,800 | 32,595,700 | 28,424,500 | 3,796,900 |

### ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL PROF. POSTS | PERSONNEL LOCAL POSTS | PERSONNEL CONS. DAYS | PERSONNEL AMOUNT | DUTY TRAVEL AMOUNT | FELLOWSHIPS MONTHS | FELLOWSHIPS AMOUNT | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 4,787,800 | 6 | 4 | 1655 | 2,011,600 | 265,300 | 99 | 198,000 | 832,500 | 762,500 | 153,000 | 564,900 |
| WHO - WR | 7,563,000 | 21 | 10 | 1320 | 5,095,600 | 406,500 | 79 | 158,000 | 687,300 | 410,700 | 61,100 | 743,800 |
| TOTAL | 12,350,800 | 27 | 14 | 2975 | 7,107,200 | 671,800 | 178 | 356,000 | 1,519,800 | 1,173,200 | 214,100 | 1,308,700 |
| % OF TOTAL | 100.0 | | | | 57.6 | 5.4 | | 2.9 | 12.3 | 9.5 | 1.7 | 10.6 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 5,990,900 | 12 | 3 | 975 | 3,229,400 | 331,400 | 105 | 210,000 | 844,400 | 621,500 | 201,300 | 552,900 |
| WHO - WR | 8,669,600 | 20 | 11 | 1607 | 5,612,900 | 564,600 | 83 | 166,000 | 859,600 | 611,300 | 38,500 | 816,700 |
| TOTAL | 14,660,500 | 32 | 14 | 2582 | 8,842,300 | 896,000 | 188 | 376,000 | 1,704,000 | 1,232,800 | 239,800 | 1,369,600 |
| % OF TOTAL | 100.0 | | | | 60.4 | 6.1 | | 2.6 | 11.6 | 8.4 | 1.6 | 9.3 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 6,543,000 | 12 | 3 | 975 | 3,473,000 | 371,000 | 105 | 210,000 | 950,800 | 693,500 | 217,700 | 627,000 |
| WHO - WR | 9,441,800 | 20 | 11 | 1607 | 6,047,600 | 619,600 | 83 | 166,000 | 962,400 | 685,400 | 42,200 | 918,600 |
| TOTAL | 15,984,800 | 32 | 14 | 2582 | 9,520,600 | 990,600 | 188 | 376,000 | 1,913,200 | 1,378,900 | 259,900 | 1,545,600 |
| % OF TOTAL | 100.0 | | | | 59.5 | 6.2 | | 2.4 | 12.0 | 8.6 | 1.6 | 9.7 |

## HEALTH SITUATION ANALYSIS

1. The economic crisis that hit the Region during the decade of the eighties and the adjustment policies that were imposed had a profound impact on the social development of the people in this hemisphere. The effects ranged from clearly harmful stagnation in some sectors to setbacks that were difficult to overcome without making substantial changes in development models and without redoubling efforts to achieve well-being for the populations in the Region of the Americas.

2. This bleak socioeconomic picture has been aggravated by the demographics of the Region as a whole. The total population of the Region will have reached more than 550 million by the year 2000, or double the number of inhabitants in 1970. The urban population has grown even faster, so that it will have gone from 160 to 420 million inhabitants during the same 30-year period. This means that the American hemisphere is becoming increasingly urbanized, with massive urban centers, which presents a challenge to environmental conservation and protection efforts as well as social services planning. The health problems associated with haphazard urbanization processes manifest themselves mainly in terms of social behaviors and lifestyles.

3. The growth of the older adult population--as a result of increased life expectancy at birth--coupled with the effects of urbanization and industrialization, means that the health problems associated with backwardness (extreme poverty and poor basic sanitation) coexist with those attributed to modern life. The following epidemiological analysis of the Region deals principally with the health problems that fall into the second category.

4. Heart disease is the leading cause of death in most of the countries in the Region. Malignant neoplasms are the second leading cause of death in North America, the English-speaking Caribbean, southern Brazil, the countries of the Southern Cone, Cuba, Colombia, and Costa Rica. Accidents and injuries are among the five leading causes of death in all the countries, and diabetes mellitus is also one of the leading causes in several countries in the different subregions. Chronic respiratory diseases and their complications in the circulatory system are also important contributors to the pathologies of adults and elderly people.

5. Ischemic heart disease as well is responsible for a large number of deaths from heart disease in all the countries, and mortality analysis reveals that, in some countries, the rates are on the increase, especially in the English-speaking Caribbean, Costa Rica, Cuba, and Mexico.

6. Arterial hypertension is one of the most common disorders in the populations of Latin America and the Caribbean, with prevalences ranging from 10%-18% among those over the age of 15, according to data from surveys carried out in general population groups in several of the countries. Mortality from cerebrovascular disease is higher in populations where the epidemiological evidence shows a high prevalence of hypertension, in conjunction with inadequate control in the services.

7. Diabetes mellitus, besides constituting a major risk factor for illness or death from cardiovascular disease, is itself a public health problem in most of the countries. The prevalence in the adult population ranges from 4%-6%, according to various studies that support this conclusion on an international level.

8. The disorders that affect the arteries, such as hypertension and diabetes, can also present ophthalmological complications such as cataracts and eventual blindness. The most frequent cause of significant loss of eyesight in adults in most of the countries is cataracts. This problem tends to become worse with age.

9. Cancer in women accounts for most of the mortality from malignant neoplasms in the majority of the countries; the distribution pattern differs, however, between the more developed and the less developed countries. In the latter group, there is a higher incidence of and greater mortality from invasive cervical cancer; in more affluent societies, breast cancer has reached epidemic proportions.

10. Lung cancer, directly associated with tobacco consumption, is the leading cause of mortality from malignant neoplasms among males in North America, and in some countries of Latin America where smoking is highly prevalent, such as Argentina, Cuba, and Uruguay. Although the death rates from this cancer in women are significantly lower than in men in the countries as a whole, recently they have been on the rise in several countries, possibly because of increased tobacco consumption by young women in today's society.

11. Other social pathologies are affecting large population nuclei, especially in the urban and suburban areas of Latin America and the Caribbean, causing extensive disability and suffering in families and individuals. In this complex group, drug addiction and alcoholism stand out, along with the effects of violence and accidents, because of their sizable impact on health. Added to these are mental diseases, suicide, and chronic neurological disorders.

12. Accidents and injuries of all types cause the greatest loss of potential years of life, especially childhood accidents and traffic accidents involving young people. Prevention, which goes beyond the realm of the health sector, should promote changes in attitudes and risky behaviors. Other types of violence are causing serious losses of young lives in various countries, along with domestic violence such as child abuse, violence against women, and abuse of the elderly, which, as a whole, are caused by factors closely linked to social inequality and inequity.

13. It is increasingly difficult for the poor to gain access to specialized services; high quality health care coverage continues to be very inequitable; and disease prevention and health promotion are not being given the priority they deserve.

14. Efforts to increase health services coverage for vulnerable groups, especially adolescents, older adults, and women of non-reproductive age, as well as to improve the efficiency and capacity of those services, should be an ongoing

concern of the technical cooperation agencies in the health field, and part of the operational activities of health promotion and protection.

15. In summary, the complex problems associated with demographic and epidemiological changes, persistent problems linked to poor health conditions, and the increase in unhealthy lifestyles are making it necessary to reexamine the work of health promotion and protection. They are also making it essential to come up with innovative interventions--at the community and individual level--which provide health information to the population, strengthen citizen awareness and solidarity, energize the democratic processes of social participation, and make health a job and agenda for all sectors.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

16. The situation analysis in the preceding section of this document reveals the sizeable challenges that the Member Governments and all the international and bilateral cooperation agencies will have to face during the next decade.

17. These challenges mean that it will be essential to transform the role and work of the health sector, and to ensure that the health sector participates in the comprehensive development of the societies in this hemisphere.

18. The Organization's technical cooperation in health promotion and protection is based on three principles: equity (fair distribution of opportunities, goods, and services); mass communication and community involvement (the transmission of health information to the population, and the involvement of that population in the process of identifying needs and formulating social demands); and human solidarity (wherein the common good is equal in importance to the individual good).

19. There are also three central strategies that integrate its technical cooperation activities and resources:

20. Promotion of healthy lifestyles. Efforts in this area lead to recognition and internalization of the concept of health as an individual and social good, and as a resource and investment for development; the formulation of sectoral and intersectoral policies at the local, municipal, and national level that encourage improvements in living conditions; and the expression of those policies through legislation at the three different levels; and the development and execution of plans and programs to promote healthy communities based on intersectoral partnerships.

21. Protection of population groups. This main thrust of this activities is the identification of the population groups most vulnerable to noncommunicable diseases, as well as ophthalmological diseases, diseases attributable to old age, mental disorders, and violent injuries. The goal is to develop social, environmental, and safety measures that reduce risks, treat and rehabilitate patients, and promote peaceful coexistence among citizens.

22. Food and nutrition. These cooperation efforts are aimed at optimizing the physical and intellectual development of human beings, and at protecting people against the diseases associated with unhealthy eating habits.

23. The lines of action are grouped into three categories:

### Formulation of policies, plans, and programs

24. Promotion of intersectoral action and political commitment for the development of programs and activities in health promotion and protection at the national and local level.

25. Promotion of the formulation of public policies that allow an optimum level of health and nutrition to be achieved and maintained in the population.

26. Support for the formulation and development of plans and programs to reduce the risks associated with unhealthy lifestyles, such as poor diet, addiction to tobacco, alcohol, and drugs, sedentary lifestyles and stress, and risky behavior leading to accidents and violence.

27. Promotion of individual and public safety through intersectoral and interagency action with broad community participation.

### Management of knowledge

28. Support for the countries in their use of mass communication in health and information dissemination to strengthen individual and collective responsibility for and participation in improving health levels.

29. Collaboration in training activities that involve the concepts, methodologies, and operational development of health promotion. Promotion of training in the implementation of mass communication strategies and techniques.

30. Promotion of research on information, attitudes, and practices relating to health promotion and protection, along with applied research on services to further reforms of the health care models.

### Health care services and individual interventions

31. Promotion of reorientation of services in order to meet the new challenges posed by the epidemiological and sociodemographic profiles, with an emphasis on risk prevention and reduction.

32. Strengthening of health services in the diagnosis and management of protein-energy malnutrition, specific nutritional deficiencies, and malnutrition caused by relative excess or imbalance in energy consumption, and in the prevention of risk factors for chronic noncommunicable diseases.

33. Promotion of restructuring of psychiatric care and use of alternative community-based models that rely on community social support networks.

Health promotion and prevention and control of noncommunicable diseases (NCD)

BIENNIAL TARGETS

34. To consolidate between 5 and 10 "healthy cities" projects using broad health promotion approaches in which mass communication is used as an effective instrument to improve the people's health status.

35. To promote mass communication activities directed toward changing the lifestyles associated with risk factors for chronic noncommunicable diseases in most of the countries.

36. To consolidate 8 research projects in cancer and cardiovascular services using a clinical-epidemiological approach.

37. To move ahead with the incorporation and development of program content dealiang with health promotion at the local level with an emphasis on local health systems, taking into account the changes that are needed to reorient services and provide adequate health care.

38. To collaborate with the countries in the situation analysis of noncommunicable diseases in the Region so that the necessary information can be provided to the public and to policy-makers that will allow prevention and control policies and programs to be implemented.

39. To collaborate in providing epidemiology training, and in formulating programs for health promotion and practice and the prevention of noncommunicable diseases.

LINES OF ACTION

40. Promotion of methodological development and systematization of participatory processes at the local level in coordination with local health systems.

41. Promotion of the formulation of public policy at the national and local level in support of health promotion and protection.

42. Promotion of the dissemination of appropriate scientific and technical information to different types of users in order to strengthen technical cooperation in health promotion and protection.

43. Identification and mobilization of resources for the execution of health promotion and mass communication activities aimed at changing unhealthy lifestyles.

44. Support for the countries through activities that provide training in the use of mass communication to inform and educate the public about health.

45. Improvement of the technical and administrative response capacity of social services, including health, and coordination with NGOs and self-help groups to improve health and prevent risky behaviors.

46. Mobilization of political, technical, and financial resources to improve the entire population's awareness of health promotion and lifestyle changes aimed at preventing NCDs.

47. Promotion of population surveys of knowledge, attitudes, and practices in relation to disease risks and threats to well-being, in order to produce knowledge that makes it possible to work on health promotion and mass communication.

48. Support for the countries in the diagnosis and analysis of health situations with regard to NCDs.

49. Promotion of human resources training in technical fields and methodologies that facilitate the work with the program strategies and priorities.

50. Continued support of research to determine the changes needed in the health services in order to cope with noncommunicable diseases.

Tobacco or health (TOH)

BIENNIAL TARGETS

51. To identify and mobilize resources for continued implementation of the Regional Plan of Action for the Prevention and Control of Smoking.

52. To identify and mobilize resources for the utilization of educational/informational material on smoking control in support of national programs.

53. To support epidemiological research on causes, effects, and prevention and control of smoking in the Region.

54. To develop strategies and mechanisms for political mobilization of the public and decision-makers toward anti-smoking action.

55. To promote the formulation of anti-smoking legislation and/or the adaptation of current legislation in the developing countries.

LINES OF ACTION

56. Implementation of the Regional Plan of Action for the Prevention and Control of Smoking through the establishment of national programs and operational programs at the local level, according to the comprehensive principles of health promotion.

57. Support for the countries in mass communication efforts to inform and educate the public about the dangers of smoking.

58. Promotion of and cooperation in analysis of the situation and causes of smoking in the Region.

59. Support for the development and adaptation of anti-smoking legislation.

Prevention and treatment of mental and neurological disorders (MND)

BIENNIAL TARGETS

60. To develop mental health plans for children and adolescents in most of the countries.

61. To strengthen aid to community-based mental health programs with an emphasis on self-help groups.

62. To promote mental health as an important value in society.

63. To facilitate the inclusion of psychosocial dimensions in the understanding of health disorders in general, as well as in their prevention and control.

LINES OF ACTION

64. Promotion of the incorporation of mental health promotion into integrated health promotion and protection activities.

65. Improvement of the capacity to provide technical support in mental health services research. Continued implementation of the initiative for restructuring of psychiatric care.

66. Strengthening of technical support activities in information.

Cancer (CAN)

BIENNIAL TARGETS

67. To contribute to the analysis of the problem of increasing cancer frequency.

68. To develop strategies of investment in health promotion in order to reduce cancer incidence and mortality.

LINES OF ACTION

69. Health promotion as a strategy to prevent risk factors for cancer.

70. Development of cancer information that focuses on recording incidence in order to promote knowledge of the epidemiological patterns of cancer in the Region.

71. Promotion of epidemiological research on cancer.

72. Support for national cancer prevention programs with an emphasis on cancer in women.

Accident prevention (APR)

BIENNIAL TARGETS

73. To promote the design and execution of projects and programs using the "safe communities" strategy, in which the local population is involved in trying to achieve optimum levels of safety and prevention of traumatic and violent injuries and deaths.

74. To promote government intervention in most of the countries that is articulated with other public sectors and nongovernmental agencies, in order to achieve the highest possible levels of accident prevention and control.

75. To collaborate with the countries in situation analysis through the collection and processing of information on accidents and violence, and in the identification of simple statistical methods for surveillance and control.

76. To cooperate with the countries in the organization and rationalization of health care to prevent or minimize the physical, spiritual, and economic effects of accidents and violence.

LINES OF ACTION

77. Promotion of community interventions aimed at achieving optimum levels of safety in that setting.

78. Documentation of the magnitude of the accident problem and dissemination of relevant information in order to sensitize the different sectors that deal with the problem.

79. Promotion of initiatives which allow the governmental and nongovernmental agencies that deal with the prevention and control of accidents and violence to show tangible achievements.

Health of the elderly (HEE)

BIENNIAL TARGETS

80. To contribute to the analysis of the demographic changes that are occurring in the countries of Latin America and the Caribbean, so that valid information is available for planning activities to respond to the accelerated aging of the population.

81. To promote the development of intersectoral plans and social programs that improve the quality of life for elderly people in all the countries of the Region.

82. To develop interventions that make it possible to achieve optimum levels of comprehensive health in the elderly population in the context of local health systems.

83. To promote and support understanding of population aging processes through epidemiological research and incorporation of scientific content into education programs, in order to facilitate an adequate response to the specific demands of this social group.

LINES OF ACTION

84. Promotion and support of health promotion interventions for elderly people as part of national health and social development plans.

85. Promotion of activities to strengthen elderly people as a group, as well as the NGOs and volunteers who protect their rights.

86. Promotion and support of epidemiological studies in clinical and social settings that provide information on the normal aging process and identify high-risk groups.

87. Promotion of intra- and intersectoral collaboration to adequately strengthen current structures and programs and formulate specific public policy in this area.

SPECIFIC PROGRAMS

Prevention and control of alcoholism and drug abuse (ADA)

BIENNIAL TARGETS

88. To strengthen health sector leadership in the implementation of multidisciplinary national policies and programs and adequate intersectoral articulation for the prevention and control of drug dependence.

89. To consolidate health promotion plans and programs in order to foster behaviors and lifestyles that discourage the consumption of psychoactive substances and alcoholic beverages, with an emphasis on mass communication and participatory education methodologies.

90. To strengthen and adapt the health sector's capacity to respond to problems related to abuse of psychoactive substances, alcoholic beverages, and tobacco.

91. To promote programs for intersectoral coordination and collaboration with NGOs and self-help groups in the prevention and treatment of dependence on psychoactive substances.

92. To continue and increase the implementation of research and epidemiological surveillance methodologies to assess the situation and trends of abuse of psychoactive substances in the Region.

LINES OF ACTION

93. Health promotion as a strategy to prevent all types of drug abuse.

94. Strengthening of health sector leadership within national and local programs in order to fight drug abuse.

95. Improvement of the technical and administrative response capacity of social services, including health, and strengthening of coordination with NGOs and self-help groups.

96. Consolidation of epidemiological surveillance systems in order to determine the magnitude, nature, and trends of abuse of psychoactive substances and alcohol.

Ocular health (PBD)

BIENNIAL TARGETS

97. To improve planning and management in existing ocular health services in order to increase their coverage and efficiency in 10 countries of the Region.

15. HEALTH PROMOTION (Cont.)

98. To promote programs for the promotion of ocular health in the countries of the Region.

99. To identify and motivate human and institutional resources in the countries in order to ensure the provision of ocular health services and the prevention of blindness.

100. To increase coordination and cooperation in ocular health programs through articulation with governmental health plans at the local level.

LINES OF ACTION

101. Promotion of Regional and subregional meetings to identify and mobilize the institutional resources available in the Region to participate in the development of ocular health programs.

102. Promotion of training programs in ocular health for health workers at all levels, including program management.

103. Implementation of mass communication and community participation programs in ocular health.

104. Promotion of prevention-of-blindness committees at all levels (municipal, departmental, provincial, national) in order to improve coordination between the governmental and nongovernmental agencies that direct the activities, thus achieving more articulated and efficient programs.

PROGRAM BUDGET DISTRIBUTION BY LOCATION

| LOCATION | PAHO AND WHO REGULAR BUDGET 1992-1993 | 1994-1995 | 1996-1997 | EXTRABUDGETARY FUNDS 1992-1993 | 1994-1995 | 1996-1997 |
|---|---|---|---|---|---|---|
| DIRECT COOPERATION WITH COUNTRIES | 4,312,900 | 4,712,200 | 5,125,500 | 1,185,100 | 0 | 0 |
| REGIONAL PROGRAMS | 2,136,200 | 2,692,700 | 2,922,300 | 182,700 | 0 | 0 |
| CENTERS | 0 | 0 | 0 | 12,700 | 0 | 0 |
| TOTAL | 6,449,100 | 7,404,900 | 8,047,800 | 1,380,500 | 0 | 0 |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL PROF. POSTS | PERSONNEL LOCAL POSTS | PERSONNEL CONS. DAYS | PERSONNEL AMOUNT | DUTY TRAVEL AMOUNT | FELLOWSHIPS MONTHS | FELLOWSHIPS AMOUNT | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| **1992-1993** | | | | | | | | | | | | |
| PAHO - PR | 3,944,300 | 8 | 4 | 1360 | 2,243,100 | 241,700 | 59 | 118,000 | 625,800 | 256,100 | 0 | 459,600 |
| WHO - WR | 2,504,800 | 5 | 3 | 955 | 1,583,900 | 120,200 | 51 | 102,000 | 355,600 | 142,900 | 0 | 200,200 |
| TOTAL | 6,449,100 | 13 | 7 | 2315 | 3,827,000 | 361,900 | 110 | 220,000 | 981,400 | 399,000 | 0 | 659,800 |
| % OF TOTAL | 100.0 | | | | 59.4 | 5.6 | | 3.4 | 15.2 | 6.2 | .0 | 10.2 |
| **1994-1995** | | | | | | | | | | | | |
| PAHO - PR | 4,737,500 | 9 | 5 | 1136 | 2,699,900 | 293,900 | 65 | 130,000 | 722,700 | 337,000 | 0 | 554,000 |
| WHO - WR | 2,667,400 | 5 | 3 | 925 | 1,731,900 | 107,400 | 51 | 102,000 | 366,800 | 147,900 | 0 | 211,400 |
| TOTAL | 7,404,900 | 14 | 8 | 2061 | 4,431,800 | 401,300 | 116 | 232,000 | 1,089,500 | 484,900 | 0 | 765,400 |
| % OF TOTAL | 100.0 | | | | 60.0 | 5.4 | | 3.1 | 14.7 | 6.5 | .0 | 10.3 |
| **1996-1997** | | | | | | | | | | | | |
| PAHO - PR | 5,158,000 | 9 | 5 | 1136 | 2,900,400 | 321,300 | 65 | 130,000 | 811,000 | 376,100 | 0 | 619,200 |
| WHO - WR | 2,889,800 | 5 | 3 | 925 | 1,855,300 | 117,600 | 51 | 102,000 | 411,700 | 165,800 | 0 | 237,400 |
| TOTAL | 8,047,800 | 14 | 8 | 2061 | 4,755,700 | 438,900 | 116 | 232,000 | 1,222,700 | 541,900 | 0 | 856,600 |
| % OF TOTAL | 100.0 | | | | 59.1 | 5.5 | | 2.9 | 15.2 | 6.7 | .0 | 10.6 |

## HEALTH SITUATION ANALYSIS

1. There are more than 200 known zoonoses, and current patterns of migration and urbanization are putting more persons at risk of these diseases, especially vulnerable groups of workers, children and women.

2. Canine rabies continues to be a public health problem in Latin America, where more than 95% of cases in the region occur. The number of cases fell by 38% during the four-year period 1989-1992 compared with 1985-1988. The disease has been largely controlled in urban areas, but persists in periurban and rural areas, especially those with less than 50,000 inhabitants. Rabies transmitted by wild animals has resulted from increased economic activity in forested areas inhabited by vampire bats.

3. Equine encephalitis is present in several countries, posing a risk to both humans and horses. An epidemic of Venezuelan Equine Encephalitis that was detected in December 1992 threatens to extend itself, requiring that systems for surveillance, diagnosis and control of this disease be reactivated.

4. Bovine tuberculosis reduces meat and milk production by 10% to 20% and results in the destruction of 60% of infected cattle. Mycobacterium bovis is the cause of 6% of pulmonary tuberculosis and 8% of extrapulmonary tuberculosis in humans, primarily in workers exposed to cattle. Brucellosis infects an estimated 30,000 persons per year, primarily workers in animal industries. Economic loses from this disease are estimated at US$ 200 million per year.

5. Hydatidosis continues to be a public health problem in the Southern Cone and some Andean countries, with more than 2,500 persons requiring surgical treatment each year. The frequency of detectable Taenia solium infection is 1% to 6% in several countries, with seropositivity rates of 3% to 12%. Human neurocysticercosis increased in the Americas as a result of the high prevalence of this infection.

6. Foot-and-mouth disease causes serious economic loses by lowering cattle production and leading to restrictions in international commerce. The infection rate in the Americas is estimated to be 5.9 per 10,000 head of cattle. The program for the eradication of foot-and-mouth disease, which covers 90% of cattle produced in the Americas, has achieved extension and consolidation of areas free of this disease.

7. Food-borne disease remains the most common cause of morbidity and mortality among children in the region. The appearance of cholera in 1991 has focused new attention on this problem. In many countries of Latin America and the Caribbean, street vendors manipulate and distribute 75% of foods consumed in urban areas, posing enormous problems for surveillance and control. Intoxication with foods of marine origin, such as ciguatera poisoning, is also a problem requiring increased attention.

8. Laboratory animals, especially nonhuman primates, serve important functions in public health, especially for disease diagnosis, studies of pathogenesis and vaccine quality control. While the expansion of human populations into rural areas disrupts natural habitats of nonhuman primates, the exploitation of these animals for commercial purposes has decreased considerably as a result of conservation efforts.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

9. The Strategic Orientations and Program Priorities for 1991-1994 and the Regional Plan for Investment in Environment and Health provide the basic framework for the strategy of cooperation in veterinary public health and food protection. These fields offer multiple opportunities for relationships with sectors other than health, including agriculture, economy, commerce, industry and education, thereby reinforcing the linkage of health and development.

10. The Program and specialized centers will promote norms and regulations which are compatible and consistent between countries and sectors in order to facilitate international commerce and subregional interchange. In addition, efforts will focus on the development and consolidation of local services for agricultural production, animal health and food protection. Reorganization of the health sector and strengthening management capacity will be essential for elimination of canine rabies, prevention of other zoonoses, eradication of foot-and-mouth disease and other projects.

11. The efficient application of resources requires a focus on risk groups, for example, in areas experiencing rapid migration where there is a heavy demand on existing health services and the threat of introduction of new diseases, including zoonoses. In tourist areas, there is a need to improve the health of local populations, as well as protect tourists' health, since tourism is important source of income to local populations.

12. Activities in health promotion, social communication and community involvement will be utilized to achieve goals of eradication of foot-and-mouth disease, elimination of canine rabies and the protection of foods. The strategy of consumer protection will promote availability of safe and nutritious foods.

13. In many settings, women and children are at particular risk of several zoonoses because of their role in handling domestic animals. Since women play a key role in the home and in small agricultural production, their health is important to secure family income and food safety.

14. The management of knowledge and information is essential for the efficient and effective use of available resources. Mobilization of additional resources

will be necessary to ensure the elimination of canine rabies, the eradication of foot-and-mouth disease and the implementation of regional programs for food protection. In additional to cooperation with other international agencies, involvement of the private sector will be essential.

15. Technical cooperation among countries will be necessary for the control and elimination of disease in border areas and the free movement of commercial products.

SPECIFIC PROGRAMS

Food safety (FOS)

BIENNIAL TARGETS

16. To complete the inventory of institutions performing food protection activities in the countries of Latin America and the Caribbean.

17. To promote the organization of intersectoral and interinstitutional national committees for food protection in the countries of the English-speaking Caribbean and in Central America, the Andean Region, the Southern Cone, and Brazil.

18. To collaborate in performing situation analyses and formulating national plans of action for food protection in the countries of the Caribbean and Central America.

19. To promote and contribute to the harmonization of food protection standards under the subregional integration initiatives, using the Codex Alimentarius as a frame of reference.

20. To collaborate in reviewing and adapting legislation and standards for food protection, in the countries of the Caribbean, Central America, the Andean Region, the Southern Cone, and Mexico.

21. To arrange for the organization of national food analysis laboratory networks in the countries of the Andean Region, the Southern Cone, and Brazil.

22. To promote the development of subregional food analysis laboratory networks in the English-speaking Caribbean, the Latin Caribbean, and Central America.

23. To collaborate in the application of the Hazard Analysis Critical Control Point (HACCP) method of food inspection in all countries of the Region.

24. To collaborate in the harmonization of analytical methods and techniques in all countries of the Region.

25. To refine the implementation of and evaluate the development of the food-borne diseases (FBD) epidemiological surveillance network.

26. To cooperate with the countries in the mobilization of the private sector and the NGOs for the development of educational programs on consumer protection. Latin Caribbean and Southern Cone.

27. To prepare guidelines and manuals on food hygiene and food handling for schoolchildren, housewives, street vendors, and institutional kitchens.

28. To promote the incorporation of food protection activities into tourism programs, in particular: surveillance of food-borne toxic infections; distribution of information on food hygiene; strengthening of education on food protection in Schools of Hotel Management and Tourism.

LINES OF ACTION

29. Creation of intersectoral committees.

30. Formulation of situation analyses and national plans of action.

31. Review and adaptation of legislation on food protection.

32. Organization of networks of laboratories for microbiological analyses and the analysis of chemical residues in food, in order to supplement measures for the sanitary surveillance of food.

33. Application of the hazard analysis critical control point (HACCP) system to food inspection.

34. Development and strengthening of the national networks and the regional network for epidemiological surveillance of FBD.

35. Mobilization and organization of community groups with a view to their participation in food protection activities.

36. Development of model educational programs in food protection for various groups.

37. Development of food protection activities in local health systems, particularly in tourist areas.

38. Development of food hygiene models for street vendors.

Foot-and-mouth disease (FMD)

BIENNIAL TARGETS

39. To safeguard the status of those countries that are free of foot-and-mouth disease in Central America, North America, Uruguay, and Chile.

40. To strengthen the project for the eradication of foot-and-mouth disease in the La Plata River Basin, including the border areas of Brazil.

41. To sustain the program for the eradication of foot-and-mouth disease in the Andean Subregion and to extend the free area from the north of Colombia.

42. To foster control in the central eastern, eastern, and northeastern regions of Brazil in the Amazon Subregion.

43. To collaborate in the strengthening of the systems for epidemiological surveillance and prevention in ports, airports, and land borders in all the countries free of foot-and-mouth disease.

44. To strengthen the Argentina-Chile, Argentina-Uruguay, Brazil-Uruguay, Brazil-Guyana, and Colombia-Panama border programs for the prevention of foot-and-mouth disease.

45. To lend support to the countries in the affected area and those free of foot-and-mouth disease for the operation and enhancement of the system of information and epidemiological surveillance.

46. To continue to lend support so that the countries may incorporate other animal diseases and zoonoses into the hemispheric system of epidemiological surveillance.

47. To support the development of production models for organic comprehensive stock breeding for small producers in Central America and South America.

48. To support the countries of South America in the development of standards and procedures to be used in the international markets for animals and products of animal origin.

LINES OF ACTION

49. Intrainstitutional, interinstitutional, intersectoral, and intercountry coordination to strengthen programs for the eradication of foot-and-mouth disease.

50. Strengthening of laboratories for the production and monitoring of vaccines for foot-and-mouth disease.

51. Structuring of plans for the prevention of foot-and-mouth disease and other exotic diseases.

52. Organization of emergency plans for possible outbreaks of exotic diseases.

53. Strengthening of quarantine services.

54. Expansion and strengthening of the hemispheric system of epidemiological surveillance.

Zoonosis (ZNS)

BIENNIAL TARGETS

55. To update the identification of areas at risk for urban rabies in all the countries.

56. To support the continuation of mass canine vaccination campaigns in high-risk areas in Brazil, Bolivia, Peru, Ecuador, Mexico, El Salvador, Haiti, Honduras, and Guatemala.

57. To support the development of selective vaccination of the canine population in medium-risk areas in Mexico, Nicaragua, Costa Rica, Belize, Colombia, Venezuela, Argentina, Chile, and Paraguay.

58. To support the maintenance of ongoing vaccination programs in order to prevent the reintroduction of urban rabies into cities and areas that are free of the disease.

59. To collaborate with the governments in the development of a methodology to declare countries, cities, and areas free of urban rabies (Argentina, Chile, Uruguay, Paraguay, Colombia, Venezuela, Peru, Panama, Costa Rica, Nicaragua, Cuba, and the English-speaking Caribbean).

60. To support the ongoing education of human resources on procedures for the care of people exposed to the risk of rabies.

61. To arrange for the strategic availability of canine rabies vaccines for high-risk areas.

62. To strengthen epidemiological surveillance of urban rabies and the integration of wildlife rabies into the system in all the countries.

63. To support the characterization of areas of risk and the implementation of surveillance systems for rabies transmitted by vampire bats in Guyana, Suriname, Trinidad and Tobago, Colombia, Venezuela, Brazil, Ecuador, Peru, Central America and Mexico.

64. To collaborate in the strengthening of the network of laboratories for rabies diagnosis in Guyana, Suriname, Trinidad and Tobago, Colombia, Brazil, Ecuador, Peru, Mexico, El Salvador, Guatemala, and Honduras.

65. To collaborate with the countries of the Caribbean in the implementation of plans for the surveillance and control of leptospirosis.

66. To support the implementation of national plans for the eradication of bovine tuberculosis in Uruguay, Paraguay, Chile, Colombia, Venezuela, Costa Rica, Cuba, and Guyana.

67. To formulate regional strategies and a regional plan of action for the eradication of bovine brucellosis.

68. To collaborate in the implementation and development of systems of epidemiological surveillance for equine encephalitis in the Andean Region, Central America, and the English-speaking Caribbean.

69. To collaborate in the establishment of programs for eradication of hydatid disease in Argentina, Chile, Brazil, Uruguay, and Peru.

70. To promote and support the development of programs for the elimination of taeniasis and cysticercosis in at least fifty foci of the affected countries.

71. To support the characterization of zoonoses prevalent in major cities. (Argentina, Brazil, Uruguay, Chile, Colombia, Venezuela, and Mexico).

72. To collaborate in the development of diagnostic techniques for the zoonoses emerging in urban areas.

73. To support the development of activities for the control of harmful fauna in the health and tourism program of the English-speaking Caribbean.

74. To formulate guidelines and policies for the protection of the environment with regard to the possession of productive and pet animals.

75. To continue support for the development of national primatology programs in Bolivia, Brazil, Colombia, Peru, Paraguay, Mexico, Guyana, and Barbados.

76. To support the provision of an adequate supply of laboratory animals for the diagnosis of diseases and control of biologicals.

77. To promote the application of programs for the control of zoonoses or for food protection in local health systems, in six countries of the Region.

78. To collaborate in the improvement of laboratory services for animal health and/or veterinary public health in all countries of the Region.

79. To support the institutional development of schools of veterinary medicine with regard to courses in veterinary public health education.

LINES OF ACTION

80. Identification of urban rabies risk areas.

81. Consolidation of national plans for mass canine vaccination in high-risk areas.

82. Strengthening of the system for epidemiological surveillance of rabies.

83. Updating of the procedures for the care of exposed persons.

84. Production and availability of vaccines for canine use.

85. Improvement of diagnostic techniques.

86. Declaration of countries, cities, and areas free of urban rabies.

87. Development of programs for the eradication of tuberculosis and brucellosis.

88. Development of programs for the elimination of hydatid disease and of taeniasis and cysticercosis.

89. Development of subregional programs of surveillance for equine encephalitis and leptospirosis.

90. Characterization of zoonosis risks in urban areas.

91. Control of harmful fauna.

92. Surveillance of potentially zoonotic diseases.

93. Protection of the environment with regard to the possession of productive and pet animals.

94. Control of the rational use of pesticides in animal production.

95. Conservation, breeding, and rational use of nonhuman primates.

96. Strengthening of animal colonies.

97. Development of in vitro models for the gradual replacement of in vivo models.

98. Development of zoonosis control programs and food protection programs for application in local health systems.

99. Strengthening of organizational, administrative, and technical aspects of animal health laboratories and veterinary public health laboratories.

100. Strengthening of education in veterinary public health in the schools of veterinary medicine.

## 16. VETERINARY PUBLIC HEALTH (CONT.)

### PROGRAM BUDGET DISTRIBUTION BY LOCATION

| LOCATION | PAHO AND WHO REGULAR BUDGET 1992-1993 | 1994-1995 | 1996-1997 | EXTRABUDGETARY FUNDS 1992-1993 | 1994-1995 | 1996-1997 |
|---|---|---|---|---|---|---|
| DIRECT COOPERATION WITH COUNTRIES | 4,178,700 | 4,193,600 | 4,579,000 | 2,791,600 | 550,000 | 0 |
| REGIONAL PROGRAMS | 1,079,100 | 1,185,600 | 1,287,000 | 150,600 | 159,600 | 170,700 |
| CENTERS | 11,724,300 | 11,665,800 | 13,031,800 | 8,603,200 | 8,554,700 | 9,020,000 |
| TOTAL | 16,982,100 | 17,045,000 | 18,897,800 | 11,545,400 | 9,264,300 | 9,190,700 |

### ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL PROF. POSTS | PERSONNEL LOCAL POSTS | PERSONNEL CONS. DAYS | PERSONNEL AMOUNT | DUTY TRAVEL AMOUNT | FELLOWSHIPS MONTHS | FELLOWSHIPS AMOUNT | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 14,176,900 | 30 | 57 | 670 | 10,115,900 | 589,800 | 150 | 300,000 | 433,600 | 716,700 | 0 | 2,020,900 |
| WHO - WR | 2,805,200 | 7 | 4 | 820 | 1,927,900 | 240,100 | 43 | 86,000 | 206,800 | 176,700 | 0 | 167,700 |
| TOTAL | 16,982,100 | 37 | 61 | 1490 | 12,043,800 | 829,900 | 193 | 386,000 | 640,400 | 893,400 | 0 | 2,188,600 |
| % OF TOTAL | 100.0 | | | | 70.8 | 4.9 | | 2.3 | 3.8 | 5.3 | .0 | 12.9 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 13,811,100 | 29 | 54 | 917 | 10,198,400 | 555,100 | 125 | 250,000 | 711,300 | 758,000 | 0 | 1,338,300 |
| WHO - WR | 3,233,900 | 8 | 4 | 896 | 2,312,400 | 225,200 | 40 | 80,000 | 242,100 | 199,200 | 0 | 175,000 |
| TOTAL | 17,045,000 | 37 | 58 | 1813 | 12,510,800 | 780,300 | 165 | 330,000 | 953,400 | 957,200 | 0 | 1,513,300 |
| % OF TOTAL | 100.0 | | | | 73.4 | 4.6 | | 1.9 | 5.6 | 5.6 | .0 | 8.9 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 15,388,400 | 29 | 54 | 917 | 11,340,400 | 627,200 | 125 | 250,000 | 804,600 | 859,400 | 0 | 1,506,800 |
| WHO - WR | 3,509,400 | 8 | 4 | 896 | 2,486,500 | 248,300 | 40 | 80,000 | 273,600 | 222,600 | 0 | 198,400 |
| TOTAL | 18,897,800 | 37 | 58 | 1613 | 13,826,900 | 875,500 | 165 | 330,000 | 1,078,200 | 1,082,000 | 0 | 1,705,200 |
| % OF TOTAL | 100.0 | | | | 73.3 | 4.6 | | 1.7 | 5.7 | 5.7 | .0 | 9.0 |

## ANALYSIS OF THE HEALTH SITUATION

1. Administration provides the full administrative support activities for both the Headquarters and Field Offices. It includes the formulation of policy for and the functions and operations of Budget, Finance, Personnel, General Services and Headquarters Operating Expenses, and Procurement.

2. Budgetary policies and procedures as well as budget development and execution activities provide the basic financial infrastructure for the Organization's programs. These activities include the operation, control and analysis of the monetary portion of the program budget (including extrabudgetary funding) in order to ensure an efficient and effective utilization of the available funds for the program.

3. Financial management of the Organization includes execution of financial rules and regulations with supporting procedures, sound accounting policies and systems, banking and investment of the Organization, field office financial administration, health insurance, payroll, pension and income tax administration, and financial management of extrabudgetary grants.

4. Personnel management programs will have as their primary objective the enhancement of the quality of technical cooperation which the staff of the Region renders to the Member Countries. The programs will be adapted to the continuing goals of administrative reforms designed to achieve decentralization and simplification of administrative procedures and decision-making processes. Within this context, major emphasis will be placed on providing support to augment the administrative skills and capabilities of the Region at the country level. The various approaches selected will further reflect policies and priorities concerning the geographical representation of the Member Countries on the staff and the recruitment of women to professional and higher-graded posts. The use of special agreements will be expanded for the hiring of national project personnel on PAHO/WHO projects in order to mobilize the diversity and scope of the cooperation available from national sources. For staff at all levels, their development, training, utilization and evaluation will likewise receive priority attention. In the process, more emphasis will be put on participatory, rather than individualistic, management, and the staff will be encouraged to participate effectively by providing inputs into personnel advisory boards and working groups.

5. General Services and Headquarters Operating Expenses activities include responsibility for providing administrative services support, building and other services for the Organization. Specific responsibilities include the development of administrative norms and guidelines on telecommunications, mail, management of reproduction services, building maintenance and insurance coverage for real estate, installations and equipment throughout the Organization. The estimates for the various general operating expenses for the Washington Office are shown by major expense items in the schedules. Costs are apportioned on a pro rata basis between funds budgeted under PAHO and WHO.

6. The procurement and related supply services for the operating programs of the Organization and procurement and shipment of supplies and equipment on behalf of Member Countries and of WHO are essential activities of administrative support for the Organization's Program.

## GLOBAL STRATEGY OF COOPERATION

7. The basic strategy is to provide efficient and effective administrative support for both Headquarters and Field Offices, to include budgetary, financial, personnel, general services and procurement activities.

8. The specific programs under Administration will respond to the Program Priorities established by the Governing Bodies and the Director by providing required administrative support to the programs established by the Headquarters technical units and country offices and by supervising the administrative support activities of the Organization.

## SPECIFIC PROGRAMS

### BUDGET AND FINANCE (BFI)

#### BIENNIAL TARGETS

9. Maintain policies and procedures for the functions and operations of a sound budgetary system for the Organization.

10. Maintain policies and procedures for the functions and operations of a sound financial management system for the Organization.

#### LINES OF ACTION

11. Establish, formulate and maintain budgetary policies and procedures to provide basic budgetary infrastructure for the implementation of program activities of the Organization and to continue to maintain a sound budgetary management system for the Organization.

12. To continue and maintain the integration of the computerized program budget planning system with the overall financial management system.

13. Supervision of the analysis and forecasting of delivery rates and make recommendations to top management as to whether the program budget should be increased due to projected savings or cut due to projected deficits in order to insure maximum deployment and utilization of funds.

14. Operation, control and analysis of the monetary portion of the annual operating program budget, including extrabudgetary funding, in order to insure efficient and effective utilization of the available funds to the programs. Determination of the status of the APB delivery in order to prepare supporting documentation and recommendations for periodic budget reviews and potential adjustments. Rephasing and closure of extrabudgetary projects. Constant analysis of the funding situation and delivery in order to advise the Director on the efficient and effective utilization of funds.

15. Establish and maintain sound financial management policies and procedures for the effective implementation of program activities of the Organization and continue to comply with the financial rules and regulations of the Organization. To continue to cooperate and participate in the development and implementation of an effective computerized accounting and payments system within the overall financial management system. Maintenance of books and records which accurately reflect the financial transactions of the Organization and provision of financial reports thereon which meet generally accepted accounting principles and standards. Establish and maintain a sound financial payment services system in support of the Organization's programs and projects.

## GENERAL SERVICES AND HEADQUARTERS OPERATING EXPENSES (PGS)

### BIENNIAL TARGETS

16. To assure effective management of PAHO's properties, communication services and other general operations.

### LINES OF ACTION

17. Activities related to the overall management and operation of the headquarters building, provision of office supplies, equipment and furniture, insurance, inventory, transportation, parking, receiving and dispatching, warehousing, communications, word processing, printing and reproduction. Maintenance and repair of the headquarters building and leased office space. Management of the funds for general operating expenses and other special funds that may be allocated to ACG.

## PERSONNEL (PER)

### BIENNIAL TARGETS

18. To execute effective, coordinated personnel services and programs throughout the Organization, fulfilling the commitments of the Secretariat to the Governing Bodies, as well as the essential needs of the management and the staff in areas of broad personnel administration.

### LINES OF ACTION

19. To determine the classification level of the professional and general services positions throughout the Organization.

20. To coordinate compensation and salary matters including GS salary scales, post adjustment, allowances, benefits, and other related issues.

21. To develop and recommend revised or new post classification criteria.

22. To coordinate with other international and UN organizations on matters related to post classification and salaries.

23. To define and administer the recruitment and promotion functions of the Organization, including the provision of information to applicants and the maintenance of the candidate register.

24. To issue and provide advice on the use of Contractual Service Agreements.

25. To administer the recruitment programs related to Short-Term Consultants (STC), Temporary Advisers (TA), Conference Staff and National Professionals, in accordance with the Organization's policies and practices.

26. To maintain pertinent data and files for analysis and reporting of these programs.

27. To maintain the personnel files of staff members from their date of appointment to their date of termination and to ensure, in the process, the provision of the benefits due to the staff under the Staff Regulations and Rules.

28. To be responsible for the issuance of the Staff Information Roster and other computer-generated reports on the staff.

29. To coordinate personnel program activities within the Department and to establish effective consultative relation with the staff representatives by way of correspondence, meetings, and discussions.

30. To prepare appeals at the level of the Board of Appeal.

31. To develop and administer the Staff Regulations and Rules and other personnel administrative procedures.

32. To review the documentation/actions emanating from CCAQ/ACC and ICSC and to maintain an appropriate system of records on personnel policy matters.

33. To collect and study statistical information and to prepare reports in the field of PAHO personnel management.

## PROCUREMENT (SUP)

### BIENNIAL TARGETS

34. To assure timely an efficient procurement of supplies, equipments and services for the Organization and for the Member Countries.

### LINES OF ACTION

35. Purchase equipment, supplies and services in a worldwide market in response to requests from PAHO headquarters, PAHO/WHO projects, Member Governments and other agencies. Arrange shipment of equipment and supplies to ultimate consignees.

17. ADMINISTRATION (CONT.)

PROGRAM BUDGET DISTRIBUTION BY LOCATION

| LOCATION | PAHO AND WHO REGULAR BUDGET 1992-1993 | 1994-1995 | 1996-1997 | EXTRABUDGETARY FUNDS 1992-1993 | 1994-1995 | 1996-1997 |
|---|---|---|---|---|---|---|
| TECHNICAL AND ADMINISTRATIVE DIRECTION | 24,905,300 | 26,765,100 | 29,129,700 | 6,882,300 | 4,607,600 | 4,957,100 |
| TOTAL | 24,905,300 | 26,765,100 | 29,129,700 | 6,882,300 | 4,607,600 | 4,957,100 |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL PROF. POSTS | PERSONNEL LOCAL POSTS | PERSONNEL CONS. DAYS | PERSONNEL AMOUNT | DUTY TRAVEL AMOUNT | FELLOWSHIPS MONTHS | FELLOWSHIPS AMOUNT | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 18,007,700 | 31 | 81 | 0 | 12,134,500 | 115,000 | 0 | 0 | 0 | 14,300 | 0 | 5,743,900 |
| WHO - WR | 6,897,600 | 9 | 22 | 0 | 3,563,500 | 52,300 | 0 | 0 | 0 | 0 | 0 | 3,281,800 |
| TOTAL | 24,905,300 | 40 | 103 | 0 | 15,698,000 | 167,300 | 0 | 0 | 0 | 14,300 | 0 | 9,025,700 |
| % OF TOTAL | 100.0 | | | | 63.0 | .7 | | .0 | .0 | .1 | .0 | 36.2 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 20,347,200 | 32 | 80 | 0 | 13,510,400 | 109,800 | 0 | 0 | 0 | 48,700 | 0 | 6,678,300 |
| WHO - WR | 6,417,900 | 7 | 22 | 0 | 3,534,400 | 52,400 | 0 | 0 | 0 | 18,400 | 0 | 2,812,700 |
| TOTAL | 26,765,100 | 39 | 102 | 0 | 17,044,800 | 162,200 | 0 | 0 | 0 | 67,100 | 0 | 9,491,000 |
| % OF TOTAL | 100.0 | | | | 63.6 | .6 | | .0 | .0 | .3 | .0 | 35.5 |
| 1998-1999 | | | | | | | | | | | | |
| PAHO - PR | 22,147,300 | 32 | 80 | 0 | 14,749,900 | 118,900 | 0 | 0 | 0 | 52,600 | 0 | 7,225,900 |
| WHO - WR | 6,982,400 | 7 | 22 | 0 | 3,862,400 | 56,700 | 0 | 0 | 0 | 19,900 | 0 | 3,043,400 |
| TOTAL | 29,129,700 | 39 | 102 | 0 | 18,612,300 | 175,600 | 0 | 0 | 0 | 72,500 | 0 | 10,269,300 |
| % OF TOTAL | 100.0 | | | | 63.9 | .6 | | .0 | .0 | .2 | .0 | 35.3 |

## III. SUMMARY BY LOCATION

## III. SUMMARY BY LOCATION

COUNTRY PROGRAMS

1. The country programs continue to be the central focus of the proposed program and budget for 1994-1995 and this philosophy represents a further strengthening of the key principle underlying the managerial strategy of PAHO/WHO which emphasizes the country as the basic unit of production. All the resources of the Organization, whether or not they are applied primarily at the country level serve to strengthen the technical cooperation at that level.

2. The process for formulating the country program is rooted in discussions and agreement with national authorities. These discussions take account of the national economic and social situation, the prevailing priorities in the health sector, the priority needs for technical cooperation, and ultimately the identification of those needs for which technical cooperation is required from PAHO/WHO.

3. The development of the country programs also takes account, where pertinent, of the recommendations of the Joint Evaluations of the PAHO/WHO technical cooperation at the country level. This process involves an examination by the national authorities and PAHO/WHO of the effectiveness of technical cooperation given and determination of the adjustments needed in terms of strategy or resource allocation.

4. The country programs reflect not only the peculiarly local situation, but also the collective Regional mandates and recommendations agreed upon by the Governing Bodies of the Organization. The programs have also been cast in such a manner that the technical cooperation from PAHO/WHO faithfully reflects the Strategic Orientations and Program Priorities for the Quadrennium 1991-1994 which were adopted by the XXIII Pan American Sanitary Conference in September 1990. These Strategic Orientations and Program Priorities give emphases and directions appropriate to new realities and provide continuity with similar directions accepted by the previous Sanitary Conference in which particular stress was laid on technical cooperation to strengthen and transform the health system infrastructure, particularly through the development and/or improvements of the local health systems. This focus on local health systems will permeate all the country programs. Particular attention will be given to that strategic orientation which deals with Health Development, in particular to the national expressions of the activities which PAHO/WHO will carry out to promote the acceptance of health as an indicator of and an instrument of human development. The country program will also reflect the local operations of the Regional Plan for investment in the Environment and Health.

5. In addition to indicating the key results areas to which the PAHO/WHO technical cooperation can best be applied, the country programs also reflect the strategic approaches to be used in delivering such cooperation. Among the most important of these is the mobilization of resources to address the identified problems. In this context the technical cooperation among countries will assume greater importance and the country programs will also indicate the participation in the various subregional health initiatives. Considerable attention has been given to identifying results to be expected, and the indicators for achieving these results, thus enhancing the capacity of the Organization to monitor and evaluate the technical cooperation.

6. The process of preparing the country programs involves discussion with national authorities, as mentioned above, formulation of a program and budget within the framework of a series of projects, examination of these by the appropriate technical units and final review by the Director and his Advisory Committee. The results of this iterative and participatory process are found in the following section.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 58,459,800 | 70.2 | 64,815,900 | 69.2 | 71,886,200 | 69.6 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 20,852,300 | 25.0 | 24,469,600 | 25.9 | 27,582,200 | 26.6 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 20,852,300 | 25.0 | 24,469,600 | 25.9 | 27,582,200 | 26.6 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 2,371,800 | 2.8 | 2,704,700 | 2.9 | 3,067,200 | 3.0 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 2,371,800 | 2.8 | 2,704,700 | 2.9 | 3,067,200 | 3.0 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 5,119,600 | 6.1 | 5,586,200 | 6.0 | 6,127,400 | 5.9 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 5,119,600 | 6.1 | 5,586,200 | 6.0 | 6,127,400 | 5.9 |
| HEALTH POLICY DEVELOPMENT | | 1,445,600 | 1.8 | 1,467,000 | 1.6 | 1,632,700 | 1.6 |
| HEALTH POLICY ANALYSIS AND DEVELOPMENT | HDP | 1,301,000 | 1.6 | 1,198,400 | 1.3 | 1,335,300 | 1.3 |
| HEALTH ECONOMICS AND FINANCING | HDE | 98,200 | .1 | 106,900 | .1 | 115,900 | .1 |
| WOMEN, HEALTH AND DEVELOPMENT | WHD | 46,400 | .1 | 161,700 | .2 | 181,500 | .2 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 22,171,100 | 26.7 | 23,334,300 | 25.1 | 25,501,200 | 24.8 |
| HEALTH SERVICES DEVELOPMENT | DHS | 21,099,200 | 25.3 | 22,214,900 | 23.8 | 24,263,900 | 23.5 |
| ESSENTIAL DRUGS AND VACCINES | EDV | 633,900 | .8 | 855,100 | .9 | 946,300 | .9 |
| ORAL HEALTH | ORH | 143,300 | .2 | 76,100 | .1 | 84,400 | .1 |
| DISASTER PREPAREDNESS | DPP | 62,900 | .1 | 52,900 | .1 | 59,900 | .1 |
| HEALTH EDUCATION AND COMMUNITY PARTICIPATION | HED | 126,000 | .2 | 59,500 | .1 | 66,100 | .1 |
| REHABILITATION | RHB | 105,800 | .1 | 75,800 | .1 | 80,600 | .1 |
| HUMAN RESOURCES DEVELOPMENT | | 5,683,100 | 6.8 | 5,827,900 | 6.2 | 6,383,000 | 6.2 |
| HUMAN RESOURCES TRAINING | HRC | 950,100 | 1.1 | 1,064,700 | 1.1 | 1,192,400 | 1.2 |
| HUMAN RESOURCES EDUCATION | HRE | 4,733,000 | 5.7 | 4,763,200 | 5.1 | 5,190,600 | 5.0 |
| HEALTH INFORMATION SUPPORT | | 396,400 | .5 | 856,800 | .9 | 966,700 | .9 |
| PUBLIC INFORMATION | HBF | 0 | - | 175,800 | .2 | 199,300 | .2 |
| SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION | HBD | 396,400 | .5 | 681,000 | .7 | 767,400 | .7 |
| RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT | | 419,900 | .5 | 569,400 | .6 | 625,800 | .6 |
| RESEARCH PROMOTION AND DEVELOPMENT | RPD | 321,800 | .4 | 223,800 | .2 | 250,900 | .2 |
| HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT | HDT | 98,100 | .1 | 106,300 | .1 | 115,200 | .1 |
| RESEARCH AND DEVELOPMENT IN THE FIELD OF VACCINES | RDV | 0 | - | 239,300 | .3 | 259,700 | .3 |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| III. HEALTH SCIENCE AND TECHNOLOGY | | 24,957,300 | 29.8 | 28,708,500 | 30.8 | 31,524,100 | 30.4 |
| FOOD AND NUTRITION | | 705,400 | .8 | 652,700 | .7 | 723,900 | .7 |
| NUTRITION | NUT | 705,400 | .8 | 652,700 | .7 | 723,900 | .7 |
| ENVIRONMENTAL HEALTH | | 9,006,400 | 10.8 | 10,362,800 | 11.1 | 11,325,100 | 11.0 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 7,421,600 | 8.9 | 8,397,300 | 9.0 | 9,165,700 | 8.9 |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 1,521,400 | 1.8 | 1,898,800 | 2.0 | 2,084,900 | 2.0 |
| WORKERS' HEALTH | OCH | 63,400 | .1 | 66,700 | .1 | 74,500 | .1 |
| MATERNAL AND CHILD HEALTH | | 3,901,000 | 4.7 | 5,416,400 | 5.8 | 5,973,400 | 5.7 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 3,744,200 | 4.5 | 5,013,900 | 5.4 | 5,516,900 | 5.3 |
| IMMUNIZATION | EPI | 156,800 | .2 | 284,900 | .3 | 323,100 | .3 |
| DIARRHEAL DISEASES | CDD | 0 | - | 117,600 | .1 | 133,400 | .1 |
| COMMUNICABLE DISEASES | | 5,981,000 | 7.1 | 6,235,500 | 6.7 | 6,883,400 | 6.6 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 5,207,200 | 6.2 | 5,362,600 | 5.7 | 5,920,400 | 5.7 |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 15,700 | .* | 241,700 | .3 | 269,600 | .3 |
| VECTOR-BORNE DISEASES | VBC | 458,400 | .5 | 329,200 | .4 | 359,200 | .3 |
| MALARIA | MAL | 299,700 | .4 | 302,000 | .3 | 334,200 | .3 |
| HEALTH PROMOTION | | 3,145,500 | 3.8 | 3,509,700 | 3.8 | 3,847,700 | 3.7 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 3,088,500 | 3.7 | 3,509,700 | 3.8 | 3,847,700 | 3.7 |
| CANCER | CAN | 57,000 | .1 | 0 | - | 0 | - |
| VETERINARY PUBLIC HEALTH | | 2,218,000 | 2.6 | 2,531,400 | 2.7 | 2,770,600 | 2.7 |
| FOOD SAFETY | FOS | 957,000 | 1.1 | 916,600 | 1.0 | 1,000,500 | 1.0 |
| ZOONOSES | ZNS | 1,261,000 | 1.5 | 1,614,800 | 1.7 | 1,770,100 | 1.7 |
| GRAND TOTAL | | 83,417,100 | 100.0 | 93,524,400 | 100.0 | 103,410,300 | 100.0 |

* LESS THAN .05 PER CENT

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 33,878,100 | 46.3 | 8,212,600 | 26.5 | 413,000 | 46.6 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 1,334,800 | 1.8 | 391,000 | 1.3 | 413,000 | 46.6 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 1,334,800 | 1.8 | 391,000 | 1.3 | 413,000 | 46.6 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 136,800 | .2 | 0 | - | 0 | - |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 136,800 | .2 | 0 | - | 0 | - |
| HEALTH POLICY DEVELOPMENT | | 288,400 | .4 | 61,500 | .2 | 0 | - |
| HEALTH POLICY ANALYSIS AND DEVELOPMENT | HDP | 22,600 | .* | 0 | - | 0 | - |
| WOMEN, HEALTH AND DEVELOPMENT | WHD | 265,800 | .4 | 61,500 | .2 | 0 | - |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 31,945,400 | 43.7 | 7,760,100 | 25.0 | 0 | - |
| HEALTH SERVICES DEVELOPMENT | DHS | 22,084,600 | 30.1 | 6,630,100 | 21.4 | 0 | - |
| ESSENTIAL DRUGS AND VACCINES | EDV | 4,173,600 | 5.7 | 0 | - | 0 | - |
| ORAL HEALTH | ORH | 51,300 | .1 | 0 | - | 0 | - |
| DISASTER PREPAREDNESS | DPP | 4,347,800 | 6.0 | 0 | - | 0 | - |
| HEALTH EDUCATION AND COMMUNITY PARTICIPATION | HED | 52,700 | .1 | 0 | - | 0 | - |
| REHABILITATION | RHB | 1,235,400 | 1.7 | 1,130,000 | 3.6 | 0 | - |
| HUMAN RESOURCES DEVELOPMENT | | 167,600 | .2 | 0 | - | 0 | - |
| HUMAN RESOURCES EDUCATION | HRE | 167,600 | .2 | 0 | - | 0 | - |
| HEALTH INFORMATION SUPPORT | | 5,100 | .* | 0 | - | 0 | - |
| PUBLIC INFORMATION | HBF | 3,000 | .* | 0 | - | 0 | - |
| LANGUAGE SERVICES | HBL | 2,100 | .* | 0 | - | 0 | - |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 39,074,000 | 53.7 | 22,816,000 | 73.5 | 472,700 | 53.4 |
| FOOD AND NUTRITION | | 335,800 | .5 | 0 | - | 0 | - |
| NUTRITION | NUT | 335,800 | .5 | 0 | - | 0 | - |

## PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| ENVIRONMENTAL HEALTH | | 2,195,800 | 3.1 | 432,500 | 1.5 | 58,700 | 6.6 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 1,294,300 | 1.8 | 54,900 | .2 | 58,700 | 6.6 |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 784,700 | 1.1 | 361,600 | 1.2 | 0 | - |
| WORKERS' HEALTH | OCH | 116,800 | .2 | 16,000 | .1 | 0 | - |
| MATERNAL AND CHILD HEALTH | | 13,798,500 | 19.0 | 2,653,200 | 8.6 | 414,000 | 46.8 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 8,939,300 | 12.3 | 2,653,200 | 8.6 | 414,000 | 46.8 |
| ADOLESCENT HEALTH | ADH | 285,800 | .4 | 0 | - | 0 | - |
| ACUTE RESPIRATORY INFECTIONS | ARI | 334,300 | .5 | 0 | - | 0 | - |
| IMMUNIZATION | EPI | 1,650,900 | 2.3 | 0 | - | 0 | - |
| DIARRHEAL DISEASES | CDD | 2,588,200 | 3.5 | 0 | - | 0 | - |
| COMMUNICABLE DISEASES | | 21,866,700 | 30.0 | 19,730,300 | 63.4 | 0 | - |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 2,615,700 | 3.6 | 54,700 | .2 | 0 | - |
| TUBERCULOSIS | TUB | 3,700 | .* | 0 | - | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 12,560,600 | 17.2 | 15,603,000 | 50.1 | 0 | - |
| VECTOR-BORNE DISEASES | VBC | 796,200 | 1.1 | 0 | - | 0 | - |
| MALARIA | MAL | 5,028,100 | 6.9 | 4,066,400 | 13.1 | 0 | - |
| PARASITIC DISEASES | PDP | 622,500 | .9 | 0 | - | 0 | - |
| LEPROSY | LEP | 72,300 | .1 | 0 | - | 0 | - |
| SEXUALLY TRANSMITTED DISEASES | VDT | 167,600 | .2 | 6,200 | .* | 0 | - |
| HEALTH PROMOTION | | 483,800 | .6 | 0 | - | 0 | - |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 36,000 | .* | 0 | - | 0 | - |
| TOBACCO OR HEALTH | TOH | 20,000 | .* | 0 | - | 0 | - |
| CANCER | CAN | 299,400 | .4 | 0 | - | 0 | - |
| PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE | ADA | 38,300 | .1 | 0 | - | 0 | - |
| OCULAR HEALTH | PBD | 90,100 | .1 | 0 | - | 0 | - |
| VETERINARY PUBLIC HEALTH | | 393,400 | .5 | 0 | - | 0 | - |
| FOOT-AND-MOUTH DISEASE | FMD | 239,100 | .3 | 0 | - | 0 | - |
| ZOONOSES | ZNS | 154,300 | .2 | 0 | - | 0 | - |
| GRAND TOTAL | | 72,952,100 | 100.0 | 31,028,600 | 100.0 | 885,700 | 100.0 |

* LESS THAN .05 PER CENT

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 49,291,100 | 69 | 111 | 9697 | 22,337,800 | 1,360,400 | 1424 | 2,836,000 | 6,365,800 | 3,892,900 | 107,200 | 12,391,000 |
| WHO - WR | 34,126,000 | 67 | 45 | 9390 | 17,403,400 | 1,184,300 | 1410 | 2,820,000 | 4,302,900 | 2,659,000 | 15,400 | 5,741,000 |
| TOTAL | 83,417,100 | 136 | 156 | 19087 | 39,741,200 | 2,544,700 | 2834 | 5,656,000 | 10,668,700 | 6,551,900 | 122,600 | 18,132,000 |
| % OF TOTAL | 100.0 | | | | 47.6 | 3.1 | | 6.8 | 12.8 | 7.9 | .1 | 21.7 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 53,996,500 | 64 | 119 | 8735 | 24,470,600 | 1,631,900 | 1200 | 2,400,000 | 6,801,600 | 3,975,200 | 613,200 | 14,104,000 |
| WHO - WR | 39,527,900 | 67 | 46 | 9556 | 19,551,800 | 1,294,900 | 1412 | 2,824,000 | 5,827,000 | 3,229,800 | 11,400 | 6,789,000 |
| TOTAL | 93,524,400 | 131 | 165 | 18291 | 44,022,400 | 2,926,800 | 2612 | 5,224,000 | 12,628,600 | 7,205,000 | 624,600 | 20,893,000 |
| % OF TOTAL | 100.0 | | | | 47.1 | 3.1 | | 5.6 | 13.5 | 7.7 | .7 | 22.3 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 60,065,600 | 64 | 119 | 8735 | 26,905,200 | 1,850,100 | 1200 | 2,400,000 | 7,713,400 | 4,507,700 | 695,400 | 15,993,800 |
| WHO - WR | 43,344,700 | 67 | 46 | 9556 | 21,071,000 | 1,468,100 | 1412 | 2,824,000 | 6,607,800 | 3,662,300 | 12,900 | 7,698,600 |
| TOTAL | 103,410,300 | 131 | 165 | 18291 | 47,976,200 | 3,318,200 | 2612 | 5,224,000 | 14,321,200 | 8,170,000 | 708,300 | 23,692,400 |
| % OF TOTAL | 100.0 | | | | 46.4 | 3.2 | | 5.1 | 13.8 | 7.9 | .7 | 22.9 |

## HEALTH SITUATION ANALYSIS

### Demography

1. Antigua and Barbuda had a population of 63,880 in 1991 with 32,767 females and 31,113 males.

### Health status indicators

2. The life expectancy at birth is 68.6 years for males and 71.9 for females. The infant mortality rate is 21.22 per 1,000 live births. The leading causes of mortality in 1992 were malignant neoplasms, heart disease, cerebrovascular diseases, hypertensive disease, diabetes mellitus, diseases of the digestive system, injury and poisoning. Among the children under 1 year, the main causes of mortality continue to be related to conditions in the perinatal period, acute respiratory infections and gastroenteritis. The recent program, conducted in schools, which seeks to change children's attitude towards eating habits and exercise has so far been successful.

### Factors affecting health status

3. The environment is a main concern. Solid waste disposal requires an improvement in management and the Cooks' dump site still requires upgrading. There is illegal dumping which is reflective of poor management of solid waste. Although some attempts were made at improving basic sanitation in Barbuda the problem is still serious. The sewerage system is presently operating inefficiently and the system of treating hospital sewage which runs through the city of St. Johns, cannot be described as adequate treatment. The exponential growth of itinerant vendors is presenting officials with a serious concern for food protection.

4. The decline in economic growth which started in 1988 continued into 1992. Preliminary estimates indicated that the growth rate in 1991 was 21%. The weak fiscal situation has led to the absence of public savings and has seriously constrained capital expenditure. In addition, the absence of an ongoing process of economic planning and investment has contributed to serious unplanned development with projects being devised without reference to national or sectoral objectives.

5. The health system, although reasonably distributed across the islands, is operated inefficiently due to the absence of good organization, management and leadership. This has impacted on the motivation of the workers in the deliver of the health care system. Attempts are being made to address the district health system which has the boundaries of the various sections of the health services cutting across each other. It is however, expected that the situation should improve due to the recent appointment of the new Chief Medical Officer.

### Plans and priorities for national health development

6. The Ministry of Health has the central authority for health. The Government has a stated commitment to the primary health care approach and the Caribbean Cooperation in Health. Thus the seven priority areas of the Caribbean Cooperation in Health are the priority areas together with the health of the elderly and mental health. Within these areas the priorities are: improvement in the management of the Holberton Hospital and the community health services; human resource development; environmental health; maternal and child health; and AIDS/STD.

7. Improvement in managing the Holberton Hospital and the community health services will require upgrading the information system including medical records at Holberton Hospital and the establishment of a hospital board to support the managerial change which is expected; the development of human resources will be addressed by manpower planning and intensification of effort in training a variety of areas; and the rationalization of the boundaries of all sections of the health system and the development of guidelines for the functioning of the district health services.

8. The environment is of major concern with challenge being in the area of solid waste management; sewage treatment and food protection. A health promotion program will be developed to address the behavioral changes required for the reduction of mortality from chronic non-communicable diseases with emphasis on hypertension, diabetes and HIV infection and other sexually transmitted diseases. The focus on vulnerable groups specifically on mothers and children will continue. The Ministry will work towards the attainment of the subregional targets of polio eradication of measles elimination. In addition the reduction of perinatal mortality has been identified as a priority.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

9. The Government will seek external assistance in the following areas: strengthening of health services; human resource development; environmental health; health promotion; and AIDS/STD.

10. To strengthen the health services, assistance will be sought to improve the management of the Holberton Hospital, with specific reference to the patient registration system and the medical records department. Environmental conditions must be improved especially in the areas of solid waste management, sewage treatment, food protection and the prevention and control of cholera. The establishment of a health promotion program is necessary to encourage modification in lifestyles in relation to the reduction of morbidity and mortality, as it relates to hypertension, diabetes and HIV infection and other sexually transmitted diseases. The retention of personnel and well trained staff is vital, hence support is required in manpower planning and training in a number of areas. Support is required in the prevention and control of AIDS and other sexually transmitted diseases.

National priorities for technical cooperation from PAHO/WHO

11. The areas for Technical Cooperation identified above are those which the Ministry will be requesting from PAHO/WHO. These priority areas are consistent with the priorities of the Caribbean Cooperation in Health and the Strategic Orientations and Programmatic Priorities.

12. In addition to the projects under the regular budget, extrabudgetary resources were mobilized for the following projects within the Caribbean Cooperation in Health: management of the community health information system, funded by the Inter-American Development Bank; projects are supported by the Italian Government in the following areas: maternal and child health, community based vector control and community based rehabilitation. A project for the prevention and control of cancer of the cervix is funded by the French Government. USAID has also approved a project which seeks to address financing, policy formulation and management of the system and UNDCP will be supporting activities relating to drug abuse.

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Community water supply and sanitation (CWS)

13. The purpose of the project is to increase the capacity to address environmental health issues. Achieving this purpose will require development of food protection programs; development of solid waste collection systems; and development of sewage treatment facilities.

Health services development (DHS)

14. The purpose of the project is to strengthen management systems to improve the efficiency of health services. To achieve this purpose it will be necessary to develop health manpower systems and support training for MCH personnel in key areas affecting mother and child mortality and morbidity; develop guidelines for the management of a child and family guidance program and audio-visual materials for public education; training will be provided to strengthen the management system at the hospital and community levels.

Growth, development & human reproduction (MCH)

15. The purpose of the project is to strengthen the functioning of MCH services through human resource development. To achieve this purpose, it will be necessary to update MCH personnel in the management of neonatal and infant mortality and morbidity; develop guidelines for the management of a child and family guidance program; and support the development and producing of audio visual materials aimed at public education.

## PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 121,300 | 70.5 | 128,300 | 70.2 | 135,300 | 70.1 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 121,300 | 70.5 | 128,300 | 70.2 | 135,300 | 70.1 |
| HEALTH SERVICES DEVELOPMENT | DHS | 121,300 | 70.5 | 128,300 | 70.2 | 135,300 | 70.1 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 50,800 | 29.5 | 54,400 | 29.8 | 57,700 | 29.9 |
| ENVIRONMENTAL HEALTH | | 33,800 | 19.6 | 36,100 | 19.8 | 38,400 | 19.9 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 33,800 | 19.6 | 36,100 | 19.8 | 38,400 | 19.9 |
| MATERNAL AND CHILD HEALTH | | 17,000 | 9.9 | 18,300 | 10.0 | 19,300 | 10.0 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 17,000 | 9.9 | 18,300 | 10.0 | 19,300 | 10.0 |
| GRAND TOTAL | | 172,100 | 100.0 | 182,700 | 100.0 | 193,000 | 100.0 |

## PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| III. HEALTH SCIENCE AND TECHNOLOGY | | 127,200 | 100.0 | 89,800 | 100.0 | 0 | |
| MATERNAL AND CHILD HEALTH | | 37,500 | 29.5 | 0 | - | 0 | |
| ADOLESCENT HEALTH | ADH | 37,500 | 29.5 | 0 | - | 0 | |
| COMMUNICABLE DISEASES | | 89,700 | 70.5 | 89,800 | 100.0 | 0 | |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 89,700 | 70.5 | 89,800 | 100.0 | 0 | |
| GRAND TOTAL | | 127,200 | 100.0 | 89,800 | 100.0 | 0 | |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 155,100 | 0 | 0 | 105 | 29,300 | 9,300 | 33 | 66,000 | 17,400 | 10,400 | 0 | 22,700 |
| WHO - WR | 17,000 | 0 | 0 | 40 | 10,700 | 0 | 0 | 0 | 5,100 | 1,200 | 0 | 0 |
| TOTAL | 172,100 | 0 | 0 | 145 | 40,000 | 9,300 | 33 | 66,000 | 22,500 | 11,600 | 0 | 22,700 |
| % OF TOTAL | 100.0 | | | | 23.2 | 5.4 | | 38.4 | 13.1 | 6.7 | .0 | 13.2 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 164,400 | 0 | 0 | 105 | 30,600 | 10,500 | 33 | 66,000 | 19,800 | 11,800 | 0 | 25,700 |
| WHO - WR | 18,300 | 0 | 0 | 40 | 11,100 | 0 | 0 | 0 | 5,800 | 1,400 | 0 | 0 |
| TOTAL | 182,700 | 0 | 0 | 145 | 41,700 | 10,500 | 33 | 66,000 | 25,600 | 13,200 | 0 | 25,700 |
| % OF TOTAL | 100.0 | | | | 22.8 | 5.7 | | 36.2 | 14.0 | 7.2 | .0 | 14.1 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 173,700 | 0 | 0 | 105 | 30,800 | 11,900 | 33 | 66,000 | 22,500 | 13,400 | 0 | 29,100 |
| WHO - WR | 19,300 | 0 | 0 | 40 | 11,100 | 0 | 0 | 0 | 6,600 | 1,600 | 0 | 0 |
| TOTAL | 193,000 | 0 | 0 | 145 | 41,900 | 11,900 | 33 | 66,000 | 29,100 | 15,000 | 0 | 29,100 |
| % OF TOTAL | 100.0 | | | | 21.7 | 6.2 | | 34.1 | 15.1 | 7.8 | .0 | 15.1 |

## HEALTH SITUATION ANALYSIS

### Demography

1. According to the national population census (1991), Argentina has approximately 33 million inhabitants, with an average annual growth rate of 1.5% between 1960 and 1990. The birth rate is 21 per thousand population, and mortality is nine per thousand. In 1990, 86% of the population was urban, compared with 74% in 1960.

### Health status indicators

2. Life expectancy at birth is 71 years (1990), and infant mortality has been calculated at 31 per thousand live births in 1989, which means that it has been reduced by half in the past three decades. Variations in this rate have been noted in the different provinces: for example, 16.9 per thousand in the federal capital and 34.6 per thousand in Jujuy. In 1988 only 15% of neonatal deaths were unavoidable (25% in the federal capital, and 7% in Jujuy). From an analysis of the provinces with the highest infant mortality rates in 1980 and of trends in these ratios, it can be seen that after a decade the situation remains essentially unchanged in most places.

3. An analysis of the period 1984-88 reveals that 60% of deaths among children aged 1-4 could have been avoided by means of simple and low-cost measures. The variations may be illustrated as follows: Unavoidable deaths accounted for 60% in the federal capital, as opposed to 12% in Chaco, and 9% in Salta.

4. Maternal mortality also shows significant variations, ranging from 13.2 per 10,000 live births in Chaco, down to 1.8 in Neuquen. The national average has experienced a downward trend in the past decade.

5. In regard to the major categories of causes of death, accidents and violence constitute the category that is growing most steadily. From 1970 to 1985, with respect to the category of circulatory system-related causes, there was an upward trend which has leveled off, and this cause began to be less significant in the last five years analyzed. The category of deaths caused by tumors has not undergone any drastic changes.

6. The most frequently reported communicable diseases are diarrhea, influenza, viral hepatitis, sexually transmitted diseases, and measles. In the case of Chagas' disease, it is mainly confined to endemic areas, but it is noteworthy that seropositive persons have been found areas traditionally considered non-endemic, such as La Plata (1.2%), the federal capital (1%), Neuquen (1%), and Bahía Blanca (0.5%).

### Factors affecting health status

7. The government has achieved significant progress in stabilizing the economy. The 1992 inflation rate was the lowest in the previous 20 years. There is great concern, however, about the difficulty of reversing the trend of ever-increasing poverty induced by the crisis of the past decade. The launching of the so-called social plan is an attempt to ameliorate that situation.

8. Environmental deterioration is also a matter of profound social concern. Just 59% of the population had access to drinking water in 1988. There are still major problems with the disposal of solid and toxic waste, low sewerage coverage, and industrial contamination.

9. The medical care system is made up of three large groups: The social welfare system encompasses 300 entities with annual revenue on the order of U.S$ 3.5 billion and furnishes health care for 65% of the population. The private providers, comprising 200 entities under a prepaid health care plan, cover 18% of the population and collect some $3 billion annually. Public health, which offers free services to 17% of the population, spends about $1.5 billion each year.

10. The participants in this market are changing, however. Having deregulated the social welfare system by decree, the government is preparing to allow private insurance companies to make inroads into the sector. The current changes have provoked a bitter debate between the unions and the private providers, particularly since some $7 billion a year are at stake.

### Plans and priorities for health development

11. Presidential Decree No. 1269-92 provides the legal framework for the substantive and administrative policies enunciated by the health authorities. These policies strive to integrate the health areas with the other social sectors. They seek, in addition, to reorganize health systems and health resources around the development of local services.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

12. The national authorities have recognized the need for technical cooperation in the following areas: implementation of the health policies formulated in 1992; decentralization, through strategic management of the local health services; deregulation of the social welfare system; environmental health; intersectoral coordination; health promotion through five operational areas, namely formulation of public policy, creation of an atmosphere of social support, strengthening of community action, development of personnel skills, and reorganization of health services; strengthening of the analytical capacity of health services; treatment for vulnerable groups, such as mothers, children, and elderly people; training of human resources; development of the state's capacity to exercise quality control over food, drugs, and medical technology consumed or used by the population; and formulation and implementation of national policies for the training and utilization of human resources for health.

13. The country receives significant financial cooperation from various institutions. Those relating to health are: the IDB program for municipal social investment ($300 million), the World Bank municipal development program ($40 million) the Government-IBRD program for maternal and child health and nutrition ($160 million),the IDB project for the construction and equipping of 40 health centers, and the IDB project for the development of primary health care ($12 million).

National priorities for technical cooperation from PAHO/WHO

14. The Argentine Government, through the Department of Health under the Ministry of Health and Social Action, and PAHO have agreed that technical cooperation in Argetina will be pricipally focused on: management of the environment and its influence on health; development of human resources for health; strengthening of the health services' capacity to analyze information with a view to facilitating decision-making; decentralization of health services; strengthening of the central level in its capacity to exercise quality control over products and services; and promotion of health integration with neighboring countries.

15. In addition to activities supported by regular funds, PAHO/WHO handles projects supported by non-regular funds. In the case of Argentina, the HIV project will be continued; that project seeks to design and coordinate actions to reduce the impact of the AIDS epidemic on the country's society.

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Community water supply and sanitation (CWS)

16. The purpose of this project is to aid in the implementation of environmental health policies, mainly those involving waste water and solid waste. In order to achieve this purpose, it will be necessary to strengthen the Department of Health's capacity for coordination; to mobilize technical groups to formulate policies and actions on health-related environmental management; and to carry out studies on specific problems, placing priority on the problem of drinking water. It will also be necessary to train supervisory and operational personnel.

Health services development (DHS)

17. The purpose of this project is to boost the implementation of the national health policies enacted during 1992. In order to achieve this end, it will be necessary, jointly with national, provincial, and municipal institutions, to develop local programming as a tool to support decision-making and facilitate the processes of negotiation and social participation within the frame of reference established by global policies and strategies; to establish multidisciplinary provincial committees for integrated work on the prevention and control of the principal health problems; to support the development of public quality control laboratories to test products consumed by the population; to consolidate the provincial maternal and child health care programs; and to train health personnel to prepare for natural disasters and other emergencies.

Human resources education (HRE)

18. The purposes of this project are to strengthen capacity for comprehensive management of human resources at the provincial level and to help meet needs in critical areas in the education of health personnel. In order to achieve these purposes, it will be necessary to consolidate the functions of the national commissions coordinating development of human resources, including physicians, nursing personnel, public health workers, and other health professionals; to define standards of accreditation for graduate-level medical programs at the national level; to train the technical teams of the provincial human resources units in methods of health personnel management; to support projects for innovation and transformation of the training models for physicians and nurses; and to enhance effectiveness of graduate-level programs in public health.

Health situation and trend assessment (HST)

19. The purpose of this project is to improve the quality of analysis of available information. In order to do so, it will be necessary to support the organization of epidemiological analysis units at the national, provincial, and local levels; to strengthen the analytical capacity of the health services; and to compile, publish, and disseminate the country's epidemiological studies.

Managerial support for national health development (MPN)

20. The purpose of this project is to provide management, technical, and administrative support for the delivery of technical cooperation. In order to achieve this purpose, it will be necessary to efficiently mobilize human, physical, and financial resources; to promote regional and subregional initiatives; and to monitor the delivery of technical cooperation.

Technical cooperation among countries (TCC)

21. The purpose of this project is to support subregional integration initiatives. In order to achieve this end, it will be necessary to concentrate efforts initially on the establishment of common norms and standards for the manufacture and marketing of food and drugs.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 3,983,400 | 91.5 | 4,498,800 | 84.6 | 5,117,500 | 84.8 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 1,575,500 | 36.1 | 1,930,300 | 36.3 | 2,262,000 | 37.5 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 1,575,500 | 36.1 | 1,930,300 | 36.3 | 2,262,000 | 37.5 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 132,800 | 3.1 | 150,600 | 2.8 | 170,800 | 2.8 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 132,800 | 3.1 | 150,600 | 2.8 | 170,800 | 2.8 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 396,500 | 9.1 | 180,800 | 3.4 | 203,900 | 3.4 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 396,500 | 9.1 | 180,800 | 3.4 | 203,900 | 3.4 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 982,200 | 22.6 | 1,103,900 | 20.8 | 1,254,800 | 20.8 |
| HEALTH SERVICES DEVELOPMENT | DHS | 982,200 | 22.6 | 1,103,900 | 20.8 | 1,254,800 | 20.8 |
| HUMAN RESOURCES DEVELOPMENT | | 896,400 | 20.6 | 1,133,200 | 21.3 | 1,226,000 | 20.3 |
| HUMAN RESOURCES EDUCATION | HRE | 896,400 | 20.6 | 1,133,200 | 21.3 | 1,226,000 | 20.3 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 370,300 | 8.5 | 816,400 | 15.4 | 918,900 | 15.2 |
| ENVIRONMENTAL HEALTH | | 370,300 | 8.5 | 816,400 | 15.4 | 918,900 | 15.2 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 370,300 | 8.5 | 816,400 | 15.4 | 918,900 | 15.2 |
| GRAND TOTAL | | 4,353,700 | 100.0 | 5,315,200 | 100.0 | 6,036,400 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 833,900 | 36.2 | 0 | - | 0 | |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 649,800 | 28.2 | 0 | - | 0 | |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 649,800 | 28.2 | 0 | - | 0 | |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 184,100 | 8.0 | 0 | - | 0 | |
| HEALTH SERVICES DEVELOPMENT | DHS | 159,000 | 6.9 | 0 | - | 0 | |
| ESSENTIAL DRUGS AND VACCINES | EDV | 25,100 | 1.1 | 0 | - | 0 | |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 1,467,900 | 63.8 | 540,000 | 100.0 | 0 | |
| ENVIRONMENTAL HEALTH | | 10,100 | .4 | 0 | - | 0 | |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 10,100 | .4 | 0 | - | 0 | |
| COMMUNICABLE DISEASES | | 1,457,800 | 63.4 | 540,000 | 100.0 | 0 | |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 1,324,300 | 57.6 | 0 | - | 0 | |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 133,500 | 5.8 | 540,000 | 100.0 | 0 | |
| GRAND TOTAL | | 2,301,800 | 100.0 | 540,000 | 100.0 | 0 | |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| **1992-1993** | | | | | | | | | | | | |
| PAHO - PR | 3,480,300 | 4 | 13 | 195 | 1,665,200 | 71,900 | 102 | 204,000 | 354,300 | 209,000 | 0 | 975,900 |
| WHO - WR | 873,400 | 2 | 0 | 60 | 435,600 | 80,500 | 0 | 0 | 183,600 | 78,300 | 0 | 95,400 |
| TOTAL | 4,353,700 | 6 | 13 | 255 | 2,100,800 | 152,400 | 102 | 204,000 | 537,900 | 287,300 | 0 | 1,071,300 |
| % OF TOTAL | 100.0 | | | | 48.2 | 3.5 | | 4.7 | 12.4 | 6.6 | .0 | 24.6 |
| **1994-1995** | | | | | | | | | | | | |
| PAHO - PR | 3,217,800 | 3 | 13 | 60 | 2,080,100 | 19,700 | 0 | 0 | 158,700 | 184,900 | 0 | 774,400 |
| WHO - WR | 2,097,400 | 3 | 0 | 150 | 828,000 | 97,900 | 150 | 300,000 | 408,200 | 140,500 | 0 | 322,800 |
| TOTAL | 5,315,200 | 6 | 13 | 210 | 2,908,100 | 117,600 | 150 | 300,000 | 566,900 | 325,400 | 0 | 1,097,200 |
| % OF TOTAL | 100.0 | | | | 54.8 | 2.2 | | 5.6 | 10.7 | 6.1 | .0 | 20.6 |
| **1996-1997** | | | | | | | | | | | | |
| PAHO - PR | 3,746,300 | 3 | 13 | 60 | 2,456,100 | 22,300 | 0 | 0 | 180,000 | 209,700 | 0 | 878,200 |
| WHO - WR | 2,290,100 | 3 | 0 | 150 | 890,700 | 111,000 | 150 | 300,000 | 463,000 | 159,300 | 0 | 366,100 |
| TOTAL | 6,036,400 | 6 | 13 | 210 | 3,346,800 | 133,300 | 150 | 300,000 | 643,000 | 369,000 | 0 | 1,244,300 |
| % OF TOTAL | 100.0 | | | | 55.4 | 2.2 | | 5.0 | 10.7 | 6.1 | .0 | 20.6 |

BAHAMAS

## HEALTH SITUATION ANALYSIS

### Demography

1. The Commonwealth of The Bahamas is an archipelago of some 700 islands and cays in the Atlantic Ocean. Of these islands, about 29 are inhabited. Nassau, the capital city, is located on New Providence island on which some 65% of the population live. The population of The Bahamas is estimated at 259,000 for 1992. The percentage of the population under 5 years is 32.2, whilst those over 65 years number 4.7. The annual population growth rate 1980-1990 was 1.97.

### Health status indicators

2. The life expectancy at birth (1990) is 67.5 for men and 74.9 for women. The leading causes of mortality for 1990 were malignant neoplasms, diseases of the heart and accidents/violence, in that order.

3. The infant mortality for 1990 was 24.4 per 1,000 live births, whilst maternal mortality was 0.2 per 1,000 live births.

4. The principal causes of death among children under one year include: perinatal conditions, congenital abnormalities, pneumonia, and accidents.

5. The coverage achieved by the Expanded Program on Immunization (EPI) has showed a steady increase since 1989. It is considered that coverage is in excess of 90% of those eligible.

6. Accidents and acts of violence are on the increase and, after maternity cases, are now the second leading cause of hospital admission.

7. The National Health and Nutrition Survey, 1988-1989, demonstrated that malnutrition was not a problem in The Bahamas, however, obesity, diabetes, and hypertension were major causes of morbidity. Of children under 5 years of age, 84% were of normal nutritional status, whilst 21.3% of adults were found to be moderately to severely obese.

8. As of September 1992, 1,010 cases of AIDS had been reported with 623 deaths and Bahamas has one of the highest reported incidences of AIDS in the region.

### Factors affecting health status

9. The wide geographical dispersion of The Bahamas presents inevitable logistical problems for the organization and delivery of health services.

10. The recent advances in the environmental situation are being challenged by a diversifying economy and the rapid demands for water and disposal services. Solid waste management as a problem has proven somewhat intractable and increasing policy initiatives for further industrialization are bringing up for consideration issues of pollution, industrial hygiene and occupational health. The percentage of households for 1989 without piped water was 19.4 and the percentage of households using pit latrine was 14.2.

11. The Bahamian economy, which is heavily dependent on tourism, has suffered as a consequence of the economic recessions in the United States, the source of the majority of tourists. The health sector has been adversely affected by the economic downturn, but Hurricane Andrew which struck The Bahamas in August 1992 and caused US$ 250 million worth of damage in North Eleuthera, Bemini and the Berry Island has also contributed to the problem.

12. The health services will be put under increasing strain to care for more of the increasing numbers of elderly and their chronic diseases as The Bahamas progressively shows the results of the demographic transition. The large influx of Haitian nationals to The Bahamas has also placed an added burden on the services. Alcohol and drug abuse, the latter mainly of cocaine, are also significant health problems.

13. In 1991, Government expenditure on health was US$ 361 per capita, and 15.6% of the government budget was allocated to health.

14. There are 14.6 physicians and 24.8 registered nurses per 10,000 population.

### Plans and priorities for national health development

15. The newly elected government has determined that the Ministry of Health be renamed the Ministry of Health and Environment, this change serving to highlight the priority being placed on environmental health and sustainable development. Emphasis will be placed on the efficient management of resources, decentralization of the health care systems, decentralizing management of hospitals and institutions to the institutional level, construction and expansion of community clinics and the provision of essential supplies and medicines.

16. At the secondary and tertiary care levels, the public sector operates three hospitals. Two of these are located in New Providence (the Princess Margaret Hospital - providing general acute care and specialized services; the Sandilands Rehabilitation Center - providing joint psychiatric and geriatric care). The third institution, Rand Memorial Hospital, is in Grand Bahamas. There are also two small private hospitals in New Providence.

17. The delivery of health care is based on a tiered approach comprising a network of health facilities, both public and private, with referral linkages between different levels of care. Increasing attention is being given to the strengthening of primary health care as the most feasible strategy to provide effective and efficient services to scattered population settlements throughout

the archipelago. To this end, a number of new primary care facilities are currently being completed in The Family Islands, whilst existing ones are being upgraded to provide increased services.

18. The Government has stated that it believes that all Bahamians have a right to full access to the health care system.

19. Health promotion, particularly as it relates to lifestyle changes is seen as a priority area. In this regard, the involvement of NGOs is already underway.

20. The number of activities relating to TCC can be seen to be on the increase and the Caribbean Cooperation in Health (CCH) initiative is reflected in the priorities of the Ministry of Health and Environment.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

21. The Government has identified the following areas for technical cooperation: institutional and management strengthening leading to evolution of the major health care institutions;decentralization of services and the further development of local health systems emphasizing the efficient management of resources; human resources development, particularly given the increased emphasis in maternal and child health, AIDS and drug abuse, care of the elderly and environmental issues; expanded coverage of potable water and correspondingly, increasing development of wastewater treatment and disposal systems; establishment of improved regulatory and enforcement capability in solid waste sector and marine and industrial pollution and occupational health; increasing capabilities in information systems and disease surveillance and control; support for the further development of the health promotion program follow-up on lifestyle changes, particularly in the areas of drug and alcohol abuse, AIDS, nutrition and certain types of cancer; and AIDS prevention and control.

22. To meet these needs for technical cooperation the National Drug Council has been meeting with UNDCP with a view to developing a demand reduction program. The IDB has shown interest in providing assistance in the areas of solid waste and sewage disposal and health planning. The private sector has been targetted for general support in developing local environmental programs and there is the real possibility that UNEP would provide support to the DEHS.

### National priorities for technical cooperation from PAHO/WHO

23. The Ministry of Health and Environment have agreed that PAHO/WHO will cooperate in all seven of the national priority areas. The general consensus is that PAHO/WHO's technical cooperation should, however, encompass major aspects of institutional strengthening, particularly in the decentralization of services; health promotion; strengthening of the drug management; financial and human resources sectors of the Ministry. The issues related to environment and sustainable development, should receive special attention and would include such issues as water quality, solid and liquid wastes disposal, marine and coastal pollution. This approach permits PAHO/WHO technical cooperation to provide increasing levels of support in the development of policies and plans related to manpower development, efficient uses of available resources, data gathering and interpretation, and the application of medium and long term planning criteria for improvements in the primary health care system. Tourism in general and ecotourism were identified also as topics in which PAHO/WHO should be involved.

24. The Bahamas, as a CARICOM country, participates in the CCH and is therefore involved particularly in the subregional projects; e.g., the MCH, Rehabilitation and Vector Control Projects which are receiving funding from the Italian Government. The relatively high per capita income of the country has reduced the possibility of major external concessionary funding in health, but there are still projects such as those in AIDS which will have the continued support of GPA with particular emphasis on educational efforts and laboratory (blood screening) strengthening. Proposals are now being developed for funding and improved water quality monitoring network.

## PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

### Community water supply and sanitation (CWS)

25. The purpose of this project is to improve the levels of water quality and the sanitation services in New Providence as well as in The Family Islands with emphasis on improved regulation and enforcement capability. The main line of cooperation will be the strengthening of a suitable institutional framework and training the needed personnel. Support will be given to developing the necessary policies and legislation to assist the decentralization of the management of the environmental health services. PAHO/WHO will cooperate in the design of the relation and enforcement procedures that are needed. The water resources in The Family Islands must be explored and exploited and least cost solution found for the problems of waste treatment and disposal.

### Health services development (DHS)

26. The purpose of this project is to enhance the management of resources allocated to the health sector with special reference to the decentralization of the health system to facilitate the delivery of care. The legislation will be updated and support will be given to improving the management practices in services. The local health systems will be developed or strengthened and particular attention given to the cooperation needed to advance the evolution of the major health care institutions. Key supervisory and operational personnel will be trained, mainly in the health administration areas and in the planning and coordination that would improve the functioning of major institutions and reduce the duplication of resources and services.

BAHAMAS (Cont.)

Acquired immunodeficiency syndrome (HIV)

27. The purpose of this project is to reduce the incidence of sexually transmitted diseases (STDs) and HIV infections. Non-traditional/innovative approaches to public education such as drama, street theater and peer outreach will be supported to increase condom use and delay sexual involvement. Training will be offered to a wide range of personnel and in The Family Islands this will be complemented by the provision of equipment to enhance the capacity to diagnose and treat STDs. Good quality reagents will continue to be made available. Support will be given to ensuring the continued safety of the blood supply and on enhancing clinical management and care.

Health situation and trend assessment (HST)

28. The purpose of this project is to enhance national capability in developing and maintaining systems for information collection, disease surveillance and control. The main direction of the technical cooperation will be towards the training of current staff through a variety of mechanisms including courses, seminars and workshops locally and abroad. PAHO/WHO will assist in providing expertise for further development of the existing surveillance system and the national policies to guide its most efficient use as a key ingredient in this planning and delivery of health care.

Growth, development and human reproduction (MCH)

29. The purpose of this project is to assist in strengthening the coordination of the Maternity and Child Health Services at the country level via a decentralized system. It is expected that the project will help to strengthenthe adolescent and school health services together with health promotion and health education in MCH. Technical cooperation for the EPI program is to be provided and the purchase of vaccines facilitated via the revolving fund. Research, with particular emphasis on CDD/ARI will also be supported.

Managemerial support for national health development (MPN)

30. The purpose of this project is to provide the support necessary for the most efficient planning, implementation, evaluation and coordination of the program of technical cooperation. PAHO/WHO will continue to provide the managerial support necessary not only for its technical cooperation program but also to enhance the functioning of the Ministry of Health and the Environment as it goes through the processes of organizational development decentralization andadministrative reform. The administrative and information processing capabilities of the Representation will be further developed and the documentation center progressively upgraded. This project will facilitate the liaison with other Caribbean countries particularly through the CCH. The activities related to women, health and development will fall within this area.

Health promotion and prevention and control of noncommunicable diseases (NCD)

31. This project will seek to stimulate the adoption of health promotion across several disciplines. A major effort will be geared towards mobilizing institutional resources, particularly non-governmental organizations (NGOs) to carry out health promotion activities, particularly at the community level. Health promotion will be directed mainly towards changing the life styles associated with chronic noncommunicable disease and prevention and control of alcohol and drugs. The National Drug Council will be supported. Key strategies will be the collection and dissemination of information and the training of a wide range of health and non-health personnel. Attempts will be made to stimulate the formulation of a national nutrition policy.

Technical cooperation among countries (TCC)

32. The purpose of this project is to promote and support those inter-country activities that benefit mutually The Bahamas and the cooperating countries. The project will identify those technical cooperation needs that can best be filled through TCC, but in addition will permit The Bahamas to contribute its expertise in specific areas that can be of benefit to other countries.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 705,500 | 67.9 | 775,500 | 68.2 | 842,700 | 68.0 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 516,800 | 49.8 | 512,900 | 45.1 | 558,200 | 45.1 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 516,800 | 49.8 | 512,900 | 45.1 | 558,200 | 45.1 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 20,100 | 1.9 | 22,800 | 2.0 | 25,900 | 2.1 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 20,100 | 1.9 | 22,800 | 2.0 | 25,900 | 2.1 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 16,700 | 1.6 | 29,300 | 2.6 | 32,600 | 2.6 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 16,700 | 1.6 | 29,300 | 2.6 | 32,600 | 2.6 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 151,900 | 14.6 | 210,500 | 18.5 | 226,000 | 18.2 |
| HEALTH SERVICES DEVELOPMENT | DHS | 151,900 | 14.6 | 210,500 | 18.5 | 226,000 | 18.2 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 334,200 | 32.1 | 363,200 | 31.8 | 396,900 | 32.0 |
| ENVIRONMENTAL HEALTH | | 252,400 | 24.3 | 286,200 | 25.1 | 311,200 | 25.1 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 252,400 | 24.3 | 286,200 | 25.1 | 311,200 | 25.1 |
| MATERNAL AND CHILD HEALTH | | 0 | - | 40,300 | 3.5 | 45,200 | 3.6 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 0 | - | 40,300 | 3.5 | 45,200 | 3.6 |
| COMMUNICABLE DISEASES | | 45,200 | 4.3 | 0 | - | 0 | - |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 45,200 | 4.3 | 0 | - | 0 | - |
| HEALTH PROMOTION | | 36,600 | 3.5 | 36,700 | 3.2 | 40,500 | 3.3 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 36,600 | 3.5 | 36,700 | 3.2 | 40,500 | 3.3 |
| GRAND TOTAL | | 1,039,700 | 100.0 | 1,138,700 | 100.0 | 1,239,600 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| III. HEALTH SCIENCE AND TECHNOLOGY | | 358,000 | 100.0 | 449,900 | 100.0 | 0 | |
| COMMUNICABLE DISEASES | | 335,100 | 93.6 | 449,900 | 100.0 | 0 | |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 335,100 | 93.6 | 449,900 | 100.0 | 0 | |
| HEALTH PROMOTION | | 22,900 | 6.4 | 0 | - | 0 | |
| PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE | ADA | 22,900 | 6.4 | 0 | - | 0 | |
| GRAND TOTAL | | 358,000 | 100.0 | 449,900 | 100.0 | 0 | |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 467,100 | 1 | 0 | 105 | 331,300 | 22,900 | 0 | 0 | 40,600 | 30,700 | 0 | 41,600 |
| WHO - WR | 572,600 | 1 | 1 | 90 | 343,400 | 13,900 | 18 | 36,000 | 22,800 | 26,300 | 0 | 130,200 |
| TOTAL | 1,039,700 | 2 | 1 | 195 | 674,700 | 36,800 | 18 | 36,000 | 63,400 | 57,000 | 0 | 171,800 |
| % OF TOTAL | 100.0 | | | | 64.9 | 3.5 | | 3.5 | 6.1 | 5.5 | .0 | 16.5 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 463,900 | 1 | 0 | 60 | 333,800 | 24,500 | 0 | 0 | 40,200 | 23,900 | 0 | 41,500 |
| WHO - WR | 674,800 | 1 | 1 | 265 | 446,700 | 13,600 | 16 | 32,000 | 31,300 | 25,000 | 0 | 126,200 |
| TOTAL | 1,138,700 | 2 | 1 | 325 | 780,500 | 38,100 | 16 | 32,000 | 71,500 | 48,900 | 0 | 167,700 |
| % OF TOTAL | 100.0 | | | | 68.6 | 3.3 | | 2.8 | 6.3 | 4.3 | .0 | 14.7 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 503,600 | 1 | 0 | 60 | 356,000 | 27,800 | 0 | 0 | 45,600 | 27,100 | 0 | 47,100 |
| WHO - WR | 736,000 | 1 | 1 | 265 | 481,700 | 15,400 | 16 | 32,000 | 35,500 | 28,300 | 0 | 143,100 |
| TOTAL | 1,239,600 | 2 | 1 | 325 | 837,700 | 43,200 | 16 | 32,000 | 81,100 | 55,400 | 0 | 190,200 |
| % OF TOTAL | 100.0 | | | | 67.6 | 3.5 | | 2.6 | 6.5 | 4.5 | .0 | 15.3 |

BARBADOS

## HEALTH SITUATION ANALYSIS

### Demography

1. Barbados had a population of 257,082 in 1990. Population growth over the decade of the 1980s has been influenced by migration and the population is expected to remain relatively stable during the biennium. Rates of natural increase are slowing, with the crude death rate increasing (from 7.6 per 1000 in 1981 to 9.1 per 1000 in 1990) and the crude birth rate falling (from 19.3 per 1000 in 1982 to 16.1 per 1000 in 1989). The population is ageing, with 11.8% being over the age of 65 in 1990, when 1.2% was very old (aged 85 and over).

### Health Status Indicators

2. Total life expectancy at birth was 75.1 years in 1990. Age-specific death rates have fallen during the decade of the 1980s, except for the age groups 15-44, where the death rates have increased.

3. The principal causes of mortality continue to be noncommunicable diseases and accidents. Paramount among these are: heart disease, cerebrovascular accidents, hypertension, diabetes mellitus and cancer. Hypertension is frequently a predisposing factor to both heart disease and cerebrovascular accidents and the available evidence indicates that there is an increase in prevalence of diabetes. Nutritional factors such as obesity and increasing fat consumption, are believed to underlie the increasing prominence of the chronic noncommunicable diseases mentioned.

4. Mortality in childhood has continued to decline, with perinatal causes, congenital anomalies and accidents now constituting the main cause of death in childhood. Asthma is becoming increasingly prominent as a cause of morbidity and mortality in childhood. In 1983, AIDS was the fourth leading cause of death in children under the age of 5, but the numbers were very small (3).

5. AIDS is now a significant cause of death in adult males, and mortality from external causes and violence has increased. Mortality from breast cancer in women is increasing and has now overtaken cervical cancer as the main cause of cancer mortality in women.

6. Problems affecting adolescents have been more prominent than previously: police data indicate increasing use of crack/cocaine in young males and consequent antisocial behavior, including violent crime.

7. Age-specific fertility for women aged 15-19 increased from 46.9 per 1000 in 1987 to 65.6 per 1000 in 1990, an increase of 40%. Abortion was the fifth leading cause of admission to hospital during 1990.

8. In Barbados, the AIDS pandemic continued to spread, with heterosexual transmission becoming increasingly important. The male to female ratio of AIDS cases shifted from 7:1 in 1987 to almost 3:1 in 1992. The incidence of AIDS is increasing more rapidly in females. Just under 1% of asymptomatic persons tested for the HIV virus (blood donors, antenatals, and US Visa applicants) were positive.

### Factors affecting health status

9. The economy of Barbados expanded in the later half of the 1980s, peaking in 1989, when Barbados recorded the highest per capita gross domestic product in its history. However, the economy has contracted since 1990, and there have been three successive years of negative growth (-3% in 1990, -4% in 1991, and -4% in 1992).

10. In September 1991, the Government entered into a structural adjustment program agreement with the International Monetary Fund, which is still in progress. The program has emphasized maintenance of exchange rate parities and providing the conditions for the resumption of sustainable economic growth. Public sector expenditures have been rigidly controlled and there has been a loss of some 3000 jobs in the public sector: this has contributed to a further increase in unemployment, which now stands at 23.6% of the work force. Unemployment rates are particularly high among the school leavers, where it approaches 70%.

11. Inflation is currently estimated at 8% and has increased from 3% in 1990. The economic downturn has been associated with the recession in North America and Western Europe, which has severely affected the vital tourist industry. Cautious optimism expressed for recovery following improvements in the economy of the US must however to tempered by the continuing difficulties in the United Kingdom, Germany and Scandinavia - important markets for Caribbean tourism. During the biennium, the Barbados economy will continue to be heavily influenced by external forces.

12. The future of the sugar industry, which has been an important earner of foreign exchange, is uncertain because of the possible loss of preferential markets in the European Community. The manufacturing sector has also suffered because of competition from the Pacific rim countries and the loss of CARICOM markets.

13. As part of the structural adjustment program, the Government is negotiating projects with the World Bank as well as the Inter-American Development Bank (IADB). Significant investment from the IADB is expected in the environmental sector for sewerage, water, coastal conservation and solid waste disposal. Environmental health conditions on the whole remain good, with 98% of the population having access to potable water.

14. The economic difficulties have not to date impacted severely upon the health sector and the whole population has access to health care. However there has been an increasing shift from the private to the public sector for primary health care and the latter is experiencing some difficulty in coping with the demand.

Plans and priorities for national health development

15. The Government proposes to prepare a new Five-Year Development Plan, which is expected to reflect a continuation of the main policies, strategies and priorities established under the 1988-1993 Health Plan. These were: the continued provision of health care to the nation through the polyclinics; development of programs and provision of increased facilities for the disabled; development of programs for rehabilitative care in institutions and in the home; improved health care in the Queen Elizabeth, psychiatric, and geriatric hospitals; implementation of all levels of mental health care in the primary health care setting; increased emphasis on family life development in place of family planning; corrective action to enhance the environment; establishment of better programs for the management of chronic noncommunicable diseases; improvement of management services through a "management by objectives" approach; and continued rationalization of the use of all resources, manpower, building, finance and equipment.

16. Health promotion is expected to have greater prominence than previously and it is expected that there will be more vigorous and sustained efforts to improve the management systems and to develop modern information systems, including epidemiological and management information services. Health manpower planning will also be emphasized. Continued development of the psychiatric and geriatric services will be a major priority.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

National priority areas for technical cooperation

17. Based on the analysis conducted during 1992 at the Joint Country Evaluation of Technical Cooperation, the Government has established the following priorities for technical cooperation: analysis of the health sector, its structure and management systems; support for the development of psychiatric and geriatric services, including their closer integration with the general health services; improvement in the management systems at all levels of the service, the achievement of a greater degree of decentralization and integration of services at the local level; development of epidemiological services; development of management information systems; human resource development planning; health promotion through health education, community participation and involvement of non-governmental organizations; establishment of programs for control of the chronic noncommunicable diseases - cancer, heart disease, diabetes, hypertension and asthma; environmental health, emphasizing protection of the water supplies, efficient methods of disposal of solid waste, and the protection of the coastal and marine environment through efficient and effective sewerage works; maintenance of a comprehensive maternal and child health program, including the development of programs for the adolescent, perinatal care, and the achievement of universal child immunization; management of disaster preparedness and mitigation programs; and development of comprehensive, community-based programs for vector control and food safety and protection.

18. Barbados has been successful in mobilizing reserves from the traditional donor agencies as well as international non-governmental agencies like the World Aids Foundation and Lions International. Over two million dollars will be provided by the latter to establish a Caribbean Eye Care Centre. The IDB is funding projects to improve the physical infrastructure of the health services to complete studies to rationalize the health services as well as to improve the management of the environment. UNICEF has provided aprroximately US$40,000.00 for several small projects related to nutrition and AIDS. Other agencies contributing to the AIDS programme include EEC and CIDA.

National priorities for technical cooperation from PAHO/WHO

19. The 1992 Joint Country Evaluation of Technical Cooperation established the priority areas for technical cooperation with PAHO/WHO. These areas are fully consistent with the priorities of the Organization, as set out in the SOPP, and with the goals and targets of the Caribbean Cooperation in Health Initiative (CCH), which is fully supported by the Government of Barbados.

20. Based on the review, it was agreed that PAHO/WHO would extend technical cooperation to the Government to increase the operating capacity of the health services to deliver services to the whole population, emphasizing the local health systems approach; the development of efficient and effective information systems; epidemiological systems; human resource development; health promotion; the control of the chronic noncommunicable diseases; environmental health, emphasizing protection of the water supply and improvement of solid waste disposal; maternal and child health, emphasizing adolescent and perinatal care and universal child immunization; disaster preparedness; vector control; food safety and protection; and AIDS.

21. PAHO/WHO's cooperation with Barbados will include the execution of several extra-budgetary projects. While the project to control AIDS funded through GPA is a national project perse, several are natural manifestations of a sub-regional or multi-country project including Integrated Vector Control (funded by the government of Italy) and the project for the control of mortality due to cancer of the cervix (funded by the government of France). Barbados will be a direct benefactor of the IDB funded project to strengthen the Health Information Systems of Community Services.

## PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Community water supply and sanitation (CWS)

22. The purpose of the project is to improve the capacity of the country to monitor and control environmental hazards, and to manage environmental health programs. To achieve this purpose, it will be necessary to: continuously disseminate information on environmental matters; fully use REPIDISCA and the publications of ECO; mobilize social participation through providing information to the mass media and to NGOs; collaborate with the IADB in the development of a project which will assist the Government as required in the formulation of written policies with respect to the environment.

Health services development (DHS)

23. The purpose of this project is to develop comprehensive health services, utilizing the local health systems approach. During the biennium, there will be a focus on the development of a new five-year strategic health plan and on strengthening of the planning process, utilizing the logical framework approach. Human resource planning and utilization will receive particular attention. There will be continuous focus on improvement of the health information systems, including epidemiological and management information, and improved efficiency of the local health systems (polyclinic services). The role of communities and NGOs will be emphasized.

Growth, development and human reproduction (MCH)

24. The purpose of the project is to develop comprehensive maternal and child health programs with special emphasis on perinatal care, the health of the adolescent, and immunization. Social communication on the health problems of mothers and children, especially the problems of adolescents, will be emphasized. Research studies on adolescent health will be conducted and assistance will be provided in the development of comprehensive MCH programs at the national and local levels, with clearly-defined goals and indicators consistent with the CCH Goals and Targets. Projects will be developed to mobilize additional resources for adolescent health care, immunization and perinatal care.

Management Support for National Health Development (MPN)

25. The purpose of this project is to provide managerial, technical and administrative support for the delivery of the technical cooperation project as defined in the instruments of the AMPES. To achieve this purpose, it will be necessary to inform Government officials about PAHO/WHO policies on health and development; work closely with the Government in resource mobilization; and collect and disseminate information on investments in health by donor agencies.

Health promotion and prevention and control of noncommunicable diseases (NCD)

26. The purpose of this project is develop and implement a comprehensive program for the prevention and control of the chronic noncommunicable diseases, emphasizing diabetes and hypertension, including preventive, curative and rehabilitative aspects. To achieve this purpose it will be necessary to disseminate information on all aspects of the chronic noncommunicable diseases collaborate with the mass media and NGOs for the widest possible dissemination of information about the risk behaviors with respect to the NCDs; support the formulation of healthy policies and the preparation of a comprehensive plan of action for the control of the NCDs; develop adequate information systems for monitoring and evaluation involve the NGOs the mobilization of resources; provide extensive training in social communication, project management in epidemiology; data processing and in the disposal of hazardous waste; and support research on the state of the groundwater in Barbados.

General Communicable Disease Prevention and Control Activities (OCD)

27. The purpose of this project is to further develop the infectious disease control programs, emphasizing improvements in surveillance, social communication and social participation. To achieve this purpose it will be necessary to support the further development of automated surveillance systems for communicable diseases, including the preparation of appropriate disease registers; provide training for the deputy epidemiologists in disease surveillance and outbreak investigation; adopt appropriate policies, legislation and regulations with respect to food protection.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| | PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|---|
| II. | HEALTH SYSTEM INFRASTRUCTURE | | 502,700 | 67.9 | 652,600 | 81.6 | 704,200 | 81.5 |
| | MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 176,100 | 23.8 | 207,500 | 25.9 | 235,300 | 27.3 |
| | MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 176,100 | 23.8 | 207,500 | 25.9 | 235,300 | 27.3 |
| | HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 326,600 | 44.1 | 445,100 | 55.7 | 468,900 | 54.2 |
| | HEALTH SERVICES DEVELOPMENT | DHS | 326,600 | 44.1 | 445,100 | 55.7 | 468,900 | 54.2 |
| III. | HEALTH SCIENCE AND TECHNOLOGY | | 236,800 | 32.1 | 147,300 | 18.4 | 159,100 | 18.5 |
| | ENVIRONMENTAL HEALTH | | 104,900 | 14.2 | 61,900 | 7.7 | 64,400 | 7.5 |
| | COMMUNITY WATER SUPPLY AND SANITATION | CWS | 104,900 | 14.2 | 61,900 | 7.7 | 64,400 | 7.5 |
| | MATERNAL AND CHILD HEALTH | | 27,200 | 3.7 | 21,200 | 2.7 | 23,300 | 2.7 |
| | GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 27,200 | 3.7 | 21,200 | 2.7 | 23,300 | 2.7 |
| | COMMUNICABLE DISEASES | | 50,000 | 6.8 | 28,800 | 3.6 | 32,700 | 3.8 |
| | GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 50,000 | 6.8 | 28,800 | 3.6 | 32,700 | 3.8 |
| | HEALTH PROMOTION | | 54,700 | 7.4 | 35,400 | 4.4 | 38,700 | 4.5 |
| | HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 54,700 | 7.4 | 35,400 | 4.4 | 38,700 | 4.5 |
| | GRAND TOTAL | | 739,500 | 100.0 | 799,900 | 100.0 | 863,300 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 31,600 | 4.2 | 0 | - | 0 | |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 31,600 | 4.2 | 0 | - | 0 | |
| HEALTH SERVICES DEVELOPMENT | DHS | 3,300 | .4 | 0 | - | 0 | |
| ESSENTIAL DRUGS AND VACCINES | EDV | 28,300 | 3.8 | 0 | - | 0 | |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 718,600 | 95.8 | 522,700 | 100.0 | 0 | |
| MATERNAL AND CHILD HEALTH | | 149,800 | 20.0 | 0 | - | 0 | |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 149,800 | 20.0 | 0 | - | 0 | |
| COMMUNICABLE DISEASES | | 543,300 | 72.4 | 522,700 | 100.0 | 0 | |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 543,300 | 72.4 | 522,700 | 100.0 | 0 | |
| HEALTH PROMOTION | | 25,500 | 3.4 | 0 | - | 0 | |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 25,500 | 3.4 | 0 | - | 0 | |
| GRAND TOTAL | | 750,200 | 100.0 | 522,700 | 100.0 | 0 | |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 712,300 | 0 | 0 | 415 | 110,900 | 0 | 94 | 188,000 | 77,600 | 41,700 | 13,300 | 280,800 |
| WHO - WR | 27,200 | 0 | 0 | 30 | 8,000 | 0 | 0 | 0 | 10,000 | 9,200 | 0 | 0 |
| TOTAL | 739,500 | 0 | 0 | 445 | 118,900 | 0 | 94 | 188,000 | 87,600 | 50,900 | 13,300 | 280,800 |
| % OF TOTAL | 100.0 | | | | 16.1 | .0 | | 25.4 | 11.8 | 6.9 | 1.8 | 38.0 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 778,700 | 0 | 0 | 360 | 100,100 | 0 | 111 | 222,000 | 79,500 | 61,700 | 19,600 | 295,800 |
| WHO - WR | 21,200 | 0 | 0 | 20 | 5,600 | 0 | 0 | 0 | 8,100 | 7,500 | 0 | 0 |
| TOTAL | 799,900 | 0 | 0 | 380 | 105,700 | 0 | 111 | 222,000 | 87,600 | 69,200 | 19,600 | 295,800 |
| % OF TOTAL | 100.0 | | | | 13.2 | .0 | | 27.8 | 11.0 | 8.7 | 2.5 | 36.8 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 840,000 | 0 | 0 | 360 | 100,100 | 0 | 111 | 222,000 | 90,200 | 70,000 | 22,200 | 335,500 |
| WHO - WR | 23,300 | 0 | 0 | 20 | 5,600 | 0 | 0 | 0 | 9,200 | 8,500 | 0 | 0 |
| TOTAL | 863,300 | 0 | 0 | 380 | 105,700 | 0 | 111 | 222,000 | 99,400 | 78,500 | 22,200 | 335,500 |
| % OF TOTAL | 100.0 | | | | 12.2 | .0 | | 25.7 | 11.5 | 9.1 | 2.6 | 38.9 |

## HEALTH SITUATION ANALYSIS

### Demography

1. The demographic profile is one of a "young population" with 44.0% below the age of 15 years. In 1980, the corresponding figure was 46.0 below this age. Of the total population, 49.1% were women and 50.9% were men. In 1991, 3.0% of the population was under one year of age, 16.1% were under 5 years and 21.1% were women in reproductive age. The percentage of elderly, those 65 years and over comprise 4.2% of the population.

2. The average annual growth rate between 1980 and 1990 was 2.75% per year. The total fertility rate (TFR) for Belize is around 4.6 children per woman, considered high when compared with CARICOM sister states. Nevertheless, it has decreased since 1980. The Mayas are reported to be the most fertile ethnic group and the Creoles the least fertile. The crude birth rate in 1989 was 37.2 per 1,000 population dropping from 39.0 per 1.000 in 1980.

3. A large amount of refugees from Central American countries have been flowing into Belize during the last years. This amount has been estimated to be between 15,000 and 40,000 refugees. This has changed the linguistic profile of the country where, for the first time, the 1991 Census has shown a large number of Spanish-speaking than English-speaking people.

### Health status indicators

4. Life expectancy at birth averages 69.85 years for males and 71.78 years for females.

5. General mortality rate has been stable during the period 1980-1989 varying between a rate of 4.9 per 1.000 population in 1980 and 4.2 in 1989; there was a slight decrease to 3.9 during 1987 and 1988.

6. Principal causes of death, all ages, in 1988, were: other diseases of the respiratory system; diseases of the pulmonary circulation and other forms of heart diseases; certain conditions originating the perinatal period and cerebrovascular diseases. These four main causes of death accounted for 36.1% of all deaths in Belize City.

7. Infant mortality rate decreased from 20.7 per 1.000 live births in 1987 to 19.4 in 1989, although the data is being revised. The leading causes of infant mortality in 1987 were: certain conditions originating in the perinatal period, disease of the respiratory system and all infections and parasitic diseases. Almost all infant deaths from infections and parasitic diseases are due to intestinal infectious diseases and most occur in the first week of life. Measles, whooping cough, and tenatus have almost been eliminated as most causes of death in infants and in children aged 1-4 years.

8. Most of the evidence of maternal mortality is fragmentary and indirect with clear indication of major problems in the existing vital registration system and recording in the death certificates by health professionals. The official figures report that maternal mortality rate dropped from 0.49 per 1,000 live births in 1987 to 0.36 in 1989. Nevertheless, recent reviews of maternal mortality conducted by the MOH indicate a much higher mortality than officially reported. The main causes of maternal deaths, according to a review conducted in 1991 are eclampsia and post-partum hemorrhage.

9. Ten principal causes of hospitalization, all ages, according to a total of 14,173 discharge diagnosis in 1989, were: normal birth delivery, direct obstetric complications, other diseases of the respiratory tract, diseases of other parts of the digestive system, abortion, intestinal infectious diseases, endocrine and metabolic diseases, immunity disorders, certain conditions originating in the perinatal period, hypertensive diseases and ill defined conditions.

10. Communicable diseases constitute an important cause of morbidity in the country. The five most frequently reported communicable diseases in 1986 were: malaria, gastroenteritis, gonorrhea, chicken pox and syphilis. The incidence of tuberculosis continues to decline, from 3.9 per 10,000 population in 1985 to 2.4 in 1987.

11. The first AIDS case was reported in 1986. Since then, 65 symptomatic AIDS and 200 HIV-Positive cases have been reported. The prevalence of the disease within the country is not known. As from January 1988, all blood is being screened for HIV using the ELISA Test.

12. Malaria is endemic. The extensive eradication program carried out in the 1950s and 1960s virtually eradicated malaria. However, fiscal constraints that led to insufficient follow-up after the campaign and new agricultural production patterns have resulted in a dramatic increase in incidence of cases from 876 in 1977 to 4,595 in 1983. From 1984 to 1986, the number of cases decreased, but they remain at around 3,000 cases per year.

13. Tropical diseases of concern in Belize are: leishmaniasis, which is endemic in the country; and Chagas' disease.

14. In 1989, approximately two thirds of all births were attended in hospitals. This number added to discharges related to complications of pregnancy, childbirth and puerperium and abortion constitute more than 50% of total discharges.

### Factors affecting health status

15. Government health services are practically free, funded by central government including the provision of pharmaceutical. The basic infrastructure

for health care delivery is provided by a national network of seven district hospitals (388 beds in the country which gives 2.1 beds per 1.000 inhabitants), 34 health centers (1.8 per 10,000 inhabitants) and 17 health posts.

16. The secondary level of health services is the main concern of the Ministry of Health. Forty-seven percent (186 beds) of the total number of beds are at the Belize City Hospital, the Referral Center for the country. In 1990, 57.0% of the total admissions to the health services were to the Belize City Hospital. The bed occupancy was 75.4%.

17. Other district hospitals (one in each of the six districts, with a total of 202 beds) serve mainly for primary care to the general public, deliveries, post-partum care and minor surgical needs leaving much room for updating. A specialized hospital, situated 30 miles away from the Capital, takes care of the chronic mental cases, but its installations are quite rudimentary.

18. Approximately 88.6% of the population is covered by services provided by health centers; 56.1% have close direct access and 32.5% are served through periodic visits by mobile clinics on a prearranged schedule. Of those with direct access, 92.1% are urban dwellers living in the district capitals or major towns. According to the Ministry's figures, 8.9% of the rural dwellers have direct access to the health centers, 3% have intermittent access, and 24% have no access.

19. In regards to human resources, in 1992 there were 116 physicians (public and private) corresponding to a rate of 6.3 physicians per 10,000 inhabitants; 12 dentists (0.65 per 10,000 inhabitants), 102 registered nurses (5.5 per 10,000 population); and 135 practical nurses (7.3 per 10,000 inhabitants).

20. The lack of health professionals in terms of quantity and specialized has been a concern recognized by the Government. Traditionally, physicians receive graduate training abroad (Guatemala, Jamaica, Mexico) and arrive periodically in a reasonable number for the country's needs. Nurses are trained at the Belizean School of Nurses to supply the national needs and compensate the emigration to the USA. Recently, the Belize University College started a program to train health technicians.

21. The lack of availability of health professionals is a major obstacle for the development of health programs. Around 43% of physicians and 30% of the dentists were working for the Ministry in 1990, which is less than the 58% and the 40%, respectively, in 1984. All nurses are employed by the Government, but the number did not increase in the last years despite the annual production by the nursing school, this is due to their migration to other countries.

22. The Government, through bi-lateral cooperation agreements has developed a program with Cuba for post-graduate training of health professionals.

23. The current benefit structure of the social Security is designed to protect the worker against the risk of income loss for the following contingencies: sickness, work-related accidents, old age, maternity, invalidity and disablement. Health coverage is not a benefit except for treatment in the case of work related accidents. The Social Security makes an annual contribution to the Ministry of Health (MOH). This assists in the maintenance of the infrastructure and improvement of services delivery by the MOH to the population.

24. The 1991 reports from the Water and Sewerage Authority (WASA) indicate an overall improvement in the provision of potable water and sanitation facilities to the population. Nevertheless, the rural areas are still the least benefitted and in need of attention, especially in the area of sanitation. In 1991, a total of 85.0% of the total population had access to potable water through metered systems, hand pumps and rudimentary water systems and 46.0% had access to adequate sanitation facilities through the sewerage system, septic tanks and ventilated improved pit latrines (VIP).

Plans and priorities for national health development

25. The Government recognizes health as a basic human right and a fundamental aspect of the development process and is committed to provide health services to every Belizean utilizing community participation and intersectoral coordination as key elements. The National Health Policy is guided by the principles of democracy, comprehensiveness, education, participation and accessibility.

26. The Health Plan identifies mothers and children under the age of 5 years, low income groups, the disabled, the elderly and those living in underserved areas as priority groups. In addition, the prevention and treatment of highly prevalent diseases is also considered a priority.

27. A National Health Plan was established for the period 1990-1994 which sets up priorities for primary and secondary levels of health services. These are:

28. The provision of health services which is responsive to the needs of the population in terms of quality care, appropriateness and accessibility.

29. The development of health and management infrastructure required to produce an efficient and effective health service.

30. Increase the number of well qualified health personnel in all health sectors.

31. Strengthening of the health information system and the development of epidemiological surveillance.

32. Strengthening and further develop a comprehensive Health Education Program.

BELIZE (Cont.)

33. Further development of the Environmental Health Program.

34. The strategies proposed to achieve health care which is responsive to the needs of the Belizean peoples, of high quality, appropriate and accessible are as follows:

35. Continuous manpower training in appropriate technical and managerial skills geared to local needs and resources with an integrated approach emphasizing preventive health care and with the capability to function as part of health team. The decentralization of planning, administration and management to the peripheral level through a local health systems approach is also considered.

36. The primary health care approach will be complemented with a basic secondary level as district hospitals of Dangriga, Belmopan and Orange Walk will be upgraded. The construction of the new Belize City Hospital will start soon. Maintenance is essential and will continue to be strengthened.

37. A successful technical cooperation program has been implemented between Belize and other Countries such as: Mexico, Guatemala, Cuba, Honduras and Nigeria. The development of technical cooperation programs will continue to be a main focus of the MOH.

38. The main epidemiological characteristics identified for Belize as priority health problems are: communicable, sexual and vector transmitted diseases. Control programs will continue to be strengthened.

39. The collaboration of specialized agencies, such as INCAP and CFNI will be maintained in order to address and promote initiatives to improve the food and nutrition status of the Belizean population.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

40. Based on the priorities identified and described above, the following are the proposed areas of technical cooperation for the biennium 1994-1995:

41. Continued support to the restructuring of the health sector.

42. Support the process of policy development, planning, monitoring and evaluation within the health sector.

43. Support identified needs, in terms of training and technical assistance for the new Belize City Hospital.

44. Support the development of the health information system and epidemiological surveillance.

45. Strengthening of health promotion, education and community participation at the local levels and in schools.

46. Continued support for the development of the maintenance of the health service infrastructure.

47. Support further analysis of the human resources situation in the country, Policy/Plan development and implementation.

48. Strengthen bi-lateral technical cooperation in terms of health manpower development.

49. Continued support for the prevention and control of communicable diseases of major concern, such as: vaccine preventable diseases, intestinal and respiratory infections, sexually transmitted diseases including AIDS and vector transmitted diseases.

50. Support the improvement of environmental health, support the improvement of the food and nutrition situation in Belize, support actions to improve the health of women, children and adults, participation in sub-regional initiatives.

### National priorities for technical cooperation from PAHO/WHO

51. The national priorities identified are a total of thirteen and these constitute the proposed areas for PAHO's technical cooperation to the MOH.

52. Further to developing the group of projects described below using regular PAHO/WHO funds, the Organization will continue the mobilization of national and external resources, brought about by the Subregional Initiatives in which Belize takes part, including the following technical areas:

53. Prevention and control of diarrheal diseases, with special reference to cholera, maintenance of equipment and health installations, prevention and control of AIDS, prevention and control of malaria, environment and health, women, health and development.

## PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

### Community water supply and sanitation (CWS)

54. The purpose of the project is to improve water quality, sewerage disposal and solid waste management in the country.

55. In order to contribute to attaining this purpose, PAHO will provide: Technical cooperation in the development of a National Water Policy and Water Legislation; training of district teams in water quality techniques including data collection for improved planning; increased public awareness through the development of materials on the subject; increased coordination with other sectors and continued technical cooperation in the area of sewerage disposal systems and solid waste management.

Health services development (DHS)

56. The purpose of this project is to continue supporting the goal of providing improved health care to the population.

57. Central level activities will be focussed on assisting in developing a new organizational structure to be proposed to decision-makers in the Ministry of Health, as well as to improving management skills through training at all levels of the system. PAHO will provide technical cooperation in priority areas in the development of the New Belize City Hospital Project and will assist in the evaluation of the Health Information System. The extension of primary health care programs and the promotion of the concept of Local Health Systems will also be a line of action of this project. Health education techniques will be strengthened through training. Further integration of the refugee communities into Belizean Society through promotion of self-help and community participation, will also be supported.

Human resources education (HRE)

58. The purpose of this project is to improve the mechanisms to identify human resources needs in the short, medium and long-term through the development of a plan, a corresponding database system and an improved administration and nursing education.

59. PAHO will provide technical assistance in the development of a Human Resources Development Plan and a Database System. Training in Health Manpower Planning will also be supported. PAHO/WHO will also provide technical cooperation in nursing administration and education.

Health situation and trend assessment (HST)

60. The purpose of this project is to improve the Health Sector Information System and Epidemiological Surveillance.

61. This will entail evaluating the existing health information system and epidemiological surveillance and propose changes to authorities. Training of key personnel in the six districts and continuous technical cooperation will be essential in order to achieve improved capability of the staff to analyze and utilize information.

Growth, development and human reproduction (MCH)

62. The purpose of the Project is to improve those interventions for the maternal and child population related to growth monitoring, breastfeeding practices, immunization, perinatal care, control of diarrhoeal diseases, acute respiratory infections and adolescent health.

63. PAHO/WHO will provide technical cooperation in the evaluation of specific interventions, and the development of plans for the reduction of maternal mortality, as well as norms for the control of Acute Respiratory Infections. Epidemiological surveillance of vaccine preventable diseases, diarrhoeal disease and respiratory infections will also be supported as well as increased Expanded Programme on Immunization (EPI) coverage. Special activities for adolescent health promotion and protection will be developed.

Management support for national health development (MPN)

64. The purpose of this project is to further develop the Belize Office in order to increase efficiency and effectiveness in the delivery of planned PAHO/WHO's technical cooperation to the Heath Sector.

65. This will be done with the assistance of Headquarters through the introduction of the Field Financial Management System (FFMS), training of the local staff in this new system, additional staff and strengthening of the documentation center.

Health promotion and prevention and control of noncommunicable diseases (NCD)

66. The purpose of the project is to improve the diagnosis, management and to contribute to the reduction of certain non-communicable diseases affecting the Belizean population, emphasizing mental health and cardiovascular diseases.

67. PAHO/WHO will provide technical cooperation in the evaluation of the mental health situation and the formulation of a Mental Health Policy based on its results. PAHO/WHO will also cooperate in the development of norms for management of the diabetic. An evaluation of the situation of cardiovascular diseases in the country will also be supported.

Nutrition (NUT)

68. The purpose of this project is to assist in the establishment of the basic needed infrastructure to follow-up on plans made in food and nutrition.

69. The coordination with specialized centers, such as CFNI and INCAP will be highly emphasized and the technical cooperation between Belize and these institutions in areas related to food and nutrition will continue in the biennium.

BELIZE (Cont.)

General communicable disease prevention and control activities (OCD)

70. The purpose of the project is to ultimately improve the epidemiological surveillance of communicable diseases, the efficient utilization of information and increase the capability in taking appropriate action or control measures.

71. PAHO/WHO will provide technical cooperation in program evaluation and strategy revision of the malaria program. Community participation in control measures will be supported, as well as improved information system for Vector Control and Rabies Program and improved diagnosis of vector transmitted diseases.

Technical cooperation among countries (TCC)

72. The purpose of this project is to assist in clear formulation of bi-lateral cooperation plans and to support its implementation, monitoring and evaluation.

73. PAHO/WHO will provide technical cooperation in the formulation of plan of actions and will support formation of border health committees.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 729,800 | 79.7 | 879,300 | 81.8 | 958,400 | 81.8 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 367,000 | 40.0 | 490,200 | 45.6 | 538,400 | 46.0 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 367,000 | 40.0 | 490,200 | 45.6 | 538,400 | 46.0 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 71,000 | 7.8 | 80,500 | 7.5 | 91,300 | 7.8 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 71,000 | 7.8 | 80,500 | 7.5 | 91,300 | 7.8 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 17,300 | 1.9 | 18,800 | 1.7 | 20,000 | 1.7 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 17,300 | 1.9 | 18,800 | 1.7 | 20,000 | 1.7 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 165,800 | 18.1 | 175,000 | 16.3 | 186,500 | 15.9 |
| HEALTH SERVICES DEVELOPMENT | DHS | 165,800 | 18.1 | 175,000 | 16.3 | 186,500 | 15.9 |
| HUMAN RESOURCES DEVELOPMENT | | 108,700 | 11.9 | 114,800 | 10.7 | 122,200 | 10.4 |
| HUMAN RESOURCES EDUCATION | HRE | 108,700 | 11.9 | 114,800 | 10.7 | 122,200 | 10.4 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 184,400 | 20.3 | 196,400 | 18.2 | 211,900 | 18.2 |
| FOOD AND NUTRITION | | 25,400 | 2.8 | 28,000 | 2.6 | 30,600 | 2.6 |
| NUTRITION | NUT | 25,400 | 2.8 | 28,000 | 2.6 | 30,600 | 2.6 |
| ENVIRONMENTAL HEALTH | | 46,600 | 5.1 | 47,300 | 4.4 | 50,100 | 4.3 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 46,600 | 5.1 | 47,300 | 4.4 | 50,100 | 4.3 |
| MATERNAL AND CHILD HEALTH | | 38,000 | 4.2 | 39,200 | 3.6 | 42,200 | 3.6 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 38,000 | 4.2 | 39,200 | 3.6 | 42,200 | 3.6 |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| COMMUNICABLE DISEASES | | 36,400 | 4.0 | 40,200 | 3.7 | 43,900 | 3.8 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 36,400 | 4.0 | 40,200 | 3.7 | 43,900 | 3.8 |
| HEALTH PROMOTION | | 38,000 | 4.2 | 41,700 | 3.9 | 45,100 | 3.9 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 38,000 | 4.2 | 41,700 | 3.9 | 45,100 | 3.9 |
| GRAND TOTAL | | 914,200 | 100.0 | 1,075,700 | 100.0 | 1,170,300 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 641,300 | 51.7 | 0 | - | 0 | |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 22,600 | 1.8 | 0 | - | 0 | |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 22,600 | 1.8 | 0 | - | 0 | |
| HEALTH POLICY DEVELOPMENT | | 1,000 | .1 | 0 | - | 0 | |
| WOMEN, HEALTH AND DEVELOPMENT | WHD | 1,000 | .1 | 0 | - | 0 | |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 617,700 | 49.8 | 0 | - | 0 | |
| HEALTH SERVICES DEVELOPMENT | DHS | 617,700 | 49.8 | 0 | - | 0 | |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 600,400 | 48.3 | 328,900 | 100.0 | 0 | |
| ENVIRONMENTAL HEALTH | | 211,700 | 17.1 | 0 | - | 0 | |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 187,400 | 15.1 | 0 | - | 0 | |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 24,300 | 2.0 | 0 | - | 0 | |
| MATERNAL AND CHILD HEALTH | | 153,200 | 12.3 | 0 | - | 0 | |
| DIARRHEAL DISEASES | CDD | 153,200 | 12.3 | 0 | - | 0 | |
| COMMUNICABLE DISEASES | | 224,100 | 18.0 | 328,900 | 100.0 | 0 | |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 174,100 | 14.0 | 215,900 | 65.6 | 0 | |
| MALARIA | MAL | 50,000 | 4.0 | 113,000 | 34.4 | 0 | |
| HEALTH PROMOTION | | 11,400 | .9 | 0 | - | 0 | |
| OCULAR HEALTH | PBD | 11,400 | .9 | 0 | - | 0 | |
| GRAND TOTAL | | 1,241,700 | 100.0 | 328,900 | 100.0 | 0 | |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 442,600 | 1 | 1 | 45 | 257,400 | 28,400 | 24 | 48,000 | 11,600 | 11,600 | 0 | 85,600 |
| WHO - WR | 471,600 | 0 | 0 | 435 | 116,100 | 5,800 | 30 | 60,000 | 90,500 | 63,800 | 0 | 135,400 |
| TOTAL | 914,200 | 1 | 1 | 480 | 373,500 | 34,200 | 54 | 108,000 | 102,100 | 75,400 | 0 | 221,000 |
| % OF TOTAL | 100.0 | | | | 40.9 | 3.7 | | 11.8 | 11.2 | 8.2 | .0 | 24.2 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 556,700 | 1 | 1 | 43 | 353,600 | 32,300 | 24 | 48,000 | 13,200 | 13,600 | 0 | 96,000 |
| WHO - WR | 519,000 | 0 | 1 | 431 | 140,300 | 6,600 | 30 | 60,000 | 92,700 | 73,500 | 0 | 145,900 |
| TOTAL | 1,075,700 | 1 | 2 | 474 | 493,900 | 38,900 | 54 | 108,000 | 105,900 | 87,100 | 0 | 241,900 |
| % OF TOTAL | 100.0 | | | | 46.0 | 3.6 | | 10.0 | 9.8 | 8.1 | .0 | 22.5 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 604,900 | 1 | 1 | 43 | 380,900 | 36,700 | 24 | 48,000 | 15,000 | 15,400 | 0 | 108,900 |
| WHO - WR | 565,400 | 0 | 1 | 431 | 143,900 | 7,500 | 30 | 60,000 | 105,100 | 83,500 | 0 | 165,400 |
| TOTAL | 1,170,300 | 1 | 2 | 474 | 524,800 | 44,200 | 54 | 108,000 | 120,100 | 98,900 | 0 | 274,300 |
| % OF TOTAL | 100.0 | | | | 44.8 | 3.8 | | 9.2 | 10.3 | 8.5 | .0 | 23.4 |

## HEALTH SITUATION ANALYSIS

### Demography

1. The last National Census on Population and Housing was carried out on 3 June 1992, and its preliminary results yield a total of 6,344,396 inhabitants. Of that figure, 58% is urban population and 70% is indigenous population, basically Aymara (plateau), Quechua (valleys) and Guarani (plains).

2. One third of the population lives in the Department of La Paz, where the largest urban concentration is located. (La Paz and El Alto together have 1,000,000 inhabitants.)

3. The population density is 6.1 inhabitants per km². Fifteen percent of the population are children under 5. Fourteen percent are children aged 5-9. Twenty-two percent are children aged 10-19, and 24% are women of childbearing age. The average age of the population is 19. Life expectancy at birth is 48.5 (males) and 53.0 (women). The crude death rate is 12 per 1,000 population.

### Health status indicators

4. The figures for mortality are the highest in the Americas. The infant mortality rate is 91 per 1,000 (1992 census); half of those deaths occur in the first month (respiratory problems, 37%; problems related to pregnancy and delivery, 25%; and diarrhea, 13%). The highest rates are found in the plateau and in the valleys. Breast-feeding is widely practiced: five out of every six children are breastfed until 1 year of age, and two of every three children, until 18 months of age.

5. Diarrheal diseases are the leading cause of morbidity and mortality in children 6-24 months of age. Acute respiratory infections are the second leading cause with pneumonia being the main cause of death. Malnutrition affects 38% of all children 3-36 months of age with growth retardation. The diseases preventable by vaccination are solidly under control, with the national annual average for complete immunization at 80%.

6. Maternal mortality is 480 per 100,000 live births. Fifty-three percent of live births had no prenatal care. Forty percent of births were attended by trained health personnel and 38% by family members. The leading causes of maternal deaths are hemorrhage, infection, and toxemia. The estimated rate of abortion is 130 per 100,000 live births, although the procedure is illegal.

7. Fertility has declined from 6.7 (1976) to 5.0 (1989). Seventy-three percent of women have knowledge of some method of contraception (periodic abstinence and intrauterine devices are the most commonly utilized), but only 30% of women with live-in partners practice any method.

8. The country does not have a mortality registry system, which means that all data are from special studies.

9. With regard to communicable diseases, the rates for tuberculosis are the highest in the Americas. Chagas' disease is a risk for 55% of the population. The transfusion risk is as high as 50% in some areas, and 100% of the women of childbearing age in the endemic area (which encompasses 60% of Bolivian territory) are infected.

10. Malaria continues to be a serious problem in the Amazon area, and it is on the rise. The presence of P. falciparum and its resistance to drugs pose a threat. Jungle yellow fever continues to be a problem, and there is risk of reentry of dengue in Santa Cruz, with a risk of DHF. Conditions have fostered the spread of cholera since that disease entered the country in August 1991, and it produced 21,324 cases by the end of 1992, with a mortality rate of under 1%.

11. Leprosy, leishmaniasis, cysticercosis, and other diseases continue to be present, and there have been no organized actions to bring them under control. Zoonoses have a strong health and economic impact. Foot-and-mouth disease limits access to exports for the country's large livestock supply.

12. There have been 57 cases of AIDS since 1989, but the lack of transfusion control and sociocultural changes augur a short-term increase.

13. Health service coverage is very low; only 40% of the population has access to any type of institutional care, with around 0.8 consultations per inhabitant/year. The average bed occupation index is 45%. The number of physicians per 10,000 population is 7.2 (1990).

14. The factors causing this low health service coverage are Bolivia's high population density and the scarcity of roads and means of transportation, together with the country's ethnic and cultural diversity and poverty.

### Factors affecting health status

15. The country, after a prolonged period of negative growth rates (1980-1986) and acute hyperinflation (23.000% in 1985), is experiencing a stage of economic stability, thanks to a neoliberal-type policy of adjustment and restructuring which, nevertheless, affected the middle-and low-income sectors of the population. In 1991, for the first time in a decade, the economic growth exceeded demographic growth and is now stabilized at 3.5%.

16. Illiteracy affects large sectors; it is 60% (52% for men and 68% for women). The percentage of children under 15 years of age who do not attend school is 52% (boys) and 42% (girls) in the urban area; those figures are 63% and 67% for the rural area.

17. The national housing shortage is estimated at 650,000 units, representing 65% of the total required. The average number of people per dwelling is 4.09. Ninety percent of rural dwellings do not meet minimum living standards. Twenty-three percent of dwellings have sewerage (42% in the urban area and 3% in the rural area); only 60% have access to water (89% urban and 30% rural), and only 59% have electrical power (92% urban and 26% rural).

BOLIVIA (Cont.)

Plans and priorities for national health development

18. The sector comprises the Ministry of Social Welfare and Public Health and the Office of Social Security (divided into various funds), and it covers 20% of the population. Traditional medicine is widely praticed.

19. The current policy focus is Supreme Decree 22407, which integrates the social sectors with a view to eliminating the accumulated social deficit. In this task, external assistance from multilateral and bilateral agencies is considered essential; in 1992, such assistance reached the record figure of US$ 800 million (equivalent to the figure for national exports). This assistance is regulated by Supreme Decree 23171, approving the 1992-1996 National Technical Cooperation Program, based on the Bolivian Social Strategy and on Supreme Decree 22964 (campaign against poverty). The third objective of the National Program refers to the quantifiable increase in the Human Development Index (1990 HDI: 0.418), for which there are four strategic programs in health (child survival and maternal health; control of Chagas' disease; decentralized and local health systems; and drinking water and basic sanitation).

20. Of these, actions have already been taken to establish the "Water for All" Plan; the National Chagas' Disease Program; and the Ten-year Plan for Survival, Child Development, and Maternal Health. The Health Decentralization Plan is about to begin. The "Water for All" Plan led to a reassignment of authority to the Ministry of Urban Affairs (MAU)--Departmental Corporations and Mayor's Offices--with the Ministry of Social Welfare and Public Health retaining supervisory duties. The Chagas' Disease Program culminated in the creation of an intersectoral coordinating unit (UNGECH).

21. The Ten-Year Maternal and Child Health Plan was established by an interinstitutional committee, and the delivery of services under that Plan is a function of the Ministry of Social Welfare and Public Health and includes reproductive health, child health, and the promotion of women.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

National priority areas for technical cooperation

22. The fundamental strategies defined in the Health Plan are: the survival, reproductive health and child development plan, social management, and decentralization through local health systems. It includes the following programs: comprehensive health service for women; comprehensive care of children under five; comprehensive care of schoolchildren and adolescents; environmental services; epidemiological surveillance; and institutional strengthening.

23. The Government considers it important to receive technical cooperation in the following areas: health sector analysis and policy development--including decentralization, district development, social security reform, redefinition of the role of hospitals, provision of supplies and drugs, financing and economics of the social sectors, quality of care, and extension of coverage-- health situation analysis, establishment of an intersectoral poverty map, stratification and identification of vulnerable groups, and making living conditions the focus in the formulation of policies and plans--including those on women and health, workers' health, interinstitutional coordination, work with nongovernmental organizations, and integration with bordering countries (Andean Area, Southern Cone)--care for the environment with emphasis on basic rural sanitation, sanitation of establishments (hospitals, schools, marketplaces), and communicable disease control, health promotion and social management, analysis of the health resource at all levels (basic training, continuing education, special training), and disaster response.

24. The public health sector depends largely on external support for the execution of the national program. There are a myriad of international, nongovernmental, and multilateral organizations that provide technical and financial assistance to the program. The World Bank supports several projects: a project with the Social Investment Fund (FIS) to support the first phase of efforts to improve health and the education ($23.3 million); a $20 million comprehensive maternal and child health project with the Ministry; a $35 million project for water and sanitation in large cities, including an $8 million component from Germany; and another $40 million development project for local health services with the Ministry of Health. The Inter-American Development Bank supports a project of basic health services with the Ministry for $34 million. There are multiple support packages from the Governments of Holland, France, the Scandinavian Countries, the Agency for the International Development, the International Program of the United Nations for Drug Control, the United Nations Population Fund, etc. A large number of nongovernmental agencies also contribute.

25. Disbursements of external assistance for the health sector rose from US$ 10,111,000 (1988) to US$ 36,253,000 (1991), with a prediction for 1992 of U$ 44,304,000. In 1991, multilateral support for health was US$ 19,141,000, with these principal donors: EEC (52%), the World Food Program (15%), AIF (14%), and PAHO/WHO (7.2%). Bilateral support was US$ 17,112,000, with these principal donors: the United States of America (38%), the Netherlands (22.5%), Italy (17%), and Canada (8.7%).

National priorities for technical cooperation from PAHO/WHO

26. In addition to utilizing the regular funds allocated to the country, PAHO supports the national program with resources from other agencies. In this regard PAHO/WHO manages resources for local health services development from: the International Program of the United Nations for Drug Control, under the World Health Organization and from France; from the United Nations Population Fund for Maternal and Child health and from Holland for essential drugs; from Belgium for

the management of the sector. In addition, there is collaboration with the United Nations Children's Fund with projects of both multilateral banks.

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Community water supply and sanitation (CWS)

27. The purpose is to increase the coverage of water and sanitation services, to strengthen the urban sanitation service companies, and to improve the final disposal of solid wastes in medium-size cities, to improve sanitary conditions of dwellings, and to support the national workers' health plan in coordination with all the institutions of the sector.

28. To that end, support will be extended for all aspects of the national "Water for All" plan; to facilitate and support the formulation of national policies, strategies, standards, regulations, plans, and programs of basic sanitation; to promote actions and interventions in environmental sanitation through the local health systems; to promote the strategy of "healthy cities"; to implement and develop a national management plan for solid wastes; to strengthen the urban sanitation service companies; to formulate and develop a national plan for improving housing conditions; to facilitate and support the formation, within the Ministry of Health, of a unit for the evaluation of environmental risks; and to train human resources in the fields of health and the environment, environmental epidemiology, and toxicology.

29. To collaborate in the development of a national occupational health plan; to promote the implementation of occupational health actions through the health districts.

30. To facilitate and support the coordinated action of the National Institute of Occupational Health, the Ministry of Labor, and the Social Security Funds; to formulate plans of action for emergency situations in the water and sanitation service institutions, as well as in those health districts identified as vulnerable; and to train and educate human resources.

Health services development (DHS)

31. The purpose is to strengthen the process of development of the local health systems (health districts) in Bolivia.

32. The lines of action will be the following: the mobilization of national and external resources of technical and financial cooperation; the identification of the resources necessary for operating and maintenance expenditures required to relieve the current physical, economic, and cultural inaccessibility to services; the strengthening of the national political will to promote health as a central part of human development and a just foundation for a democratic society; the coordination of different sources of financing and multilateral and bilateral technical cooperation for the health districts for the consolidation of a national health development project in Bolivia; the strengthening of the technical-administrative capacity of the health districts and their power to resolve health problems at the local level; the exchange of national and international experiences, as well as operations research, in the field of local health system development, with its components of service delivery, social participation, local management, and sources of financing, taking into account the local health systems, nongovernmental organizations, social security and mixed systems--integrated or with different degress of intrasectoral coordination.

33. The identification of improved tools for intersectoral coordination, with the health districts as the point of articulation; the promotion of the integration of regional hospitals into the network of services and their structural and functional links with the health districts for the referral and back-referral of patients and information and for the strengthening of the democratic participation of all in decision-making, definition of priorities, and programming, execution, and control of health actions.

Dissemination of scientific and technical information (HBD)

34. The purpose is to improve the capacity of the national team through access to pertinent scientific and technical information produced in the Region and at the world level.

35. Through continuous support of the activities of the national health information network, the aim is to develop and strengthen this network, with a view to promoting activities of interinstitutional cooperation that will succeed in optimizing the use of the resources available in the various institutions of the health sector. There will be a continuous program of support for the development and consolidation of the Documentation Center of the PAHO/WHO Representative's Office, inasmuch as that Center is to serve as an important instrument of the Organization's technical cooperation in the country. There will be promotion of workshops geared toward training users of bibliographic information services in the utilization of the resources available in this area at the national, regional, and world levels. Efforts will be directed toward supporting the establishment and consolidation of documentation centers located in service institutions outside the National District in order to contribute to the training of persons working in these institutions, and that of the community in general, on health subjects. Ongoing contact will be maintained with the professional associations and with editors of biomedical publications, in order to carry out activities that help form public opinion on health subjects and promote knowledge and use of PAHO/WHO publications, including those of the Expanded Program of Textbooks and Instructional Materials.

Health policy analysis and development (HDP)

36. The purpose is to strengthen the process of formulation of national health policies and their implementation in health plans and programs.

37. Action is proposed to support Bolivia's commitment to adopt the concept of health as a part of development and as a tool for the strengthening of democracy; to identify national instruments for the design of health development objectives and targets; to define priorities; to formulate plans and programs and to supervise, control, and evaluate them; to strengthen the legal base of the Bolivian health system and the ties of coordination between the different subsectors and sectors of economic and social development; to furnish advisory services in the strategic design of health planning, placing special emphasis on the search for equity with quality, efficiency, and effectiveness in the actions of the health sector and other sectors of development; to identify operational planning instruments at the various levels of the system and levels of local programming that will allow for the decentralized management of the health resources; to consolidate instruments and regulations governing the professional practice of the various health sciences--among them the codes of professional ethics; and to review the health code.

Human resources education (HRE)

38. Action is proposed to help strengthen the regulatory, policy-making, management and interinstitutional coordination capacities of the Ministry of Social Welfare and Public Health, aimed at generating a new qualitative and quantitative basis for human resources and for scientific and technological knowledge in health, which would make the transformation of the sector viable.

39. In order to accomplish the foregoing, it is proposed that efforts be made to implement mechanisms for the monitoring, reformulation, and generation of national policies on human resources, while strengthening the regulatory capacity of the Ministry of Social Welfare and Public Health; to strengthen the health personnel planning and management systems, adjusting the performance of training institutions to the needs of the services; to operationalize the framework agreement on teaching and service integration between the Ministry of Health and the Executive Committee of the Bolivian University, through specific agreements and cooperative projects in the various areas of knowledge, emphasizing the qualitative and quantitative adaptation of training to utilization of health personnel; to strengthen the decision-making capacity of the health districts through the training of personnel, advisory services, and support for the programming and local development of the processes of continuing education; and to formulate policies on the generation, adaptation, and evaluation of scientific and technological knowledge, strengthening the dissemination and effective utilization of scientific and technical information systems.

Health situation and trend assessment (HST)

40. The purpose is to strengthen the capacity of the health sector, at all levels, to compile, process, and analyze data on the epidemiological situation and its utilization in decision-making.

41. In order to carry out this objective, it is proposed that human resources training be conducted at every level, at varying levels of difficulty; that policies and standards be formulated for the epidemiological analysis and utilization of information; that the mortality information system be implemented; and that technical resources be mobilized in support of the development of the country's capacity for epidemiological analysis.

Growth, development, and human reproduction (MCH)

42. The purpose of the project is to strengthen the managerial, technical, and administrative capacity of the Ministry of Social Welfare and Public Health, at all its levels, for the planning, execution, and evaluation of health programs for women, children, and adolescents and the development of the plan of child survival and maternal health, with a view to strengthening the comprehensive health care of women, children, and adolescents.

43. In order to achieve this purpose, it is proposed that action be taken to support institutional strengthening and the strengthening of services; training and education in reproductive health and the health of children and adolescents; the formulation of plans and the continuous updating, with practical application, of technical-administrative standards and procedures of care; the improvement of information systems and epidemiological surveillance; the mobilization of official institutional resources and of nongovernmental organizations, the community, and external cooperation; the compiling and dissemination of information and means of social communication and participation; the performance and dissemination of operations research; the establishment of systems for the programming, monitoring, supervision, and evaluation of programs and projects; and technical support in order to increase the participation and leadership of women in the planning, execution, and follow-up of action plans for women's health.

Managerial support for national health development (MPN)

44. The purpose is to promote managerial support (technical, political, and administrative) for the timely and pertinent delivery of technical cooperation to the country.

45. The PAHO/WHO Representative's team will establish a close relationship with government officials and national and international institutions of importance to the country, for the formulation of policies, plans, and standards leading to the commitment to Health for All, primary health care, and development of local health services. It will also carry out actions for the mobilization of resources; incorporation of the country into subregional initiatives; incorporation of health in the process of development and national decentralization; continuous evaluation of health conditions and of the needs and impact of cooperation.

46. The Development Plan formulated in 1992 will be carried forward--in particular in the modernization of its internal procedures, the training of professional personnel, general services, and the updating of its administrative systems.

Health promotion and prevention and control of noncommunicable diseases (NCD)

47. The purpose of this project will be to sensitize the national authorities to the importance of some of the components and to strengthen the actions already being initiated by the Ministry of Social Welfare and Public Health and other institutions of the health sector.

48. It is proposed that action be taken to develop policies, plans, and standards for the most important problems; that information be disseminated and human resources trained in health promotion; and that research be conducted with a view to identifying the country's most important health problems.

Nutrition (NUT)

49. The purpose of the project is to contribute to the development and strengthening of national technical capability in order to orient, formulate, and evaluate plans, programs, and projects directed toward the control and monitoring of actions aimed at the reduction or elimination of micronutrient and protein-caloric deficiencies, intensifying operational and social management processes with multidisciplinary and intersectoral approaches of a comprehensive nature.

50. This project will be geared toward the development of institutional capacity in the delivery of services on the basis of the utilization of information generated from the local health levels and from the community; the establishment of sentinel posts to improve the quality of information derived from systems for epidemiological surveillance of nutritional status; community interventions according to the national risk model; operations research, integration, and application of the plan of action for the elimination of vitamin A deficiency and control of iron deficiency in population groups vulnerable to a deficiency in these micronutrients, within the context of strengthening the local health systems; the preparation, planning, and programming of comprehensive activities for plans and projects in nutrition or in socioeconomic development that will respond to the many and varied causes of the food and nutrition problems identified in the populations of greatest risk for malnutrition; the sharing of experiences in the national and international technical area on modalities and strategies to deal with the health and nutrition problems prevalent in the context of the socioeconomic and cultural characteristics and particulars of different ecological areas of the country; to improve the level of training and development of personnel; to carry out plans for the evaluation, adjustment, and extension of experience for the introduction of nutrition and health in the curriculum at teachers' colleges; to consolidate and continue multisectoral technical participation and that of nongovernmental organizations within the Ministry of Planning and Coordination, following up on the efforts made at the international conference on nutrition (December 1992), the World Summit for Children, and the Ten-Year Plan of Action for Bolivian Children; and to disseminate and furnish educational information, with community participation and institutional support, for promotion and instruction in the area of food and nutrition to ensure that needy social groups have an adequate and safe diet.

General communicable disease prevention and control activities (OCD)

51. The purpose is to strengthen the capacity of health services to take timely and effective action in the prevention and control of communicable diseases that are prevalent and significant in their area of action.

52. In order to achieve the above purpose, work will be done for the review and dissemination of standards at specific levels; the integration of activities for prevention and control of communicable diseases at the local health services; the training of institutional and community human resources for a prompt response to the occurrence of outbreaks; joint health service-community action to combat priority health problems; operations research on prevalent problems; mobilization of resources to ensure the realization of activities for the prevention and control of the most important communicable diseases; and dissemination of scientific information and information on the occurrence of communicable diseases to all levels of the health sector.

Technical cooperation among countries (TCC)

53. The purpose is to strengthen subregional integration through support for Andean Cooperation in Health and for the Southern Cone initiative and to promote, intensify, and consolidate the processes of technical, scientific, technological, cultural, and financial cooperation among countries.

54. It is proposed that action be taken for institutional strengthening and for management and leadership in international cooperation, through support for organizational projects, from the International Relations Office of the Ministry of Social Welfare and Public Health, establishing a functional internal and external structure; for technical training for personnel involved in international relations and international cooperation, as well as in the planning, follow-up, and evaluation of the commitments undertaken by Andean Cooperation in Health (ACH) and the Southern Cone initiative, in the program areas of the same, and within the context of the development and reorganization of the local health systems; for the mobilization of resources for the execution of research, training, and epidemiological surveillance and control programs, as well as for the identification of large-scale technological cooperation needs in the areas of Andean Cooperation in Health and the Southern Cone initiative; for the development of bilateral relations, with support for meetings, courses, and seminars at the country level, among others; for the follow-up of commitments and agreements signed with countries such as Peru, Ecuador, Brazil, Argentina, and Paraguay--especially at the operational level--in which the health districts are involved; and for the sharing of experiences and technology in health services, maintenance, epidemiology, vector control, occupational health and industrial safety, essential drugs, medicinal plants, training in maternal and child health, research, etc. with Cuba, Mexico, and other countries not included in Andean Cooperation in Health or the Southern Cone initiative.

Zoonoses (ZNS)

55. The purpose is to achieve the elimination of rabies transmitted through dogs, to control the most prevalent zoonoses, to eradicate foot-and-mouth disease in the eastern area, and to improve food quality.

56. The lines of action will be directed toward the strengthening of veterinary public health services, with a focus on the local health systems; toward the mass promotion of canine vaccination campaigns, supported by community participation and by organization and execution at the district level; toward the development of local plans for the eradication of foot-and-mouth disease, with autonomy for administrative and financial management, supported by the participation of livestock producers; toward intercountry cooperation, achieving binational areas of control of zoonoses and of foot-and-mouth disease, control of the transit of animals and products of animal origin, and joint actions in order to achieve supply and control of biologicals; and toward the development of integrated programs of food protection, through the promotion of regional and local committees, with the participation of the public and private institutions involved in the problem.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 2,588,800 | 64.6 | 2,710,400 | 60.8 | 3,012,300 | 61.1 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 760,500 | 19.0 | 956,100 | 21.4 | 1,069,500 | 21.7 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 760,500 | 19.0 | 956,100 | 21.4 | 1,069,500 | 21.7 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 76,800 | 1.9 | 87,100 | 2.0 | 98,800 | 2.0 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 76,800 | 1.9 | 87,100 | 2.0 | 98,800 | 2.0 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 0 | - | 78,200 | 1.8 | 87,000 | 1.8 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 0 | - | 78,200 | 1.8 | 87,000 | 1.8 |
| HEALTH POLICY DEVELOPMENT | | 91,000 | 2.3 | 121,800 | 2.7 | 134,300 | 2.7 |
| HEALTH POLICY ANALYSIS AND DEVELOPMENT | HDP | 91,000 | 2.3 | 121,800 | 2.7 | 134,300 | 2.7 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 1,168,300 | 29.1 | 1,001,400 | 22.5 | 1,107,000 | 22.4 |
| HEALTH SERVICES DEVELOPMENT | DHS | 1,079,600 | 26.9 | 890,200 | 20.0 | 982,200 | 19.9 |
| ESSENTIAL DRUGS AND VACCINES | EDV | 0 | - | 111,200 | 2.5 | 124,800 | 2.5 |
| HEALTH EDUCATION AND COMMUNITY PARTICIPATION | HED | 88,700 | 2.2 | 0 | - | 0 | - |
| HUMAN RESOURCES DEVELOPMENT | | 492,200 | 12.3 | 353,300 | 7.9 | 389,200 | 7.9 |
| HUMAN RESOURCES EDUCATION | HRE | 492,200 | 12.3 | 353,300 | 7.9 | 389,200 | 7.9 |
| HEALTH INFORMATION SUPPORT | | 0 | - | 112,500 | 2.5 | 126,500 | 2.6 |
| SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION | HBD | 0 | - | 112,500 | 2.5 | 126,500 | 2.6 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 1,411,000 | 35.4 | 1,748,000 | 39.2 | 1,916,100 | 38.9 |
| FOOD AND NUTRITION | | 106,900 | 2.7 | 142,800 | 3.2 | 155,800 | 3.2 |
| NUTRITION | NUT | 106,900 | 2.7 | 142,800 | 3.2 | 155,800 | 3.2 |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| ENVIRONMENTAL HEALTH | | 459,200 | 11.5 | 512,100 | 11.5 | 556,800 | 11.3 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 459,200 | 11.5 | 512,100 | 11.5 | 556,800 | 11.3 |
| MATERNAL AND CHILD HEALTH | | 111,000 | 2.8 | 358,300 | 8.0 | 390,000 | 7.9 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 111,000 | 2.8 | 358,300 | 8.0 | 390,000 | 7.9 |
| COMMUNICABLE DISEASES | | 538,500 | 13.5 | 518,000 | 11.6 | 571,500 | 11.6 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 538,500 | 13.5 | 518,000 | 11.6 | 571,500 | 11.6 |
| HEALTH PROMOTION | | 91,800 | 2.3 | 89,700 | 2.0 | 100,100 | 2.0 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 91,800 | 2.3 | 89,700 | 2.0 | 100,100 | 2.0 |
| VETERINARY PUBLIC HEALTH | | 103,600 | 2.6 | 127,100 | 2.9 | 141,900 | 2.9 |
| ZOONOSES | ZNS | 103,600 | 2.6 | 127,100 | 2.9 | 141,900 | 2.9 |
| GRAND TOTAL | | 3,999,800 | 100.0 | 4,458,400 | 100.0 | 4,928,400 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 1,597,900 | 51.2 | 0 | - | 0 | |
| HEALTH POLICY DEVELOPMENT | | 22,600 | .7 | 0 | - | 0 | |
| HEALTH POLICY ANALYSIS AND DEVELOPMENT | HDP | 22,600 | .7 | 0 | - | 0 | |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 1,536,100 | 49.2 | 0 | - | 0 | |
| HEALTH SERVICES DEVELOPMENT | DHS | 453,300 | 14.5 | 0 | - | 0 | |
| ESSENTIAL DRUGS AND VACCINES | EDV | 1,052,800 | 33.7 | 0 | - | 0 | |
| DISASTER PREPAREDNESS | DPP | 30,000 | 1.0 | 0 | - | 0 | |
| HUMAN RESOURCES DEVELOPMENT | | 39,200 | 1.3 | 0 | - | 0 | |
| HUMAN RESOURCES EDUCATION | HRE | 39,200 | 1.3 | 0 | - | 0 | |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 1,524,000 | 48.8 | 1,099,200 | 100.0 | 0 | |
| FOOD AND NUTRITION | | 12,300 | .4 | 0 | - | 0 | |
| NUTRITION | NUT | 12,300 | .4 | 0 | - | 0 | |
| ENVIRONMENTAL HEALTH | | 7,100 | .2 | 0 | - | 0 | |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 7,100 | .2 | 0 | - | 0 | |
| MATERNAL AND CHILD HEALTH | | 1,259,900 | 40.4 | 829,400 | 75.5 | 0 | |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 1,259,900 | 40.4 | 829,400 | 75.5 | 0 | |
| COMMUNICABLE DISEASES | | 203,600 | 6.5 | 269,800 | 24.5 | 0 | |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 203,600 | 6.5 | 269,800 | 24.5 | 0 | |
| HEALTH PROMOTION | | 41,100 | 1.3 | 0 | - | 0 | |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 800 | .* | 0 | - | 0 | |
| PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE | ADA | 15,400 | .5 | 0 | - | 0 | |
| OCULAR HEALTH | PBD | 24,900 | .8 | 0 | - | 0 | |
| GRAND TOTAL | | 3,121,900 | 100.0 | 1,099,200 | 100.0 | 0 | |

* LESS THAN .05 PER CENT

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 2,140,600 | 3 | 3 | 390 | 821,900 | 69,500 | 25 | 50,000 | 315,700 | 265,100 | 0 | 618,400 |
| WHO - WR | 1,859,200 | 2 | 0 | 780 | 600,400 | 13,900 | 48 | 96,000 | 535,100 | 265,500 | 0 | 348,300 |
| TOTAL | 3,999,800 | 5 | 3 | 1170 | 1,422,300 | 83,400 | 73 | 146,000 | 850,800 | 530,600 | 0 | 966,700 |
| % OF TOTAL | 100.0 | | | | 35.4 | 2.1 | | 3.7 | 21.3 | 13.3 | .0 | 24.2 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 2,487,600 | 3 | 3 | 427 | 945,400 | 129,300 | 30 | 60,000 | 372,700 | 244,600 | 0 | 735,600 |
| WHO - WR | 1,970,800 | 2 | 0 | 645 | 585,600 | 13,600 | 57 | 114,000 | 566,000 | 322,200 | 0 | 369,400 |
| TOTAL | 4,458,400 | 5 | 3 | 1072 | 1,531,000 | 142,900 | 87 | 174,000 | 938,700 | 566,800 | 0 | 1,105,000 |
| % OF TOTAL | 100.0 | | | | 34.3 | 3.2 | | 3.9 | 21.1 | 12.7 | .0 | 24.8 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 2,757,600 | 3 | 3 | 427 | 1,016,600 | 146,600 | 30 | 60,000 | 422,600 | 277,400 | 0 | 834,400 |
| WHO - WR | 2,170,800 | 2 | 0 | 645 | 615,200 | 15,400 | 57 | 114,000 | 641,900 | 365,400 | 0 | 418,900 |
| TOTAL | 4,928,400 | 5 | 3 | 1072 | 1,631,800 | 162,000 | 87 | 174,000 | 1,064,500 | 642,800 | 0 | 1,253,300 |
| % OF TOTAL | 100.0 | | | | 33.2 | 3.3 | | 3.5 | 21.6 | 13.0 | .0 | 25.4 |

## HEALTH SITUATION ANALYSIS

### Demography

1. The total population of Brazil, as estimated in 1990, was 150,367,800 inhabitants, with 43% in the southeastern region (the most highly populated area); 28% in the northeastern region; 16% in the southern region; and 6% in the northern region. Population density for the country as a whole is 17.8 inhabitants per square kilometer, and this indicator ranges from 2.5 inhabitants/Km² in the northern region up to 71.3 inhabitants/Km² in the southeastern region. Of the total population, 84.9% inhabits urban areas, while the remaining 15.5% lives in rural areas. Population growth reached 2.4% in 1980 but has declined steadily over the past decade. The rate of population migration is quite high in some regions. Historically, migration has tended to flow away from the northeastern region and toward the southern region, but there now appears to be a reversal in this trend. The total fertility rate was 3.6 in 1990. The decline in the mortality and fertility rates has been a factor in the aging of the population: in 1990, persons over 64 years of age accounted for 4.65% of the total population, and it is estimated that by the year 2000 there will be 14 million inhabitants over 60 years of age.

### Health status indicators

2. In 1988, the leading causes of death (of those deaths for which causes were identified) were cardiovascular diseases (34.5% of the total), followed by external causes (14.26%), infectious and parasitic diseases (12.9%), and malignant neoplasms (11.75%).

3. Although morbidity statistics are acknowledged to be deficient, there is still evidence of continued high rates of prevalence for the traditional endemic diseases, such as the Chagas' disease (4.2%) and schistosomiasis. There were 533,360 confirmed cases of malaria in 1990-1991, 95% of which were concentrated in the Amazon region. Added to these problems are outbreaks of dengue, in 1986-1987 and 1990-1991, the reintroduction of cholera in 1991, the increase in the prevalence of leprosy over the last 20 years (1.8 per 1,000), and the recent tragedy of AIDS, with 34,880 cases reported as of January 1993. The nationwide average for maternal mortality is 140 deaths per 100,000 live births, with great variations among the regions, ranging from 70 per 100,000 in the southeastern region to 313 per 100,000 in the northern region. The basic causes are complications of pregnancy (64%), complications of the puerperium (17.9%), abortion (10.7%), and complications of childbirth(5.4%).

4. Infant mortality has been on the decline, though with extreme variations among regions. From 113 per 1,000 live births, in 1970, it declined to 80.2 per thousand in 1980, and to 56.54 per thousand in 1990. The regional variations ranged from a rate of 47.9 per thousand in the southern region to 135.6 per thousand in the northeastern region.

5. In 1988, the leading causes of death in children under one year of age were diseases of the perinatal period (47,32%) and infectious and parasitic diseases (33.3%). Of deaths from infectious diseases, diarrheal diseases and acute respiratory infections are the leading causes.

6. National research on nutrition indicated that, in 1989, 30.7% of children under 5 were suffering from some degree of malnutrition, with 5.1% of the cases classified as severe malnutrition.

### Factors affecting health status

7. Among the basic factors that have a negative impact on the health situation are the political, economic, and social uncertainty reflected in high inflation rates (20% to 25% monthly), the high fiscal deficit, the deep recession, and unresolved structural problems (government and tax reforms). These factors are linked to high rates of unemployment, which has affected, on the average, 12% to 14% of the economically active population (with 16.1% in the São Paulo metropolitan area in August 1992). Information on Greater São Paulo indicates that the average monthly salary of wage earners in July 1992 was only 54% of the 1985 figure.

8. With regard to the supply of goods and social services, difficulties connected with the financial crisis and administrative discontinuity have made it impossible to maintain previous averages in current expenditures over the past decade. In addition, investments in low-cost housing showed a marked decline; and the average supply of houses decreased from 550,000 in 1980-1882 to 244,000 in 1989-1991.

9. Urban environmental problems in Brazil basically stem from the poverty that affects large population groups, especially in the large cities, and, in addition, from the concentration of economic activities, particularly industrial ones, in the urban areas.

10. Rapid urbanization has caused a shortfall in the urban service infrastructure, the most serious manifestation of which is the lack of basic sanitation. The problem is particularly severe among the nearly 33 million people who live on the periphery of large cities, 35% in urban residences that are largely located in "favelas," or slum areas, and are considered inadequate from a sanitation standpoint.

11. The coverage of water services in Brazil has expanded considerably over the past 10 years. In 1980 the general water supply system covered 57.2% of the urban population, expanding by 1990 to 90% urban coverage. However there are still differences between the rural areas (16%) and the urban areas (90%). Despite the high urban coverage, only 73.4% of residences are supplied by the general network. Another problem is that of the water quality, inasmuch as 23.3% of municipios do not have any type of water treatment, and 32% have simple disinfection systems.

BRAZIL (Cont.)

12. In water supply system coverage, there are disparities among regions and within States and cities, with higher coverage in the most developed States and, within the States, in the capital cities.

13. In regard to sewerage systems, in 1989, 2092 municipios or 47.3% of the total, had a sewerage system, but of this total, only 350 (8%) had any type of treatment. Only 51 municipios had a sewage treatment station. The population covered by sewerage systems was 28.9 million in 1989, increasing to 29.2 million in 1991. With more critically low levels of coverage than those of water supply, sewerage systems also present major regional inequalities. While the southeastern and southern metropolitan regions enjoy adequate coverage (with septic systems or septic tanks), averaging 83.3%, in the Recife metropolitan area there are satisfactory systems in only 27.6% of all residences.

14. The status of solid waste collection and treatment systems is no less serious. Most of the Brazilian municipios have refuse collection services only in their principal districts. Only 21% of the municipios have coverage in their other districts. The situation is aggravated by the fact that there is adequate disposal of less than 50% of the solid waste collected; in most cases, disposal means dumping in open-air sites or in waterways, with consequent air, soil, and water pollution.

15. In regard to health services, the country is undergoing a process of sectoral transformation directed toward the establishment of a National Health System, based on decentralization and respect for the federative system and for integration, social control, and participation, as well as for comprehensive health actions.

16. In 1987, Brazil had 30,176 health establishments, 19,178 of them public and 10,998 private. In addition, it had 501,660 beds, of which 125,215 were in the public sector and 376,445, in the private sector.

17. With regard to human resources, in 1988, per 10,000 population, there were 11.7 physicians; 2.9 nurses; 11.2 nursing auxiliaries; and 6.8 dentists. For the education of human resources for health, Brazil has 78 medical schools, 93 nursing schools, 76 dental schools, 40 pharmacy programs, 85 psychology programs, and 65 social service programs.

18. Sectoral resources ensure acceptable coverage for the urban populations; however, there are still difficulties in access for rural and marginal urban populations which, for various reasons, continue to lack acess to timely and adequate health care.

19. Brazil has achieved good vaccination coverage in recent years, and in 1991 it succeeded in routinely vaccinating 67% of all children under 1 year of age against poliomyelitis. That same year two national campaigns were conducted for children under 5, with 95% coverage. With regard to other vaccines, 78% coverage was obtained with DTP vaccine, 88% with measles vaccine, and 87% with BCG vaccine, all in children under 1 year of age.

20. The number of health care consultations carried out by the INAMPS per inhabitant per year was 1.78 in 1987.

## Plans and priorities for national health development

21. The conceptual frame of reference for the formulation of health policies is given in the 1988 Constitution, the Constitutions of the States, the Organic Health Law, the Organic Law of the Municipalities, and the recommendations of the National Health Conferences (VIII and IX). These instruments provide for the establishment of a unified health system that would be decentralized, integrated, and participatory. The fundamental processes of reformulation of the health system are, then, decentralization and municipalization, community participation, and, coordinated action by all economic and social sectors, of all political-administrative levels, and of all public, private, and civil institutions.

22. The principal problem is that no adequate political consensus has been achieved as yet for implementing the conceptual frameworks through a systems model. There are, however, many and varied experiences that can and should be utilized. This delay in the implementation of the system is due, to a great extent, to what is being called "ungovernability" in the political process.

23. The causes of this "ungovernability" are multiple, and they influence and strengthen one another. For example, now more than ever, political and economic events are difficult to predict, both in terms of their occurrence and in terms of their consequences and implications. The persistence of high inflation, the decline in the purchasing power of wages, and high underemployment and unemployment have had the cumulative effect of aggravating social conditions. In recent years there has been an increase in the process of dismantling the federal public administration, with significant repercussions for the administrations of the States and municipios. There have been no clear and consistent "rules of the game" established in the economic field. Deterioration in the industrial plant, technological underdevelopment, low productivity, the relative idleness of installed capacity owing to reduced demand and the channeling of reinvestment, austerity in public spending, the rationalization of such spending, and a delay in the tax-related reform plan that is supposed to reduce the diversity of taxes, change the regressive nature of the current system, and effectively curb income tax evasion, have all dramatically reduced the allocation of public resources, especially to the social sectors. Furthermore, the low health service coverage of the public sector is exacerbated by the still high population growth and has become further complicated by a demographic transition that makes it necessary to increase and diversify the range of social actions. An additional factor is the expansion of supply, linked to the social progress in the conceptual framework established by the Constitution of 1988.

24. Factors specific to the health system: the persistent requirement of working within a systems model that is practically exhausted, and in which attempts are made to make cosmetic or relatively inefficient changes, without trying to initiate a process of reconstruction of a new system with conceptual frameworks. The current model is administratively destructured, technically dismantled, financially asphyxiated, greatly fragmented among its various politico-administrative levels, and alienated from society. Other factors are the lack of continuity in the political leadership of the sector - with four different ministers from March 1990 to January 1993 - and the consequent instability of the technical cadres at the high and intermediate levels of the administration; the discontinuity of policies, priorities, and programs; the reorientation of programs under way and the creation of new ones without the sufficient backing of financial and material resources and without the necessary recycling of human resources; and the independent, parallel, uncoordinated, and sometimes contradictory action of the federal, State, and municipal levels, as well as that among institutions at each level.

25. It is anticipated that the 1994-1995 biennium will be characterized by unpredictable variables that may cause significant setbacks and stagnation, or may lead to advances in the process of establishing the unified health system. In 1993 there will be a plebiscite to determine what system and what form of government the country will have: whether it will continue to have a republic or return to a monarchy, and, whether there will be a presidential or a parliamentary system. Added to this are substantive modifications in the rules of the political process: district voting, partisan loyalty, the law of political parties, the dissolution of Congress, administrative reform, etc. The results of the plebiscite is expected to produce a realignment in the political parties and a restructuring within them. In 1994 there will be general elections and so it will be an electoral year which, although it generates conditions of instability and discontinuity, can also offer opportunities to strengthen political support for the changes that are necessary for the establishment of the new system.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

26. The Government requested technical cooperation in the following priority areas: monitoring of the impact of the environment on health, especially with reference to mercury and toxic agrochemicals; improvement of the coverage and quality of water and sanitation services; implementation of a new decentralized and participatory model of health care (SUS) capable of raising the health levels of the population; implementation of a system for the technological development of biomedical equipment and recovery program equipment; improvement of systems for production and quality control of drugs, immunobiologicals, and vaccines; implementation of quality control in all products subject to the health surveillance system; improvement in the surveillance and control of poliomyelitis, measles, and neonatal tetanus; decentralization of actions for the sanitary surveillance of food at the municipal level; implementation of a national laboratory network for the sanitary control of food; studies of the effect of political situations on various health care modalities with respect to the relationship between the public an private sectors, and on sectoral financing; program for the prevention and control of AIDS and of sexually transmitted diseases; planning and management of human resources, with emphasis on the implementation of plans for job duties, careers, and wages; development of studies on health sector work force dynamics and relationships; establishment of epidemiological analysis units at all SUS levels; health situation and trend assessment and promotion of the evaluation of health services; program for integrated prevention and control of malaria, especially in the Amazon region; reduction of infant, maternal, and neonatal mortality; reduction in the incidence and prevalence of diarrheal and acute respiratory diseases; increase in the coverage and improvement of the quality of preventive and recovery programs for women, mothers, children, and adolescents; training in epidemiology and management of integrated interventions for noncommunicable chronic disease prevention and control, especially hypertension and diabetes; prevention of morbidity and mortality caused by communicable diseases, and integrated control thereof, with emphasis on decentralized actions; establishment of programs for the innovation, incorporation, and utilization of health technologies; decentralization of measures for the control of zoonoses at the municipal level; and establishment of standardized laboratory methods for the diagnosis of the prevalent zoonoses.

27. With regard to cooperative projects and resources from other health-related agencies, for the 1994-95 period, the UNDP "Country Programme Management Plan" for Brazil provides for projects and resources for the prevention and control of AIDS (US$ 8.9 million); for the environment (U$S 1.2 million); for the development of human resources for health (US$ 18 million); for sanitation (US$ 4.5 million); for quality control of food (US$ 100,000); for the education and health of women (US$ 122,000); and for health services in two States of the Northeast (U$S 1.2 million).

28. In addition, UNICEF, if it provides the same budgetary allocations it made in the 1993-1994 period, will have resources of nearly US$ 18 million in 1994-1995. These resources will be allocated mainly to programs in the areas of social policies, mass communication, child survival, education, women and development, and the environment.

National priorities for technical cooperation from PAHO/WHO

29. The Ministry of Health has established requests and agreements for technical cooperation with PAHO in all of the areas identified as "priority" that were listed under the previous heading. In general, the Organization's technical cooperation will be focused on the process of decentralization and the integration of health programs and activities at the local level; institutionalization of reliable systems for epidemiological and health surveillance at the local level; human resource development; improvement of systems for the production and quality control of drugs, immunobiologicals, and vaccines; and development of programs for communicable and noncommunicable disease prevention and control, with integrated activities at the local level.

30. In addition to projects supported with the regular funds of the Organization, other projects financed with funds from other sources are being managed by PAHO. In the case of Brazil, the estimated total amount for 1994-1995 is approximately US$ 5 million, distributed among the following projects: the Expanded Program on Immunization, geared toward the achievement of effective coverage for the control of diseases preventable by vaccination; the program for the prevention and control of AIDS; the program for malaria control, especially in the Amazon Region; the program for the control of endemic diseases in the northeast, especially of leishmaniasis, Chagas' disease, and schistosomiasis; and the program for the development of the health service infrastructure.

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Control of environmental health hazards (CEH)

31. The purpose of this project is to furnish technical cooperation to the Government of Brazil for the development of programs directed toward the improvement of the environment and the monitoring of environmental impact on the health of the population. In order to achieve this purpose, it will be necessary: to train human resources in the management of technologies for the diagnosis and treatment of problems related to the environment and health; to strengthen the health, environmental, and sanitation sectors at the Ministries of Environment and Welfare; to expand intersectoral cooperation with support for programs of integrated action; to expand the dissemination of information from the REPIDISCA and ECOLINE systems and to strengthen the collaborating centers; and to promote technologies for the assessment of impact on environment and health.

Community water supply and sanitation (CWS)

32. The purpose of this project is to furnish technical cooperation to the government in the development of plans and programs for the improvement of the coverage and quality of basic sanitation services. In order to achieve this purpose, it will be necessary: to support the strengthening of the institutions of the sector, through the formulation of national plans for institutional development, basic sanitation, and investments in environment and health; to promote the coordination of international cooperation to the sector (PAHO, UNDP, UNICEF); to promote the integration of basic sanitation activities at the level of the local health systems; to disseminate the use of appropriate low-cost technologies for solving basic sanitation problems; to support the development of programs, standards, and training of human resources in water quality control; to cooperate in the development of programs for protection of water sources and for final wastewater disposal; and to expand ECO and CEPIS support for activities of technical cooperation to the country.

Health services development (DHS)

33. The purpose of the project is to furnish technical cooperation to the government for the implementation of a new health care model in the SUS, with emphasis on decentralization, universalization, and community participation. In order to achieve this purpose, it will be necessary to do the following: to formulate plans on issues relating to decentralization and health services development and to improve management capacity at all levels; to develop a system for the production, evaluation, and review of technical standards of safety and quality for medical facilities and medical equipment; to support programs for mass communication in health; and to support the National Plan for Investment in Environment and Health.

Essential drugs and vaccines (EDV)

34. The purpose of this project is to furnish technical cooperation to Brazil for the improvement of the processes of production, quality control, and utilization of drugs and immunobiologicals. In order to achieve this purpose, it will be necessary: to support the establishment of policies and training in regard to human resources the sector; to strengthen sanitary surveillance of drugs; and to support programs for pharmaceutical assistance and expansion in coverage, with emphasis on the primary care level.

Food safety (FOS)

35. The purpose of this project is to furnish technical cooperation on food protection, targeting the reorganization and decentralization of services, as well as their integration into MERCOSUR. In order to achieve this purpose, it will be necessary to do the following: to support the decentralization of actions for the sanitary surveillance of food; to support the formulation of sanitary standards for food; to support the development of a national network of food monitoring

laboratories; to train human resources in health inspection and sanitary surveillance of food; and to support the harmonization of food standards among the MERCOSUR countries.

Health policy analysis and development (HDP)

36. The purpose of this project is to furnish cooperation to the government in the field of macro-policies in health, with emphasis on defining the scope of the sector, constitutional review, sectoral financing, and strategic planning. In order to achieve this purpose, it will be necessary: to assist in the process of constitutional review in regard to the financing of the health sector; to train human resources in strategic planning; and to systematize and disseminate knowledge on trends in the spending of state and municipal resources on health.

Human resources education (HRE)

37. The purpose of this project is to furnish technical cooperation to the Government at selected federal, state, and municipal levels for the development and implementation of technologies for the training of technicians and leaders in the areas of management of systems and services, and in the delivery of health care. In order to achieve this purpose, it will be necessary: to increase the quality of the human resources involved in health care delivery and in the planning and management of services; to support the laying of the legal and operational groundwork for the regulation of the work force in the context of MERCOSUR; to propose new administrative and legal bases for government regulation of the processes of training and utilization of human resources of the health sector; to expand and systematize the knowledge necessary for governmental decision-making with respect to expenditures on personnel and regarding the productivity and the operational structure of the sector; and to establish leadership in the areas of teaching and service and in corporations committed to the modernization of the paradigms guiding the processes of training and administration of human resources in the health sector.

Health situation and trend assessment (HST)

38. The purpose of this project is to furnish technical cooperation to the government in the implementation of health information systems, with emphasis on living conditions and incorporation of the systems into local health programs. In order to achieve this purpose, it will be necessary: to support the training of human resources in epidemiology and epidemiological surveillance and to support the performance of studies on the health situation and trends.

Malaria (MAL)

39. The purpose of this project is to furnish technical cooperation to the government for the prevention of mortality from malaria, and for integrated control, especially in the Amazon Region, with emphasis on decentralized actions for the diagnosis, treatment, and referral of patients; these actions are to be incorporated into the local health services. In order to achieve this purpose, it will be necessary: to mobilize the resources of governmental and nongovernmental organizations in support of integrated programs for malaria control; to increase public knowledge of the bases, purposes, methodology, and benefits of integrated control; to increase community participation; to carry out a plan for the education and training of personnel at the central, regional, and local levels in the activities of malaria prevention and control; to update epidemiological criteria and standards for the diagnosis and treatment of cases of malaria at the local service level; and to delineate epidemiological areas of control in each State and define the functional responsibilities for that control.

Growth, development and human reproduction (MCH)

40. The purpose of this project is to cooperate with the government in the development of national capacities for increasing the organization, quality, and coverage of programs and services for the prevention, treatment, and rehabilitation of health problems of women, mothers, children, and adolescents in Brazil. In order to achieve this purpose, it will be necessary: to support programs for the extension of coverage and the improvement of the quality of care for diarrheal diseases, including cholera, and for acute respiratory infections in the network of services; to lend technical support for the process of dissemination of standards, procedures, and technical and conceptual bases for the delivery of comprehensive health care for adolescents; to support approaches and programs of comprehensive health care for women, with the participation of women's organizations; to cooperate in the implementation of a system of nutritional surveillance in the country and in the incorporation of a curriculum on basic care for mothers and children into educational programs on nutrition; to cooperate in the implementation of the system for epidemiological surveillance of maternal, child, and adolescent morbidity and mortality; and to cooperate in programs of education and training of human resources that deal with the extension of coverage reatment, and rehabilitation of mothers, children, and adolescents, as well as those of women.

Managerial support for national health development (MPN)

41. The purpose of this project is to furnish effective and efficient managerial, technical, and administrative support for projects of cooperation in which PAHO/WHO is the responsible agency. In order to achieve this purpose, it will be necessary: to lend managerial support to technical cooperation in the

mobilization of resources and formulation of standards, plans, and policies for the country; and to promote regional and subregional programs and initiatives, as well as those of the Plan for Investment in Environment and Health.

Health promotion and prevention and control of noncommunicable diseases (NCD)

42. The purpose of this project is to furnish technical cooperation to the Government for the development of programs for the incorporation of integrated health promotion actions at the level of services. In order to achieve this purpose, it will be necessary: to support the development of programs of integrated intervention for the prevention and control of the prevalent NCDs; to train human resources in epidemiology and the management of integrated interventions for the prevention and control of NCDs; to develop epidemiological information models and profile study models for NCDs; and to educate decision-makers in the health sector about the use of highly complex technologies.

General communicable disease prevention and control activities (OCD)

43. The purpose of this project is to furnish technical cooperation to the Government for the prevention of morbidity and mortality from communicable diseases and for their integrated control, with emphasis on the decentralization of diagnosis and treatment and on the referral and counter-referral systems. In order to achieve this purpose, it will be necessary: to promote in governmental and nongovernmental organizations, and in the community in general, support for programs of communicable disease control; to disseminate throughout society information on the purposes, methodologies, and benefits of integrated control of communicable diseases and participation in activities of promotion, diagnosis, and treatment of the prevalent diseases within the group; to educate and train personnel at the central, regional, and local levels in epidemiology and in prevention and treatment of the prevalent communicable diseases; to update epidemiological criteria and standards for the diagnosis and treatment of communicable diseases in a decentralized fashion, with the participation of the local health services; to support control plans in the States of Brazil; and to develop research financed through TDR and other resources.

Research promotion and development (RPD)

44. The purpose of this project is to furnish technical cooperation to the government for the formulation of policies on health science and technology, and to collaborate in the strengthening of structures suitable for the implementation of the policies. In order to achieve this purpose, it will be necessary to mobilize and motivate decision-makers through the conduct of national seminars and national forums on the subject of health science and technology.

Technical cooperation among countries (TCC)

45. The purpose of this project is to furnish technical cooperation to the government for the development of projects in technical cooperation among countries of the Region, geared toward solving problems of common interest. In order to achieve this purpose, it will be necessary: to develop projects among countries geared toward solving problems of common interest.

Zoonoses (ZNS)

46. The purpose of this project is to furnish technical cooperation in the control of zoonoses, with emphasis on the decentralization and integration of actions. In order to achieve this purpose, it will be necessary: to decentralize prevention and control activities; to support the establishment of standards in reference laboratories for the diagnosis of the principal zoonoses; to update standards for the diagnosis, prevention, and control of the most prevalent zoonosis; and to train human resources in the planning and administration of zoonosis control services.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 5,458,000 | 61.5 | 5,623,300 | 60.6 | 6,332,000 | 61.4 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 2,417,500 | 27.3 | 2,354,600 | 25.3 | 2,697,800 | 26.2 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 2,417,500 | 27.3 | 2,354,600 | 25.3 | 2,697,800 | 26.2 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 127,000 | 1.4 | 144,000 | 1.6 | 163,300 | 1.6 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 127,000 | 1.4 | 144,000 | 1.6 | 163,300 | 1.6 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 454,700 | 5.1 | 509,300 | 5.5 | 558,200 | 5.4 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 454,700 | 5.1 | 509,300 | 5.5 | 558,200 | 5.4 |
| HEALTH POLICY DEVELOPMENT | | 537,100 | 6.1 | 558,300 | 6.0 | 621,500 | 6.0 |
| HEALTH POLICY ANALYSIS AND DEVELOPMENT | HDP | 537,100 | 6.1 | 558,300 | 6.0 | 621,500 | 6.0 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 1,597,800 | 18.0 | 1,452,200 | 15.7 | 1,618,400 | 15.7 |
| HEALTH SERVICES DEVELOPMENT | DHS | 963,900 | 10.9 | 980,000 | 10.6 | 1,104,600 | 10.7 |
| ESSENTIAL DRUGS AND VACCINES | EDV | 633,900 | 7.1 | 472,200 | 5.1 | 513,800 | 5.0 |
| HUMAN RESOURCES DEVELOPMENT | | 232,900 | 2.6 | 262,500 | 2.8 | 296,100 | 2.9 |
| HUMAN RESOURCES EDUCATION | HRE | 232,900 | 2.6 | 262,500 | 2.8 | 296,100 | 2.9 |
| RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT | | 91,000 | 1.0 | 342,400 | 3.7 | 376,700 | 3.6 |
| RESEARCH PROMOTION AND DEVELOPMENT | RPD | 91,000 | 1.0 | 103,100 | 1.1 | 117,000 | 1.1 |
| RESEARCH AND DEVELOPMENT IN THE FIELD OF VACCINES | RDV | 0 | - | 239,300 | 2.6 | 259,700 | 2.5 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 3,409,900 | 38.5 | 3,627,300 | 39.4 | 3,992,000 | 38.6 |
| FOOD AND NUTRITION | | 78,100 | .9 | 88,700 | 1.0 | 100,700 | 1.0 |
| NUTRITION | NUT | 78,100 | .9 | 88,700 | 1.0 | 100,700 | 1.0 |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| ENVIRONMENTAL HEALTH | | 812,300 | 9.1 | 832,400 | 9.0 | 911,100 | 8.8 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 471,100 | 5.3 | 449,000 | 4.9 | 493,400 | 4.8 |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 341,200 | 3.8 | 383,400 | 4.1 | 417,700 | 4.0 |
| MATERNAL AND CHILD HEALTH | | 801,800 | 9.0 | 821,800 | 8.9 | 902,700 | 8.7 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 801,800 | 9.0 | 821,800 | 8.9 | 902,700 | 8.7 |
| COMMUNICABLE DISEASES | | 1,023,100 | 11.6 | 1,123,000 | 12.2 | 1,241,600 | 12.0 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 750,800 | 8.5 | 821,000 | 8.9 | 907,400 | 8.8 |
| MALARIA | MAL | 272,300 | 3.1 | 302,000 | 3.3 | 334,200 | 3.2 |
| HEALTH PROMOTION | | 124,800 | 1.4 | 138,100 | 1.5 | 152,200 | 1.5 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 124,800 | 1.4 | 138,100 | 1.5 | 152,200 | 1.5 |
| VETERINARY PUBLIC HEALTH | | 569,800 | 6.5 | 623,300 | 6.8 | 683,700 | 6.6 |
| FOOD SAFETY | FOS | 377,800 | 4.3 | 411,800 | 4.5 | 452,200 | 4.4 |
| ZOONOSES | ZNS | 192,000 | 2.2 | 211,500 | 2.3 | 231,500 | 2.2 |
| GRAND TOTAL | | 8,867,900 | 100.0 | 9,250,600 | 100.0 | 10,324,000 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 742,200 | 19.1 | 271,200 | 12.9 | 0 | |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 701,700 | 18.1 | 271,200 | 12.9 | 0 | |
| HEALTH SERVICES DEVELOPMENT | DHS | 701,700 | 18.1 | 271,200 | 12.9 | 0 | |
| HUMAN RESOURCES DEVELOPMENT | | 40,500 | 1.0 | 0 | - | 0 | |
| HUMAN RESOURCES EDUCATION | HRE | 40,500 | 1.0 | 0 | - | 0 | |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 3,134,500 | 80.9 | 1,835,200 | 87.1 | 60,900 | 100.0 |
| FOOD AND NUTRITION | | 79,500 | 2.1 | 0 | - | 0 | |
| NUTRITION | NUT | 79,500 | 2.1 | 0 | - | 0 | |
| ENVIRONMENTAL HEALTH | | 10,700 | .3 | 0 | - | 0 | |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 10,700 | .3 | 0 | - | 0 | |
| MATERNAL AND CHILD HEALTH | | 907,800 | 23.4 | 55,600 | 2.6 | 60,900 | 100.0 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 907,800 | 23.4 | 55,600 | 2.6 | 60,900 | 100.0 |
| COMMUNICABLE DISEASES | | 2,115,300 | 54.6 | 1,779,600 | 84.5 | 0 | |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 958,100 | 24.7 | 1,466,200 | 69.6 | 0 | |
| MALARIA | MAL | 534,700 | 13.8 | 313,400 | 14.9 | 0 | |
| PARASITIC DISEASES | PDP | 622,500 | 16.1 | 0 | - | 0 | |
| VETERINARY PUBLIC HEALTH | | 21,200 | .5 | 0 | - | 0 | |
| ZOONOSES | ZNS | 21,200 | .5 | 0 | - | 0 | |
| GRAND TOTAL | | 3,876,700 | 100.0 | 2,106,400 | 100.0 | 60,900 | 100.0 |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 5,297,600 | 7 | 25 | 660 | 3,387,000 | 197,200 | 42 | 84,000 | 252,300 | 220,600 | 0 | 1,156,500 |
| WHO - WR | 3,570,300 | 7 | 3 | 720 | 1,877,100 | 197,200 | 74 | 148,000 | 212,500 | 156,000 | 0 | 979,500 |
| TOTAL | 8,867,900 | 14 | 28 | 1380 | 5,264,100 | 394,400 | 116 | 232,000 | 464,800 | 376,600 | 0 | 2,136,000 |
| % OF TOTAL | 100.0 | | | | 59.5 | 4.4 | | 2.6 | 5.2 | 4.2 | .0 | 24.1 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 5,422,400 | 7 | 24 | 547 | 2,944,000 | 225,800 | 42 | 84,000 | 286,300 | 270,600 | 0 | 1,611,700 |
| WHO - WR | 3,828,200 | 7 | 3 | 720 | 1,990,500 | 223,900 | 74 | 148,000 | 240,700 | 177,100 | 0 | 1,048,000 |
| TOTAL | 9,250,600 | 14 | 27 | 1267 | 4,934,500 | 449,700 | 116 | 232,000 | 527,000 | 447,700 | 0 | 2,659,700 |
| % OF TOTAL | 100.0 | | | | 53.3 | 4.9 | | 2.5 | 5.7 | 4.8 | .0 | 28.8 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 6,104,000 | 7 | 24 | 547 | 3,304,600 | 256,000 | 42 | 84,000 | 324,700 | 306,900 | 0 | 1,827,800 |
| WHO - WR | 4,220,000 | 7 | 3 | 720 | 2,156,400 | 253,700 | 74 | 148,000 | 272,800 | 200,800 | 0 | 1,188,300 |
| TOTAL | 10,324,000 | 14 | 27 | 1267 | 5,461,000 | 509,700 | 116 | 232,000 | 597,500 | 507,700 | 0 | 3,016,100 |
| % OF TOTAL | 100.0 | | | | 53.0 | 4.9 | | 2.2 | 5.8 | 4.9 | .0 | 29.2 |

## HEALTH SITUATION ANALYSIS

### Demography

1. The population of Canada is estimated at 26,947,000 for 1992. The percentage of population 15 years and under is 20.6, while those 65 and over constitute 11.8. Women age 15-49 constitute 26.7% of the people.

### Health status indicators

2. Canadians enjoy one of the highest standards of living in the world. Infant mortality has declined to 7.1 deaths per 1,000 live births (1989). Life expectancy in Canada for newborns in 1990 reached 73.8 years for men and 80.4 years for women. Infectious diseases now account for 2.69% of total deaths; heart disease and cancer, among the leading causes of death, account for 14.9% and 33.3% respectively. According to years of potential life lost before the age of 65, the five leading causes of death for women in the years 1984-1988 were breast cancer, ischaemic heart disease, lung cancer, motor vehicle traffic accidents and stroke. For men, the five leading causes of death were ischaemic heart disease, lung cancer, motor vehicle traffic accidents, suicide and stroke.

3. The Health and Activity Limitation Survey, conducted in 1991, demonstrated that 15.5% of the population experienced some level of disability compared with 13.2% reported in the 1986-1987 survey. The disability rate for the population between the ages of 0-14 was 6.9% and 12.9% for those 14-64 years. For the population aged 64 and over, the prevalence increased to 46.0%.

### Factors affecting health status

4. Canadians have access to a broad range of health services. The health care system emphasizes the importance of well-being and the quality of life, health promotion and disease prevention. Canadians have access to an extensive network of health services from community-based primary health care to hospital services provided in 1,239 general, teaching and specialty hospitals (1989-1990) with a total of approximately 7 beds per 1,000 population. Over 5,200 special care facilities (March 1990) offer nursing care, care for the elderly and other services.

5. Health personnel in 1991 included 60,559 physicians (1 per 450 residents). In 1990 there numbered over 256,000 nurses and 14,000 dentists. Primary care physicians account for about 63% of all active physicians in Canada. About 8 out of 10 primary care physicians are family physicians and general practitioners.

6. Health care expenditures reached CAN$ 66,800 million in December 1991 or CAN$ 2,474 estimate per capita. This represented 9.9% of the Gross Domestic Product. 50.8% of these expenditures were for institutional and related services. Expenditures for drugs and appliances account for 16.1% of the total.

### Plans and priorities for national health development

7. In September 1992, Provincial, Territorial and Federal Health Ministers met to begin discussions on a national approach to health designed to strengthen the Canadian health care system in the face of continued growth in health care expenditures coupled with slow economic growth. All Ministers agreed that reforms could be achieved in ways that are fully consistent with preserving the principles of the Canada Health Act, and further agreed to initiate a coordinated national process, a Blueprint for Action, to consider health services in terms of effectiveness and appropriateness. In particular, the Ministers agreed that Canada's health care system should continue to emphasize disease prevention, health promotion and healthy lifestyle choices; pursue community-based care alternatives; improve accountability within the system; and improved the planning and management of health human resources, institutional services and health technologies. The Ministers also approved in principle, the creation of an Institute for Health Information in 1993, and the support of a nation-wide health survey in 1994 which, by measuring the health status of Canadians, will provide governments, communities, providers and consumers with information to develop future directions for health care reform.

8. The focus of the health care system on disease prevention, health promotion and community-based care continues into the 1990s. Since the beginning of the 1980s, virtually all new federal health initiatives have been directed to health promotion and prevention within a broader framework of health as a social phenomenon. Some of these measures were directed to health promotion and prevention within a broader framework of health as a social phenomenon. Others were directed to reducing tobacco use, to dealing with substance abuse, to creating and maintaining healthy environments, to strengthening community services, and to preventing the spread of AIDS. In addition, much effort has been directed to improving the overall socioeconomic status of specific target groups including Native Canadians, disabled persons, children and seniors. Similarly, many provincial reforms of the 1980s were directed to the areas of community-based care, incentive funds, and partnership initiatives, moving away from the traditional treatment, health institution focus to a more comprehensive and integrated view of health.

9. Health care is a shared responsibility between the federal and provincial governments. At the federal level, the Department of National Health and Welfare is the principal agency concerned with health matters. The Department provides preventive health services, occupational and environmental health services, emergency health services and immigration medical services. It also funds applied health research, including health services research, while the Medical Research Council primarily funds biomedical research. Federal laboratories are concerned with regulatory functions to safeguard the quality and safety of foods, cosmetics, pesticides, drinking water and air, and the safety and effectiveness of drugs and medical devices. Surveillance is maintained over chronic and infectious diseases. The direct delivery of health care services by the federal government is limited to Native Canadians living on reserves, the military, inmates of federal penitentiaries, and the Royal Canadian Mounted Police.

CANADA (Cont.)

10. Health services are primarily a provincial responsibility, as is the responsibility for health sciences educational programs, certification of health personnel, allocation and management of health care resources and the delivery of health care. Provincial departments, in cooperation with regional and local health authorities, administer such services as environmental sanitation, communicable disease control, maternal and child health, school health, nutrition and vital statistics. Federal provincial cooperation is achieved through various federal provincial coordinating mechanisms.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

11. During the 1992-1993 biennium, PAHO/WHO embarked on a new strategy for technical cooperation with Canada. Under a new and unique arrangement, a non-governmental organization, the Canadian Society for International Health (CSIH), became the PAHO "technical representative" in Canada. This arrangement is unique for PAHO because for the first time, an NGO would be representing its technical interests at the country level.

12. Under this arrangement, one of the objectives of the CSIH is to increase Canadian participation in the program activities of PAHO. To this end, it has consolidated a registry of Canadian expertise in the health care sector. This registry has already helped PAHO identify Canadian experts to provide technical cooperation, and will become increasingly useful as the data base is further expanded, and as the registry becomes better known. Other activities include the conduct of workshops on various subjects related to health development, the administration of the fellowship program, and the distribution of information about the Organization, including World Health Day and World No Tobacco Day.

13. Since the PAHO office in Canada became fully operational in January 1992, the CSIH has been instrumental in assisting the Organization in meeting its commitments to undertake activities to improve the health of indigenous peoples. In this context, the CSIH organized on behalf of PAHO, a consultative workshop on the health of indigenous peoples. The workshop, hosted by Canada, was held during the International Year of the World's Indigenous Persons. It provided an opportunity for open dialogue between indigenous groups and potential partners, with recommendations which may generate a basis for policy and program development in PAHO and its member countries.

## PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

### Health services development (DHS)

14. The purpose of this project is to provide Canadian expertise to health work primarily in the Americas, and to simultaneously increase the international know-how of Canadian experts. Canadian expertise will be utilized or deployed along the lines determined by programs agreed upon by PAHO and the Canadian Government.

### Human resources education (HRE)

15. The purpose of this project is to provide specialized training to Canadians in health and socioeconomic issues of increasing relevance to public health in Canada and to its international interests. At least 24 Canadians will have been provided specialized training in health and socioeconomic issues in areas relevant to Canada and to PAHO.

### Managerial support for national health development (MPN)

16. The purpose of this project is to increase Canadian participation in the program activities of PAHO, while enhancing Canadian awareness of PAHO, its programs, and activities. The project will aim at increasing Canadian awareness, particularly non-governmental, of international health problems and opportunities in general, and of PAHO's programs in particular; having a focal point acting as PAHO's "technical representative" and link to the Canadian health and development community; providing leadership and support to the initiative concerning the health of indigenous peoples in the Americas.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 778,000 | 100.0 | 847,800 | 100.0 | 917,700 | 100.0 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 600,000 | 77.1 | 521,500 | 61.5 | 591,400 | 64.4 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 600,000 | 77.1 | 521,500 | 61.5 | 591,400 | 64.4 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 46,000 | 5.9 | 206,300 | 24.3 | 206,300 | 22.5 |
| HEALTH SERVICES DEVELOPMENT | DHS | 46,000 | 5.9 | 206,300 | 24.3 | 206,300 | 22.5 |
| HUMAN RESOURCES DEVELOPMENT | | 132,000 | 17.0 | 120,000 | 14.2 | 120,000 | 13.1 |
| HUMAN RESOURCES EDUCATION | HRE | 132,000 | 17.0 | 120,000 | 14.2 | 120,000 | 13.1 |
| GRAND TOTAL | | 778,000 | 100.0 | 847,800 | 100.0 | 917,700 | 100.0 |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 712,000 | 1 | 0 | 80 | 345,700 | 30,000 | 33 | 66,000 | 95,300 | 0 | 0 | 175,000 |
| WHO - WR | 66,000 | 0 | 0 | 0 | 0 | 0 | 33 | 66,000 | 0 | 0 | 0 | 0 |
| TOTAL | 778,000 | 1 | 0 | 80 | 345,700 | 30,000 | 66 | 132,000 | 95,300 | 0 | 0 | 175,000 |
| % OF TOTAL | 100.0 | | | | 44.4 | 3.9 | | 17.0 | 12.2 | .0 | .0 | 22.5 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 787,800 | 0 | 0 | 742 | 206,300 | 0 | 30 | 60,000 | 0 | 0 | 521,500 | 0 |
| WHO - WR | 60,000 | 0 | 0 | 0 | 0 | 0 | 30 | 60,000 | 0 | 0 | 0 | 0 |
| TOTAL | 847,800 | 0 | 0 | 742 | 206,300 | 0 | 60 | 120,000 | 0 | 0 | 521,500 | 0 |
| % OF TOTAL | 100.0 | | | | 24.3 | .0 | | 14.2 | .0 | .0 | 61.5 | .0 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 857,700 | 0 | 0 | 742 | 206,300 | 0 | 30 | 60,000 | 0 | 0 | 591,400 | 0 |
| WHO - WR | 60,000 | 0 | 0 | 0 | 0 | 0 | 30 | 60,000 | 0 | 0 | 0 | 0 |
| TOTAL | 917,700 | 0 | 0 | 742 | 206,300 | 0 | 60 | 120,000 | 0 | 0 | 591,400 | 0 |
| % OF TOTAL | 100.0 | | | | 22.5 | .0 | | 13.1 | .0 | .0 | 64.4 | .0 |

## HEALTH SITUATION ANALYSIS

### Demography

1. The English-speaking Caribbean had a population of approximately 6 million in 1990. Details of the population census conducted in 1990 and 1991 are not yet available from all countries for analysis, but available evidence indicates that the rate of population growth has been heavily influenced by migration, which may have been underestimated in the preparation of population projections.

2. The population of the subregion is expected to grow at about 1% per annum. As a whole, the populations are relatively young, with 40% being under the age of 15 in most countries. However, the period of demographic transition has commenced and the populations of Barbados, Montserrat, and Anguilla are becoming increasingly mature, with more than 10% of the population being 65 and over.

### Health status indicators

3. Life expectancy at birth has increased steadily during the 1980s in most territories. In 1990, life expectancy ranged from a high of 76.1 in Dominica to a low of 64.0 in Guyana. In seven territories, life expectancy exceeded 70 years. The reported rates for protein-energy malnutrition were low, although research conducted by CFNI indicates that pockets of PEM are identified when data is desegregated by district. Obesity is on the increase in all countries. The patterns of mortality are similar to those of the industrialized countries, with the main causes of death being the chronic non-communicable diseases and accidents. The Caribbean reports very high mortality rates from hypertension, diabetes mellitus; mortality in women from cancer of the cervix remains high but is decreasing; mortality from cancer of the breast is on the increase and now exceeds mortality from cervical cancer in most countries. There has been a significant decrease in all countries in mortality from diarrhoeal disease in children: perinatal causes now constitute the most common cause of death in infancy.

4. The AIDS pandemic continues to affect the Caribbean; all countries have now reported the occurrence of at least one case of AIDS and the number of cases of AIDS reported from the English-speaking Caribbean up to the end of September 1992 was 3,195 with a cumulative incidence rate of 53/100,000 - amongst the highest in the world. The cholera pandemic in the Americas has spread into the subregion, with cases being reported from Belize, Guyana, Suriname and French Guiana.

### Factors affecting health status

5. The English-speaking Caribbean has continued to be politically stable, with vibrant democratic institutions. The Caribbean economies continued to be fragile and subject to external forces: thus, the global economic crisis of the 1980s impacted severely on the economies of nearly all countries and many countries have demonstrated adverse effects from the recession in North America and western Europe. The two countries most affected have been Guyana and Jamaica; however, the economies of these countries have grown in the past two years and exchange rates appear to have stabilized. However, there have been three consecutive years of negative growth in Barbados since 1989 and Antigua and Barbuda as well as Grenada are experiencing severe fiscal problems. The economies of the banana-producing countries (Grenada, St. Lucia, Dominica and St. Vincent) are threatened by the potential loss of preferential marketing arrangements in the European Community, as is the case in the sugar industries of Guyana, Trinidad and Tobago, Barbados, St. Kitts/Nevis, and Jamaica. The vital tourism industry has not yet fully recovered from the effects of the recession in North America and the Gulf War. It is threatened by the loss of newly acquired markets in Europe consequent on the devaluations of the Scandinavian currencies. The hotel sector is losing business to the cruise ships, which do not contribute as much to the economy. More positively, though, eco-tourism is on the increase, particularly in Guyana, Trinidad and Tobago, Belize and Dominica. The immediate economic future of the subregion is at best uncertain.

6. Environmental protection remains an area of major concern. The goals of the International Decade of Water and Sanitation were not fully achieved and large segments of Caribbean populations still do not have full access to potable water and basic sanitation services, particularly in rural areas, and the sewerage systems in capital towns and cities are inadequate in many countries. The fragile ecosystems of the Caribbean island states are threatened by inadequate liquid and solid waste disposal, industrialization and pesticide abuse. Cholera would appear to be becoming endemic in rural Guyana and there has been water-borne Typhoid in Jamaica for the first time in a decade. Through the Port-of-Spain Accord, the Caribbean countries have pledged concerted action to improve environmental conditions during this decade, and several projects to provide the funding are now being negotiated with the developmental banks (IBRD and IADB).

7. Vector-borne disease constitutes a potential threat to the health and economies of Caribbean countries. Malaria is still endemic in Guyana and Belize. Hemorrhagic dengue has been reported in some territories and remains a threat. Recent evidence indicates that leptospirosis associated with rodents is being increasingly reported. Action is now being taken in all countries with support from the CCH vector control project to bring about improvements.

8. The major challenges in the field of maternal and child health are reduction of maternal mortality and morbidity, the improvement of perinatal care, and the development of programs to deal with the burgeoning problems of the adolescent, where young people are increasingly involved in violent crime and drug abuse, STDs and AIDS. The political will to develop comprehensive adolescent health care programs now appears to be increasing. The concept of women in health and development is being increasingly accepted, but much remains to be done to ensure that Caribbean women play their full role in health and development issues.

9. New approaches to the control of noncommunicable diseases are being developed, but there still remains a need for all countries to formulate and

execute policies on health promotion which will utilize the full potential of community-based organizations, NGOs and PVOs, as well as the mass media. Action taken by the Conference of Ministers Responsible for Health in supporting the formulation of a Caribbean Charter for Health Promotion, creates an opportunity for significant change in this area.

10. The continuing economic problems have focused attention on the management of the health services. Management deficiencies persist and there is considerable inertia, which has impeded efforts to bring about change. The political will is emerging to ensure that there is change in the way in which the services are managed, and that in particular management decisions are made on the basis of the best available information rather than on intuition and on historical experience. Alternative methods of financing of the health sector are being investigated in several countries; these include examination of the role of the private sector and NGOs. For the first time, the social security systems are being involved in financing health care delivery in several countries. Significant changes in the way the health services are managed and organized are expected in the biennium, particularly in the British-Dependent Territories (ECA and NCA).

Plans and priorities for national health development

11. The Caribbean Cooperation in Health Initiative remains the main focus of the subregion. The Conference of Ministers Responsible for Health has formally adopted the Goals and Targets (G&T) for the initiative: the achievement of these G&T constitute the priority of the subregion. The goals which have been adopted are: environmental protection, including vector control - to reduce health risks associated with environmental conditions through the promotion of environmental health programs aimed at the provision of safe water supply and appropriate excreta disposal, the control of pollution, the safety of food, proper disposal of solid wastes and the control of toxic chemicals; chronic diseases and injury prevention - the development and implementation of comprehensive programs for the prevention and control of the chronic non-communicable diseases prevalent in the Caribbean, including preventive, curative and rehabilitative aspects; strengthening of health systems - to increase the operating capacity within all CARICOM countries, to deliver efficient and effective health services to the total population, emphasizing the local health systems approach; maternal and child health - to ensure the provision of a wide range of preventive, curative, rehabilitative and supportive services to meet the basic health needs of mothers, children and adolescents, giving special attention to high risk individuals and groups; human resource development - to plan for, train and optimally utilize the appropriate types and numbers of health personnel required to implement the national strategies for achievement of improved health status; food and nutrition - to prevent malnutrition in all its forms and to prevent and control those diseases conditioned by nutrition practice and behavior; and AIDS prevention and control - to increase the capacity of countries to prevent and control Sexually Transmitted Diseases (STDs) and Acquired Immunodeficiency Syndrome (AIDS).

12. The Caribbean Subregion will continue to promote the development of the Initiative. The subregion will complete preparation of a Caribbean Investment Plan in Health and the Environment and will promote investment in the priority areas. However, as requested by the CMH, the focus will shift to a more vigorous promotion of technical cooperation between countries than has been the case and to supporting national efforts in meeting the agreed subregional goals and targets. The strategy will also emphasize the sharing of information among countries and regular meetings of the senior officials responsible for the priority areas.

GLOBAL STRATEGY FOR TECHNICAL COOPERATION

National priority areas for technical cooperation

13. The Subregion will seek external assistance in the priority areas of the Caribbean Cooperation in Health and in meeting the goals and targets, which have already been stated. The targets to be achieved during the biennium, 1994-1995 are: each country should have developed written policies to pursue at the regional and national levels improvements in environmental health designed to achieve specified goals in water supply, liquid waste and excreta disposal, solid waste, industrial waste, beach pollution, pesticides, food safety and vector control; by 1995, all CARICOM countries which support the subregional information system at CEHI should have established national information systems for assessing and monitoring the most significant threats to environmental health; by 1995, each country should ensure that safe potable water is available in adequate quantities 24 hours a day; by 1995, all CARICOM countries will ensure that each house is provided with an approved means of disposal of liquid waste and excreta, including the provision of waste-water collection systems and treatment in primary towns and densely-populated centers; by 1995, each country should have developed a solid waste management plan to ensure that, without posing an environmental health hazard, solid waste produced by any source in the country is safely disposed of and should have adopted suitable measures for solid waste disposal in urban, rural and isolated communities respectively; by 1995, each Government should have formulated national policies and programs to control coastal pollution and have supported the formulation of international agreements to control pollution of the sea generally and, in particular, the Caribbean Sea; by 1995, each country should have developed legislation relevant to pesticides control and established the machinery necessary for the implementation of control measures; by 1995, each country should have developed mechanisms to ensure that environmental impact assessments are undertaken prior to any type of development/construction which may adversely affect the environment; by 1995, each country will have developed policies and implemented programs for vector control based on an integrated approach; and by 1995, the countries of the Region will have developed a surveillance system capable of detecting all potential outbreak situations, as well as identifying risk potential for food contamination.

14. Chronic Diseases and Injury Prevention. By 1995, all countries will have formulated policies and developed functional integrated programs for the prevention and control of the most prevalent chronic noncommunicable diseases and related problems including, but not limited, to hypertension, diabetes, cancers of the breast and cervix and traffic injuries; by 1995, all countries will have developed and begun implementation of health promotion programs aimed at changing unhealthy lifestyles in whole communities, and involving all related sectors including the mass media, Non-Governmental Organizations (NGOs), professional societies and community groups; CARICOM countries will have effective health and management information systems installed and in use for planning and management of the national health systems, and for contributing to subregional information systems for monitoring and evaluating progress towards subregional, regional and global health goals; by 1994, all CARICOM countries should have developed effective measures to address quality assurance in the health care services; and

by 1995, all countries should have a functioning national disaster health sector plan and have in place the infrastructure to allow them to cope with disasters in all the health areas, including the appropriate budget.

15. Maternal & Child Health. By 1995, each country of the region will have ensured that every pregnant woman receives adequate care by trained health personnel; by 1995, in each country every pregnant woman will have access to intranatal services adequate to meet the needs of the mother and infant, including obstetrical emergencies; in all countries, all families and individuals will have access to family planning services, including educational and counselling services; by 1995, each country will have allocated adequate resources and developed facilities for the care and follow-up of newborn infants, both normal and those of high risk, utilizing the perinatal team approach; by 1995, all countries will have been certified as having eliminated measles; by 1995, surveillance systems will indicate that indigenous measles will have been eliminated from all CARICOM countries; by 1995, 95% of children under 16 months of age will have received at least one dose of measles vaccine; by 1995, at least 50% of the infants in all countries should be breast-feeding solely for the first four months of life; by 1995, each country shall have in place community-based programs for the care of children disabled by mental or physical handicaps and disorders of the special senses; and by 1995, all countries will have incorporated special activities/programs for the care of the adolescents into the MCH program.

16. Human Resource Development. By 1994, each country should have an established manpower information system in use of health manpower planning, at national and regional levels, as well as personnel management; by 1994, each country should have developed policies and strategic plans for meeting health manpower needs, in particular nursing, taking into account the changing levels of care, the categories and functions of staff required, and utilizing an intersectoral approach; and by 1994, CARICOM countries collectively should have agreed on policies regarding the optimization of scarce human resources and have indicated the role of national and subregional institutions in meeting human resource needs.

17. Food and Nutrition. By 1994, all CARICOM countries will have developed a national food and nutrition policy as part of a national health policy; by 1995, all CARICOM countries will have food and nutrition strategies which are consistent with the Caribbean Food and Nutrition strategy; by 1995, all CARICOM countries will have nutritional surveillance systems to identify those at risk of and actually suffering from the most prevalent nutrition diseases; by 1995, all CARICOM countries will have programs/activities which are preventing and controlling the most prevalent nutritional disorders, i.e. iron deficiency, anaemia, protein-energy malnutrition, and obesity; by 1995, all CARICOM countries will have included a nutrition component in the health education programs directed to the populations generally and to the young in particular; and by 1995, all CARICOM countries will have significantly reduced health risks from food contamination and implemented measures to protect consumers.

18. AIDS Prevention and Control. By the end of 1995, all CARICOM countries should have STD/AIDS programs integrated with comprehensive services at the PHC level; by 1995, there will be national and regional information systems established to monitor programs and evaluate progress in the control of STD/AIDS; and by 1995, all countries will have developed programs for care and counselling with respect to STD/AIDS.

19. The Caribbean sub-region receives technical and financial cooperation from many sources with increasing use of the CCH as the framework for the development of projects. While the majority of cooperation is delivered through bi-lateral agreements, a significant proportion is delivered through subregional or multi-country projects. Many agencies are providing support for the improvement of the environment including the German Agency for Technical Cooperation (Deutsches Gesselschuft fur Techniche Zusammenarbert GTZ) in institutional development and the World Bank in solid waste management; CIDA and UNDP are also contributing. Other areas which have attracted funding are the strengthening of the health systems, control of chronic diseases and AIDS. The IDB is funding a $1.8 million project to strengthen information systems in the community services in Barbados and the Eastern Caribbean. The Government of France continues to support projects to control the mortality due to cancer of the uterine cervix and to change the lifestyles of school children. Contributions to the sub-regional project for the control of AIDS, Cholera (executed by CAREC) and EPI are received from GPA, CIDA and USAID and the Government of the Netherlands. UNICEF cooperates with a focus on the health and well being of children and women.

National priorities for technical cooperation from PAHO/WHO

20. PAHO/WHO has been requested to provide technical cooperation in all the national priorities listed in the previous section. In addition, PAHO/WHO technical cooperation is requested in improving the functioning of the Joint Secretariat of the Caribbean Cooperation in Health Initiative and in establishing the databases needed for evaluating the progress of the Initiative. Technical cooperation will be required with respect to the Caribbean Plan of Investment in Health & the Environment.

21. PAHO/WHO technical cooperation will continue to focus upon full implementation of the CCH Initiative. Broadly, it will emphasize the role of the Initiative in promoting health and development and Caribbean integration. Special focus will be on technical cooperation between countries, on sharing of information, and on social communication. The strategy will emphasize the achievement of the agreed health goals and targets of the Caribbean Community. The main focus will be to catalyze the change needed to ensure that the health services can meet the needs and aspirations of the Caribbean peoples in a climate of economic uncertainty. Technical cooperation will emphasis social participation and genuine intersectoral articulation. Health and development issues will be continuously brought to the attention of the governments.

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Community water supply and sanitation (CWS)

22. The purpose of the project is to reduce health risks associated with environmental conditions through the promotion of environmental health programs aimed at the provision of safe water supply and appropriate excreta disposal, the control of pollution, proper disposal of solid wastes and the control of toxic chemicals. Building of networks for information sharing between Caribbean institutions will be promoted. Social communication strategies will be pursued and information provided to the public on environmental health matters. A major focus will be resource mobilization, which will be conducted through the CARICOM/PAHO Plan of Action for Investment in Health & the Environment. Support will be provided to the countries for the development of written policies designed to facilitate the achievement of the Goals & Targets of the CCH Initiative. Training in liquid and solid waste management, as well as the disposal of hazardous waste, will be conducted. Research on the effects of developmental activities on environmental health will be undertaken.

Health services development (DHS)

23. The purpose of this project is to increase the operating capacity within all CARICOM countries to deliver efficient and effective health services to the total population, emphasizing the Local Health Systems approach. Social communication strategies will be pursued and increased social participation in health services will be promoted. Support will be provided to countries for the sharing of information on health service development efforts. Resource mobilization under the CCH Initiative will be conducted. Training will be provided to nationals in the use of the Logical Framework Approach for project preparation. The planning process will be emphasized and the preparation of national strategic plans will be promoted. Health services research will be conducted and nationals trained in research methodology. Information systems development will be emphasized.

Human resources education (HRE)

24. The purpose of this project is to plan for, train and optimally utilize the appropriate types and numbers of health personnel required to implement the national strategies for achievement of improved health status. Training will be provided in the techniques of health manpower planning. Information on health manpower issues will be disseminated to the governments and to the public and there will be continuing research on the most appropriate methods of manpower utilization and production.

Growth, development and human reproduction (MCH)

25. The purpose of the project is to ensure the provision of a wide range of preventive, curative, rehabilitative and supportive services to meet the basic health needs of mothers, children and adolescents giving special attention to high risk individuals and groups. Appropriate social communication strategies will be developed, particularly in the area of adolescent health care, where health promotion will be emphasized. Assistance will be provided to the governments in the development of comprehensive MCH plans and in their monitoring and evaluation. Research into the health of women and adolescents will be conducted and assistance will be given to the countries in project development and mobilizing resources for these programs.

Health promotion and prevention and control of noncommunicable diseases (NCD)

26. The purpose of this project is to develop and implement comprehensive programs for the prevention and control of the chronic noncommunicable diseases prevalent in the Caribbean, including preventive, curative and rehabilitative aspects. All means of social communication will be mobilized to assist in bringing about behavioral change. Assistance will be provided in the development of appropriate policies and plans for comprehensive NCD programs. Research on risk behaviors in the Caribbean and on the epidemiology of NCD will be supported. Training will be provided in health promotion, social communication, and in chronic diseases epidemiology.

Technical cooperation among countries (TCC)

27. The purpose of this project is to develop mechanisms for increasing technical cooperation between Caribbean countries. The project will support regular meetings of heads of the units responsible for the CCH priority areas. Assistance will be provided in developing the mechanisms which will facilitate the sharing of human and other resources and in implementing joint action on common problems. Specific projects will be developed to mobilize resources.

Vector-borne diseases (VBC)

28. The purpose of the project is to strengthen the subregional capacity for prevention and control of vector-borne diseases. Activities will contribute to the development of community-based integrated strategies for the control of insect and rodent vectors and pests. The strategies will include source reduction and biological control in addition to the use of chemicals. Health communication methods will be employed for the promotion of sustainable social participation leading to improvements in environmental sanitation at the household level. Training efforts will be designed to improve the technical skills necessary for management and implementation of these strategies. Extrabudgetary support will remain critical for the consolidation of national policies and programs of dengue prevention and control.

Zoonoses (ZNS)

29. The purpose of the project is to develop veterinary public health programs emphasizing food protection, the control of zoonotic diseases, and the prevention of importation of exotic animal diseases. To achieve this purpose information on the occurrence of zoonoses and on animal health will be disseminated. Social communication relating to animal health will be emphasized. Training will be conducted in food protection and in the diagnosis of rabies. Countries will be urged to adopt policies and plans of action with respect to food protection and to enact appropriate legislation. With the assistance of PANAFTOSA, the efforts of the subregion to prevent the importation of exotic animal diseases will be coordinated.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 2,053,300 | 54.6 | 2,246,200 | 53.9 | 2,464,600 | 54.1 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 377,600 | 10.0 | 431,400 | 10.4 | 489,200 | 10.7 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 377,600 | 10.0 | 431,400 | 10.4 | 489,200 | 10.7 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 1,351,900 | 36.0 | 1,479,800 | 35.5 | 1,610,600 | 35.4 |
| HEALTH SERVICES DEVELOPMENT | DHS | 1,351,900 | 36.0 | 1,479,800 | 35.5 | 1,610,600 | 35.4 |
| HUMAN RESOURCES DEVELOPMENT | | 323,800 | 8.6 | 335,000 | 8.0 | 364,800 | 8.0 |
| HUMAN RESOURCES EDUCATION | HRE | 323,800 | 8.6 | 335,000 | 8.0 | 364,800 | 8.0 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 1,710,800 | 45.4 | 1,915,300 | 46.1 | 2,088,800 | 45.9 |
| FOOD AND NUTRITION | | 183,300 | 4.9 | 14,900 | .4 | 16,900 | .4 |
| NUTRITION | NUT | 183,300 | 4.9 | 14,900 | .4 | 16,900 | .4 |
| ENVIRONMENTAL HEALTH | | 369,400 | 9.8 | 381,900 | 9.2 | 417,800 | 9.2 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 369,400 | 9.8 | 381,900 | 9.2 | 417,800 | 9.2 |
| MATERNAL AND CHILD HEALTH | | 271,900 | 7.2 | 301,600 | 7.2 | 328,000 | 7.2 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 271,900 | 7.2 | 301,600 | 7.2 | 328,000 | 7.2 |
| COMMUNICABLE DISEASES | | 238,500 | 6.3 | 292,400 | 7.0 | 319,100 | 7.0 |
| VECTOR-BORNE DISEASES | VBC | 238,500 | 6.3 | 292,400 | 7.0 | 319,100 | 7.0 |
| HEALTH PROMOTION | | 608,400 | 16.2 | 638,800 | 15.4 | 695,600 | 15.3 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 608,400 | 16.2 | 638,800 | 15.4 | 695,600 | 15.3 |
| VETERINARY PUBLIC HEALTH | | 39,300 | 1.0 | 285,700 | 6.9 | 311,400 | 6.8 |
| ZOONOSES | ZNS | 39,300 | 1.0 | 285,700 | 6.9 | 311,400 | 6.8 |
| GRAND TOTAL | | 3,764,100 | 100.0 | 4,161,500 | 100.0 | 4,553,400 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 1,744,100 | 47.9 | 497,300 | 88.4 | 0 | - |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 1,719,300 | 47.2 | 497,300 | 88.4 | 0 | - |
| HEALTH SERVICES DEVELOPMENT | DHS | 1,240,700 | 34.1 | 497,300 | 88.4 | 0 | - |
| ESSENTIAL DRUGS AND VACCINES | EDV | 47,500 | 1.3 | 0 | - | 0 | - |
| DISASTER PREPAREDNESS | DPP | 221,000 | 6.1 | 0 | - | 0 | - |
| HEALTH EDUCATION AND COMMUNITY PARTICIPATION | HED | 52,200 | 1.4 | 0 | - | 0 | - |
| REHABILITATION | RHB | 157,900 | 4.3 | 0 | - | 0 | - |
| HUMAN RESOURCES DEVELOPMENT | | 24,800 | .7 | 0 | - | 0 | - |
| HUMAN RESOURCES EDUCATION | HRE | 24,800 | .7 | 0 | - | 0 | - |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 1,902,000 | 52.1 | 65,500 | 11.6 | 70,100 | 100.0 |
| MATERNAL AND CHILD HEALTH | | 796,700 | 21.8 | 65,500 | 11.6 | 70,100 | 100.0 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 766,700 | 21.0 | 65,500 | 11.6 | 70,100 | 100.0 |
| DIARRHEAL DISEASES | CDD | 30,000 | .8 | 0 | - | 0 | - |
| COMMUNICABLE DISEASES | | 796,200 | 21.8 | 0 | - | 0 | - |
| VECTOR-BORNE DISEASES | VBC | 796,200 | 21.8 | 0 | - | 0 | - |
| HEALTH PROMOTION | | 309,100 | 8.5 | 0 | - | 0 | - |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 9,700 | .3 | 0 | - | 0 | - |
| CANCER | CAN | 299,400 | 8.2 | 0 | - | 0 | - |
| GRAND TOTAL | | 3,646,100 | 100.0 | 562,800 | 100.0 | 70,100 | 100.0 |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| **1992-1993** | | | | | | | | | | | | |
| PAHO - PR | 995,400 | 2 | 1 | 70 | 479,000 | 54,400 | 0 | 0 | 62,800 | 6,600 | 0 | 392,600 |
| WHO - WR | 2,768,700 | 10 | 3 | 475 | 2,287,800 | 231,200 | 0 | 0 | 123,500 | 49,400 | 0 | 76,800 |
| TOTAL | 3,764,100 | 12 | 4 | 545 | 2,766,800 | 285,600 | 0 | 0 | 186,300 | 56,000 | 0 | 469,400 |
| % OF TOTAL | 100.0 | | | | 73.5 | 7.6 | | .0 | 4.9 | 1.5 | .0 | 12.5 |
| **1994-1995** | | | | | | | | | | | | |
| PAHO - PR | 1,071,200 | 2 | 1 | 70 | 513,300 | 50,400 | 0 | 0 | 56,300 | 6,400 | 0 | 444,800 |
| WHO - WR | 3,090,300 | 10 | 3 | 475 | 2,516,400 | 280,300 | 0 | 0 | 139,600 | 71,900 | 0 | 82,100 |
| TOTAL | 4,161,500 | 12 | 4 | 545 | 3,029,700 | 330,700 | 0 | 0 | 195,900 | 78,300 | 0 | 526,900 |
| % OF TOTAL | 100.0 | | | | 72.8 | 7.9 | | .0 | 4.7 | 1.9 | .0 | 12.7 |
| **1996-1997** | | | | | | | | | | | | |
| PAHO - PR | 1,188,100 | 2 | 1 | 70 | 555,500 | 57,100 | 0 | 0 | 63,800 | 7,300 | 0 | 504,400 |
| WHO - WR | 3,365,300 | 10 | 3 | 475 | 2,714,400 | 317,900 | 0 | 0 | 158,300 | 81,600 | 0 | 93,100 |
| TOTAL | 4,553,400 | 12 | 4 | 545 | 3,269,900 | 375,000 | 0 | 0 | 222,100 | 88,900 | 0 | 597,500 |
| % OF TOTAL | 100.0 | | | | 71.8 | 8.2 | | .0 | 4.9 | 2.0 | .0 | 13.1 |

CHILE

## HEALTH SITUATION ANALYSIS

### Demography

1. The preliminary count of the national census conducted in April 1992 put Chile's population at 13,231,803 inhabitants. The annual average population growth for the five-year period 1990-1995 is expected to be 1.55% and should continue to decline due to the 50% reduction over the last 30 years in the total fertility rate, which is estimated at 2.66 for 1990-1995. The effect of this trend on the age structure of the population can be seen in the reduction of the proportion of individuals under 15 years of age to 30.5% of the population and the increase in the proportion of adults 65 years of age and older, which rose to 6.1%. The aging of Chilean society is just beginning, but it is expected to intensify over the next ten years.

### Health status indicators

2. Mortality continues its downward trend in almost all population groups. As a result, total mortality fluctuates at around 6 deaths per 1,000 population, and life expectancy at birth for the period 1990-1995 is estimated at 68.5 years for men and 75.6 years for women.

3. Infant mortality has continued to decline; the rate was reduced by 50% over the last decade and is currently below 16 deaths per 1,000 live births among infants under 1 year of age. Similar gains have been made in mortality among children from 1 to 4 years of age, which stands at around 7 deaths per 10,000 children between those ages. There have also been major declines in maternal mortality, which in 1990 stood at 4 deaths per 10,000 live births.

4. Diseases of the circulatory system constitute the largest group of causes of deaths (27.5% of total deaths), and within this group 36% are due to ischemic heart disease and 32.5% to cerebrovascular diseases. Cancer, accounting for 18% of all deaths, is in second place. Within this group, malignant neoplasms of the digestive organs (49.5%), those of the genitourinary organs, (17.7%), and those of the respiratory organs (11.4%) are the most common. The third group, accounting for 12.3% of deaths, consists of diseases of the respiratory system, among which pneumonia causes 62.5% of deaths. Injuries, poisonings, and violence are in fourth place, accounting for 12.2% of deaths, accidents being the leading cause and traffic accidents accounting for one-third of them.

5. With regard to mortality, there has been a general trend in the country toward lower incidence and prevalence of infectious and parasitic diseases, but growing concern over chronic and degenerative diseases.

6. To judge by the information obtained from the 1.4 million patients who were discharged from hospitals in the country in 1990--excluding normal deliveries, which constitute 12.4% of all discharges--the leading cause of hospitalization is the group of diseases and conditions associated with obstetric and gynecological causes and abortion, which account for 19.3% of discharges.

7. Communicable diseases show a marked declining trend. Vaccination programs have had a major impact on all of them, and in particular poliomyelitis has been practically eradicated. Mortality from tuberculosis was reduced 50% over the past 10 years, but morbidity has shown a less spectacular decline. Intestinal infections have also shown reductions in mortality of almost 50% in 10 years, but morbidity remains at high levels, particularly in the case of typhoid and hepatitis. Cholera, which first occurred in April 1991, remains under control, although small, sporadic outbreaks could not be avoided. Sexually transmitted diseases have also shown an appreciable decline, although their relative importance, given the decline in the incidence of other communicable diseases, holds steady within this group. Vigorous measures have been taken to control AIDS, which appeared in the country in 1984.

### Factors affecting health status

8. The Chilean economy continued to expand in 1992 for the ninth consecutive year, showing at the same time a balance in its leading macroeconomic indicators that make this year the best of the last 30. The growth of the gross domestic product, the highest in Latin America, reached 9.5% and was accompanied by a major surplus in the balance of payments, a steady increase in investment, which hit the unprecedented figure of US$ 1.389 billion, an increase in net reserves, the maintenance of fiscal discipline, and a marked decline in the relative burden of the external debt. Inflation was reduced to just 12.7% a year, amid a sharp increase in demand and consumption. There was a 5% rise in the average real wages of workers, who thus shared in part of the increased productivity of the economy. Unemployment showed a decline, affecting 4.8% of the work force, which, in turn, expanded with the creation of nearly 200,000 new jobs.

9. In 1990 it was estimated that 40% of the population was living in poverty and that 13.8% found themselves in extreme poverty. The socioeconomic policy of the Government and the appropriate handling of the national economy have made it possible to reduce these proportions by amounts that have not yet been precisely calculated; but the result can be estimated from the increased share of the poor in national revenues from 12.6% to 14.7% in three years.

10. In the area of education, illiteracy has declined to below 8% among those 15 years and older. It is estimated that, in 1989, 90% of the population from 6 to 14 years of age was attending school at the intermediate level.

11. It is estimated that the housing shortage affects more than one million people, 800,000 of whom lack housing and 300,000 of whom live in inadequate dwellings.

12. With regard to water and sanitation services, 99% of the urban population and 80% of the concentrated rural population have water service, and 84.5% of the urban population has access to excreta disposal services. More than 98% of the urban population has solid waste collection service, although only 72.3% has access to sanitary waste disposal.

13. The available information indicates a major improvement in food and nutrition. This fact can be seen in some surveys on protein and calorie intake among the various socioeconomic groups and can be seen clearly among children under the age of 6, only 7.4% of whom are slightly undernourished. Severe malnutrition has almost disappeared. Control of the sanitary quality of food has been maintained, and the percentage of bacteriologically and chemically nonconforming samples has been reduced considerably.

14. The zoonoses of significance to human health remain under close surveillance and have been reduced drastically. There have not been any cases of human rabies since 1972, and foot-and-mouth disease, which is subject to strict border control, has been eradicated.

15. The social security system in Chile is made up of three main components: The pension system, which covers the risks of old age, disability, and survival through private institutions, called Administrators of Pension Funds (AFL), by means of the individual investment of a 10% contribution deducted from workers' paychecks; the health insurance scheme, financed through a 7% contribution from their workers' paychecks and; the plan for occupational accidents and diseases, to which companies contribute a variable sum (at least 0.9% of taxable pay) into a fund that pays out pensions, indemnities, and subsidies and that takes preventive measures and provides for the medical care and rehabilitation of workers.

16. The health insurance system covers all workers and their dependents, who can choose to direct their contribution to: The National Health Fund (FONASA), an official organ of the Ministry of Health, which finances the benefits provided by State-run hospitals and establishments or those provided by the private sector in the event that the beneficiaries decide to avail themselves of the free-choice system; and the health insurance companies (ISAPREs), private entities that offer medical-care services on their own or, most commonly, through payments to third parties.

Plans and priorities for national health development

17. The health sector in Chile consists of a public subsector and a private subsector. The highest authority of the Sector is the Minister of Health. The Public Subsector is made up of the agencies that constitute the National System of Health Services (SNSS) and the health areas of certain government institutions (State-run companies, the Armed Forces, and others). The SNSS, which is under the Ministry of Health, consists of: The services, 26 in number, which are responsible for the organization and provision of comprehensive health services for the population of the area in which they operate; the National Health Fund (FONASA), a financial institution in charge of collecting, administering, and distributing the state funds allocated for health care; the Institute of Public Health, which performs the functions of a national and reference laboratory and produces certain biologicals, aside from discharging other functions involving monitoring, regulation, and sanitary control; the supply headquarters, which is in charge of the centralized procurement of equipment and supplies for the SNSS in cases in which they are required.

18. The private subsector is made up of institutions that are not tied to the state and that are grouped, depending on their purpose, into nonprofit and for-profit organizations. Among the latter are the private practices of the various health professions, which encompass a wide range of organizational expressions. Prominent among them are the health insurance companies (ISAPREs), which are financing institutions, although some can provide services with their own resources.

19. The physical infrastructure of the country consists of 400 hospitals or clinics, with a total of 42,460 beds (3.2 beds per 1,000 population). Of these, 190 are hospitals, with 34,200 beds (80.5%), belonging to the public subsector, and 310 are clinics, with 8,260 beds, belonging to the private subsector. For outpatient care, in addition to the physician's offices (external) at the hospitals, the SNSS has 345 general physician's offices, 1,040 rural health posts, and 1,214 rural medical stations. The great majority of these outpatient care units belong to the municipalities. For outpatient care the private subsector has 1,220 medical centers, physician's offices, and polyclinics; more than 500 laboratories; and 1,427 pharmacies.

20. With regard to human resources, advanced training in the health professions is provided by 30 universities and institutes of higher learning that offer 16 areas of specialization. Six offer a specialization in medicine and graduate a total of 500 physicians a year on the average. There are three schools of dentistry, which graduate around 200 dentists annually. Nursing is offered at nine schools, which annually graduate 300 university-trained nurses (the number is declining). In 1991 there were 14,450 physicians registered with the Medical Association, which would give a ratio of 11 physicians per 10,000 population. There are approximately 7,000 dentists (5.2 per 10,000). The SNSS employs 2,830 nurses and 23,400 nursing auxiliaries.

21. With regard to the financing of the sector, central Government spending on health has declined steadily between 1974, when it stood at US$ 429.5 million, in 1988 dollars (US$ 42.80 per capita), and 1988, when the figure was 270.3 million, in 1988 dollars (US$ 21.20 per capita). In 1989, spending on health reached its lowest level, 0.77% of the gross domestic product. In 1991, appropriations rose to 1.07% of the GDP and in 1992 to 1.24%, with the additional advantage of a major increase in the GDP in those two years.

22. Officially, Chile covers 100% of its population with health care services. There are constraints on access to these services, however. Some of these, the minority, are geographical, but mostly access to health care is limited for socioeconomic reasons, as a result of which the population living in extreme poverty sometimes lacks coverage. The Government is trying to rectify this situation by expanding its programs of primary care and nutrition.

CHILE (Cont.)

23. The public subsector has an official coverage level of close to 80% of the population of the country, comprising the beneficiaries of the National Health Fund, public companies and some State-run institutions, as well as the indigent. Benefits are provided mostly by the National System of Health Services, or the institutions of the private subsector in the case of the beneficiaries of FONASA who avail themselves of the free-choice system. The private subsector covers 20% (and this proportion is rising) of the population, consisting almost entirely of the beneficiaries of the ISAPREs. The actual care is provided by private institutions and, in certain cases (with prior payment), by the SNSS.

24. During 1991, the SNSS, FONASA, and the ISAPREs provided 26.8 million medical consultations, which comes to 2.0 consultations per person. Fifty-seven percent of these consultations were provided by the SNSS. Some 36.7 million diagnostic examinations were performed (68% by the SNSS) and around 20 million clinical and therapeutic support procedures (71% by the SNSS). Some 1.46 million surgeries were performed (78% by the SNSS). Ninety-nine percent of deliveries are attended in hospitals. In 1990, there were 323,000 deliveries, of which 30% (only 17% in the SNSS) were by cesarean section.

25. Around 1.38 million patients (10.4% of the population) are hospitalized annually in the 400 hospitals and clinics in the country, (which is 32.5 patients per bed). Patients are discharged after an average stay of 7.6 days and occupy 72% of the beds. Seventy-six percent of the discharges are from the SNSS.

26. The SNSS administered 3.2 million different vaccinations in 1991, and estimates are that the coverage achieved among children against common diseases preventable by vaccination (DPT, polio, measles, and tuberculosis) exceeds 90%.

27. The national priorities in health have been established within the framework of a Government social policy and a specific health policy that takes due account of the epidemiological situation of the country and the operating capacity of the health sector. The guiding criteria for the Government's social policy, which have also been incorporated into the health policy, are: equity, with a view towards equal access for all Chileans to the goods and services of society, thus eliminating marginality among certain population groups, especially those living in poverty; community participation, which means that the community itself contributes information and action in identifying, prioritizing, and confronting its problems; respect for the human rights and the dignity of the individual; and solidarity.

28. The following are the specific priority policies and strategies of the health sector: reorientation of the sector; resolution of the hospital crisis through investment projects aimed at improving, expanding, remodeling, and maintaining installed capacity and equipment; development of human resources through training and enhancement, as well as through the improvement of their conditions of employment; maintenance and extension of surveillance, prevention, and control of communicable diseases, particularly AIDS; strengthening of health promotion and of the prevention and control of noncommunicable diseases and accidents; surveillance, prevention, and control of environmental risks to health, in particular ecological problems, pollution, and food quality; enhancement of the capacity to gather and analyze epidemiological data, and the strengthening of cooperation with other countries.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

29. The policy of international cooperation has been reoriented recently in order to maintain the country's active involvement in world affairs. Higher priority is being given to the programs for international cooperation aimed at less advantaged social groups, such as women, young people, and the indigenous peoples; support for scientific and technological development; the protection and improvement of the environment; the development of small and medium-sized business geared towards the second phase of the exporting model; and regional and local development combined with the processes of decentralization and the management of development, with special emphasis on improving the administration by the State. The transfer of technical knowledge, support for the development of national scientific and technological capabilities, and human resources education are also receiving greater emphasis. With regard to the national actors who participate in international cooperation, the previous concentration of cooperation in the apparatus of the central government will give way to other entities that have had a smaller relative share up to now. Universities and technological institutes, regional development agencies, nongovernmental agencies, and production enterprises will be integrated in the future into technical cooperation programs. With regard to the modalities and instruments utilized in carrying out cooperation, the country will see a decline in funding received in the form of donations. This applies to both public sector programs and the programs implemented by nongovernmental Organizations (NGO's). On the other hand, other instruments will remain available, such as technical cooperation in its various forms, human resources education, certain programs of concessionary loans, cooperation between regions, and horizontal cooperation.

30. The Ministry of Health/World Bank project, "Adaptation of the Public System of Health Care," will continue during the period; this US$ 344 million project will be carried out between 1991-1997 with a governmental contribution of 66%. With funds from the IDB and with a 37% contribution from the Government of Chile, two projects totaling US$ 224 million will continue between 1991 and 1995. The first, a US$ 112 million project with the Ministry of Health is aimed at the functional and physical rationalization of health services, and the second, with the National Fund for Regional Development for the same amount, involves the primary level of care and low-complexity hospitals. Among the projects with bilateral financing, the US$ 17.5 million loan granted by the German Government for the rehabilitation of hospitals will continue during the period. A second stage of the same project, totaling US$ 14,250,000, is very far along, and a third stage (US$ 16,000,000) is under study. Also under study are two projects worth a total of US$ 3 million, the first with the United Kingdom involving the

management and planning of services, and the second with Holland concerning care for pregnant teenagers. During the biennium the schools of medicine of the Universities of Chile and Temuco will continue executing the project "A new initiative in the education of health professionals. Union with the community," a US$ 2.5 million project with financing from the Kellogg Foundation. The objective of this project is for medical and paramedical students to carry out extrahospital activities, both educational and service-related, so as to enhance their skills for solving health problems at the primary care level.

National priorities for technical cooperation from PAHO/WHO

31. Among the national priorities for health is the adaptation of the health sector, which will continue to be revamped so as to achieve maximum effectiveness in the operations of all its institutions. This includes a study of modifications in the current legal and administrative frameworks that will lead to better coordination between the public and private subsectors and to a readjustment of the sources, amounts, and applications of financing. Special attention will continue to be given to the resolution of the hospital crisis, to which much of the funding for projects financed by the World Bank and the Inter-American Development Bank is allocated. Particular stress will be laid on the development of management, which is recognized as a present need at all levels of action in the sector, particularly in local areas, where the process of decentralization has placed particular pressure on health services. The development of human resources, which is geared mainly towards training personnel at the different levels of the national health system, will also remain a priority. Also included as national priorities are the prevention and control of communicable diseases; the improvement of epidemiological analysis; health promotion and control of chronic diseases; strengthening the network of scientific and technical information; and environmental health, in which Chile has pledged support for the Regional Plan for Investment in the Environment and Health. For the biennium the Government is requesting cooperation from PAHO/WHO in the areas mentioned previously, excluding the investment plan aimed at resolving the hospital crisis.

32. In addition to the projects with regular funding, the Organization will support with extrabudgetary resources the activities to control AIDS and research on meningococcic infections. In the area of women, health, and development, a project with five Chilean NGO's, for a total of US$ 200,000, will continue in 1994.

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Control of environmental health hazards (CEH)

33. The purpose of this project is to strengthen the technical and administrative capabilities of the health sector in solving problems and identifying factors of environmental deterioration. In order to accomplish this, technical activities during the biennium will be oriented toward incorporating epidemiological techniques into the assessment of problems and decision-making in the environmental area, especially with regard to the identification of environmental factors related to the health problems of the population. As a result, it is expected that specific new programs on the environment will be developed in line with the reality of the country. Priority will be given to the creation of information centers in the area. Seminars, workshops, and courses to train local professionals will be offered, especially in the areas of evaluation of environmental impact, risk assessment, and environmental and occupational epidemiology. In research, there will be participation in studies in specific areas of interest, such as, for example, the impact of cholera on environmental sanitation. The hope is to strengthen the linkage between the Ministry of Health, environmental programs, and the Regional Program on Environmental Health through the pursuit of joint activities in the areas of research and training.

Health services development (DHS)

34. The purpose of this project is to redesign the sector and lend it a configuration conducive to achieving maximum effectiveness in the operations of all its institutions. To this end, during the biennium there will be cooperation mainly in the preparation of plans, standards, and policies for the development and modernization of management systems, including information systems at all levels of operation of the sector; the reinforcement of the Ministry of Health so that, as head of the sector, it can effectively promote and support the pursuit of the other strategies and fulfill the regulatory and control functions incumbent upon it by law; an intensification of the decentralization process; close coordination and complementarity between the public and private subsectors so as to better utilize national health resources; the study and modernization of the legal and administrative framework of the sector; and the study and adjustment of the systems of sector financing with a view to achieving equity in health care.

Scientific and technical information dissemination (HBD)

35. The purpose of this project is to strengthen the national network of scientific and technical information in health sciences. In order to achieve this end, during the biennium there will be continued support for the development of the national network of scientific and technical information through the training of personnel at local levels and the transfer of available technologies, both data bases and computer and communication supports. Emphasis will be placed on the medical and professional personnel in hospitals and other establishments of the national health system.

Human resources education (HRE)

36. The purpose of this project is to strengthen the training of health services personnel both in management and in public health. In order to achieve this end, training en masse will be undertaken, which will require the mobilization of all resources available in Chile both in the health sector and others. Policies will be developed which will concentrate on the patterns of utilization and distribution of trained health professionals. Research will be conducted which should yield information on the status of human resources and the improvement of their working conditions. Training in human resources development and priority public health areas will continue.

CHILE (Cont.)

Health situation and trend assessment (HST)

37. The purpose of this project is to improve the capacity of the health sector to utilize epidemiology in the planning, execution, and evaluation of the programs for individuals and the environment and in the organization of health services. During the biennium the hope is to strengthen communication between the Ministry of Health and the regional program of PAHO through the pursuit of joint training and research activities with the epidemiologists of the services. It is also hoped that research can continue on the local level in the area of health conditions and health profiles so that pursuant to it interventions can be undertaken among high-risk groups. In training, the hope is to continue training the country's epidemiologists in epidemiological techniques for analyzing information with an emphasis on the use of computer programs. Another hope is to implement a system of environmental epidemiological surveillance and to improve the epidemiological surveillance systems that already exist for certain acute diseases. This applies particularly to the utilization of information produced for timely action and for decision-making at the local level, in contrast to having only a registration system.

Growth, development and human reproduction (MCH)

38. The purpose of this project is to train personnel at the intermediate managerial and executive levels of the health services in strategies of organization, programming, and management of the maternal and child health programs. During the biennium it is expected to continue the process of identifying priority areas for the targeting of preventive measures through operations research at the local levels. It is also expected to implement the information system of the Latin American Center for Perinatology and Human Development throughout the country in order to improve the registry of maternal and child health indicators. Courses and seminars will continue to be conducted in the control of diarrheal diseases and acute respiratory infections, health care for disabled children, and adolescent health. With regard to TCAC, there will be continued participation in training professionals from countries of the region in the area of adolescent health. The dissemination and implementation of the new standards of the Program of Supplementary Feeding and Breast-feeding will continue.

Managerial support for national health development (MPN)

39. The purpose of this project is to provide managerial, technical, and administrative support for the delivery of technical cooperation as defined in joint programming. The managerial, technical, and administrative support of the PAHO/WHO Representative Office will concentrate on the development of standards, plans, and policies. Cooperation in training services personnel and the strengthening of horizontal cooperation will also be very important. In addition, the information processing capacity of the Representative Office will be increased. It is expected that a joint evaluation meeting will be held in the first year of the biennium.

Health promotion and prevention and control of noncommunicable diseases (NCD)

40. The purpose of this project is to support the adaptation of the sector in order to improve the handling of the prevalent and emerging problems among adults typical of the period of epidemiological transition that the country is going through, with an emphasis on health promotion. During the biennium training will be continued for the people in charge of the programs to control cancer, hypertension, and diabetes through early detection, strategies of intervention, and the programming, monitoring, and evaluation of such interventions. The intervention projects in smoking and arterial hypertension will continue, as will the health promotion project "Valdivia, A Healthy City." There will also be participation as a counterpart in several projects being pursued by NGOs, with Netherlands Government/PAHO support, in relation to cancer and the quality of life of elderly women. With regard to the improvement of information systems, cancer registries will be implemented in three regions of the country, and the process of accrediting old-age homes will continue.

General communicable disease prevention and control activities (OCD)

41. The purpose of this project is to train the people in charge of communicable disease control programs in activities of programming, execution of intervention strategies, and evaluation, with an emphasis on activities of epidemiological surveillance. In the area of training, the training of epidemiologists in the epidemiology services will be completed, with emphasis on implementing systems of epidemiological surveillance for enteric diseases (typhoid, hepatitis, diarrhea). Operational studies will be continued in light of outbreaks in the community. In addition, the methodology will be developed for evaluating the impact of specific interventions on the incidence of communicable diseases. Communities around the country will continue to be stratified in accordance with risk in order to improve the targeting of activities. The mass campaigns to prevent cholera, which have an impact on the rates of all enteric diseases, will continue. As for meningitis, testing will continue on a vaccine, developed by the U.S. Government, in two northern regions of the country with a high incidence of the disease. As part of the effort to address the problem of nosocomial infections, the process of accrediting hospitals in the country will continue.

Technical cooperation among countries (TCC)

42. The purpose of this project is to facilitate the implementation of border, bilateral, and subregional agreements. The main approach will be support for the preparation of plans of action for border, bilateral, and subregional activities.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 1,740,600 | 81.6 | 2,046,300 | 85.8 | 2,268,200 | 85.7 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 722,300 | 33.8 | 845,400 | 35.5 | 946,800 | 35.8 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 722,300 | 33.8 | 845,400 | 35.5 | 946,800 | 35.8 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 23,200 | 1.1 | 26,300 | 1.1 | 29,800 | 1.1 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 23,200 | 1.1 | 26,300 | 1.1 | 29,800 | 1.1 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 0 | - | 69,300 | 2.9 | 76,900 | 2.9 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 0 | - | 69,300 | 2.9 | 76,900 | 2.9 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 745,400 | 35.0 | 911,000 | 38.2 | 999,200 | 37.8 |
| HEALTH SERVICES DEVELOPMENT | DHS | 641,000 | 30.1 | 911,000 | 38.2 | 999,200 | 37.8 |
| ORAL HEALTH | ORH | 69,600 | 3.3 | 0 | - | 0 | - |
| REHABILITATION | RHB | 34,800 | 1.6 | 0 | - | 0 | - |
| HUMAN RESOURCES DEVELOPMENT | | 249,700 | 11.7 | 148,900 | 6.2 | 164,000 | 6.2 |
| HUMAN RESOURCES EDUCATION | HRE | 249,700 | 11.7 | 148,900 | 6.2 | 164,000 | 6.2 |
| HEALTH INFORMATION SUPPORT | | 0 | - | 45,400 | 1.9 | 51,500 | 1.9 |
| SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION | HBD | 0 | - | 45,400 | 1.9 | 51,500 | 1.9 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 392,400 | 18.4 | 337,700 | 14.2 | 379,700 | 14.3 |
| ENVIRONMENTAL HEALTH | | 139,200 | 6.5 | 132,700 | 5.6 | 150,400 | 5.7 |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 139,200 | 6.5 | 132,700 | 5.6 | 150,400 | 5.7 |
| MATERNAL AND CHILD HEALTH | | 58,000 | 2.7 | 40,800 | 1.7 | 46,300 | 1.7 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 58,000 | 2.7 | 40,800 | 1.7 | 46,300 | 1.7 |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| COMMUNICABLE DISEASES | | 58,000 | 2.7 | 68,000 | 2.9 | 77,100 | 2.9 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 58,000 | 2.7 | 68,000 | 2.9 | 77,100 | 2.9 |
| HEALTH PROMOTION | | 137,200 | 6.5 | 96,200 | 4.0 | 105,900 | 4.0 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 80,200 | 3.8 | 96,200 | 4.0 | 105,900 | 4.0 |
| CANCER | CAN | 57,000 | 2.7 | 0 | - | 0 | - |
| GRAND TOTAL | | 2,133,000 | 100.0 | 2,384,000 | 100.0 | 2,647,900 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| III. HEALTH SCIENCE AND TECHNOLOGY | | 986,800 | 100.0 | 594,700 | 100.0 | 0 | |
| COMMUNICABLE DISEASES | | 966,800 | 98.0 | 594,700 | 100.0 | 0 | |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 358,500 | 36.3 | 54,700 | 9.2 | 0 | |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 608,300 | 61.7 | 540,000 | 90.8 | 0 | |
| HEALTH PROMOTION | | 20,000 | 2.0 | 0 | - | 0 | |
| TOBACCO OR HEALTH | TOH | 20,000 | 2.0 | 0 | - | 0 | |
| GRAND TOTAL | | 986,800 | 100.0 | 594,700 | 100.0 | 0 | |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| **1992-1993** | | | | | | | | | | | | |
| PAHO - PR | 1,242,300 | 1 | 2 | 0 | 389,100 | 13,900 | 10 | 20,000 | 263,400 | 106,800 | 0 | 449,100 |
| WHO - WR | 890,700 | 1 | 0 | 445 | 323,400 | 13,900 | 20 | 40,000 | 82,100 | 193,700 | 0 | 237,600 |
| TOTAL | 2,133,000 | 2 | 2 | 445 | 712,500 | 27,800 | 30 | 60,000 | 345,500 | 300,500 | 0 | 686,700 |
| % OF TOTAL | 100.0 | | | | 33.4 | 1.3 | | 2.8 | 16.2 | 14.1 | .0 | 32.2 |
| **1994-1995** | | | | | | | | | | | | |
| PAHO - PR | 1,254,800 | 1 | 2 | 0 | 468,700 | 17,500 | 12 | 24,000 | 187,700 | 52,400 | 0 | 504,500 |
| WHO - WR | 1,129,200 | 1 | 0 | 637 | 373,700 | 17,000 | 24 | 48,000 | 298,600 | 120,300 | 0 | 271,600 |
| TOTAL | 2,384,000 | 2 | 2 | 637 | 842,400 | 34,500 | 36 | 72,000 | 486,300 | 172,700 | 0 | 776,100 |
| % OF TOTAL | 100.0 | | | | 35.4 | 1.4 | | 3.0 | 20.4 | 7.2 | .0 | 32.6 |
| **1996-1997** | | | | | | | | | | | | |
| PAHO - PR | 1,407,800 | 1 | 2 | 0 | 519,700 | 19,800 | 12 | 24,000 | 212,900 | 59,400 | 0 | 572,000 |
| WHO - WR | 1,240,100 | 1 | 0 | 637 | 389,900 | 19,300 | 24 | 48,000 | 338,500 | 136,400 | 0 | 308,000 |
| TOTAL | 2,647,900 | 2 | 2 | 637 | 909,600 | 39,100 | 36 | 72,000 | 551,400 | 195,800 | 0 | 880,000 |
| % OF TOTAL | 100.0 | | | | 34.4 | 1.5 | | 2.7 | 20.8 | 7.4 | .0 | 33.2 |

COLOMBIA

## HEALTH SITUATION ANALYSIS

### Demography

1. Colombia has a population of 32,987,170, distributed by age as follows: approximately 36.5% are between 0 and 14 years of age, 48.3% between 15 and 44, 9.0% between 44 and 59, and 6.2% over 44. Forty-two percent of the population lives in major cities and 58% in smaller towns and other rural jurisdictions. Growth projections for the end of the decade point to a population increase of 19.5% with regard to the 1990 census.

### Health status indicators

2. The statistical indicators of the level of health registered in Colombia show some positive results, such as a reduction in child mortality from all causes from 41.6% in 1985 to 38.3% in 1990, although mortality from acute respiratory diseases in infants under 1 year of age has increased. A reduction was observed in the prevalence of malnutrition in children from 6 to 35 months of age from 18.1% in 1980 to 12.5% in 1988. In addition, low case fatality rates from cholera have been achieved (<1%), except in some isolated indigenous population groups. Among the diseases preventable by vaccination, the incidence of diphtheria fell from 2.5 cases per 100,000 population (1981) to 0.14 cases per 100,000 in 1991.

3. The country shares with the rest of the subregion the characteristics of a mixed epidemiological profile, in which modern-day pathologies are mixed with lifestyles and pathologies usually associated with poverty and environmental deterioration. The 40,000 cases of cholera that have been identified since the beginning of the epidemic in 1991 and the re-emergence of cases of malaria and other communicable diseases are evidence of this phenomenon. However, some progress may be noted in the control of some diseases preventable by vaccination, such as poliomyelitis, for which there have been no confirmed cases for a period of 15 months, and measles, whooping cough, and urban rabies (transmitted by dogs).

4. There has been a considerable increase in AIDS cases, mainly in the age group from 15 to 44 years, with increases in heterosexual and perinatal transmission.

5. Violence in its varied forms, however, is an important public health problem in Colombia. The increase in violence in the country is the result of a combination of structural, socioeconomic, transitional and ethical factors, and the severe problems brought on by narcoterrorism and political-military confrontation. Homicide is the leading cause of death in the country in all age groups over 9 years. Mortality by homicide in 1991 was 81.2 per 100,000, double that of 4 years ago. Other forms of violence have also increased, such as the abuse of women and children, kidnapping and extortion, and everyday violent acts.

### Factors affecting health status

6. The process of institutional transformation of the health sector, initiated in 1990 under Law No. 10, was given a constitutional mandate to strengthen policies aimed at health promotion, decentralization, and efficient management, which are still the main actions being used to bring about change in the health care system.

7. Nevertheless, Colombia has not escaped the process of "tertiarization" of health care, in which the primary sector, called upon to serve 80% of curative cases, receives only 20% of the budgetary resources. Analysis of the budget shows the sector's traditionally small share in the distribution of the country's funds (3.2% of the gross domestic product in 1973, 3.6% in 1983, 2.2% in 1990, and 5.4% in 1993). As a result, private spending on health has increased, accounting for 3.93% of the gross domestic product in 1991. This figure is compatible with the State's average per capita expenditure on medical care, which is on the order of US$ 30.00 per month.

8. There is a broad national debate on the coverage of the health systems. The public health system serves 39% of the population, private medicine covers 17%, and social security, is responsible for 16%. These figures indicate that virtually one fourth of the Colombian population does not have access at all to the health services.

9. The creation of ECOSALUD, an organization that collects a tax from instant-win lotteries and transfers them to the local funds of the Sectional Health Services in order to support the decentralization process, can assist in improving the situation.

10. The question of training health resources is a source of concern, as regards both the content and the methodologies employed in the various undergraduate and graduate-level courses and the training of these resources to satisfy the country's health needs and problems.

11. The nonrational use of drugs in Colombia has more to do with the way such products are used than with the money spent on them. Self-medication, multiple-drug formulations, and the preference shown for expensive drugs by reason of their brand names or their newness, are patent examples of such nonrational use. Nearly one third of the Colombian population does not have any access to drugs, and large areas of the country lack a good source of supply of retail drugs, forcing individuals to buy in pharmacies or dispensaries where the prices are inordinately high.

### Plans and priorities for national health development

12. The political decision to correct inequities through the collective health services by combating the causes of poverty and harmful living conditions and lifestyles on the one hand, and strengthening positive values on the other, requires a new approach. It demands gradual replacement of short-term paternalistic and sectoral policies by a concept and practice of health culture that will enlist community participation in carrying out activities for health promotion. The health policy is now seeking the commitment of all institutional

and community levels for participatory building of health and well-being in a framework of comprehensive development that respects cultural diversity and takes into account the viewpoints of the people and also local possibilities.

13. The International Conference on Health Promotion, which was held last November in Bogotá, proposed the following strategies and commitments as a guide for activities to be carried out in Colombia during the decade:

13.1 Promotion of the concept of health as a productive force closely linked to political, economic, social, cultural, environmental, behavioral, and biological factors, in addition to strengthening the sector's capacity to enlist support for implementing the strategy of health promotion.

13.2 Strengthening of the people's capacity to participate in decisions that affect their lives and to opt for healthy lifestyles, reevaluation of the current model of service delivery, and ensuring the accessibility, quality, and timeliness of delivery with community participation.

13.3 Recognition of women as managers of life and well-being and therefore as important elements in health promotion policies.

13.4 Stimulation of research on health promotion in order to engender appropriate science and technology, making optimum use of professional experiences and empirical community knowledge.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

14. Based on the policies described above and on the commitments assumed by the Government of Colombia, the principal policies of technical cooperation identified by the Ministry of Health are: expansion of the coverage of service delivery; support for the processes of decentralization and strengthening of management with emphasis on local levels; the strengthening of institutional capacity at the local level for structuring the campaigns for the control/eradication of communicable diseases, especially vector-borne diseases; the continuation of research on risk factors and lifestyles, especially as regards nutritional and deficiency problems; expansion of the coverage of drinking water, sanitation, and waste disposal services; control of air, water, and soil pollution, and increased health coverage of workers; dissemination of registry and control of food at the local levels; consolidation and maintenance of the epidemiological situation of urban rabies; implementation of local/area programs for other important zoonoses; consolidation of regional subprojects for control/eradication of foot-and-mouth disease and epidemiological studies of vesicular stomatitis; consolidation of the process of eradication poliomyelitis as well as the extension and consolidation of activities for the prevention of measles and neonatal tetanus; implementation of epidemiological surveillance at the local level with strong community involvement as a component for decision-making and evaluation of measures to control diseases; restructuring of the process of professional training and advancement; better training of auxiliary and technical personnel; intensification of social participation and training at the regional and local levels; promotion of research at all levels; maintenance of activities to prevent the spread of AIDS through sexual transmission, transfusion, and perinatal transmission and the spread of other sexually transmitted diseases; support for the program on child and adolescent growth and development; and reinforcement of the systems for the surveillance of maternal and perinatal mortality.

### External cooperation for the health sector

15. In addition to the resources contributed by PAHO/WHO and the efforts made by the Government to solve the country's health problems, support will be received in the form of external resources. The World Bank is providing US$ 24 million for the project on Child Health and Nutrition, in addition to project financing in the amount of US$ 50 million to strengthen basic municipal health services with a large component of human resources; a US$ 30 million project, of which US$ 13.2 million will be allocated to Environmental Health; a US$ 200 million project for restructuring, of which US$ 2 million will be allocated to an environmental component; and a water and sanitation project for Cúcuta in the amount of US$ 18.5 million. The Inter-American Development Bank has granted a loan of US$ 40 million to improve the health services.

### National priorities for technical cooperation from PAHO/WHO

16. Among the national cooperation priorities that have been identified are environmental sanitation; adult health and nutrition; the strengthening of local health systems and primary care systems; prevention and control of diseases preventable by vaccination, especially poliomyelitis, measles, and neonatal tetanus; the zoonoses; support for the implementation of regional foot-and-mouth disease subprojects and studies of the epidemiology of vesicular stomatitis; dissemination of the system of surveillance of food-borne diseases; the use of epidemiology at the local level as a decision-making instrument for the health programs; training of professional personnel in the provision of primary care; and continuation of community education and information activities with respect to sexually transmitted diseases, especially AIDS.

17. In addition to the programming of regular funds, as indicated below, PAHO/WHO will continue to manage projects with extrabudgetary resources for the prevention and control of AIDS with a contribution of US$ 210,000 from the Global Program on AIDS; US$ 320,000 for essential drugs; and US$ 129,000 in resources provided by the Ministry of Health to support control of rabies, taeniasis/cysticercosis, and equine encephalitis. Maternal and child health has received US$ 900,000 per year from United Nations Population Fund for its population program; CAR and CVC have current agreements in the amount of US$ 60,000 for environmental sanitation, and an agreement has been signed with ECOPETROL for US$ 1.1 million for workers' health. The Project for Health, the Environment, and the Campaign Against the Poverty, financed by the Italian Government, has allocated US$ 30,000 to carry out the Project's final stage in Agua Blanca, Cali.

COLOMBIA (Cont.)

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Community water supply and sanitation (CWS)

18. The purpose of this project is to strengthen the environmental subsector in order to improve environmental conditions. It includes cooperation activities aimed at establishing an information mechanism as a means of identifying environmental risk factors; strengthening the system for identifying, formulating, and executing projects in the area; improving the quality of the services; promoting efficient use of water resources; improving pollution control; and supporting health education activities.

Health services development (DHS)

19. The purpose of this project is to strengthen the health sector in order to improve service delivery by integrating various actions and sectors so as to strengthen local levels and foster true social participation. The project will continue to develop and strengthen the local health systems by supporting incorporation of the health sector into community development through health promotion and self-care and the use of mass communication. It will promote the incorporation of women into the management of health and the allocation of resources and technical support at the local levels. In addition, support will be sought for linking the social security system to the local health systems. Support will also be given to setting up information systems at the local level and to the implementation of health support groups. Actions will be taken to prevent and mitigate disasters by training technical and community personnel; and lastly, support will be given to implementing the hospital accreditation program in the country.

Human resources education (HRE)

20. This project is aimed at ensuring that the training, refresher training, and management of health personnel will increasingly contribute to understanding and managing the country's priority health problems.

21. The project's activities will be aimed at training health personnel, with special emphasis on the training of representatives of the local government (mayors, aldermen) and of health workers on the basis of previously prepared profiles, in addition to setting up local health committees based on community participation. Support will be given to reformulating graduate programs and the contents of undergraduate courses in the area of health, in addition to the processes of modernization, with emphasis on self-management of social and community organizations. Support will also be provided for setting up a data bank on human resources that will provide information on their structure and dynamics. Research will be promoted on the history and socioanthropological structure of the country's health personnel and on the actions of the local health committees. Finally, there will be ongoing participation in analyzing, formulating, and implementing policies in the field of health resources and in health science and technology in the country.

Health situation and trend assessment (HST)

22. The purpose of this project is to develop epidemiology as an instrument for gaining knowledge, developing the health management process, and transforming the health situation.

23. The program will support the strengthening of epidemiological practice in the health services, with emphasis on the local levels, other institutions, and the community for assessment of the health situation and its trends, epidemiological surveillance, and evaluation of the impact of health actions on special population groups and subject areas. It will promote the development of health analysis with community participation. Intervention strategies based on population risk will be promoted, in addition to the risk approach to priority impairments and positive values as they pertain to health. Support will be given to improving local capacity for participatory and multicenter research.

Growth, development, and human reproduction (MCH)

24. This project is aimed at strengthening the capacity to analyze the causes of maternal and child morbidity and mortality, expand the corresponding surveillance systems, and develop interventions for their control.

25. Human and physical resources will be mobilized to promote research and intervention with regard to the factors that affect the health of women of childbearing age, mothers, children under five years of age, schoolchildren, and adolescents.

26. Analysis of the results will provide the basic elements for community participation in priority areas, as well as information on critical problems faced by the institutions concerned with maternal, child, and adolescent health. Advisory services will be provided to support the institutions in organizing and executing strategies, especially as a means of reducing the most frequent causes of maternal mortality, such as abortion; in addition to perinatal mortality caused by premature birth and low birthweight; child morbidity from respiratory infections and infectious diseases; growth and development retardation; and the various forms of violence and abuse perpetrated against children and women. An attempt will be made to allocate resources to direct the transfer of technology toward improving personnel capacity to manage such technology by orienting cooperation activities to the granting of fellowships and the training of personnel to prepare them for carrying out these functions.

27. The international technical cooperation required for implementing the process described at the national level is more than US$ 1.5 million per year, since the Colombian Government's programs on Maternal and Child Health and National Planning have traditionally been sustained almost entirely by this source.

28. In the near future these resources would be maintained by the same sources (PAHO/WHO, UNFPA, and UNICEF) and would at the same time fulfill the function of developing self-sufficiency mechanisms.

Managerial support for national health development (MPN)

29. The purpose of this project is to provide managerial, technical, and administrative support for the delivery of PAHO/WHO technical cooperation in Colombia.

30. The resources will be used for supporting national, regional, and local authorities in formulating policies and standards, and in mobilizing national and international resources.

Health promotion and prevention and control of noncommunicable diseases (NCD)

31. It is hoped to raise the level of health of the population through actions to promote health and prevent chronic noncommunicable diseases in the framework of a culture of health.

32. Under the strategies of "healthy families, healthy environments, healthy departments with healthy municipalities, strengthening of the services at the local level, and communication for health," promoted by the Ministry of Health, support will be given to health organizations in the promotion of health and the use of epidemiological surveillance in the planning of health actions, as well as to the training of institutional and community human resources with emphasis on prevention and the use of a positive approach to health. Coordination of adult health activities will be promoted in the local health systems and in the "healthy municipalities." As regards the health education of specific population groups, research will be performed on the cultures of specific population groups that will be applied to the mass and personal communication processes.

Nutrition (NUT)

33. The intention of this project is to strengthen the plans and programs of the Ministry of Health and of other entities in the health sector with the aim of providing adequate food and nutrition for the population.

34. Emphasis will be placed on the following areas: prevention and control of iodine deficiency disorders based on the results of research carried out in 1992 to determine the magnitude and severity of endemic goiter in the country; noncommunicable chronic disease prevention and control through the modification of risk factors related to diet and nutrition; development of professions in the areas of nutrition and dietetics; increase in the coverage of the Food and Nutrition Surveillance System through the incorporation of new municipalities and control of micronutrient deficiencies (iron, vitamins) in mothers and children of limited economic resources.

General communicable disease prevention and control activities (OCD)

35. The purpose of this project is to strengthen health actions to prevent mortality and reduce morbidity from malaria and other communicable diseases.

36. This project carries out technical cooperation activities that contribute to promoting decentralization in order to adapt such activities to the current situation; supporting the formal and nonformal training of personnel to strengthen the decentralization process and the strategies of social participation, emphasizing the primary care level; and supporting implementation of the strategy of epidemiological stratification of malaria for the purpose of prioritizing interventions in this disease in high-risk communities. In addition, support will be given to research and to establishing mechanisms for coordination with the activities programmed with Andean Cooperation in Health (CAS).

Technical cooperation among countries (TCC)

37. Emphasis will be given to supporting technical cooperation in the bordering countries and integrating the efforts made in the Andean countries.

Zoonoses (ZNS)

38. The purpose of this project is to ensure protection of the health of those at risk of contracting food-borne diseases, in addition to controlling and eradicating primary zoonoses, including foot-and-mouth disease.

39. Health education activities will be directed to the promotion of self-care of the population with respect to food protection. The methodology of the Information and Registration System for Food and Beverages will be disseminated at the peripheral levels, as well as pilot projects for a surveillance system for food-borne diseases, preferably in support of the project on food protection in cities frequented by tourists.

40. In compliance with the hemispheric commitment, support will be given to maintaining some cities free from urban rabies and promoting its eradication in other large cities, and measures will be implemented to control rabies transmitted by bats, emphasizing surveillance activities. Support will continue to be provided to measures to control taeniasis/cysticercosis in the pilot plans of Cali and Pasto.

41. With regard to equine tuberculosis and encephalitis, support will be given to the joint work of the Ministry of Health and the Colombian Agricultural and Livestock Institute in eradicating tuberculosis from bovines and carrying out epidemiological surveillance of encephalitis.

42. Support will be given to microcharacterization of foot-and-mouth disease ecosystems in order to better program control/eradication activities. Knowledge of the epidemiology of stomatitis will make it possible to prepare a list of control measures. The development of epidemiology will be promoted at the local level and support will be given to the joint management of plans for animal health by community and state entities.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 2,401,000 | 65.2 | 2,709,300 | 65.9 | 3,007,500 | 66.0 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 866,300 | 23.5 | 1,025,500 | 24.9 | 1,152,800 | 25.3 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 866,300 | 23.5 | 1,025,500 | 24.9 | 1,152,800 | 25.3 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 88,700 | 2.4 | 100,600 | 2.4 | 114,100 | 2.5 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 88,700 | 2.4 | 100,600 | 2.4 | 114,100 | 2.5 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 379,800 | 10.3 | 411,900 | 10.0 | 449,800 | 9.9 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 379,800 | 10.3 | 411,900 | 10.0 | 449,800 | 9.9 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 1,011,500 | 27.5 | 1,113,600 | 27.2 | 1,229,600 | 27.0 |
| HEALTH SERVICES DEVELOPMENT | OHS | 1,011,500 | 27.5 | 1,113,600 | 27.2 | 1,229,600 | 27.0 |
| HUMAN RESOURCES DEVELOPMENT | | 54,700 | 1.5 | 57,700 | 1.4 | 61,200 | 1.3 |
| HUMAN RESOURCES EDUCATION | HRE | 54,700 | 1.5 | 57,700 | 1.4 | 61,200 | 1.3 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 1,281,100 | 34.8 | 1,405,600 | 34.1 | 1,548,000 | 34.0 |
| ENVIRONMENTAL HEALTH | | 428,500 | 11.6 | 465,200 | 11.3 | 507,700 | 11.1 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 428,500 | 11.6 | 465,200 | 11.3 | 507,700 | 11.1 |
| MATERNAL AND CHILD HEALTH | | 74,200 | 2.0 | 82,600 | 2.0 | 92,000 | 2.0 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 74,200 | 2.0 | 82,600 | 2.0 | 92,000 | 2.0 |
| COMMUNICABLE DISEASES | | 215,800 | 5.9 | 242,200 | 5.9 | 271,400 | 6.0 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 215,800 | 5.9 | 242,200 | 5.9 | 271,400 | 6.0 |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| HEALTH PROMOTION | | 437,600 | 11.9 | 478,400 | 11.6 | 526,200 | 11.6 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 437,600 | 11.9 | 478,400 | 11.6 | 526,200 | 11.6 |
| VETERINARY PUBLIC HEALTH | | 125,000 | 3.4 | 137,200 | 3.3 | 150,700 | 3.3 |
| ZOONOSES | ZNS | 125,000 | 3.4 | 137,200 | 3.3 | 150,700 | 3.3 |
| GRAND TOTAL | | 3,682,100 | 100.0 | 4,114,900 | 100.0 | 4,555,500 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 617,100 | 39.7 | 271,200 | 33.4 | 0 | |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 617,100 | 39.7 | 271,200 | 33.4 | 0 | |
| HEALTH SERVICES DEVELOPMENT | DHS | 206,900 | 13.3 | 271,200 | 33.4 | 0 | |
| ESSENTIAL DRUGS AND VACCINES | EDV | 409,700 | 26.4 | 0 | - | 0 | - |
| HEALTH EDUCATION AND COMMUNITY PARTICIPATION | HED | 500 | .* | 0 | - | 0 | - |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 943,600 | 60.3 | 540,000 | 66.6 | 0 | - |
| ENVIRONMENTAL HEALTH | | 167,200 | 10.7 | 0 | - | 0 | - |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 167,200 | 10.7 | 0 | - | 0 | - |
| MATERNAL AND CHILD HEALTH | | 266,300 | 17.0 | 0 | - | 0 | - |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 198,500 | 12.7 | 0 | - | 0 | - |
| DIARRHEAL DISEASES | CDD | 67,800 | 4.3 | 0 | - | 0 | - |
| COMMUNICABLE DISEASES | | 378,800 | 24.2 | 540,000 | 66.6 | 0 | - |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 99,000 | 6.3 | 0 | - | 0 | - |
| TUBERCULOSIS | TUB | 3,700 | .2 | 0 | - | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 276,100 | 17.7 | 540,000 | 66.6 | 0 | - |
| VETERINARY PUBLIC HEALTH | | 131,300 | 8.4 | 0 | - | 0 | - |
| ZOONOSES | ZNS | 131,300 | 8.4 | 0 | - | 0 | - |
| GRAND TOTAL | | 1,560,700 | 100.0 | 811,200 | 100.0 | 0 | |

* LESS THAN .05 PER CENT

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL AMOUNT | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 1,556,700 | 3 | 4 | 260 | 689,000 | 63,700 | 5 | 10,000 | 81,200 | 179,800 | 0 | 533,000 |
| WHO - WR | 2,125,400 | 3 | 1 | 250 | 747,300 | 93,400 | 106 | 212,000 | 511,200 | 112,600 | 0 | 448,900 |
| TOTAL | 3,682,100 | 6 | 5 | 510 | 1,436,300 | 157,100 | 111 | 222,000 | 592,400 | 292,400 | 0 | 981,900 |
| % OF TOTAL | 100.0 | | | | 39.0 | 4.3 | | 6.0 | 16.1 | 7.9 | .0 | 26.7 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 1,822,200 | 2 | 4 | 255 | 774,700 | 70,700 | 5 | 10,000 | 90,800 | 275,400 | 0 | 600,600 |
| WHO - WR | 2,292,700 | 3 | 1 | 280 | 810,500 | 111,400 | 107 | 214,000 | 538,500 | 120,100 | 0 | 498,200 |
| TOTAL | 4,114,900 | 5 | 5 | 535 | 1,585,200 | 182,100 | 112 | 224,000 | 629,300 | 395,500 | 0 | 1,098,800 |
| % OF TOTAL | 100.0 | | | | 38.6 | 4.4 | | 5.4 | 15.3 | 9.6 | .0 | 26.7 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 2,032,100 | 2 | 4 | 255 | 845,800 | 80,100 | 5 | 10,000 | 103,000 | 312,200 | 0 | 681,000 |
| WHO - WR | 2,523,400 | 3 | 1 | 280 | 871,200 | 126,400 | 107 | 214,000 | 610,600 | 136,200 | 0 | 565,000 |
| TOTAL | 4,555,500 | 5 | 5 | 535 | 1,717,000 | 206,500 | 112 | 224,000 | 713,600 | 448,400 | 0 | 1,246,000 |
| % OF TOTAL | 100.0 | | | | 37.7 | 4.5 | | 4.9 | 15.7 | 9.8 | .0 | 27.4 |

COSTA RICA

## HEALTH SITUATION ANALYSIS

### Demography

1. The estimated population for 1992 is 3,160,000; in 1994 it will be 3,304,000 and in 1995, 3,374,000. The population density will be 66.1 inhabitants per Km² in 1994 and 67.1 population per Km² in 1995. This density will reach 72.7 by the year 2000.

2. If current trends continue, the natural growth rate of the population for the five-year periods 1990-1995 and 1995-2000 will be 2.2% and 1.9%, respectively. Children under 15 years of age will account for 34.4% of the population, while persons over 50 years of age will account for 13% of the population.

### Health status indicators

3. The total death rate will be 4.02 and 4.16 per 1,000 population, for the five-year periods 1990-1995 and 1995-2000, respectively. The infant mortality rate, for the same five-year periods, will be 16.7 and 14.8, respectively. Life expectancy in the same periods will be 75.2 and 75.6. Most of information that is presented below corresponds to the year 1990.

4. Children under one year of age accounted for 10% of total mortality. The leading group of causes of death for this group (in accordance with the 17 major groups of causes), in order of importance, were: diseases of the perinatal period, birth defects, diseases of the respiratory tract, infectious and parasitic diseases, ill-defined symptoms and diseases.

5. Children one to four years of age accounted for 2% of total mortality. The leading causes of deaths were external: trauma and poisoning.

6. Persons from 35 to 44 years of age accounted for 5% of total mortality. The leading cause of death was cirrhosis and other chronic diseases of the liver, followed by myocardial infarction, traffic accidents, malignant neoplasms of the stomach and of the breast in women.

7. Persons from 45 to 54 years of age accounted for 7% of total mortality. The specific causes are related to those of chronic development, starting with malignant neoplasms of stomach, myocardial infarction, cirrhosis and other chronic diseases of the liver, and diabetes mellitus.

8. Persons 55 to 64 years of age accounted for 12% of total mortality. The leading causes are: acute myocardial infarction, malignant neoplasms, diabetes mellitus, and cirrhosis and other chronic diseases of the liver.

9. Persons 65 and over accounted for 54% of total mortality. The leading causes are: cardiovascular diseases, chronic obstructive respiratory ailments, malignant neoplasms of the stomach, and stroke.

10. In regard to vector-borne diseases, in 1991 there were around 2,300 new cases of malaria, a figure that rose to around 6,700 in 1992.

11. Maternal mortality which, along with child mortality, had decreased notably between 1970 and 1980 (from 1.0 to 0.2 per 1,000 births), began to level off in 1980 and has hovered around 0.2 since then. Since 1970, abortion has remained one of the leading causes of death in this population group, together with complications of pregnancy, delivery, and puerperium, and toxemias. The specific rates and the structure of births by age of the mother indicate an excess of maternal risk among adolescents and mothers over 35 years of age, not to mention the risk posed by unwanted pregnancies, which is greater for women with four children or more.

12. Another specter that threatens the country is AIDS. Among the 53 cases in 1988 were the first case of transmission from mother to child and the first case in intravenous drug users. In contrast to AIDS, of which there is risk of increase, a decline has been noted in the incidence of the principal sexually transmitted diseases.

13. With regard to aspects of animal health that affect public health, it is noteworthy that in Costa Rica no cases of urban rabies have appeared since 1980, and no case of human rabies since 1970, although rabies in bats is endemic and its transmission in cattle has been detected.

### Factors affecting health status

14. The most important achievements in communicable disease control have been reported in the area of diseases preventable by vaccination, the incidence of which has been reduced notably in the last two decades, without any reported cases of poliomyelitis or diphtheria, since 1973 and 1975, respectively. Although in 1986 and 1987 there was a measles epidemic, with 4,534 cases occurring in the first of those years, in 1988 the number of cases was 358--a reduction of 92% from the previous year.

15. Although there has been a significant decline in several waterborne diseases, there has been an increase in others, such as viral hepatitis, with a rate of 149.48 cases per 100,000 population, which demonstrates the need to supplement the extension of coverage with the improvement of water quality and continuity of service.

16. Although major efforts have made it possible to maintain vector-borne disease control, and the resumption of transmission has been avoided in a large number of areas, the capacity for timely detection of cases is reaching its limit. An additional effort has also been made to keep the national territory free of Aedes aegypti, inasmuch as some larvae were discovered on several occasions, possibly imported in used materials.

17. In light of the chronic and degenerative diseases that today dominate the national epidemiological profile, national efforts have been directed, in particular, toward the control of arterial hypertension, diabetes, rheumatic fever, and traffic accidents. With regard to the last item, it should be pointed out that there was a 10% drop in 1987, thanks to effective coordination between the Ministry of Public Works and Ministry of Transportation on enforcement against persons driving while intoxicated and the launching of information campaigns about road safety.

18. Between the first and second five-year period of the current decade, drinking water services increased from 84% to 93%; in the urban area, the percentage of coverage was maintained at 100%, while in the rural area, it increased from 69% to 82%.

19. With regard to excreta disposal, 100% of the urban population and 88% of the rural population has had sanitary sewerage, septic tanks, or sanitary latrines, which accounts for an increase in overall coverage from the 1980 figure of 87% to the current figure of 95%.

20. With regard to solid wastes, services for their disposal have been developed more slowly than have other public services, and the situation has deteriorated with the growth of population centers and centers of industrial and commercial development. It is estimated that the country produces over 1.5 million kilograms of refuse daily, 60% of which comes from urban locales, and 40% from rural communities. Sixteen percent is collected regularly, but its final disposal is inadequate, and 54% is not collected at all and accumulates indiscriminately.

21. In 1989, the country had 1,956 health establishments, 1,669 of which are under the Ministry of Health. Of these, 35% are geared toward nutrition, 8% toward dentistry-related activities, and 57% toward comprehensive health services; among the comprehensive health services, 52% were at health posts, and 4% were in mobile medical care units. In addition, the Costa Rican Social Security Fund (CCSS) has 29 hospitals--31% at the national level, 21% at the regional level, and 48% at the local level--in addition to its 237 outpatient clinics.

22. In 1987, the health sector employed 28,130 people in three of its principal institutions: CCSS, with 71% of these personnel, the Ministry of Health (MOH) with 23.6%, and the National Insurance Institute (INS) with 1.3%. With regard to CCSS and MOH human resources, 37.9% were located at the central level, with a greater proportion in social security (42.2%) than in the Ministry of Health (22.6%).

23. Of medical professionals and paramedical personnel, 84.3% and 77.5%, respectively, worked for CCSS, which indicates that the job market for professionals in the health sciences is concentrated, for practical purposes, in a single public institution.

24. With regard to the social situation, according to the Economic Commission for Latin America and the Caribbean (ECLAC), in 1988 Costa Rica was the country with the third lowest incidence of poverty, behind Argentina and Uruguay. The rates reflected a 25% poverty rate at the national level, with a 21% rate in urban areas and a 28% rate in rural areas. The country's economy had grown at a substantial rate during the sixties and seventies; wages increased, and unemployment and inflation declined. The crisis of the eighties halted the growth process, however: the real GDP dropped by nearly 10% at the beginning of that decade, causing a 30% reduction in salaries, a 9.4% increase in unemployment, and an 82% increase in inflation.

## Plans and priorities for national health development

25. Costa Rica has enjoyed great political stability during recent decades. The various governments have been important forces in the development of social plans since the sixties, with special emphasis on education and health care. CCSS, founded in 1941, is a valid example of political decisions geared toward the social protection of its citizens; its coverage, which was initially very narrow--and limited to urban salaried workers--was extended, through a 1961 law, to the entire population of the country. In 1971, a new law ordered CCSS to continue the process of universalization of coverage, and in 1973 another law was promulgated transferring all hospitals of the Ministry to CCSS. Under these legal provisions, CCSS granted compulsory coverage to all domestic employees, workers in small businesses, and their family members; it also made voluntary insurance available to self-employed workers and to unsalaried family workers. In accordance with these same provisions, health care and pensions to indigent persons and to their family members also became compulsory. At the same time, the Ministry of Health successfully carried out a policy for the extension of coverage to rural and marginal urban areas by utilizing the primary health care strategy.

26. The crisis of the eighties ended up affecting the economic situation of the sector, inasmuch as disbursements per person (in constant colones) doubled between 1970 and 1979, and although this figure had increased since 1983, in 1987 it was still below 1973 levels. As a share of the GDP, total disbursements in health increased from 4.9% in 1973 to 7.4% in 1979, declining to 5.6% in 1983, and experiencing a recovery to 6.9% in 1985. Despite these fluctuations, this share is among the highest in the subregion. CCSS, which by law covers 100% of the population, has achieved an actual coverage rate of 85% in curative medicine; the Ministry provides 52% of the population with coverage with respect to preventive medicine and primary care.

27. The notable advances achieved in health in Costa Rica are due to a combination of the health policies developed on behalf of the entire population, especially for the most vulnerable persons, and to the sustained socioeconomic development experienced in the last three decades; the two situations are clearly correlated.

28. Accordingly, the country has committed itself to government reforms with a view to modernizing its institutions and leading the nation toward an ever more egalitarian society that can provide its citizens with better services and preserve its democratic traditions.

29. In order to achieve this level of well-being, the following actions have been proposed:

29.1 To guarantee that the Ministry of Health will supervise the sector. This entails a new role for the Ministry of Health in planning, leadership, control, and sectoral evaluation.

29.2 To establish a single leader in personal health care services, for which purpose comprehensive health care programs should be consolidated into a single institution, thus achieving true integration among the services of promotion, treatment of disease, and rehabilitation. This will require a gradual transfer toward CCSS of the personal direct care services currently offered by the Ministry of Health.

29.3 To achieve institutional decentralization. That is, to consolidate effective administrative and functional decentralization and to strengthen services at the local level.

29.4 To develop new models of administration and financing in health. This objective requires an exhaustive review of the current financing system for the sector as a whole and of the institutions that compose it, which should focus on sources of financing and on allocation and control of resources and the program budget. This objective may also lead to service delivery by third parties, thus fulfilling the terms of the principle of economic democratization of the public sector.

29.5 To strengthen the current health care model. This requires action to seek the most appropriate way of organizing resources, with a view to furnishing comprehensive and more humanitarian care to individuals, families, and the community.

29.6 To transfer the administration of Occupational Hazard Insurance to CCSS. The aim is to help avoid duplication of services and transactions, to rationalize the use of materials and human resources, to further the process of universalization of the health services delivery, and to refocus and lay special emphasis on the preventive function of Social Security, classifying the responsibilities and the participation of the various agents that make up these services (the government, business persons, and workers).

29.7 To transfer the administration of the water supply systems in the municipalities to the Costa Rican Water Supply and Sewerage Institute, and to perform an administrative reorganization of the Institute with a view to its decentralization and regionalization, in addition to strengthening its role in the control and surveillance of water quality.

30. It is important to note that the objectives mentioned above, in addition to being a fundamental part of the Program for the Reform of the Health Sector, were incorporated into the conditions of the Third Structural Adjustment Program.

31. In addition to the above, other objectives have been established, namely:

31.1 To establish a sectoral information system to support decision-making. Such a system will be based on the articulation and strengthening of the various information subsystems that exist in the sector.

31.2 To establish a national health surveillance laboratory in INCIENSA, redefining the mission and the functional and structural profiles of the institution, with a view to developing that agency, mainly its role in the areas of quality control (biologicals, laboratories, exports, and imports) and health surveillance.

31.3 To reform and standardize current legislation on waters. This is necessary in order to guarantee adequate mechanisms to strengthen the supervision of the Ministry of Health over waters and the AyA's management of water supply and sewerage systems.

31.4 To establish a sectoral policy of administration and human resources education and to carry out a plan of immediate training in order to facilitate the transformation of the sector.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

32. The sector has defined the following national priorities for technical cooperation; in all of these areas, it hopes to have cooperation from PAHO:

32.1 To monitor the environmental factors that affect health so as to act on them on a timely basis and achieve a healthy and suitable environment for the economic and socially productive development of the country.

32.2 To strengthen the supervision of the Ministry of Health through the exercise of the sectoral functions of management, leadership, surveillance, regulation, research, and health promotion.

32.3 To modernize and develop the health sector and its institutions in accordance with principles of equity, universality, and solidarity, so that they may act effectively and without duplication of effort.

32.4 To expand social participation in health and to guarantee the entire population access to health services.

32.5 To strengthen local operating capacity for the adequate conservation and maintenance of local facilities and equipment.

32.6 To strengthen the human resources area in terms of the technical capability of human resources units.

32.7 To develop public health personnel, both during their academic formation and through in-service training.

32.8 To engage in planning with regard to the health sector's work force.

32.9 To provide for health personnel administration with respect to occupational profiles and the evaluation of their performance.

32.10 To provide for decentralized continuing and integrated education of health sector personnel.

32.11 To support the academic formation of health personnel, specifically those attending the University of Costa Rica.

32.12 To strengthen the capacity of personnel at the central and regional levels in the analysis of the health situation and its trends.

32.13 To train staff of the local health systems in epidemiological methods and techniques for health situation analysis based on living conditions.

32.14 To support the development and strengthening of the role of supervision in health surveillance at the various levels of management.

32.15 To improve the coverage and quality of care provided to women, children, and adolescents, with specific emphasis on the quality of care during delivery and care for the newborn, and on the fostering of child development.

32.16 To perform the research needed in programs for the comprehensive care of women, children, and adolescents.

32.17 To strengthen health promotion vis-a-vis these population groups, achieving greater levels of intersectoral integration.

32.18 To maintain high-quality epidemiological information in order to monitor health and, on the basis of this information, to design interventions for the prevention and control of noncommunicable diseases.

32.19 To strengthen the national program for the promotion of healthy lifestyles so as to reduce aggressive risk factors that lead to an increase in the incidence of the chronic noncommunicable diseases (NCD) (sedentary lifestyle, smoking, dietary habits, hypertension, stress, alcoholism, etc.) and to support the processes of decentralization in the treatment of NCDs.

32.20 To acquire basic information, based on analysis of the health situation at the local level, for the identification of the dynamics of risk factors in the population and strategies for intervention.

32.21 To control the zoonoses of greatest importance for the country.

32.22 To control food quality in the country.

33. In addition to the projects carried out with PAHO/WHO regular funds, PAHO/WHO will continue the process of mobilization of national and external resources within the framework of the Central American Initiative which, in the case of Costa Rica, includes activities in following technical areas: diarrheal disease prevention and control, with special reference to cholera; AIDS prevention and control; human resources development; malaria prevention and control; environment and health; and women, health, and development.

34. In addition, through INCAP, PAHO/WHO will continue to furnish technical cooperation in the area of food and nutrition.

35. IDB has approved a loan for the strengthening of the Ministry in its leadership role and for the expansion of the health care infrastructure, the latter under the responsibility of CCSS, in the framework of health sector reform.

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Control of environmental health hazards (CEH) and Community water supply and sanitation (CWS)

36. The purpose of this project is to improve environmental health conditions, both in terms of access to drinking water and coverage of sanitation and in terms of control of soil, air, and water pollution.

37. Technical cooperation will be furnished in the updating and enforcement of legislation on environmental health. Support will be extended for coordination among all the institutions involved in the environmental arena, with emphasis on health-related aspects. Actions will be taken to support the operationalization of the national plan for the control of pesticides and toxic substances. There will be support for the establishment of a program for the control of emissions from smokeshafts in the industrial areas and the implementation of a program for the control of river pollution caused by coffee cultivation. There will be cooperation in the implementation of the national occupational health plan, especially the "health service" and "epidemiological surveillance" components, and in the development of an occupational health program for the banana industry.

38. There will be continued cooperation to establish a program for the management of industrial, hospital, and household solid wastes. Efforts will be made to provide the entire population with drinking water and to increase the coverage of sewerage services in urban areas. There will be cooperation to improve water quality in periurban and rural areas. There will be support for the strengthening of the environmental sanitation division of the Ministry of Health.

Health services development (DHS)

39. The purpose of this project is to modernize the health sector and its institutions, strengthening the leadership role of the Ministry of Health and expanding community participation.

40. Support will continue for the reform of the health sector, through the redefinition of models of care under principles of equity, solidarity, and universality and through the redefinition of the sectoral financing model and the administration of resources from the Ministry of Health and CCSS. Support will continue for the adaptation of the body of legal standards in the health sector, in accordance with the policy and organizational requirements defined by the national government reform policy and the health sector reform project.

41. Support will be given for the processes of institutional development aimed at decentralization, deconcentration, and modernization of the Ministry of Health and CCSS. Action will be taken to support the automation of administrative procurement, personnel, and financial procedures at the Ministry of Health, as well as of systems to support supervision: planning, surveillance, regulation, and research.

42. There will be support for the processes leading to local strategic administration, through an analysis of the health situation, the prioritization of strategies of intervention, and the local programming and control of resources. A system of health surveillance will be designed and implemented at three management levels (local, regional, and national).

43. The management information system (MIS) will be implemented in modules of the resource and cost performance program (PRRC) and the health dimension in all local health systems. The analytical capacity of officials responsible for running the national referral hospitals, regional and local hospitals, and clinics, for performing interpretation of PRRC indicators will be developed.

44. Action will be taken to strengthen the integrated maintenance system (SIMSS) between the Ministry of Health and CCSS, and this system will be incorporated into other sectoral institutions involved in conservation and maintenance. There will be support for the nationwide implementation of the program for the administration of energy resources (PARE).

Human resources education (HRE)

45. The purpose of this project is to strengthen the capacity of the sector for planning, training, and managing the work force during the transformation that is currently underway.

46. Cooperation will continue for the development of greater leadership in the area of human resources development with all institutions of the sector, supporting the consolidation of the Advisory Commission on Strategic Planning for the Development of Human Resources in Health (CASPERH).

47. There will continued support for the strengthening of the Public Health Department of the University of Costa Rica, in regard to curriculum studies, in-service practice, and prospective analysis, emphasizing teaching-service integration. The graduate program in public health will be strengthened. Research on human resources will be supported, specifically with respect to the work force so as to generate information systems of the best possible quality that will provide feedback to each particular health institution.

48. Support will continue for the human resource units of the institutions of the health sector, with emphasis on their leadership capacity and on the health work force information system. There will be follow-up to the implementation of the decentralized continuing education structure at the Ministry of Health and the Costa Rican Social Security Fund, with emphasis on local health systems, in accordance with the reforms carried out at the sectoral level.

49. A group will be trained in adult pedagogy at the central, regional, and local levels, to support the decentralized program of continuing education of the Ministry of Health and the Costa Rican Social Security Fund. There will be cooperation with the local health systems (starting with the priority areas) in regard to continuing education and performance evaluations, in accordance with the reforms carried out in the health sector.

50. There will be cooperation in strategic planning vis-a-vis the health work force, in accordance with the reforms carried out in the health sector. Provision will be made for technical cooperation in the enhancement of health personnel administration, emphasizing leadership capacity for dealing with the needs identified in the country.

Health situation and trend assessment (HST)

51. The purpose of this project is to strengthen and coordinate the collection, consolidation, and analysis of health information for decision-making.

52. Support will be furnished for the development and strengthening of the supervisory function in health surveillance through a definition of the functional, structural, and organizational profile and provision of basic equipment for the performance of the health surveillance function at all levels. There will be cooperation in the design of methods to identify critical areas of intervention and of decision-making that will make possible comprehensive strategic interventions. Support will be provided for the establishment of mechanized processes that will make it possible to save time in data processing and increase its accuracy.

53. PAHO/WHO will cooperate in the in-service training of the team in charge of health situation analysis at the level of the local health systems and collaborate in the design of the functions and structure of the analysis units at the various levels of management. Cooperation will be provided in the development of methods of analysis, at the level of local health systems, in order to facilitate the decision-making process and strategic administration at this level.

54. Support will be provided for the development of a simple and practical information subsystem, based on information collected routinely, that allows for the use of pertinent data in the formulation of indicators that are significant in the context of the local system.

Growth, development and human reproduction (MCH)

55. The purpose of this project is to strengthen the regional MOH and CCSS team in its managerial and technical capacity to lend greater support to the local health systems in the area of comprehensive health of women, children, and adolescents.

56. The Organization will cooperate in providing local personnel with refresher courses in clinical management and health promotion for these population groups. Action will be taken to promote the formulation of a national youth policy under which the various sectors will have concrete activities, to be carried out in a coordinated fashion. There will be support for the updating of information on the health of these groups. Research will be promoted with regard to health conditions and services for these groups.

Managerial support for national health development (MPN)

57. The purpose of this project is to strengthen the PAHO/WHO Representative's Office and its cooperation in the national health development process.

58. To that end, action will be taken to strengthen both the policy function and the ability of the PAHO/WHO Representative's Office to mobilize opinion, human, and material resources for the achievement of national objectives and the fulfillment of the policies and program priorities of the Organization. In addition, the scientific/technical function will be developed in the search for technical excellence and in the handling of knowledge for the achievement of national priorities. Also to be strengthened is the administrative function, so as to furnish effective and efficient support for the above-mentioned functions, improving the administrative and managerial systems in use.

Health promotion and prevention and control of noncommunicable diseases (NCD)

59. The purpose of this project is to strengthen the national program of health promotion in regard to surveillance, standardization, and establishment of interventions, in order to reduce the frequency of chronic noncommunicable diseases.

60. There will be support for studies in the Health Regions for the purpose of identifying the strategy most appropriate to the reality of the country for reducing the prevalence of risk factors. Cooperation will be furnished for the selection and mass application of educational strategies in accordance with the risks and characteristics of each population group with major social impact. There will be support for the establishment of mechanisms of coordination that give rise to timely and reliable information on the prevalence of risk factors in

the development of NCDs and on the most vulnerable groups. There will be cooperation in the design and performance of surveys of groups selected according to the risk approach in order to obtain more complete information in that regard. There will be support for the administration and dissemination of new knowledge in regard to the detection and treatment of cases of NCD. Support will be furnished for the decentralization of care of patients with NCDs as part of the services provided by local health systems and for involving the family and the community in the care of persons with NCDs. There will be support for the design of health service interventions for early detection and timely treatment, with a view to a reduction in disability and mortality.

General communicable disease prevention and control activities (OCD)

61. The purpose of this project is to strengthen the national program for the prevention and control of vector-borne diseases, especially malaria and dengue.

62. There will be support for actions to be carried out in the border-area local health systems (Nicaragua and Panama) leading to the prevention and control of vector-borne diseases, especially malaria and dengue. There will be continued cooperation in the training in epidemiology of all personnel at the local level for the management of programs for the prevention and control of communicable diseases. Action will be taken to strengthen management capacity in the border-area local health systems and the banana industry's areas of expansion--the zones where these diseases have the highest incidence. There will be support for the decentralization of epidemiological surveillance and of the decision-making processes. Reporting and treatment of cases at the local level with a view to reducing incidence will continue to receive special support. Action will be taken to strengthen the local levels in their research into the effectiveness and cost of insecticides.

Technical cooperation among countries (TCC)

63. The purpose of this project is to support cooperation among countries in areas of common interest. To this end, it will continue to support the successful initiatives undertaken with the border countries, Panama and Nicaragua, in the development of border-area local health systems. In addition, it will continue to support coordinated work among social security institutions in Central America, and continued efforts will be made to explore areas of cooperation in the framework of the Central American process of integration.

Zoonoses (ZNS)

64. The purpose of this project is to keep the country free of urban rabies and foot-and-mouth disease, consolidating the national zoonosis control program.

65. There will be continued cooperation in the strengthening of programs for the control of rabies and of foot-and-mouth disease. There will be support for control of the zoonoses of greatest importance to the country, namely: brucellosis, bovine tuberculosis, encephalitis, and other zoonoses. There will be cooperation in the implementation of the 1991-1995 national food protection plan.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 1,670,900 | 71.4 | 1,921,800 | 70.4 | 2,116,400 | 70.5 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 649,700 | 27.7 | 802,200 | 29.4 | 897,200 | 29.9 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 649,700 | 27.7 | 802,200 | 29.4 | 897,200 | 29.9 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 53,100 | 2.3 | 60,200 | 2.2 | 68,300 | 2.3 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 53,100 | 2.3 | 60,200 | 2.2 | 68,300 | 2.3 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 202,900 | 8.7 | 243,200 | 8.9 | 262,300 | 8.7 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 202,900 | 8.7 | 243,200 | 8.9 | 262,300 | 8.7 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 589,600 | 25.2 | 628,500 | 23.0 | 675,800 | 22.5 |
| HEALTH SERVICES DEVELOPMENT | DHS | 589,600 | 25.2 | 628,500 | 23.0 | 675,800 | 22.5 |
| HUMAN RESOURCES DEVELOPMENT | | 175,600 | 7.5 | 187,700 | 6.9 | 212,800 | 7.1 |
| HUMAN RESOURCES EDUCATION | HRE | 175,600 | 7.5 | 187,700 | 6.9 | 212,800 | 7.1 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 671,100 | 28.6 | 813,600 | 29.6 | 885,300 | 29.5 |
| ENVIRONMENTAL HEALTH | | 266,900 | 11.4 | 313,500 | 11.4 | 340,300 | 11.3 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 266,900 | 11.4 | 93,800 | 3.4 | 103,100 | 3.4 |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 0 | - | 219,700 | 8.0 | 237,200 | 7.9 |
| MATERNAL AND CHILD HEALTH | | 255,000 | 10.9 | 336,200 | 12.3 | 365,500 | 12.2 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 255,000 | 10.9 | 336,200 | 12.3 | 365,500 | 12.2 |
| COMMUNICABLE DISEASES | | 26,000 | 1.1 | 28,100 | 1.0 | 30,300 | 1.0 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 26,000 | 1.1 | 28,100 | 1.0 | 30,300 | 1.0 |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| HEALTH PROMOTION | | 94,800 | 4.0 | 105,300 | 3.8 | 116,600 | 3.9 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 94,800 | 4.0 | 105,300 | 3.8 | 116,600 | 3.9 |
| VETERINARY PUBLIC HEALTH | | 28,400 | 1.2 | 30,500 | 1.1 | 32,600 | 1.1 |
| ZOONOSES | ZNS | 28,400 | 1.2 | 30,500 | 1.1 | 32,600 | 1.1 |
| GRAND TOTAL | | 2,342,000 | 100.0 | 2,735,400 | 100.0 | 3,001,700 | 100.0 |

## PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 1,935,500 | 45.4 | 0 | - | 0 | |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 14,200 | .3 | 0 | - | 0 | |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 14,200 | .3 | 0 | - | 0 | |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 11,300 | .3 | 0 | - | 0 | - |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 11,300 | .3 | 0 | - | 0 | - |
| HEALTH POLICY DEVELOPMENT | | 234,200 | 5.5 | 0 | - | 0 | - |
| WOMEN, HEALTH AND DEVELOPMENT | WHD | 234,200 | 5.5 | 0 | - | 0 | - |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 1,675,800 | 39.3 | 0 | - | 0 | - |
| HEALTH SERVICES DEVELOPMENT | DHS | 255,800 | 6.0 | 0 | - | 0 | - |
| ESSENTIAL DRUGS AND VACCINES | EDV | 1,119,000 | 26.2 | 0 | - | 0 | - |
| ORAL HEALTH | ORH | 45,300 | 1.1 | 0 | - | 0 | - |
| DISASTER PREPAREDNESS | DPP | 255,700 | 6.0 | 0 | - | 0 | - |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 2,343,900 | 54.6 | 1,828,400 | 100.0 | 0 | - |
| ENVIRONMENTAL HEALTH | | 663,200 | 15.4 | 377,600 | 20.7 | 0 | - |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 87,600 | 2.0 | 0 | - | 0 | - |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 476,200 | 11.1 | 361,600 | 19.8 | 0 | - |
| WORKERS' HEALTH | OCH | 99,400 | 2.3 | 16,000 | .9 | 0 | - |
| MATERNAL AND CHILD HEALTH | | 188,400 | 4.4 | 0 | - | 0 | - |
| DIARRHEAL DISEASES | CDD | 188,400 | 4.4 | 0 | - | 0 | - |
| COMMUNICABLE DISEASES | | 1,492,300 | 34.8 | 1,450,800 | 79.3 | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 699,100 | 16.3 | 885,800 | 48.4 | 0 | - |
| MALARIA | MAL | 793,200 | 18.5 | 565,000 | 30.9 | 0 | - |
| GRAND TOTAL | | 4,279,400 | 100.0 | 1,828,400 | 100.0 | 0 | |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL AMOUNT | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 1,417,900 | 4 | 4 | 20 | 881,600 | 28,100 | 12 | 24,000 | 75,700 | 63,700 | 0 | 344,800 |
| WHO - WR | 924,100 | 2 | 0 | 455 | 470,800 | 15,000 | 69 | 138,000 | 163,600 | 66,100 | 0 | 70,600 |
| TOTAL | 2,342,000 | 6 | 4 | 475 | 1,352,400 | 43,100 | 81 | 162,000 | 239,300 | 129,800 | 0 | 415,400 |
| % OF TOTAL | 100.0 | | | | 57.9 | 1.8 | | 6.9 | 10.2 | 5.5 | .0 | 17.7 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 1,712,900 | 4 | 4 | 34 | 1,077,100 | 35,600 | 18 | 36,000 | 74,500 | 64,500 | 0 | 425,200 |
| WHO - WR | 1,022,500 | 2 | 0 | 400 | 535,700 | 17,700 | 26 | 52,000 | 203,100 | 88,700 | 0 | 125,300 |
| TOTAL | 2,735,400 | 6 | 4 | 434 | 1,612,800 | 53,300 | 44 | 88,000 | 277,600 | 153,200 | 0 | 550,500 |
| % OF TOTAL | 100.0 | | | | 59.1 | 1.9 | | 3.2 | 10.1 | 5.6 | .0 | 20.1 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 1,888,100 | 4 | 4 | 34 | 1,171,900 | 40,400 | 18 | 36,000 | 84,500 | 73,100 | 0 | 482,200 |
| WHO - WR | 1,113,600 | 2 | 0 | 400 | 568,700 | 20,100 | 26 | 52,000 | 230,300 | 100,600 | 0 | 141,900 |
| TOTAL | 3,001,700 | 6 | 4 | 434 | 1,740,600 | 60,500 | 44 | 88,000 | 314,800 | 173,700 | 0 | 624,100 |
| % OF TOTAL | 100.0 | | | | 58.0 | 2.0 | | 2.9 | 10.5 | 5.8 | .0 | 20.8 |

## HEALTH SITUATION ANALYSIS

### Demography

1. In 1991 Cuba's population totaled 10,693,800. Based on the current growth rate of 0.9%, it should reach 11,502,300 by the year 2000. The population density per square kilometer rose from 81.2 in 1973 to 89.2 in 1983, and reached 96.0 in 1990. The urban proportion of the population grew from 60.5% in 1970 to 69.0% in 1981, and was 72.8% in 1990.

2. The age structure of the population changed between 1970 and 1990. The group under age 15 went from 37.0 to 22.7%; the group from 15 to 64 years of age went from 57.1 to 68.8%, and the group aged 65 years and over climbed from 5.9 to 8.5%. These figures show a clear trend toward aging of the country's population. During the same period, the ratio of males to females edged down from 102 to 101 men per 100 women.

### Health status indicators

3. With regard to the evolution of the health status of Cuba's population over recent decades, the mortality and morbidity indicators reflect an increase in life expectancy at birth, a substantial decline in premature deaths, and a rising trend in noncommunicable diseases and the violent deaths, while evidencing a decline in communicable diseases, primarily those preventable by vaccines.

4. Life expectancy at birth increased between 1980-1985 and 1985-1990, going from 71.4 to 72.2 years for males, from 75.2 to 75.8 years for females, and from 73.6 to 74.0 for both sexes.

5. In 1972, of every 1,000 children born live, 28.7 died before reaching age one. In 1992, infant mortality in Cuba was 10.2 per 1,000 live births, a figure nearly half that recorded twenty years before. The decline in infant mortality has taken place in all three components of this age group but has been particularly noticeable in the early neonatal and post-neonatal groups. Mortality among Cuban children under 5 declined from 53.6 per 1,000 live births in 1969 to 13.0 in 1992. The rate of decline in this rate, measured by calculating the annual reduction rate for the decade 1980-90, was 5.8%. Between 1970 and 1990, maternal mortality dropped from 7 to 3.1 per 10,000 live births.

6. Cardiovascular diseases are the leading cause of death. Ischemic heart disease, particularly one of its specific components--myocardial infarction--is responsible for most of the deaths (85%) attributable to cardiovascular diseases.

7. Mortality by three-year periods--comparing 1963-1965 with 1982-1984--for all ages, according to leading causes of death, shows a decline in standardized rates of mortality for diseases of the heart, malignant neoplasms, and cerebrovascular diseases. However, it is noteworthy that over the decade of the eighties there was practically no change in mortality rates for these three leading causes of death. On the other hand, mortality due to violent causes increased during the period. Significantly, between the first and second three-year periods there was a major decline in mortality from enteritis and tuberculosis, which dropped out of the group of ten leading causes of death. In this regard, between 1970 and 1990 mortality from infectious and parasitic diseases went from 7.2% down to 1.5% of total deaths.

8. Accidents are the leading cause of death for the group from 1 to 49 years of age, the most frequent occurrences being motor vehicle accidents and accidental falls.

9. A general idea of morbidity rates for noncommunicable diseases may be obtained by reviewing the figures for some of the diseases treated. Based on cases treated involving arterial hypertension, diabetes mellitus, and bronchial asthma, rates of prevalence in 1989 were 41.5, 15.2, and 23.9, respectively, per 1,000 population in the total population, and 62.0, 17.2, and 42.8 respectively per 1,000 among those served by family physicians. The difference between the population served by family physicians and the general population may be explained by the increased case-finding capability of the new health care system.

10. A substantial decline has been registered in infectious diseases preventable by vaccine in recent years. Many of them have been reduced to the level of elimination, including poliomyelitis, tetanus of the newborn, diphtheria, rubella, measles and mumps. This decline is due to the universal coverage of vaccinations at the national level.

11. With regard to AIDS, as of September 1992, 12,815,644 blood samples had been tested. The number of seropositive cases detected was 835; of this number, 144 currently have AIDS and 77 have died. Tests began among groups with risk behavior and were then expanded to the general population; the seropositivity rate resulting from total testing was 0.006, i.e., 56 seropositive results per million tests carried out.

### Factors affecting health status

12. In recent years, Cuba's economic situation has deteriorated, primarily due to external factors. The country's yearly import capability, $8.1 billion dollars in 1989, declined in 1992 to $2.2 billion. When the trading conditions that the country had enjoyed with the former socialist bloc and the USSR ceased to exist, Cuba lost more than the three fourths of its market, both in terms of supplies of raw materials for domestic production and consumer products and the market for the country's exports. By the end of 1992, Cuba's trade with these countries had dropped to 7% of its previous level. On top of this, prices on the world market increased, while the prices of some of Cuba's major export products declined.

13. However, the domestic picture is marked by aggressive development in the research and production of biotechnological products, reagents for diagnosis, vaccines, drugs, medical equipment, and technology in general, which are utilized in the field of health. These efforts are supported by a National Network of Research Centers and Institutes, which have the double purpose of covering the needs of the country and producing export product lines. In other production and service areas within the domestic economy changes have also taken place that allow

for growth and development and provide openings for foreign capital investment. There has been orderly growth in economic associations in the areas of tourism, basic industry, steel and metalworking, the building materials industry, and agriculture.

14. With regard to some of the specific factors that affect health status, the situation is generally favorable due to the development achieved in previous years. Health service coverage is universal and guaranteed to all citizens, even under the current adverse conditions.

15. Drinking water is available to 100% of the Cuban population, either at home or within a reasonable distance, i.e., no more than 200-m away in urban areas, and less than one hour away in rural areas. Household connections are in place for 66% of the total population, which translates to 80% of the urban population and 20% of the rural. By the end of 1988, 65% of the total population and 82% of the urban population was being served by water supply systems. The proportion of the water treated with chlorine in water supply systems is 92.5%.

16. In 1988 the urban population benefiting from sewerage was 2,797,200, or 37%. This 37% does not reflect the actual sanitary conditions enjoyed by the population, however, since all dwellings in areas without sewerage have individual systems of collection and treatment of liquid waste. There are wastewater treatment systems in all new human settlements, and plants are under construction in several important cities.

17. The levels of contaminants in the air are not considered critical and they have only exceeded admissible maximum concentrations in some areas of the City of Havana at certain times of the year.

18. A favorable factor is the high level of education achieved in the country and the absence, in practice, of illiteracy, which contribute to the population's ability to care for and enhance its health.

Plans and priorities for national health development

19. Cuba has a single comprehensive and decentralized public health system overseen by the Ministry of Public Health (MINSAP), which is in charge of establishing overall guidelines for coordination and control.

20. The National Health System adheres to the following major principles: planning the development of the system and improving the health of the population; establishing the preventive approach as the basic guiding principle; providing free medical care with services accessible to the whole population; keeping up with scientific advances and putting them into practice; promoting participation by the people in health work; and providing assistance whenever possible to other peoples needing it.

21. One fundamental element of the national health system is the Family Doctor Program, through which a doctor and a nurse are assigned to every 120-160 families (600-700 people). Through the work of this doctor-nurse team, comprehensive care is provided to the population, the focal point being the family unit, with emphasis on education, health promotion, and prevention.

22. In early 1992, the Ministry of Public Health drafted an important document containing the health policy and strategy of Cuba, under the title "Objectives, Purposes, and Guidelines to Enhance the Health of the Cuban Population 1992-2000" (OPG-2000). This document became the major guiding principle for MINSAP's work and the fundamental basis for PAHO/WHO cooperation with the country in the years ahead.

23. The change in intervention strategies is characterized essentially by greater emphasis on preventive actions and, above all, health promotion. The aim is to maintain the levels achieved in terms of coverage and quality of care, and to take advantage of the high degree of development of the productive forces of the sector in order to strengthen the mobilization and capabilities of society as a whole, in terms of transforming lifestyles and living conditions of different sectors of the population. In sum, the idea is to attain a new stage in which priority will be given to the development of population intervention strategies.

24. The changes defined in OPG-2000 are aimed at bringing about greater decentralization, more intersectoral action, enhanced community participation in the entire process of health management, planning based on a strategic approach, and the identification of profiles of problems in population groups defined according to living conditions.

25. To this end, an effort will be made to achieve a change of attitude among provincial and municipal management teams, in line with the new health strategy based on strengthening the peripheral levels and the search for creative solutions appropriate to actual conditions in each locality.

26. Thus, PAHO cooperation in the next biennium should respond to the new challenges and priorities set forth in OPG-2000.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

National priority areas for technical cooperation

27. Analyzing the sector and developing of health policies, and supporting the process of decentralization by strengthening the local health systems at the provincial and municipal levels.

28. Strengthening the ability to analyze the health situation at the national, provincial and municipal levels.

29. Strengthening the ability to conduct economic analyses of health management with a view to optimizing the efficiency and quality of services. Identifying and mobilizing more resources from national and international sources.

30. Developing promotion and prevention with a view to improving living conditions and achieving positive modification of lifestyles associated with chronic noncommunicable diseases.

31. Supporting the development of research and the application of new health technologies.

32. Scientific and technical information network.

33. Strengthening of the capacity for enhancing human resources, essentially in the area of services at the provincial and municipal level.

34. Supporting the development of evaluation programs and management of environmental health risks at the local level in order to improve the environment, public health, and the quality of life of the community.

35. Control of communicable diseases preventable by vaccination, sexually transmitted diseases, and AIDS.

36. Veterinary public health.

37. Maternal and child health.

38. In the next biennium a project financed by the World Food Program will be under way in the Province of Las Tunas that is designed to improve the level and quality of dairy production. Due to the evident linkages with the activities of the Organization in veterinary public health, PAHO's cooperation will be coordinated with that of the WFP.

National priorities for technical cooperation from PAHO/WHO

39. These priorities are derived from the document "Objectives, Purposes,and Guidelines to Enhamce the Health of the Cuban Population 1992-2000", mentioned previously.

40. The basic priority of Cuba's health system is to guarantee that all the achievements of the previous 30 years are preserved. This is implicit in the purposes and guidelines drafted for the future. Obviously, demographic changes, as well as reductions in morbidity and mortality, are the strategic objective of highest priority in order to continue to bring about favorable developments in the health status of the population. In order for this to occur, promotion and prevention must become cornerstones, without neglecting the need to recover health whenever it has been lost, or the need for rehabilitation when it is required.

41. In order to improve health it is essential to reduce mortality from noncommunicable diseases and from accidents and other violent causes, and to control risk factors such as smoking, obesity, arterial hypertension, hypercholesterolemia and other problems. Reduction of morbidity and mortality from infectious diseases and reduction of infant and maternal mortality will also receive priority.

42. In order to reach the above objectives the principal lines of action along which organizational efforts will be concentrated were defined, as a result of which 27 general and 38 specific guidelines were set forth. The general guidelines orient health leaders at all levels of the system throughout the country, showing them how to achieve objectives and follow guidelines through the most rational utilization of human, material, and financial resources. In addition, they set out the responsibilities of each level of care and highlight the fundamental role of primary health care through the family doctor program and the role of medical specialties. The guidelines also underscore the importance of multisectoral interaction, the evaluation of health levels, medical ethics, required research, supervision and control of the process, accurate complention of death certificates in order to more precisely determine causes of death, the population's satisfaction with care received, and other aspects. All of the above is aimed at achieving a coherent set of actions in order to fulfill the objectives established.

43. In addition, the guidelines include definitions and references to the mass media (radio, press, television); the health programs that should be included in the National System of Primary, Middle, and Higher Education; physical exercise and recreational programs; cultural projects; traffic safety, water safety, and safety in the workplace; community hygiene, control of harmful substances in food; and the development of legislation in areas related to health. All of this requires closer intersectoral cooperation at all levels in the country.

44. The cornerstone of the strategy up to the year 2000 is clearly primary health care coverage by family doctors and nurses. In a few years there are expected to be 25,000 physicians and an equal number of nurses, which will be enough to ensure total coverage of the country by the system.

45. Other sector priorities will be: maintaining development in various health fields, such as genetic engineering and biotechnology; building medical equipment; the pharmaceutical industry; training and improvement of health personnel, including programs for developing more than 35 areas of medical specialization; enhancing care provided to patients in serious condition by expanding intensive care services; extending rehabilitation services to the polyclinic and local hospital levels; and support for scientific research and expeditious practical application of the results.

46. Application of the clinical, epidemiological, and social approach in assessment and analysis of the health situation, epidemiological surveillance, causal research, evaluation of services and programs, and management of health services. Periodic analyses of health problems at the various levels of care should be carried out, with the participation of managerial, professional, and technical staff, based primarily on assessment of the health situation, including the environment.

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Managerial support for national health development (MPN)

47. The purpose of this project is to ensure the comprehensive execution, monitoring and evaluation of PAHO/WHO cooperation.

48. To this end the administrative capability of the PAHO/WHO Representative Office will continue to be strengthened, with special emphasis on completing the automation of administrative processes and on personnel training and advancement, while developing technical evaluation, both in the country's programs and in PAHO cooperation.

49. Technical support will be provided to define policies and strategies of cooperation with PAHO, coherent with national health priorities and with the programs of PAHO and WHO and their regional and global targets.

50. Support will continue to be given for the identification of new sources of technical and financial resources for cooperation, as well as for better utilization of the regular resources of PAHO.

51. Coordination of actions with other cooperation agencies, basically those in the United Nations system will be emphasized.

Technical cooperation among countries (TCC)

52. The purpose of this project is to develop mechanisms of cooperation and integration between countries of the region with common interests in health problems and utilization of appropriate technologies. (TCC/TCDC).

53. Envisaged for the next biennium is the consolidation, extension, and diversification of the Operational Programs of Intercountry Work, as well as enhancement of evaluation processes, based on experience gained with this mode of cooperation through the execution of programs established in previous periods.

54. In addition, multicountry technical cooperation programs will be developed, basically in the area of health technology. Special support will be given to regional, subregional, and country initiatives through proposals developed within the framework of regional technical cooperation. Special attention will be given to developing cooperation in the area of health equipment maintenance.

Health technology policies and development (HDT)

55. The purpose of this project is to support the production of drugs, vaccines, and medical equipment and the technological enhancement of pharmaceutical dosage forms, made from medicinal plants and synthetic drugs.

56. Mechanisms to facilitate the evaluation and control of progress in research will continue to be developed, and mechanisms for analysis, development, and evaluation of technologies will be strengthened.

57. Measures will be taken to ensure interprogram cooperation with the areas of infrastructure development, programs for health promotion and prevention in all stages of life, and manpower development.

Health policy analysis and development (HDP)

58. The purpose of this project is to define and carry out intersectoral programs designed to lend comprehensive approach to health care for the population, with a view to guaranteeing the fulfillment of the objectives, purposes, and guidelines to enhance the health of Cuba's population by the year 2000 and collaborate in action taken by the legislature in the health sector.

59. This project will support intersectoral work between the Ministry of Health and the Ministries of Higher Education, Culture, Agriculture, Transportation, the Food Industry, the Medical Services of the Ministry of the Armed Forces (MINFAR), and the Ministry of the Interior (MININT), as well as with the Agencies of Social Communication for the Development of the OPG-2000. Efforts will also be aimed at developing the health legislation data base of Cuba's legislature.

Health situation and trend assessment (HST)

60. The purpose of this project is to contribute to knowledge of health conditions of the population and to see that results are reflected in health services as an operational application.

61. Support will continue to be given to developing the National System of Health Information, and to developing epidemiology as a universal work method in the field of health and as a specialized area of public health. Special emphasis will be given to the analysis of the health situation, as well as to the epidemiology of chronic noncommunicable diseases--since the latter are important among the leading causes of death--and to assessing health in the community in support of the Program of Comprehensive General Medicine and local health system.

Health services development (DHS)

62. The purpose of this project is to help to enhance the national network of health services, with emphasis on developing the Family Doctor and Nurse Program and the Provincial and Municipal Health Systems (local health systems).

63. Given that the development of the Program of Comprehensive General Medicine (with the family doctors and nurses at its center) is the country's major priority in the area of health services, the DHS Project will continue to be highly importance within the program of cooperation with PAHO. Special attention will be given to developing the infrastructure of the family doctor program and to the participation of women in community health programs, as well as to coordinating their activities with the local health systems.

64. The preventive approach to and promotion of oral health, integrated with the general health of individuals, are required as strategies for development in this field. A related activity will be to emphasize intersectoral studies on health promotion.

65. Activities will be carried out aimed at maintaining the equipment of health institutions in optimum operating condition through support for the work of the Division of Electromedicine.

Health education and community participation (HED)

66. The purpose of this project is to increase the participation of the population in health management.

67. Cooperation will be provided in promoting the participation of the population in activities aimed at achieving lifestyle changes and thus improving health conditions.

68. Steps will be taken to maintain the achievements made in the control of communicable disease, placing emphasis on STDs and AIDS.

Human resources training (HRC)

69. The purpose of this project is to help strengthen the capability for enhancing human resources in the services, at the managerial level in provinces and municipios, and in undergraduate and postgraduate training in order to meet the OPG/2000 targets.

70. The project will be aimed at strengthening continuing education of health personnel by analyzing new requirements in order to guarantee the updating and renewal of vital skills and enhance health care practice. The areas of undergraduate and graduate-level training are also included within cooperation priorities, as well as areas of specialization prioritized in the country.

71. Cooperation will be provided for the consolidation of a network of regional centers to carry out continuing education activities, encompassing the National Center, as well as medical schools and services at the local level. The National Center will be responsible for guaranteeing the means for imparting medical education in general, which means continuing to provide the equipment and materials required for this activity, including the establishment of an automated center for updating and reproducing information.

Scientific and technical information dissemination (HBD)

72. The purpose of this project is to make available, on a timely basis, the scientific and technical information needed by the National Health System, giving coverage at all levels of this system.

73. Support will be provided for the National Center for Information on the Medical Sciences, through strengthening of its information centers. With the introduction of computers, these centers have multiplied their flexibility and positive effect. Cooperation will continue to be provided for establishing efficient information systems with techniques for facilitating the management of information, to make it possible to meet the demand for training and enhancement of human resources in the health area. In addition, the project will continue to strengthen the development and establishment of efficient information systems on the medical sciences.

Health economics and financing (HDE)

74. The purpose of this project is to increase the efficiency and rationality of resources of the National Health System through the ongoing improvement of the quality of health care.

75. Cost, effectiveness studies will continue to be performed to optimize the use of resources, taking into account, inter alia, the level of development of infrastructure and management within the National Health System and the socioeconomic and political structure of the country.

76. Programs will be developed to help facilitate management, as well as the storage and processing of data necessary for the management process.

Research promotion and development (RPD)

77. The purpose of this project is to support the development of prioritized research and increase national capability in technologies, drugs, vaccines, and means of diagnosis. Cooperation will be provided for enhancing mechanisms for monitoring the progress of research; likewise, cooperation will be provided for the process of incorporating in the productive sector knowledge derived from scientific research.

Nutrition (NUT)

78. The purpose of this project is to contribute to the well-being of the individual by providing dietary information as a means of preventing diseases and promoting health, based on the strategy of the country's food plan and consonant with the guidelines of the OPG/2000.

79. This program is aimed at developing studies and actions to encourage healthy eating habits and lifestyles among the various population groups.

80. Cooperation will be provided for carrying out studies to evaluate nutritional status by finding appropriate and sensitive indicators that will take into consideration aspects relative to the socioeconomic, biological, and health status of the population. These studies will be the basis for developing strategies oriented toward optimum growth and development, as well as toward enabling man to live in harmony with his environment and preventing chronic disease, which are increasingly important in the epidemiological profile of the country.

81. Support will be given to the multidisciplinary study on food policies within the National Program of Food and Nutrition, with cooperation aimed at putting these policies into practice.

Control of environmental health hazards (CEH)

82. The purpose of this project is to improve programs in the areas of water quality control, environment, working conditions, and solid waste, with emphasis on the municipal level.

83. The project will include technical cooperation with the programs for health promotion and disease prevention in all the stages of life. This will include activities related to environmental health in residential areas, the working environment, contamination in urban and rural areas, drinking water, and solid waste disposal. Research on the environment and health promotion will be promoted, particularly for the determination of positive health indicators with regard to the community and the environment.

Growth, development and human reproduction (MCH)

84. The purpose of this project is to consolidate and improve the levels of health achieved in maternal, child, and adolescent care. Cooperation will be provided in the search for indicators capable of quantifying health, as opposed to quantifying disease and death, and contributing to the identification of effective action to enhance the quality of life and well-being by promoting healthy lifestyles.

85. Emphasis will continue to be given to programs on reproductive health and sex education for adolescents in order to reduce the number of unwanted pregnancies--which is still high--the number of abortions, and early motherhood, since these problems interfere with the self-fulfillment of adolescents. Cooperation will continue to be given to improve the quality of prenatal care through the promotion of healthy lifestyles, the incorporation of new technologies for diagnosing prenatal and postnatal diseases, and measures aimed at reducing the number of newborns with low birth weight.

General communicable disease prevention and control activities (OCD)

86. The purpose of this project is the development of the epidemiological approach in the National Health System at the national, provincial, and municipal levels, and the Family Doctor and Nurse Program, with special emphasis on personnel training.

87. The cooperation provided will seek to concentrate efforts on actions geared to the control and prevention of the most common sexually transmitted diseases.

88. Since adolescents and young adults are most affected by these diseases and are the most important groups in the sex education and human reproduction programs, the actions conceived under this project should be basically coordinated with those of MCH, as well as with other projects related to the subject, in order to guarantee comprehensive action and avoid duplication of efforts.

Health promotion and prevention and control of noncummunicable diseases (NCD)

89. The purpose of this project is to contribute to achieving the objectives, purposes, and guidelines to enhance the health of the Cuban population by the year 2000.

90. Cooperation with PAHO/WHO will be characterized by the identification of measures to be applied for the prevention of diseases and the control of risk factors, including good diet, regular physical activity, smoking cessation, and others. The introduction of these measures will require profound changes in the attitudes and living habits of the population, with substantial emphasis on mass education and on family and community participation. Priority will likewise be given to collaboration in the study, follow-up, and evaluation of program instruments.

91. Included in this project are actions in the area of mental health, prevention and control of alcohol abuse, and stress management.

Zoonosis (ZNS)

92. The purpose of this project is to consolidate and expand the system of epidemiological surveillance and to promote veterinary public health and food quality control.

93. Proposed for the biennium are actions aimed at maintaining the levels of collaboration attained. These actions will involve, basically, developing the study of zoonoses and the systems of surveillance of these diseases, and helping to reduce them in the country.

94. Actions will also be undertaken in order to contribute, through the control of zoonoses, to attaining maximum fulfillment of the country's food plan.

Acquired immunodeficiency syndrome (HIV)

95. The purpose of this project is to reduce HIV infection through the Program for Prevention, Control, and Treatment of AIDS cases.

96. Continued cooperation will be provided in educational, control, and follow-up activities targeting persons affected by this disease. Health education activities under this program are fundamental. Execution of the project financed with extrabudgetary funds will also continue.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 1,607,400 | 71.1 | 1,740,400 | 70.9 | 1,890,200 | 70.8 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 370,300 | 16.6 | 394,700 | 16.0 | 429,300 | 16.1 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 370,300 | 16.6 | 394,700 | 16.0 | 429,300 | 16.1 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 62,500 | 2.8 | 70,900 | 2.9 | 80,400 | 3.0 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 62,500 | 2.8 | 70,900 | 2.9 | 80,400 | 3.0 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 126,700 | 5.6 | 137,500 | 5.6 | 148,700 | 5.6 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 126,700 | 5.6 | 137,500 | 5.6 | 148,700 | 5.6 |
| HEALTH POLICY DEVELOPMENT | | 98,200 | 4.3 | 106,900 | 4.4 | 115,900 | 4.3 |
| HEALTH ECONOMICS AND FINANCING | HDE | 98,200 | 4.3 | 106,900 | 4.4 | 115,900 | 4.3 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 443,500 | 19.5 | 482,700 | 19.7 | 524,500 | 19.6 |
| HEALTH SERVICES DEVELOPMENT | DHS | 335,200 | 14.8 | 365,700 | 14.9 | 398,600 | 14.9 |
| HEALTH EDUCATION AND COMMUNITY PARTICIPATION | HED | 37,300 | 1.6 | 41,200 | 1.7 | 45,300 | 1.7 |
| REHABILITATION | RHB | 71,000 | 3.1 | 75,800 | 3.1 | 80,600 | 3.0 |
| HUMAN RESOURCES DEVELOPMENT | | 269,700 | 11.9 | 290,400 | 11.8 | 311,700 | 11.7 |
| HUMAN RESOURCES TRAINING | HRC | 269,700 | 11.9 | 290,400 | 11.8 | 311,700 | 11.7 |
| HEALTH INFORMATION SUPPORT | | 102,700 | 4.5 | 112,400 | 4.6 | 123,000 | 4.6 |
| SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION | HBD | 102,700 | 4.5 | 112,400 | 4.6 | 123,000 | 4.6 |
| RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT | | 133,800 | 5.9 | 144,900 | 5.9 | 156,700 | 5.9 |
| RESEARCH PROMOTION AND DEVELOPMENT | RPD | 35,700 | 1.6 | 38,600 | 1.6 | 41,500 | 1.6 |
| HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT | HDT | 98,100 | 4.3 | 106,300 | 4.3 | 115,200 | 4.3 |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| III. HEALTH SCIENCE AND TECHNOLOGY | | 653,700 | 28.9 | 713,100 | 29.1 | 777,000 | 29.2 |
| FOOD AND NUTRITION | | 54,600 | 2.4 | 59,300 | 2.4 | 64,200 | 2.4 |
| NUTRITION | NUT | 54,600 | 2.4 | 59,300 | 2.4 | 64,200 | 2.4 |
| ENVIRONMENTAL HEALTH | | 84,400 | 3.7 | 90,200 | 3.7 | 96,600 | 3.6 |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 84,400 | 3.7 | 90,200 | 3.7 | 96,600 | 3.6 |
| MATERNAL AND CHILD HEALTH | | 104,600 | 4.6 | 114,600 | 4.7 | 125,400 | 4.7 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 104,600 | 4.6 | 114,600 | 4.7 | 125,400 | 4.7 |
| COMMUNICABLE DISEASES | | 173,900 | 7.7 | 192,300 | 7.8 | 212,700 | 8.0 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 173,900 | 7.7 | 192,300 | 7.8 | 212,700 | 8.0 |
| HEALTH PROMOTION | | 200,200 | 8.9 | 217,800 | 8.9 | 236,200 | 8.9 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 200,200 | 8.9 | 217,800 | 8.9 | 236,200 | 8.9 |
| VETERINARY PUBLIC HEALTH | | 36,000 | 1.6 | 38,900 | 1.6 | 41,900 | 1.6 |
| ZOONOSES | ZNS | 36,000 | 1.6 | 38,900 | 1.6 | 41,900 | 1.6 |
| GRAND TOTAL | | 2,261,100 | 100.0 | 2,453,500 | 100.0 | 2,667,200 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 215,100 | 31.7 | 0 | - | 0 | - |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 62,500 | 9.2 | 0 | - | 0 | - |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 62,500 | 9.2 | 0 | - | 0 | - |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 152,600 | 22.5 | 0 | - | 0 | - |
| ESSENTIAL DRUGS AND VACCINES | EDV | 152,600 | 22.5 | 0 | - | 0 | - |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 462,600 | 68.3 | 438,800 | 100.0 | 8,000 | 100.0 |
| MATERNAL AND CHILD HEALTH | | 261,300 | 38.6 | 185,000 | 42.2 | 8,000 | 100.0 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 261,300 | 38.6 | 185,000 | 42.2 | 8,000 | 100.0 |
| COMMUNICABLE DISEASES | | 201,300 | 29.7 | 253,800 | 57.8 | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 201,300 | 29.7 | 253,800 | 57.8 | 0 | - |
| GRAND TOTAL | | 677,700 | 100.0 | 438,800 | 100.0 | 8,000 | 100.0 |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL AMOUNT | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 977,200 | 1 | 0 | 265 | 342,800 | 15,100 | 78 | 156,000 | 130,900 | 199,200 | 0 | 133,200 |
| WHO - WR | 1,283,900 | 0 | 0 | 685 | 182,900 | 0 | 151 | 302,000 | 309,400 | 386,200 | 0 | 103,400 |
| TOTAL | 2,261,100 | 1 | 0 | 950 | 525,700 | 15,100 | 229 | 458,000 | 440,300 | 585,400 | 0 | 236,600 |
| % OF TOTAL | 100.0 | | | | 23.2 | .7 | | 20.3 | 19.5 | 25.8 | .0 | 10.5 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 1,055,200 | 1 | 0 | 265 | 356,900 | 17,100 | 78 | 156,000 | 148,600 | 225,600 | 0 | 151,000 |
| WHO - WR | 1,398,300 | 0 | 0 | 685 | 190,500 | 0 | 151 | 302,000 | 350,700 | 437,900 | 0 | 117,200 |
| TOTAL | 2,453,500 | 1 | 0 | 950 | 547,400 | 17,100 | 229 | 458,000 | 499,300 | 663,500 | 0 | 268,200 |
| % OF TOTAL | 100.0 | | | | 22.3 | .7 | | 18.7 | 20.4 | 27.0 | .0 | 10.9 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 1,147,600 | 1 | 0 | 265 | 376,600 | 19,400 | 78 | 156,000 | 168,600 | 255,800 | 0 | 171,200 |
| WHO - WR | 1,519,600 | 0 | 0 | 685 | 190,500 | 0 | 151 | 302,000 | 397,700 | 496,500 | 0 | 132,900 |
| TOTAL | 2,667,200 | 1 | 0 | 950 | 567,100 | 19,400 | 229 | 458,000 | 566,300 | 752,300 | 0 | 304,100 |
| % OF TOTAL | 100.0 | | | | 21.3 | .7 | | 17.2 | 21.2 | 28.2 | .0 | 11.4 |

DOMINICA

## HEALTH SITUATION ANALYSIS

### Demography

1. The Commonwealth of Dominica has a population of 71,183 with a projected growth rate of 0.5%. In 1982 the school age population (5-14) years and the mature adults (25-64) populations were roughly equal in size with 29 and 31% of the total respectively. Populations projections indicated in 1990 that the school age population had decline by 9%.

### Indicators of health status

2. Life expectancy is projected to increase from 68 years at birth to 74 years for females and from 61 years to 66 years for males. Infant mortality is 15.1 as compared to 45.1 in 1970.

3. The leading causes of death are heart disease, malignant neoplasm, diseases of respiratory system, conditions originating in the perinatal period, chronic diseases, traffic accidents and diabetes mellitus.

4. Among the children in 0-5 age group, conditions in the perinatal period were the leading cause of death.

5. Death rates for motor vehicle accidents have been increasing since 1982 - injuries increased by 48%.

### Factors affecting health status

6. The problem of excreta disposal and solid waste continues to be critical. Together with this is the concomitant problem of rodents with increasing cases of leptospirosis.

7. The structural adjustments program which began in 1986-1987 was concluded. However, one of the important elements was improvement in fiscal performance through taxation reform and expenditure during 1991. Government is seeking to restrict growth in the civil service wages and salaries.

8. The health service coverage continues to be high across the island. There was an overcrowding of the Princess Margaret Hospital, especially in the obstetric and gynecology unit. Hence efforts are being made to intensify domestic deliveries. A priority is the management of the Institution. At the same time efforts are being made to improve the delivery of the service at the district hospitals. External funding was received for the improvement of the Portmouth Hospital. Availability of resources to train staff adequately continues to be a problem.

### Plans and priorities for national health development

9. The Ministry of Health has identified the following areas as being important for further development of the sector: five-year strategic health plan to replace the current which ended in December, 1992; new management and organizational structure of the Princess Margaret Hospital; human resource management; other priority area of the Caribbean Cooperation in Health; and disaster preparedness.

10. The last National Health Plan covered 1987-1992. Hence, the Government has commenced the process for the development of a Five-year Strategic Health Plan. Notwithstanding the absence of a plan, the Government has an expressed commitment to the Caribbean Cooperation in Health Initiative and its plans is in line with the priority areas and operationalizing same in accordance with the goals and targets of the CCH.

11. The Ministry wishes to improve the efficiency of the Princess Margaret Hospital and will seek to change the organizational structure and institute a training program at all levels. Human resource development continues to be a priority for the improved management planning of the institutions and district system. Also, training is needed in all areas of environmental health. Improved management of the community health services will be addressed through a strengthening of the health information system. The priority areas of the Caribbean Cooperation in Health will be addressed and operational plans developed to the Goals and Targets for the next biennium.

12. The high prevalence of diabetes and hypertension together with other problems of lifestyles will be addressed through vigorous health promotion with involvement of NGOs. Technical cooperation among countries will continue its strategic focus for the Ministry of Health. The experience of Hurricane Hugo in 1989 has placed disaster preparedness as a priority. This will be addressed through training in supplies management and participation in subregional activity Tradewinds and the mass casualty simulation.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

13. The following areas have been identified as needing technical cooperation: tertiary management of the complications of chronic disease; management of AIDS cases and HIV infected persons, along with counselling services; management of acute respiratory infection with emphasis in asthma; provision of an adequately equipped resuscitation room in the Casualty Department; support the conduct of simulation exercises and drills within and outside the hospital for management of disaster; improved vector control through community-based education programs, improved rodent control; improved excreta disposal; training of environmental officers in water quality control; improved food protection through education of the general population and providing environmental officers with necessary training; support the development of an occupational health and safety program; improve the environmental health information system; support the reorganization of the hospital and the development of a comprehensive plan for structural

improvement and future extension of the hospital; support the improvement in hospital information systems and strengthen the management information system in the ministry; support human resource development; strengthen the capacity for epidemiological analysis and health system research; development of health promotion as a strategy for the prevention and control of chronic diseases; drug abuse; and mental health.

14. The French Government will be supporting the improvement of the physical infrastructure of the maternity and surgical units. In addition, support is being provided for the physical improvement of the Portsmouth Hospital.

National priorities for technical cooperation from PAHO/WHO

15. The priority areas which have been identified to improve the national health picture through the process of technical cooperation for the next biennium are primarily the seven priority areas of the Caribbean Cooperation in Health. These priority areas are consistent with those of the SOPP. The specific areas were identified as a result of the recently concluded Joint evaluation meeting. It was agreed that the technical cooperation would be targeted towards environmental health, including excreta disposal, community-based vector control, water quality control and food protection. In the area of strengthening of health systems the emphasis would be on the managerial and organization efficiency of the distribution together with the strengthening of the information system, at the institutional and community levels. In the area of maternal and child health, emphasis will be on the management of acute respiratory infections with emphasis on asthma. Also the strengthening of the adolescent health program will be supported. The increased prevalence chronic non-communicable diseases demands the development of a strategy to change the existing lifestyles. However a health promotion program will be developed to include a wide range of social partners. Human resource development needs will be addressed.

16. In addition to the projects under the regular budget, extrabudgetary resources were mobilized for the following projects within the Caribbean Cooperation in Health: management of the community health information system, funded by the Inter-American Development Bank; projects are supported by the Italian Government in the following areas: maternal and child health, community based vector control and community based rehabilitation. A project for the prevention and control of cancer of the cervix is funded by the French Government. USAID has also approved a project which seeks to address financing, policy formulation and management of the system and UNDCP will be supporting activities relating to drug abuse.

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Community water supply and sanitation (CWS)

17. The purpose of the project is to improve the coverage the quality of environmental services. Achieving this purpose will involve promoting the participation of communities in the prevention and solution of environmental health problems; integrating environmental health workers into the district health teams and strengthening the food protection program; and promoting occupational health and safety.

Health services development (DHS)

18. The purpose of the project is to improve the effectiveness and efficiency of the health system in all districts. To achieve this purpose, it will be necessary to strengthen the management information system through training and automation; strengthen the capacity of the health sector to assess and apply health promotion and social communication at the local level to modify lifestyles; improve the delivery of mental health care; and introduce programs aimed at reducing substance abuse.

Growth, development and human reproduction (MCH)

19. The purpose of the project is to improve MCH services. Achieving this purpose will require improving management programs for ARI and upgrading of perinatal and adolescent health care services.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 209,700 | 73.6 | 222,900 | 73.2 | 236,300 | 72.9 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 209,700 | 73.6 | 222,900 | 73.2 | 236,300 | 72.9 |
| HEALTH SERVICES DEVELOPMENT | DHS | 209,700 | 73.6 | 222,900 | 73.2 | 236,300 | 72.9 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 75,500 | 26.4 | 81,600 | 26.8 | 87,800 | 27.1 |
| ENVIRONMENTAL HEALTH | | 44,000 | 15.4 | 46,600 | 15.3 | 49,200 | 15.2 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 44,000 | 15.4 | 46,600 | 15.3 | 49,200 | 15.2 |
| MATERNAL AND CHILD HEALTH | | 31,500 | 11.0 | 35,000 | 11.5 | 38,600 | 11.9 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 31,500 | 11.0 | 35,000 | 11.5 | 38,600 | 11.9 |
| GRAND TOTAL | | 285,200 | 100.0 | 304,500 | 100.0 | 324,100 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| III. HEALTH SCIENCE AND TECHNOLOGY | | 168,900 | 100.0 | 144,100 | 100.0 | 0 | |
| COMMUNICABLE DISEASES | | 168,900 | 100.0 | 144,100 | 100.0 | 0 | |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 168,900 | 100.0 | 144,100 | 100.0 | 0 | |
| GRAND TOTAL | | 168,900 | 100.0 | 144,100 | 100.0 | 0 | |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 253,700 | 0 | 0 | 145 | 44,500 | 9,300 | 55 | 110,000 | 33,300 | 20,900 | 0 | 35,700 |
| WHO - WR | 31,500 | 0 | 0 | 30 | 8,000 | 0 | 0 | 0 | 13,300 | 10,200 | 0 | 0 |
| TOTAL | 285,200 | 0 | 0 | 175 | 52,500 | 9,300 | 55 | 110,000 | 46,600 | 31,100 | 0 | 35,700 |
| % OF TOTAL | 100.0 | | | | 18.4 | 3.3 | | 38.6 | 16.3 | 10.9 | .0 | 12.5 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 269,500 | 0 | 0 | 145 | 47,000 | 10,500 | 55 | 110,000 | 37,800 | 23,700 | 0 | 40,500 |
| WHO - WR | 35,000 | 0 | 0 | 30 | 8,300 | 0 | 0 | 0 | 15,100 | 11,600 | 0 | 0 |
| TOTAL | 304,500 | 0 | 0 | 175 | 55,300 | 10,500 | 55 | 110,000 | 52,900 | 35,300 | 0 | 40,500 |
| % OF TOTAL | 100.0 | | | | 18.2 | 3.4 | | 36.1 | 17.4 | 11.6 | .0 | 13.3 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 285,500 | 0 | 0 | 145 | 47,900 | 11,900 | 55 | 110,000 | 42,900 | 26,900 | 0 | 45,900 |
| WHO - WR | 38,600 | 0 | 0 | 30 | 8,300 | 0 | 0 | 0 | 17,100 | 13,200 | 0 | 0 |
| TOTAL | 324,100 | 0 | 0 | 175 | 56,200 | 11,900 | 55 | 110,000 | 60,000 | 40,100 | 0 | 45,900 |
| % OF TOTAL | 100.0 | | | | 17.3 | 3.7 | | 33.9 | 18.5 | 12.4 | .0 | 14.2 |

DOMINICAN REPUBLIC

## HEALTH SITUATION ANALYSIS

### Demography

1. According to projections, the population of the Dominican Republic was 7.3 million in 1990, and it is estimated that by the year 2000 this population will increase to 8.6 million, with a growth rate of 2.2%. Children under 19 years of age continue to account for approximately 45% of the population.

### Health status indicators

2. Life expectancy at birth rose from 64-67 years in the period from 1980 to 1990.

3. In 1990 the leading causes of infant mortality were diarrheal diseases and acute respiratory infections, with a 1990 infant mortality rate of 65 per 1,000. The estimate for 1996 is 40 to 52 per 1,000 live births.

4. Mortality in children under five dropped from 105 to 88 per 1,000 live births between 1980 and 1990.

5. The proportion of children with moderate and severe malnutrition decreased from 14.7% to 3.8% and from 9.7% to 3.7%, respectively.

6. Generally speaking, 1985 and 1987 surveys showed the rates of undernourishment for children under five to be 41.4% and 38%, respectively.

7. Maternal mortality was 5.36 per 10,000 births in 1987-1989. An analysis of maternal maternity for the various age groups showed that for mothers between 15 and 19, the rate was 12.30 per 10,000, and for mothers 40-45 years of age, it was 13.53 per 10,000.

8. Although the morbidity and mortality picture in the country has been changing in recent years, as it has in most of the countries of Latin America, the principal causes of death and disease in almost all age groups are infectious-contagious diseases, malnutrition, and other poverty-related illnesses. Cholera has not yet entered the country, which means that it will be necessary to continue to make every effort to avoid its spread in the event that it is introduced. There were 1,841 cases of AIDS reported in 1992.

### Factors affecting health status

9. Population growth in urban areas (60% approximately) and population growth in poverty areas are factors of fundamental importance to the health status of the population.

10. Services to the population continue to be limited, and drinking water services cover only 60% of the population, while approximately three million inhabitants lack such services.

11. All cities are plagued by significant problems in their solid waste collection services (irregular collections, open-air disposal, administrative disorganization in the units responsible for this service).

12. In addition, in the peripheral areas of the principal cities, there are dwellings built on inadequate, flood-prone land with major overcrowding and inappropriate disposal of waste materials.

### Plans and priorities for national health development

13. In recent years, the Government of the Dominican Republic has undertaken a wide-ranging program of state reform. One of the changes proposed by the current authorities is to reorganize and modernize the National Health System. This proposal focuses its efforts on the planned development of a program to strengthen the leadership capacity of the Ministry of Public Health and Social Welfare (SESPAS), as a regulatory institution of the health sector. The program is also designed to contribute to the improvement of managerial capacity at the central, regional, and health area levels. To that end, efforts have been made to promote administrative decentralization and to study mechanisms that will make such decentralization viable, in coordination with other government efforts to develop the capacity of the provincial and municipal levels to govern.

14. In 1992, the legislative branch approved a proposal for the extension of coverage of the services of the Dominican Institute of Social Security (IDSS) and SESPAS, a plan for which the executive branch will have to design and implement mechanisms to make it feasible. For this process, an effort will be made to ensure greater coordination and integration between the services of IDSS, SESPAS, and the institutions that make up the subsector of private services. New financing modalities and alternatives will be studied for their timely application, in accordance with emerging needs.

15. The primary health care (PHC) strategy is reaffirmed as a priority component for the improvement of the living conditions of the population. As part of sustained efforts toward that end, action is proposed for consolidating the process of development and strengthening the Health Area Systems (local health systems) and for lending greater support to health prevention and health promotion activities. Human resources constitute substantive component of these actions and for that reason the government intends to continue supporting personnel training and education programs by improving medical residencies, the practice of rural internships, the teaching capacity of academic institutions, the development of the network of scientific and technical documentation centers, and programs of health education and social communication.

16. Of note is the great importance that has been placed on environmental health programs and activities for prevention and health promotion. Drinking water supply, the improvement of sewerage and wastewater systems, the treatment of solid wastes, and concentration on the variety of other problems that affect environmental conditions will be matters for consideration, with a view to achieving greater investment and coordination among the national and international institutions involved. Marginal urban neighborhoods are the most affected by these problems, and for that reason, the Government has proposed that a broad national campaign be launched for the improvement of living conditions of families

and communities in these localities. In a closely related area, the government will continue its programs and activities for natural disaster preparedness, supporting the initiatives for coordination among SESPAS, the Red Cross, the Fire Department, the municipal councils, Civil Defense, and other civil institutions concerned with these problems.

17. In regard to the principal problems that affect the health of the population, there has been emphasis on the particular health problems and cause of morbidity and mortality among children and women of childbearing age. With regard to this situation, the government has prioritized the work of the National Commission for Follow-up on the Agreements of the World Summit for Children. Annual plans of operation will be carried out in this sphere, mobilizing a greater proportion of national and local resources, in addition to promoting coordination and consensus among the various international agencies of cooperation committed to the achievement of these goals.

18. AIDS and other sexually transmitted diseases have also been assigned priority by the health authorities, and this is obvious from the definition and establishment of the "Policies and Strategies for the Prevention and Control of STDs and AIDS", the reorganization of the national program, and the reactivation of the National AIDS Commission (CONASIDA).

19. The achievement of higher quality medical care is one component of the national policies. In order to implement these policies, action has been proposed to improve the infrastructure of the health establishment network, to re-equip it, to provide it with drugs and other essential supplies, to train hospital management personnel, to establish a National Commission for the Accreditation of Clinics and Hospitals, and to enhance the support of services, such as laboratories, blood banks, and radiodiagnostic services.

20. The government has not neglected its cooperative relations in health with neighboring countries over the past few years, and the plan for the immediate future is to strengthen these programs, prioritizing those aspects that are of common interest to the different nations. Of particular interest is the close relationship the Dominican Republic has with Haiti, such that special treatment will be accorded that situation, mainly in the context of "border health."

21. One of the mainstays of the country's economy is tourism. The authorities are aware of the close relationship that exists between tourism and health, and programs will be developed for preventing illness in visitors and for improving the coverage of services to populations that live in and around the principal tourist destinations.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

22. Based on the national health policy and in view of the plans and priorities mentioned, the following national priority areas have been identified for the delivery of technical cooperation.

22.1 Restructuring of the public subsector of the National Health System.

22.2 Expansion of health service coverage, based on the decentralization and development of the Health Area Systems (local health systems).

22.3 Reinforcement of the family promotion and protection component (for mothers, children, adolescents, and elderly people), emphasizing work in the Health Regions and Health Areas, in order to achieve the national goals of the World Summit for Children.

22.4 Mobilization and training of SESPAS personnel, in accordance with policies and priorities.

22.5 Strengthening of all environmental health programs and activities.

22.6 Strengthening of the National Health Information System's capacity for epidemiological analysis.

22.7 Upgrading of all components relating to the drug supply system.

22.8 Strengthening of the programs for the education and training of human resources, in coordination with the country's universities, placing emphasis on the processes of teaching and service integration.

### National priorities for technical cooperation from PAHO/WHO

23. PAHO/WHO has agreed with the Government, through the Ministry of Public Health and Social Welfare (SESPAS), to furnish technical cooperation in the following areas:

23.1 To improve the managerial capacity of SESPAS and to strengthen it as a regulatory institution of the health sector.

23.2 To support the process of implementation of the local health systems.

23.3 To improve the living conditions of the population, strengthening the primary health care strategy at the national level.

23.4 To support interventions for an increase in the coverage of safe water, sewerage systems, and proper elimination of solid waste in urban fringe and rural areas.

23.5 To support the implementation of the Regional Plans and the National Plan for the Attainment of the Goals of the World Summit for Children.

23.6 To support the national program for the prevention and control of sexually transmitted diseases and AIDS.

23.7 To develop human resources in the field of health.

23.8 To promote and guide national investments in the environment and health in the framework of the PIAS.

24. The World Bank has accorded the Ministry of Health a grant in the amount of US$ 248,000 to strengthen the Ministry's institutional capacity and develop its leadership role in the sector, create conditions for the decentralization of the administration of health services, and further the administrative reform of the Ministry. PAHO/WHO will cooperate in carrying out this project.

25. The Dominican Republic is currently arranging to become a member of INCAP. It is hoped that this membership will be in effect by the 1994-1995 biennium and that the country will receive technical cooperation from INCAP in the area of food and nutrition.

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Community water supply and sanitation (CWS)

26. The purpose of this project is to improve sanitary infrastructure services, especially in urban fringe and rural areas, integrating health promotion actions into these activities, and to increase natural disaster preparedness.

27. Cooperation will be furnished in the framework of the Health Area Systems strategy (local health systems), with an effort to increase the response capability of the community and of companies, entities, and institutions of the sector for dealing with problems of drinking water and sanitation, solid waste management and household hygiene, environmental pollution, and workers' health. Activities will be directed toward the urban fringe areas and the rural areas, where the most disadvantaged population groups are located. The same activities will be carried out in the framework of primary health care, with intense promotion of community participation.

28. In addition, there will be continued support for activities associated with natural and man-made disaster preparedness, through effective intersectoral and interinstitutional coordination, and for the organization of health services to deal with situations of this nature.

Health services development (DHS)

29. The purpose of this project is to develop and strengthen the National Health System and to extend coverage and improve the quality of care of the services.

30. Action will be taken to continue to strengthen the leadership role of the sector through the Ministry of Public Health and Social Welfare (SESPAS). Sustained support will be furnished for the primary health care strategy (PHC), strengthening the process of implementation of the Health Area Systems (local health systems). Techniques, instruments, methods, and procedures will be developed for local strategic management, prioritizing the training of health personnel who have managerial functions at the different levels of the system. Support will be continued for the development of the national drug supply system, the utilization of the national basic drug formulary, and the operation of the SESPAS Drug and Pharmacy Division. In the oral-dental health area, prevention activities will be promoted. Cooperation will continue in the development of nursing services, in coordination with the country's schools of nursing, and the leadership of nursing personnel will be promoted in the practice of public health. Managerial information systems will be implemented, to keep track of production, performance, resources, and costs. Development of the territorial (provincial and municipal) information systems will be extended as much as possible.

Scientific and technical information dissemination (HBD)

31. The purpose of this project is to improve the capacity of national health personnel by means of access to pertinent scientific and technical information produced in the region and at the world level.

32. There will be continued support for the activities of the national health information network in order to optimize the use of the resources available in the various institutions of the health sector. A continuous program of support will be maintained for the development and consolidation of the Documentation Center at the PAHO/WHO Representative Office, inasmuch as the Center is an important instrument of the technical cooperation offered by the Organization to the country. Users of the bibliographic information services will be trained in the utilization of the resources available in this area at the national, regional, and world levels. Support will be furnished for the creation and consolidation of documentation centers located in service institutions outside the National District in order to help provide the human resources working in these community institutions with educational materials on health topics. There will be cooperation with professional associations and with editors of biomedical publications in order to carry out activities that will help to influence public opinion on health matters and promote knowledge and use of PAHO/WHO publications, including those of PALTEX.

Human resources education (HRE)

33. The purpose of this project is to establish a process of comprehensive human resource development with a view to achieving the target of health for all by the year 2000.

34. Processes will be consolidated in order to develop health teams at all levels of care, consistent with local health needs. There will be continued cooperation in performance evaluations in order to improve managerial capacity. The processes of training and continuing education will be organized to strengthen the capacity for health situation and service assessment, as well as for the evaluation of health service administration. Procedures will be established for

retrieving information on existing human resources at the local and regional levels in order to perfect the national system and facilitate the future orientation of the sector with regard to the supply and demand for such resources.

35. In addition, there will be cooperation in the upgrading of training processes at the university level, and strategic proposals for curriculum redesign will be developed with a view to strengthening a new vision of epidemiology, management, the approaches taken in public health and maternal and child health in general.

Health situation and trend assessment (HST)

36. The purpose of this project is to develop and strengthen the national capacity for health situation assessment as a fundamental tool for supporting the health management decision-making process.

37. Support will continue for the process of reorganizing and strengthening the Department of Epidemiology of the Ministry of Public Health and Social Welfare in its leadership role in the production, use, and dissemination of epidemiological knowledge and the integration of this knowledge into the daily work of the health services. Special emphasis will be placed on the design, implementation, and development of the National System of Epidemiological Surveillance according to Living Conditions and Local Systems, properly integrated into the National System. Furthermore, support will be furnished for the strengthening and coordination of activities for the surveillance and control of specific diseases through the Department of Epidemiology and the programs of disease control that have already been established: the Program for the Control of Sexually Transmitted Diseases and AIDS (PROCETS), the National Tuberculosis Program, the National Leprosy Control Program, the National Malaria Eradication Service, the National Rabies Center, the National Food Protection Program, and programs for the control of other tropical diseases (filariasis, schistosomiasis, leishmaniasis). Together with the human resources project, there will be cooperation in the design and development of training processes in epidemiology for the health teams in the services, with priority assigned to the regional and area levels, as well as in the teaching of epidemiology at the graduate levels.

Growth, development and human reproduction (MCH)

38. The purpose of this project is to develop programs and activities for the comprehensive management of problems that affect the lives of women, children, and adolescents.

39. The operationalization of the National Plan of Follow-up on the Agreements of the World Summit for Children will be one of the central focuses of PAHO technical cooperation under this project. Efforts will continue in support of activities related to the prevention and control of diarrheal diseases, acute respiratory infections, and the activities of the Expanded Program on Immunization (EPI). In addition, assistance will be granted in the development of comprehensive care services for adolescents, with emphasis on sex education and pregnancy prevention. Family planning activities will be supported, and exclusive breast-feeding for the first four to six months of life will be promoted.

40. Maternal and child health hospital services will be strengthened, with emphasis on the quality of care for delivery and for newborns. As part of the primary health care (PHC) strategy, work in the Health Area Systems (local health systems) will be strengthened to provide education and timely and adequate care for pregnant women, and the formulation of "Local Institutional and Intersectoral Committees in the Health Areas for the Attainment of the Goals of the World Summit for Children" will be promoted. Cooperation will be furnished for the development of the Dominican Food and Nutrition Institute (IDAN). The surveillance systems for the food and nutrition situation at the local level will receive technical support in their organization and operation. There will be continued study of the problems of micronutrient deficiencies (vitamin A, iron, and iodine), and there will be cooperation in the application of the pertinent recommendations. Broader intersectoral and interinstitutional coordination will be promoted at the national level for the management of maternal and child health problems, as will coordination and consensus among the agencies of the United Nations system, with a view to achieving a greater impact, through international cooperation, on national problems.

Managerial support for national health development (MPN)

41. The purpose of this project is to provide managerial, technical, and administrative support for the expeditious and timely delivery of technical cooperation with the Dominican Republic.

42. Support will continue for the incorporation of the country into subregional initiatives in order to increase its access to sources of cooperation. Action will be taken to strengthen the capacity for formulating and negotiating projects with the internal economic sectors and with donors. Support will continue for analysis and discussion of elements associated with health in development. The process of administrative development of the PAHO/WHO Representative Office in the Dominican Republic will continue.

Technical cooperation among countries (TCC)

43. The purpose of this project is to continue to strengthen sharing and cooperation among countries that share common health problems.

DOMINICAN REPUBLIC (Cont.)

44. Based on the priority areas identified (control and prevention of disease, training and education of human resources, development of health services, ecological and environmental issues, and transfer of laboratory technology), joint actions will be carried out with the border country, the countries of the Caribbean Basin, and the Central American countries. There will be continued participation in the LAES/PAHO regional project of technical cooperation among countries for the exchange and development of technologies. There will be a study of mechanisms and modalities of cooperation to make the activities carried out under the main priorities more successful, with effective co-participation in the rationalization of the available resources.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 1,935,600 | 70.2 | 2,465,700 | 79.9 | 2,721,800 | 80.2 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 624,700 | 22.7 | 858,400 | 27.8 | 962,400 | 28.3 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 624,700 | 22.7 | 858,400 | 27.8 | 962,400 | 28.3 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 63,700 | 2.3 | 72,200 | 2.3 | 81,900 | 2.4 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 63,700 | 2.3 | 72,200 | 2.3 | 81,900 | 2.4 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 305,600 | 11.1 | 534,600 | 17.3 | 580,500 | 17.1 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 305,600 | 11.1 | 534,600 | 17.3 | 580,500 | 17.1 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 684,500 | 24.7 | 727,600 | 23.6 | 795,800 | 23.5 |
| HEALTH SERVICES DEVELOPMENT | DHS | 659,900 | 23.8 | 727,600 | 23.6 | 795,800 | 23.5 |
| DISASTER PREPAREDNESS | DPP | 24,600 | .9 | 0 | - | 0 | - |
| HUMAN RESOURCES DEVELOPMENT | | 158,900 | 5.8 | 165,100 | 5.4 | 180,600 | 5.3 |
| HUMAN RESOURCES EDUCATION | HRE | 158,900 | 5.8 | 165,100 | 5.4 | 180,600 | 5.3 |
| HEALTH INFORMATION SUPPORT | | 98,200 | 3.6 | 107,800 | 3.5 | 120,600 | 3.6 |
| SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION | HBD | 98,200 | 3.6 | 107,800 | 3.5 | 120,600 | 3.6 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 820,200 | 29.8 | 618,200 | 20.1 | 671,000 | 19.8 |
| FOOD AND NUTRITION | | 58,800 | 2.1 | 0 | - | 0 | - |
| NUTRITION | NUT | 58,800 | 2.1 | 0 | - | 0 | - |
| ENVIRONMENTAL HEALTH | | 337,800 | 12.3 | 427,800 | 13.9 | 463,400 | 13.7 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 337,800 | 12.3 | 427,800 | 13.9 | 463,400 | 13.7 |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| MATERNAL AND CHILD HEALTH | | 139,300 | 5.1 | 190,400 | 6.2 | 207,600 | 6.1 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 139,300 | 5.1 | 190,400 | 6.2 | 207,600 | 6.1 |
| COMMUNICABLE DISEASES | | 195,700 | 7.1 | 0 | - | 0 | - |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 195,700 | 7.1 | 0 | - | 0 | - |
| VETERINARY PUBLIC HEALTH | | 88,600 | 3.2 | 0 | - | 0 | - |
| ZOONOSES | ZNS | 88,600 | 3.2 | 0 | - | 0 | - |
| GRAND TOTAL | | 2,755,800 | 100.0 | 3,083,900 | 100.0 | 3,392,800 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 522,100 | 59.3 | 271,200 | 33.4 | 0 | |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 522,100 | 59.3 | 271,200 | 33.4 | 0 | |
| HEALTH SERVICES DEVELOPMENT | DHS | 484,200 | 55.0 | 271,200 | 33.4 | 0 | |
| ESSENTIAL DRUGS AND VACCINES | EDV | 37,900 | 4.3 | 0 | - | 0 | - |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 357,600 | 40.7 | 540,000 | 66.6 | 0 | - |
| FOOD AND NUTRITION | | 94,900 | 10.8 | 0 | - | 0 | - |
| NUTRITION | NUT | 94,900 | 10.8 | 0 | - | 0 | - |
| COMMUNICABLE DISEASES | | 262,700 | 29.9 | 540,000 | 66.6 | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 262,700 | 29.9 | 540,000 | 66.6 | 0 | - |
| GRAND TOTAL | | 879,700 | 100.0 | 811,200 | 100.0 | 0 | |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 1,651,000 | 2 | 3 | 660 | 730,700 | 58,200 | 38 | 76,000 | 160,000 | 193,700 | 0 | 432,400 |
| WHO - WR | 1,104,800 | 2 | 1 | 605 | 616,200 | 30,200 | 28 | 56,000 | 123,200 | 87,000 | 0 | 192,200 |
| TOTAL | 2,755,800 | 4 | 4 | 1265 | 1,346,900 | 88,400 | 66 | 132,000 | 283,200 | 280,700 | 0 | 624,600 |
| % OF TOTAL | 100.0 | | | | 48.8 | 3.2 | | 4.8 | 10.3 | 10.2 | .0 | 22.7 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 1,631,300 | 2 | 3 | 345 | 724,600 | 115,200 | 16 | 32,000 | 164,300 | 103,200 | 0 | 492,000 |
| WHO - WR | 1,452,600 | 2 | 1 | 885 | 762,000 | 42,000 | 21 | 42,000 | 203,400 | 182,400 | 0 | 220,800 |
| TOTAL | 3,083,900 | 4 | 4 | 1230 | 1,486,600 | 157,200 | 37 | 74,000 | 367,700 | 285,600 | 0 | 712,800 |
| % OF TOTAL | 100.0 | | | | 48.2 | 5.1 | | 2.4 | 11.9 | 9.3 | .0 | 23.1 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 1,808,900 | 2 | 3 | 345 | 785,000 | 130,600 | 16 | 32,000 | 186,300 | 117,000 | 0 | 558,000 |
| WHO - WR | 1,583,900 | 2 | 1 | 885 | 806,300 | 47,600 | 21 | 42,000 | 230,700 | 206,900 | 0 | 250,400 |
| TOTAL | 3,392,800 | 4 | 4 | 1230 | 1,591,300 | 178,200 | 37 | 74,000 | 417,000 | 323,900 | 0 | 808,400 |
| % OF TOTAL | 100.0 | | | | 46.9 | 5.3 | | 2.2 | 12.3 | 9.5 | .0 | 23.8 |

## HEALTH SITUATION ANALYSIS

### Demography

1. Anguilla, British Virgin Islands and Montserrat are three British dependencies with respective populations of 7,200, 11,733 and 12,240. In the case of Anguilla, approximately half of the population is under 20 and a third is of school age. More than 10% of the population are over 65 years of age. In the case of British Virgin Islands, 34% of the population is under 15 years, whereas in the case of Montserrat 27.7% of the population is under 25 years and 59.8% between 15-64 years.

### Indicators of health status

2. There is a variation in the mortality rate among the three territories. Infant mortality rates are 13.84, 26.4, 25.0 per 1,000 live births and the crude death rate 11.5, 6.8, and 9.6 per 1,000 for Montserrat, British Virgin Islands and Anguilla respectively. Life expectancy for Montserrat, British Virgin Island and Anguilla are 66.4, 65.4 for males and 73.3 years and 73.3 years and 75.4 years for females respectively. The expanded program on immunization in children under 1 year for diphtheria, pertussis, tetanus, polio, tuberculosis, measles, mumps and rubella, achieved a rate of 90% to 100% for the three territories. Among the adult population, the leading causes of mortality are cardiovascular disease, malignant neoplasms, pneumonia/broncho-pneumonia with diabetes and hypertension being major contributors to cardiovascular disease, especially in Montserrat and British Virgin Island. Among the 1-4 age group, gastroenteritis and acute respiratory infections are the two principal causes of infant and child morbidity and mortality.

### Factors affecting health status

3. In all three countries, the environment continues to be critical with respect to both the epidemiological profile and tourism. Vector control, food protection and solid waste are the priorities with respect to the environment. The other priority area is the scarcity of invaluable human resources to address some of the problems. Although the economies are not as soft as some of the other Caribbean states, the absence of management and planning is impacting negatively on the efficient use of resources and the consequent delivery of health care in the territories.

### Plans and priorities for national health development

4. Of the three territories, Montserrat is the only one which is formally part of CARICOM. However, the three territories have all embraced the Caribbean Cooperation in Health and hence have identified activities within the seven priority areas. All three territories will be seeking to improve the utilization of resources by improved planning and management throughout the system. Specifically in Anguilla is a priority to change the organizational structure of the health system and establish a board to manage the health system. In all three territories, improvement in the information system and improved disease surveillance have been identified as important. The smallness of these countries and the constant migration of manpower demand an analysis in terms of the structure and utilization of manpower for both community health service and hospitals. Improvements in the prevention and control of AIDS/STD would be attained through greater community involvement and social communication. Due to the smallness of the countries, counselling at all levels and training in ethics and confidentiality should be emphasized. Increased surveillance and improved diagnostic capability of the laboratories are priorities. Maternal and child health will be improved through the establishment of a system for the early recognition and management of high risk pregnancies; upgrading skills at the hospital and community levels; improvement in growth and development monitoring; and infant nutrition with an emphasis on breast feeding.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

5. The Governments have identified eight major priority areas in which technical cooperation is required to improve the health situation in the countries. These areas include improving the information and disease surveillance systems; solid waste disposal; vector and rodent control; high risk pregnancies; health promotion programs; dental health; mental health; and food protection.

6. The British Government will provide support for activities to transform the health services with respect to the improvement of management services and strategic planning.

### National priorities for technical cooperation from PAHO/WHO

7. PAHO/WHO is being asked to provide technical cooperation in all areas. The technical cooperation in the areas identified will be pursued in keeping with the spirit of the Caribbean Cooperation in Health Initiative. The strategies which will be employed will be in keeping with those agreed on for the various areas in the Initiative. Special focus will also be given to the twin strategies of promotion and project development with linkages to resource mobilization and technical cooperation among countries as important activities in the pursuit of the objectives. The following working areas identified for technical cooperation with PAHO/WHO are: development of health system infrastructure; environmental health; maternal and child health; AIDS/STD; human resource development; and dental health.

8. In addition to the projects under the regular budget, extrabudgetary resources were mobilized for the following projects within the Caribbean Cooperation in Health: management of the community health information system, funded by the InterAmerican Development Bank; projects are supported by the Italian Government in the following areas: maternal and child health, community based vector control and community based rehabilitation. A project for the prevention and control of cancer of the cervix is funded by the French Government.

USAID has also approved a project which seeks to address financing, policy formulation and management of the system and UNDCP will be supporting activities relating to drug abuse.

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Community water supply and sanitation (CWS)

9. The purpose of the project is to strengthen the capacity of the environmental health department to address problems in the sector. To achieve this purpose, it will be necessary to develop an environmental health management plan and an integrated vector and rodent control program.

Health services development (DHS)

10. The purpose of this project is to improve the capacity of the departments of health to deliver quality health care. To achieve this purpose, it will be necessary to conduct a manpower study and design appropriate training programs; strengthen the managerial process through improved planning and the development of information and surveillance systems; and further develop the local health systems.

Growth, development and human reproduction (MCH)

11. The purpose of the project is to improve the capacity to manage MCH services. Achieving this purpose will require the development of human resources through the training of personnel in perinatal care, paediatrics and family planning.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 212,900 | 84.3 | 228,200 | 83.7 | 244,700 | 82.9 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 212,900 | 84.3 | 228,200 | 83.7 | 244,700 | 82.9 |
| HEALTH SERVICES DEVELOPMENT | DHS | 212,900 | 84.3 | 228,200 | 83.7 | 244,700 | 82.9 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 39,700 | 15.7 | 44,700 | 16.3 | 50,300 | 17.1 |
| ENVIRONMENTAL HEALTH | | 32,100 | 12.7 | 36,400 | 13.3 | 41,300 | 14.0 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 32,100 | 12.7 | 36,400 | 13.3 | 41,300 | 14.0 |
| MATERNAL AND CHILD HEALTH | | 7,600 | 3.0 | 8,300 | 3.0 | 9,000 | 3.1 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 7,600 | 3.0 | 8,300 | 3.0 | 9,000 | 3.1 |
| GRAND TOTAL | | 252,600 | 100.0 | 272,900 | 100.0 | 295,000 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| III. HEALTH SCIENCE AND TECHNOLOGY | | 590,000 | 100.0 | 0 | | 0 | |
| ENVIRONMENTAL HEALTH | | 98,900 | 16.8 | 0 | | 0 | |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 98,900 | 16.8 | 0 | | 0 | |
| COMMUNICABLE DISEASES | | 491,100 | 83.2 | 0 | | 0 | |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 491,100 | 83.2 | 0 | | 0 | |
| GRAND TOTAL | | 590,000 | 100.0 | 0 | | 0 | |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 37,600 | 0 | 0 | 12 | 3,200 | 0 | 0 | 0 | 4,400 | 0 | 0 | 30,000 |
| WHO - WR | 215,000 | 0 | 0 | 60 | 18,100 | 11,600 | 44 | 88,000 | 37,600 | 34,800 | 0 | 24,900 |
| TOTAL | 252,600 | 0 | 0 | 72 | 21,300 | 11,600 | 44 | 88,000 | 42,000 | 34,800 | 0 | 54,900 |
| % OF TOTAL | 100.0 | | | | 8.4 | 4.6 | | 34.9 | 16.6 | 13.8 | .0 | 21.7 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 8,300 | 0 | 0 | 12 | 3,300 | 0 | 0 | 0 | 5,000 | 0 | 0 | 0 |
| WHO - WR | 264,600 | 0 | 0 | 60 | 19,100 | 13,200 | 44 | 88,000 | 42,500 | 39,500 | 0 | 62,300 |
| TOTAL | 272,900 | 0 | 0 | 72 | 22,400 | 13,200 | 44 | 88,000 | 47,500 | 39,500 | 0 | 62,300 |
| % OF TOTAL | 100.0 | | | | 8.2 | 4.8 | | 32.3 | 17.4 | 14.5 | .0 | 22.8 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 9,000 | 0 | 0 | 12 | 3,300 | 0 | 0 | 0 | 5,700 | 0 | 0 | 0 |
| WHO - WR | 286,000 | 0 | 0 | 60 | 19,400 | 15,000 | 44 | 88,000 | 48,200 | 44,800 | 0 | 70,600 |
| TOTAL | 295,000 | 0 | 0 | 72 | 22,700 | 15,000 | 44 | 88,000 | 53,900 | 44,800 | 0 | 70,600 |
| % OF TOTAL | 100.0 | | | | 7.7 | 5.1 | | 29.8 | 18.3 | 15.2 | .0 | 23.9 |

## HEALTH SITUATION ANALYSIS

### Demography

1. The population of Ecuador in 1990 was 9,648,189, and according to estimates made by the Population and Responsible Paternity Center (CEPAR), it had increased to 10,700,000 by 1992. This figure shows surprising growth, since from a population of 1 million at the beginning of the twentieth century, the country's population has increased 10 times. It is estimated that the population will reach 12.8 million by the year 2000, at an average natural increase rate of 2.2%.

2. The population growth rate shows a trend toward deceleration, since from the rate of 3.2% observed during the period between the 1962 and 1974 censuses, it declined to 2.8% between 1970 and 1982 and to 2.4% between 1982 and 1990. This trend may be explained by the decline in the birth rate from 30.5 per 1,000 in 1982 to 25.1 per 1,000 in 1990, which is directly associated with a sustained trend toward decline of the total fertility rate. According to information obtained from the fertility surveys carried out by INEC (1979) and CEPAR (1989-1992), this indicator dipped from 7.1 children per woman of childbearing age in 1965 to 3.7 in 1992, which represents a reduction of 3.4 children--that is, a decline of 48%. This change in the total fertility rate within such a short period of time is an outstanding event in demographic terms, similar to that of Colombia and surpassed only in Cuba, Costa Rica, and Mexico. (CEPAR 1992).

3. In the period 1984-1989 the total fertility rate was 3.1 in urban areas and 5.0 in the rural areas.

4. It is considered that this situation may be attributed to both the increase in fertility regulation and to the evident reduction in child mortality.

5. In the first case, the prevalence of contraceptive use by the Ecuadorian population in the last 10 years (1979-1989) increased by 57%, especially in the rural areas, where it increased from 20% to 40%; in the urban areas the increase was 33%, which was not as important a percentage in comparison with the previous figures, since by 1979 contraceptive use in urban areas was higher.

### Health status indicators

6. The reduction in child mortality has continued. In 1950 it was estimated at 139 per 1,000 live births, and in 1989, at 33.7 per 1,000 live births.

7. As regards total mortality, a situation similar to what occurred in other countries was observed--that is, a very sizeable reduction in the period 1965-1990 from 11.7 to 5.2 per 1,000 population.

8. Life expectancy at birth in the period 1950-1990 increased by 35%, from 48.4 to 65.4 years. It is estimated that for the period 1995-2000 it will rise to 68 years.

9. These demographic facts are translated into the age structure of the country, which shows a reduction in the youngest groups and a corresponding proportional increase in the oldest population.

10. At the present time the population under 15 years of age represents 38.8% of the total, and while those over 65 years of age make up 4.3% of the national population.

11. Significant differences are evident in the indicators analyzed in the country's various provinces, cantons, and parishes. The most notable are found in the provinces of the central highlands (Cotopaxi, Tungurahua, Bolivar, Chimborazo, Cañar, Azuay, and Imbabura), to which may be added some cantons in the coastal region and several in eastern Ecuador.

12. Distribution of the Ecuadorian population shows a greater concentration in the provinces and cities, which, owing to their degree of development, offer more job opportunities and access to services, etc. A total of 54% of the population of Ecuador lives in the provinces of Guayas, Pichincha, and Manabí.

13. A critical problem is accelerated urban growth, especially in Quito and Guayaquil. At the present time 55.4% of the total population of Ecuador lives in the cities, which are growing at an annual average rate of 3.8%, pointing to a doubling of their populations in approximately 18 years.

14. Ecuador has a population density of 35.5 per km². In 1990 the most densely populated provinces were Pichincha (136.0), Guayas (122.7), and Tungurahua (108.5).

15. The most acute problems deriving from this growth are reflected in the increase in the working-age population, which is growing an annual rate of 3.0%. It is estimated that 39% of the population is under 15 years of age and 43% is dependent. At the present time the country requires the creation of 123,000 jobs a year simply to maintain its unemployment indexes, without even considering the disguised underemployment typical of the large cities.

16. These demographic changes point to a "demographic transition," which is expressed in a higher relative increase in the population over 15 years of age, similar to other Latin American and third world countries. This has an effect on the relative frequency of the different causes of death attributable to aging of the population, which should be taken into account in analyzing the changes observed in national epidemiology behavior.

17. The morbidity structure shows significant variations, pointing to an increase in chronic degenerative health problems and the persistence of diseases associated with the lack of basic sanitary conditions--that is, poverty.

18. Among the pathologies under epidemiological surveillance in Ecuador, diarrheal diseases were the leading cause of morbidity in 1991, followed by malaria, cholera, influenza, and streptococcal angina. It should be noted that the country does not process information on morbidity obtained from outpatient consultation, except in the case of reportable diseases, and consequently does not possess accurate knowledge of the national morbidity situation.

19. In a national study carried out by CONADE in 1987 based on a representative sample of the entire population of Ecuador it was found that 50% of the children under 5 years of age suffered to some degree from protein-calorie malnutrition, which was more prevalent in rural and marginal urban areas.

20. The presence of morbidity-associated deficiencies such as vitamin A, iron, zinc, and iodine, among others, is one of the country's greatest epidemiological problems by reason of its incidence on mortality, especially as regards groups at risk.

21. The growing trend of vector-borne diseases, such as malaria and dengue, and the serious risks they represent for the population is another characteristic of Ecuadorian morbidity.

22. Sexually transmitted diseases are of permanent concern to the Government. AIDS is one of the diseases that calls attention to the deficiencies in public education and health services. This is borne out by the fact that in 1991, 274 cases of HIV infection had been reported in the country, 72.3% of which were fatal.

23. In recent decades, there has been an increase in the incidence of pathologies associated with development, such as hypertension (which increased from 63.21 per 100,000 population in 1985 to 134.68 in 1990), ischemic heart disease, and injuries from accidents and violence, which could become principal causes of disease and death in the near future.

24. Childbirth is the leading cause of hospitalization for the age group from 15 to 19 years, which points to high levels of pregnancy among adolescents and their concomitant implications. Injuries and infectious diseases are very frequent causes of morbidity in this group.

25. Morbidity in the adult population is mainly work-related, derived from a mixture of old risks, such as noise, solvents, pesticides, and industrial particles, and new risks, derived from technological modernization of industry, which generate clinical profiles characterized by the persistence of high levels of work accidents and an increase in work-related diseases.

26. The trend and structure of mortality, which has been significantly modified over the years, showed a reduction of more than 50% in the 1980s, attributable principally to a decline in child and infant mortality and a slower decline in perinatal and maternal mortality.

27. According to data provided by the 1990 Yearbook of Vital Statistics published by INEC, the leading causes of total mortality show the following rates per 100,000 population: cerebrovascular diseases, 25.65; infectious diseases, 25.4; pneumonia, 23.9; motor vehicle accidents, 19.4; ischemic heart disease, 17.4; bronchitis, emphysema, and asthma, 14.1: malignant neoplasm of the stomach 11.7; tuberculosis, 11.5; homicide, 10.4; and diabetes mellitus, 9.4.

28. Many of these causes of death are preventable through the improvement of environmental conditions, efficient health care, and timely and effective treatment.

29. This distribution of causes of mortality shows a profile of diseases predominantly related to the modernization of society.

30. Analysis of infant mortality by age groups shows the principal causes to be specific infections, hypoxia, asphyxiation, and other respiratory infections of the fetus and the newborn, in addition to pneumonia, bronchitis, and malnutrition, which denotes a predominantly infectious profile related to pregnancy and delivery care.

31. It is interesting to note that on the basis of research carried out by CEPAR, a total of 2.9% of children died from malnutrition, which shows the importance of this condition in the structure of mortality.

32. For the least protected group from 15 to 19 years of age the causes of death are mainly accidents and violence, infections, and leukemia.

33. Maternal mortality is one of the indicators that has shown the least variation in recent years, moving from 1.6 maternal deaths per 1,000 live births in 1980 to 1.3 in 1989. This indicator is directly related to mortality from complications during pregnancy, delivery, and the puerperium, which are periods in which efficient preventive and gyneco-obstetric emergency care is a fundamental need. It would seem that the availability of the country's health services has not had a favorable impact on the reduction of maternal mortality.

34. In the group from 45 to 64 years of age the leading causes of death in 1987 per 100,000 population were malignant tumors, 138.7; heart disease, 99.6; accidents, 79.8; cerebrovascular diseases, 54.9; tuberculosis, 31.5; cirrhosis, 30.7; and diabetes mellitus, 27.3.

35. Malignant neoplasms show a sustained trend of increase in morbidity and mortality. Mortality from this cause has almost doubled in the last 40 years, going from 29.1 per 100,000 population in 1956 to 52.9 per 100,000 in 1990. The most common cancers in Ecuador are cancer of the cervix and of the stomach.

## Plans and priorities for national health development

36. The general policy of development has three main objectives: to reduce inflation, set the bases for economic growth, and bring about sustained improvement of living conditions. Development plans continue to be directed toward the populations in the rural and marginal urban areas. The main thrust of

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the program is to strengthen and reorganize public finances, reduce the deficit, emphasize the reduction of public spending--particularly with regard to current expenditure--and maintain high-yield economic and social investment.

37. It is important to note that the present administration has prioritized the economy as an area for intervention, further reinforced by political decisions that have been taken in recent months. At the same time an immediate improvement is expected in the social area, especially as a result of the formulation and implementation of the policies listed below.

38. Modernization of the State, effective focusing of resources, rationalization of public spending, administrative decentralization, and participation of civil society.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

39. The guidelines for the Ministry's health policy for the five-year period 1992-1996 have been established on the basis of:

40. Development of a care model oriented toward the health of the individual within the family and the community, emphasizing primary care. This includes programs for social and community participation, comprehensive programmed care, development of the referral system, improvement of the quality of care, and strategies for the horizontalization of health care programs.

41. Modernization of the health services, both hospital and ambulatory. This includes programs and actions to achieve physical, technological, and operational rehabilitation of the hospitals and to increase the coverage of ambulatory services as part of a process of functional regionalization that includes the hospitals in organizing and developing the health areas as functional units in a services system.

42. Organization, implementation, and operation of the generic drugs program as a basic element in the national pharmacology and drug surveillance system.

43. This includes components related to expediting drug registration; quality control; timely supply; promotion for the dispensing, utilization, and marketing of drugs; and updating of the legal framework.

44. Improvement of food and nutrition, which includes programs for nutritional surveillance, food supplements, treatment of serious malnutrition and specific deficiencies, and technological development.

45. Control and surveillance of the principal endemic diseases, such as malaria, dengue, and cholera, through the implementation of specific programs.

46. Promotion and development of basic sanitation by means of programs for the provision of safe drinking water, treatment of solid wastes, latrine construction, and health education, especially for priority rural and urban fringe populations.

47. Institutional development by means of programs for decentralization and regionalization of the services, local health systems, training and continuing education, research, and administration systems.

48. Development of a coordinated national health services system.

49. On the basis of current policies, the national priorities identified for the sector for the period 1994-1996 include hospital rehabilitation, with the aim of optimizing the distribution, utilization, and maintenance of the available equipment; development of a regionalized system of services and of administrative and financial decentralization through the formulation and implementation of operation standards; development of the health areas by means of intrasectoral coordination of action at the national and local levels for investment and the provision of services, including external cooperation and financing projects, social and community participation, and improvement of service delivery and basic programs; primary health care, including nutrition and basic sanitation; epidemiological control and surveillance of diseases; generic drugs; planning; research; disaster preparedness; and institutional development.

50. In order to carry out these activities the Government receives resources from various external sources in order to support several of the important areas of its programs, as follows.

51. The Inter-American Development Bank (IDB) has signed a technical cooperation agreement for institutional improvement of the drinking water company (EPAP-G) in the Province of Guayas in the amount of US$ 2 million, which will be administered by PAHO through an international coordinator, to be designated by common agreement among PAHO, EPAP-G, and IBRD.

52. For the prevention and control of cholera in Ecuador, IDB allocated US$ 140,000 for a period of two years to be used to strengthen epidemiological surveillance and diagnostic laboratories and to support environmental health and food programs. These activities are being carried out with PAHO/WHO administrative and technical support.

53. The World Bank is participating with a loan of US$ 70 million and a UNDP contribution of US$ 500,000 for the strengthening and expansion of the basic health services.

54. The Government of the Netherlands has provided US$ 60,000 for a project on the control and prevention of cholera and diarrhea in indigenous communities in the Ecuadorian highlands.

55. The Netherlands is collaborating with the project to develop and strengthen social drug programs by providing technical advisory services and a financial contribution of US$ 1,507,836 for a three-year period. This project is being executed with PAHO/WHO technical advisory services and administration.

56. The Kingdom of the Netherlands is also collaborating with experts in the areas of primary health care and disaster prevention, and is providing funds for training in the SUMA program.

57. The German Government has expressed interest in considering projects in the areas of maternal and child area, family planning, and women, health, and development. These projects are being prepared with PAHO technical cooperation.

58. The Government of Sweden will donate US$ 529,000 for the construction of latrines and the purchase of sodium hypochlorite equipment (DIP-CELL) for the Province of El Oro, in addition to US$ 1,327,995 for a vaccine development project.

59. The French Government, through the four-year Franco-Ecuadorian project, is collaborating in the control of diarrheal diseases and cholera through the installation of two laboratories, one in Quito (already in operation) and another in Guayaquil (to be inaugurated in June 1993) for the diagnosis of diarrheal diseases with the participation of French experts who will work together with national technicians.

60. The Italian Government has shown interest in collaborating in Ecuador with a grant of approximately US$ 400,000 for an 18-month program on health education, environmental sanitation, and strengthening of health care services (local health systems, UROS). This project would be carried out in coordination with the PAHO/WHO Representative Office.

National priorities for technical cooperation from PAHO/WHO

61. In accordance with the national priorities established by the health sector, PAHO/WHO will provide technical cooperation in the following 12 priority areas:

62. Technical and administrative support for the national project to strengthen and expand the basic health services, with emphasis on: a) primary care; b) institutional development and modernization; and c) nutrition.

63. This includes support for the regionalization and decentralization of the services, promotion of local health systems, nursing services, oral health, laboratories, and rehabilitation.

64. Cooperation in modernizing the health services, both hospital and ambulatory. This includes programs and actions aimed at achieving the technological, physical, and operational rehabilitation of the hospitals. Managerial administration.

65. Growth, development, and human reproduction, including activities related to mothers, children, and adolescents; breast-feeding; acute respiratory infections; prevention of diarrhea; and basic immunization.

66. Prevention, control, and surveillance of communicable diseases, such as sexually transmitted diseases, AIDS, malaria, vector-borne diseases, tuberculosis, and leprosy; veterinary public health; and food protection.

67. Analysis of trends, situation diagnosis, vital statistics, and information systems.

68. Health promotion and health education, community participation, lifestyles, risk factors, behavior changes, mental health, drug addiction, alcoholism, smoking, and drug abuse.

69. Health and the environment; environmental sanitation; water supply and solid wastes; occupational health; plan of investment in environment and health.

70. Nutritional surveillance programs, support for FNSS, food supplements, specific deficiencies.

71. Development and strengthening of social drug programs, with emphasis on four program areas: development of policies, rationalization of the supply system, system of quality control and assurance, and manpower development.

72. Special attention will be given to the national essential drugs program and to the comprehensive system of generic drug supply.

73. Emergency preparedness and coordination of disaster relief.

74. Development of health policies: sectoral analysis and planning, health legislation, coordination with the social security system, nongovernmental organizations, the Ministry of Social Welfare, and the National Legislature.

75. Human resources: support for schools of medicine and health sciences, and for the school of public health in matters related to institutional development, training, fellowships, courses, and refresher seminars.

76. Scientific and technical information: publications and dissemination of technical documents, training in library science, documentation center, and user services.

## PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Community water supply and sanitation (CWS)

77. The purpose of this project is to contribute to achieving the proposed national targets by means of activities to supplement national efforts.

78. Efforts will be made to increase the coverage of the services and to improve their quality, assigning priority to basic rural sanitation (drinking water, excreta and waste disposal, and improvement of rural living conditions); reduction of water losses; control and surveillance of drinking water quality at the national level; increase in the collection, transportation, and sanitary disposal of municipal wastes; prevention and control of environmental pollution (air, water, and soil), mainly urban; and implementation of the national health plan for workers and its incorporation into Andean PLANSAT.

Health services development (DHS)

79. This project is aimed at supporting the development of an effective, equitable, and efficient national health system, framed within national policies for modernization of the State and social compensation for the adjustment policies based on the strategies of development of local health systems, primary health care, and hospital rehabilitation.

80. The lines of action will mainly support the preparation of studies and the formulation of policies, annual plans, and standards with regard to the development of local health systems; decentralization of the technical and administrative systems; maintenance systems; managerial systems; information systems; permanent training of human resources; social communication; and essential and generic drugs.

Human resources education (HRE)

81. The aim of this project is to develop institutional capacity in health for the planning and administration of human resources, the implementation of teaching programs, and the dissemination of educational material in order to help improve the competency of the personnel in the sector and their utilization.

82. Institutions will be created in which human resources will carry out the various activities concerned with the planning, management, and permanent organization of resources. It will be necessary to formulate plans and standards for developing and carrying out the system for the administration and management of human resources. Emphasis will be placed on the execution of a continuing education program for health personnel in order to elevate their scientific and technical competency and their capacity for management, thereby using their activities and practices to ensure the quality of health care for the population.

Health situation and trend assessment (HST)

83. This project will support the development of institutional training in epidemiological surveillance, especially at the local and provincial levels, as well as promotion of the modern use of epidemiology in the health services and in research.

84. The lines of action consist of supporting training for epidemiological surveillance and the use of epidemiology in the health services, the promotion of research based on conditions and lifestyles, technical advisory services for the preparation of scientific articles and promotion of scientific publications in this field, collaboration in studies of outbreaks of diseases preventable by vaccination, development of epidemiology and related science programs, scientific-technical collaboration for the control of cholera and other acute diarrheal diseases, and dissemination of scientific material related to this branch of medical science.

Growth, development and human reproduction (MCH)

85. This project will help to improve the development of comprehensive health care services for women, children, and adolescents, mainly at the local level, in 21 provinces and 25 cantons in the country.

86. This project will promote the reorientation of health care using the risk approach and the implementation of sound methodological processes of training, management, and research; the mobilization of resources, mainly at the local level, ensuring optimal use of resources with a local strategic approach; and the monitoring of activities and evaluation of the services in order to achieve efficiency and effectiveness of the plans and programs for which cooperation has been provided.

Managerial support for national health development (MPN)

87. The aim of this project is to ensure that the delivery of PAHO technical cooperation to the Ecuadorian Government is effective and efficient. For this purpose trained technical and administrative personnel will be available.

88. In addition, the project will formulate standards, plans, and policies jointly with the national authorities to mobilize national and international resources to support technical cooperation in the country and between countries.

Health promotion and prevention and control of noncommunicable diseases (NCD)

89. The main purpose of the project is to promote healthy habits and lifestyles in the population identified as high risk.

90. Concrete activities will be developed in: the area of health promotion in order to diminish risk factors for cardiovascular diseases and cervical cancer; the identification of risk factors as the cause of accidents and promotion of an intervention program, particularly with regard to traffic accidents; the reformulation of psychiatric care; the promotion of comprehensive care programs for the elderly; and the promotion of activities to combat smoking, alcoholism, and drug addiction.

General communicable disease prevention and control activities (OCD)

91. This project seeks to contribute to communicable disease control, emphasizing malaria and dengue, and supporting national programs related to food protection, eradication of foot-and-mouth disease, elimination of urban rabies, and control of other zoonoses.

92. Efforts will be directed toward increasing malaria control, control of Aedes aegypti, and surveillance of Aedes albopictus; collaboration for the elimination of urban rabies and onchocerciasis; consolidation of the tuberculosis information system; surveillance of yaws in endemic areas; evaluation and monitoring of the elimination of leprosy; and technical support for the execution of the food protection program and for the elimination of foot-and-mouth disease.

Technical cooperation among countries (TCC)

93. The aim of this project is to improve the national operating capacity in problem and priority areas through the exchange and transfer of knowledge and resources, principally with the bordering countries.

94. The exchange of knowledge and experiences will be promoted through effective creation of awareness of the importance and continuity of technical cooperation between the countries through the establishment of intercountry relations that will make it possible to establish contacts, negotiations, and fluid communications. Projects will be developed in critical areas between border countries in accordance with plans of action duly discussed between both governments.

95. In addition to the regular resources employed to carry out the activities indicated above, PAHO/WHO will continue to administer additional resources from several sources that will serve to strengthen and support these actions, such as resources from the World Bank for health services development, nutrition, and epidemiology; resources from Italy, France, and Germany for laboratories; resources from the Netherlands for the essential drugs project; regional funds for disaster preparedness; funds from the Inter-American Development Bank and Sweden for basic sanitation; and UNFPA funds for maternal and child health.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 1,852,400 | 67.3 | 2,086,100 | 65.4 | 2,288,900 | 65.8 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 560,300 | 20.3 | 599,400 | 18.8 | 666,500 | 19.1 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 560,300 | 20.3 | 599,400 | 18.8 | 666,500 | 19.1 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 59,700 | 2.2 | 67,700 | 2.1 | 76,800 | 2.2 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 59,700 | 2.2 | 67,700 | 2.1 | 76,800 | 2.2 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 251,600 | 9.1 | 290,700 | 9.1 | 316,700 | 9.1 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 251,600 | 9.1 | 290,700 | 9.1 | 316,700 | 9.1 |
| HEALTH POLICY DEVELOPMENT | | 0 | - | 64,600 | 2.0 | 73,300 | 2.1 |
| HEALTH POLICY ANALYSIS AND DEVELOPMENT | HDP | 0 | - | 64,600 | 2.0 | 73,300 | 2.1 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 810,700 | 29.5 | 963,000 | 30.2 | 1,050,400 | 30.3 |
| HEALTH SERVICES DEVELOPMENT | DHS | 810,700 | 29.5 | 944,700 | 29.6 | 1,029,600 | 29.7 |
| HEALTH EDUCATION AND COMMUNITY PARTICIPATION | HED | 0 | - | 18,300 | .6 | 20,800 | .6 |
| HUMAN RESOURCES DEVELOPMENT | | 170,100 | 6.2 | 100,700 | 3.2 | 105,200 | 3.0 |
| HUMAN RESOURCES EDUCATION | HRE | 170,100 | 6.2 | 100,700 | 3.2 | 105,200 | 3.0 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 903,800 | 32.7 | 1,100,700 | 34.6 | 1,193,800 | 34.2 |
| FOOD AND NUTRITION | | 0 | - | 104,000 | 3.3 | 117,900 | 3.4 |
| NUTRITION | NUT | 0 | - | 104,000 | 3.3 | 117,900 | 3.4 |
| ENVIRONMENTAL HEALTH | | 251,500 | 9.1 | 388,600 | 12.2 | 417,100 | 12.0 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 251,500 | 9.1 | 388,600 | 12.2 | 417,100 | 12.0 |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| MATERNAL AND CHILD HEALTH | | 169,100 | 6.1 | 167,500 | 5.3 | 182,800 | 5.2 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 169,100 | 6.1 | 167,500 | 5.3 | 182,800 | 5.2 |
| COMMUNICABLE DISEASES | | 416,200 | 15.1 | 398,600 | 12.5 | 429,200 | 12.3 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 416,200 | 15.1 | 398,600 | 12.5 | 429,200 | 12.3 |
| HEALTH PROMOTION | | 67,000 | 2.4 | 42,000 | 1.3 | 46,800 | 1.3 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 67,000 | 2.4 | 42,000 | 1.3 | 46,800 | 1.3 |
| GRAND TOTAL | | 2,756,200 | 100.0 | 3,186,800 | 100.0 | 3,482,700 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 1,131,900 | 60.8 | 0 | - | 0 | |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 1,131,900 | 60.8 | 0 | - | 0 | |
| HEALTH SERVICES DEVELOPMENT | OHS | 287,000 | 15.4 | 0 | - | 0 | |
| ESSENTIAL DRUGS AND VACCINES | EDV | 842,500 | 45.3 | 0 | - | 0 | - |
| ORAL HEALTH | ORH | 2,400 | .1 | 0 | - | 0 | - |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 731,800 | 39.2 | 721,600 | 100.0 | 0 | - |
| ENVIRONMENTAL HEALTH | | 2,700 | .1 | 0 | - | 0 | - |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 2,700 | .1 | 0 | - | 0 | - |
| MATERNAL AND CHILD HEALTH | | 246,000 | 13.2 | 0 | - | 0 | - |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 176,500 | 9.5 | 0 | - | 0 | - |
| IMMUNIZATION | EPI | 1,700 | .1 | 0 | - | 0 | - |
| DIARRHEAL DISEASES | CDD | 67,800 | 3.6 | 0 | - | 0 | - |
| COMMUNICABLE DISEASES | | 481,300 | 25.8 | 721,600 | 100.0 | 0 | - |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 30,100 | 1.6 | 0 | - | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 451,200 | 24.2 | 721,600 | 100.0 | 0 | - |
| VETERINARY PUBLIC HEALTH | | 1,800 | .1 | 0 | - | 0 | - |
| ZOONOSES | ZNS | 1,800 | .1 | 0 | - | 0 | - |
| GRAND TOTAL | | 1,863,700 | 100.0 | 721,600 | 100.0 | 0 | |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 899,300 | 2 | 0 | 140 | 435,000 | 38,800 | 27 | 54,000 | 139,700 | 24,400 | 0 | 207,400 |
| WHO - WR | 1,856,900 | 5 | 4 | 340 | 974,800 | 72,700 | 94 | 188,000 | 227,800 | 44,000 | 11,900 | 337,700 |
| TOTAL | 2,756,200 | 7 | 4 | 480 | 1,409,800 | 111,500 | 121 | 242,000 | 367,500 | 68,400 | 11,900 | 545,100 |
| % OF TOTAL | 100.0 | | | | 51.2 | 4.0 | | 8.8 | 13.3 | 2.5 | .4 | 19.8 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 978,400 | 2 | 0 | 288 | 576,600 | 40,900 | 5 | 10,000 | 58,400 | 8,500 | 0 | 284,000 |
| WHO - WR | 2,208,400 | 4 | 4 | 525 | 1,098,600 | 69,800 | 93 | 186,000 | 300,800 | 56,000 | 11,400 | 485,800 |
| TOTAL | 3,186,800 | 6 | 4 | 813 | 1,675,200 | 110,700 | 98 | 196,000 | 359,200 | 64,500 | 11,400 | 769,800 |
| % OF TOTAL | 100.0 | | | | 52.4 | 3.5 | | 6.2 | 11.3 | 2.0 | .4 | 24.2 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 1,070,400 | 2 | 0 | 288 | 616,000 | 46,400 | 5 | 10,000 | 66,300 | 9,600 | 0 | 322,100 |
| WHO - WR | 2,412,300 | 4 | 4 | 525 | 1,179,000 | 79,100 | 93 | 186,000 | 341,000 | 63,500 | 12,900 | 550,800 |
| TOTAL | 3,482,700 | 6 | 4 | 813 | 1,795,000 | 125,500 | 98 | 196,000 | 407,300 | 73,100 | 12,900 | 872,900 |
| % OF TOTAL | 100.0 | | | | 51.5 | 3.6 | | 5.6 | 11.7 | 2.1 | .4 | 25.1 |

## HEALTH SITUATION ANALYSIS

### Demography

1. The population of El Salvador in 1992, estimated on the basis of the projections formulated by the Bureau of Statistics and contained in the Preliminary Results of the National Population Center, was 5,303,480. The population growth rate for the period 1985-1990 was 1.9%, and the projections for the 1990s, 2.5%. The urban population accounts for 44% of the total, showing a tendency toward increase, particularly as a result of the population displacement brought on by the war, which ended in 1992. Most of the displaced persons have settled in the outskirts of San Salvador. The country has a high population density (275/km²). It is estimated that 1,870,000 people have been uprooted (repatriates, displaced persons, men demobilized from the armed forces and the Farabundo Martí Front for National Liberation (FMLN), and the population of the war-torn areas), who require health services in 115 municipalities that have been assigned high priority in the national reconstruction process.

### Health status indicators

2. Life expectancy at birth in 1990 was 63.5 years. Among males it is 59.8 years, and in females, 67.2 years.

3. The general and specific death rates were influenced by the armed conflict, which led to a high number of deaths from violent causes, mainly among young men. However, despite the conflict, a declining trend was observed in the 1980s.

4. Overall mortality fell from 10.6 to 8.4 per 1,000 population in 1990. Child mortality declined from 58 per 1,000 live births in 1986 to 55 per 1,000 in 1990. Maternal mortality was 1.4 per 1,000 live births in 1989.

5. The principal causes of infant and child mortality continue to be diarrheal and acute respiratory diseases. Diseases preventable by vaccination have been reduced notably in recent years as a cause of morbidity and death. Since October 1988, no cases of poliomyelitis have been registered.

6. Protein-energy malnutrition is prevalent (50.1%) in children, and 15.2% suffer from moderate and serious malnutrition. Growth retardation (height-for-age) is 30% in schoolchildren. One fourth of children under 5 years of age have nutritional anemia. Vitamin A deficiency and iodine deficiency affect 36% and 24.8% of schoolchildren, respectively. The proportion of children with low birthweight is 16%.

7. Malaria has shown a notable decline in recent years as a result of comprehensive measures and environmental management.

8. Dengue, AIDS, and the parasitic diseases are prevalent health problems.

9. The cholera epidemic that started in August 1991 had caused nearly 9,000 cases by the end of November 1992. Hospitalization rates have declined from 50.8% to 39.9%, and case fatalities fell from 3.6% in 1991 to 0.6% in 1992. The transmission factors are contaminated water and food.

### Factors affecting health status

10. The environmental sanitation situation, characterized by low coverage of water supply and sanitary disposal of excreta, continues to be critical, especially in the rural environment and urban fringe areas. Epidemiological studies have identified water contaminated with *V. cholerae* as one of the basic factors in the spread of cholera, particularly water improperly stored in homes. Untreated domestic and industrial wastewater is discharged directly into rivers and other bodies of water that are used for irrigation of fruit and vegetable crops. Sanitary treatment of solid and agricultural wastes is very inadequate, as is the use of agricultural chemicals, thereby increasing soil and food contamination.

11. Although the country's economy has shown positive growth in recent years, the poorest among the population have low incomes and are affected by unemployment or underemployment, inflationary trends, and the structural adjustment measures that continue to allocate meager financial resources to the social sectors. In order to reduce this impact, the Salvadoran Government has set up programs to provide compensatory benefits (Social Investment Funds (FIS), National Commission on Refugees (CONARA), and the Plan for Reconstruction (PRN)) and has increased the per capita health budget for 1993 from US$9.50 to US$14.80, which is still insufficient to meet basic health needs.

12. Illiteracy affects more than one third of the economically active population. The urban population attends school for an average of 4.7 years, and the rural population, 2.8 years. Certain traditional practices used in the management of certain diseases may prolong or aggravate the problems.

13. Health service coverage varies in accordance with the profile of needs. In the area of maternal and child health, coverage levels are: prenatal care, 70%; institutional deliveries, 67%; and monitoring of child growth and development, 45%. With regard to diseases preventable by vaccination, adequate levels of coverage have been attained in some regions of the country, although efficient technical coverage has still not been achieved with regard to measles, tetanus toxoid, and DPT. Coverage of vaccination programs is being extended, which is expected to produce good results.

Plans and priorities for national health development

14. The objective of the National Health Plan for 1991-1994 is to extend health services to the entire population, focusing on groups at risk through measures aimed basically at preventive care and health promotion. A major objective is to set up a national health system under the leadership of the Ministry of Public Health that will provide universal access for the population, with the collaboration of all the social groups that make up Salvadoran society.

15. The basic strategies are the following:

15.1 Extension of health coverage to the entire population.

15.2 Increase in the capacity and effectiveness of all care levels, with universal coverage and quality control.

15.3 Decentralization and deconcentration of health care through strengthening of the health services at the regional and local levels.

15.4 Financial strengthening of the sector through public spending on health, the search for alternative sources of funding, the participation of various social groups (municipalities, NGOs, community groups), rationalization of spending, and recovery of costs by charging for services provided.

15.5 Institutional development through the use of modern administrative and managerial procedures and techniques that will permit greater efficiency and provide the ability to solve problems.

15.6 Interinstitutional and intersectoral coordination, mobilizing the entire civil society around human development, coordinating efforts, and focusing on priorities.

15.7 Coordination of external cooperation, channeling it toward the priorities identified in the National Health Plan and the National Reconstruction Plan, and utilizing it to complement national efforts in the short and medium term.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

National priority areas for technical cooperation

16. The priorities for external cooperation are:

16.1 Support for the development of local health systems.

16.2 Strengthening of the processes of decentralization and deconcentration at the regional and local levels, including the development of managerial information systems, the implementation of a personnel roster, and consolidation of supply systems, logistic support, and administrative and accounting efficiency.

16.3 Support for the training of human resources, with emphasis on health workers and auxiliary and technical personnel. In addition, support is required for the training of specialists in public health administration through a graduate-level course that will produce the critical mass needed for administrative and managerial reform of the health services in all institutions of the sector.

16.4 Support for programs to increase the coverage and quality control of the basic environmental health programs with participation by the community, municipalities, and NGOs.

16.5 Strengthening of projects to modernize and reconstruct the physical capacity installed in hospitals, health centers, and health units, increasing maintenance of the establishments and equipment.

16.6 Participation in the prevention and control of prevalent communicable diseases (cholera, malaria, dengue, AIDS, tuberculosis, acute diarrhea, acute respiratory infections).

16.7 Support for health promotion through health education and the participation of various social groups with a view to bringing about changes in behavior and conditioning factors, placing emphasis on self-care and group action.

16.8 Support for the epidemiological analysis system to hlep find solutions to risk factors and determine the most appropriate and timely interventions. Special emphasis is to be placed on the control and elimination of diseases preventable by vaccination and on the control and prevention of AIDS, tuberculosis, and vector-borne diseases.

16.9 Support for the consolidation of programs on women, health, and development and on family protection.

National priorities for technical cooperation from PAHO/WHO

17. The Ministry of Public Health has requested PAHO/WHO to provide technical cooperation in the priority areas indicated above, in close coordination with other external agencies and cooperating countries. The Interagency Committee for Technical Cooperation is expected to be formalized, which will make it possible to harmonize efforts and complement the actions agreed to within national guidelines, as well as those deriving from international commitments made at Central American and regional forums.

18. In addition to carrying out the projects described in the following section with PAHO/WHO regular funds, PAHO/WHO will continue to mobilize the national and external resources, obtained in the framework of the Central American Initiative. In the case of El Salvador, activities are planned in the following technical areas: development of local health systems; rehabilitation of the

disabled; environment and health; women, health, and development; prevention and control of malaria and dengue; prevention and control of AIDS; maintenance of health equipment; development of managerial capacity; essential drugs; human resources development; comprehensive care of displaced populations; immunization; disaster preparedness; and control of maternal mortality.

19. Furthermore, PAHO/WHO, through INCAP, will continue to provide technical cooperation in the area of food and nutrition.

## PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

### Managerial support for national health development (MPN)

20. The purpose of this project is to provide technical and administrative support to the Government of El Salvador in keeping with the spirit and objectives of the PAHO/WHO mission, the SOPPs, and the resolutions of the Governing Bodies, the presidential summit meetings, and the various forums on Central American integration.

21. Cooperation will be provided for consolidation of the National Health System under the Ministry of Public Health and Social Welfare (MSPAS) as the regulatory and coordinating entity of the various governmental institutions and NGOs, with the aim of extending health coverage to the entire Salvadoran population.

22. Central American integration in health matters will be promoted at the Special Meeting of the Health Sector of Central America (RESSCA), the Council of Ministers of Health of Central America (COMISCA), the Central American Council of Social Security Institutions (COCISS), the presidential summit meetings, and other forums, with the purpose of carrying out joint actions aimed at multiplying national efforts and fostering a spirit of solidarity.

23. The PAHO/WHO Representative Office will continue to be developed in order to enable it to fulfill the Organization's mission with regard to health policies, efficient administrative management, and management of scientific and technical knowledge.

### Technical cooperation among countries (TCC)

24. The purpose of this project is to support the development of intercountry programs and promote Central American integration by solving and managing common problems.

25. Support will be provided to identify and resolve common problems among countries of the Central American isthmus.

26. Participation in intercountry actions in border areas will be promoted regarding scientific and technical exchanges, development of human resources, health legislation to complement efforts, and initiatives oriented toward integration.

### Health situation and trend assessment (HST)

27. The purpose of this project is to strengthen assessment of the health situation and health trends in order to formulate, monitor, and evaluate health programs and build greater capacity for management and leadership in the health sector.

28. Cooperation will be provided in formulating a methodology for assessing the health situation as a managerial instrument at the national and local levels.

29. Epidemiological surveillance aimed at defining risk factors and groups will be strengthened.

30. Technical cooperation will be provided to develop the capacity to monitor and evaluate the impact of health actions at the level of the local health systems.

31. Support will be provided for the training and ongoing development of human resources, and the development of epidemiology and information systems for the monitoring, evaluation, and management of the health services.

### Health services development (DHS)

32. The purpose of this project is to consolidate the development of local health systems as the impetus for technical and administrative decentralization and as places for promoting concerted action by all social groups (local governments, NGOs, grass-roots organizations).

33. Cooperation will be provided for implementing the policies and strategies of the National Health Plan, which are aimed at extending coverage to the entire population through transformation of the service-delivery model and the use of an epidemiological risk approach.

34. Technical cooperation will be provided in technical, administrative, and managerial modernization at all care levels, giving special importance to community participation and interinstitutional coordination.

35. Support will be provided for updating laws and regulations that encourage the decentralization and deconcentration of human, physical, financial, and institutional resources, expanding the participation of local groups.

36. In addition, cooperation will be provided for developing mechanisms to promote interinstitutional and intersectoral coordination.

37. Support will be provided for efforts to coordinate external cooperation, focusing it on the priorities identified in the National Health Plan, the National Reconstruction Plan, and the National Plan for Economic and Social Development.

38. Cooperation will be provided for strengthening the essential drugs program at all health care levels, with emphasis on institutional pharmacies, quality control, education of users, and proper use of drugs.

39. Cooperation will be provided to increase dental care coverage through the use of new techniques at all health establishments and levels. Support will be provided for the fluoridation of table salt as a preventive measure.

Human resources education (HRE)

40. The purpose of this project is to strengthen the training of health workers, including workers in the Ministry of Public Health and Social Welfare, the Salvadoran Social Security Institute (ISSS), the universities, and the private learning centers, emphasizing the training of personnel for the local health systems.

41. Support will be provided for consolidation of the Human Resources Unit of the MSPAS, which will organize training for workers in the sector in accordance with national needs.

42. Cooperation will be provided in the form of human resource training centers at the university and technical levels, both in the development of the necessary infrastructure and in the formulation of methodologies and educational strategies for the process of continuing education, integration of training and service, long-distance education, availability of scientific and technical information, and incentives for intellectual production.

43. Cooperation will be provided in the development of courses in public health and public health administration to achieving the critical mass required for leadership and management of the country's health services.

Community water supply and sanitation (CWS)

44. The purpose of this project is to strengthen the basic environmental health programs (water supply, sanitary disposal of excreta and solid wastes, and control of water and soil contamination) in priority areas with limited coverage.

45. Increasing the coverage of drinking water services and sanitary disposal of excreta will be promoted in urban fringe and rural areas.

46. Cooperation will be provided for strengthening quality control of water for human consumption to support the prevention and control of acute diarrheal diseases and cholera.

47. Support will be provided for the introduction of appropriate technologies for the development of water and basic sanitation programs in marginalized regions (equipment for disinfection of water, hypochlorinators, Venturi and MOGGOD chlorination equipment, fiberglass latrines, hand pumps, etc.).

48. Cooperation will be provided for implementing environmental pollution control measures as part of the National Environmental Health Plan.

49. Cooperation will be provided for developing an emergency preparedness and disaster relief program.

Growth, development and human reproduction (MCH)

50. The purpose of this project is to strengthen health care services for mothers, infants, and schoolchildren, with emphasis on suburban and rural areas.

51. Strengthening of the EPI will be continued to attain the goals of eradication of poliomyelitis and elimination of measles and neonatal tetanus, as well as achieving adequate technical coverage for other diseases preventable by vaccination.

52. Cooperation will be provided for strengthening the programs for control and prevention of diarrheal and acute respiratory diseases with the purpose of reducing the current rates of mortality and morbidity by more than 50%. Comprehensive approaches will be developed for linking the activities of these programs with those of the programs on environmental health, food protection, safe hygiene practices, and permanent social participation.

53. Support will be provided for the actions carried out by the National Department of Family Affairs to protect women, children, adolescents, and the elderly.

General communicable disease prevention and control activities (OCD)

54. The purpose of this project is to consolidate the advances made to date in communicable disease prevention and control with respect to technological applicability, environmental management, healthy lifestyles, and the feasibility of eliminating such diseases with available technical resources.

55. Cooperation will be provided for strengthening the capacity of the health services at the local level in the areas of epidemiological surveillance, prevention measures, and preventable disease control.

56. Support will be provided for the elimination of leprosy through the use of current epidemiological and therapeutic guidelines.

57. Community participation will be promoted for the prevention and control of preventable disease.

Health promotion and prevention and control of noncommunicable diseases (NCD)

58. The purpose of this project is to strengthen the development of healthy lifestyles, self-care, and the control and prevention of chronic problems through policies and actions that assign special importance to the promotion and protection of health.

59. Cooperation will be provided for the incorporation of health promotion actions in the local health systems, with emphasis on prevention and timely control.

60. Support will be provided for health promotion actions with a multisectoral and multi-institutional approach, giving particular importance to the NGOs that are working to encourage behavior patterns and lifestyles that are favorable to healthy human development.

61. Development of the National Mental Health Plan will be promoted, emphasizing integrated actions in local and general health care services. In addition, support will be provided for psychosocial development activities at the community level with the participation of MSPAS, ISSS, and NGOs.

62. Programs for community-based rehabilitation (CBR) will continue to be strengthened, emphasizing the areas affected by the armed conflict and the institutions responsible for care of the disabled.

Zoonoses (ZNS)

63. The purpose of this project is to support the development of programs for the prevention, control, and elimination of the zoonoses prevalent in El Salvador and to promote good food manufacturing and protection practices in coordination with other sectors and with the national and international organizations involved in the development of animal health.

64. Support will be provided for the production of rabies vaccine in MSPAS laboratories in order to meet national needs.

65. Cooperation will be provided in epidemiological surveillance of the most frequent zoonoses through the Ministry of Agriculture (MAG) and the MSPAS.

66. Support will be given to strengthen food control programs and train personnel in local systems and governments.

67. Support will be given to strengthen joint work with FAO, INCAP, the Italian cooperation agency, INPPAZ, and PANAFTOSA in order to coordinate technical cooperation for El Salvador and focus on the priority areas under the National Health Plan and the National Plan for Socioeconomic Development.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 1,496,200 | 67.0 | 1,767,300 | 69.0 | 1,948,500 | 69.1 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 619,100 | 27.7 | 833,200 | 32.4 | 929,500 | 32.9 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 619,100 | 27.7 | 833,200 | 32.4 | 929,500 | 32.9 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 53,100 | 2.4 | 60,200 | 2.4 | 68,300 | 2.4 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 53,100 | 2.4 | 60,200 | 2.4 | 68,300 | 2.4 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 42,500 | 1.9 | 42,600 | 1.7 | 48,400 | 1.7 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 42,500 | 1.9 | 42,600 | 1.7 | 48,400 | 1.7 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 706,100 | 31.6 | 762,700 | 29.8 | 824,500 | 29.3 |
| HEALTH SERVICES DEVELOPMENT | DHS | 706,100 | 31.6 | 762,700 | 29.8 | 824,500 | 29.3 |
| HUMAN RESOURCES DEVELOPMENT | | 75,400 | 3.4 | 68,600 | 2.7 | 77,800 | 2.8 |
| HUMAN RESOURCES EDUCATION | HRE | 75,400 | 3.4 | 68,600 | 2.7 | 77,800 | 2.8 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 737,400 | 33.0 | 792,800 | 31.0 | 868,500 | 30.9 |
| ENVIRONMENTAL HEALTH | | 344,600 | 15.4 | 384,700 | 15.0 | 419,800 | 14.9 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 344,600 | 15.4 | 384,700 | 15.0 | 419,800 | 14.9 |
| MATERNAL AND CHILD HEALTH | | 51,800 | 2.3 | 43,900 | 1.7 | 48,100 | 1.7 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 51,800 | 2.3 | 43,900 | 1.7 | 48,100 | 1.7 |
| COMMUNICABLE DISEASES | | 265,500 | 11.9 | 304,200 | 11.9 | 333,900 | 11.9 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 265,500 | 11.9 | 304,200 | 11.9 | 333,900 | 11.9 |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| HEALTH PROMOTION | | 53,900 | 2.4 | 38,000 | 1.5 | 42,300 | 1.5 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 53,900 | 2.4 | 38,000 | 1.5 | 42,300 | 1.5 |
| VETERINARY PUBLIC HEALTH | | 21,600 | 1.0 | 22,000 | .9 | 24,400 | .9 |
| ZOONOSES | ZNS | 21,600 | 1.0 | 22,000 | .9 | 24,400 | .9 |
| GRAND TOTAL | | 2,233,600 | 100.0 | 2,560,100 | 100.0 | 2,817,000 | 100.0 |

## PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 4,965,900 | 80.4 | 0 | - | 0 | |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 11,300 | .2 | 0 | - | 0 | |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 11,300 | .2 | 0 | - | 0 | |
| HEALTH POLICY DEVELOPMENT | | 200 | .* | 0 | - | 0 | - |
| WOMEN, HEALTH AND DEVELOPMENT | WHD | 200 | .* | 0 | - | 0 | - |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 4,954,400 | 80.2 | 0 | - | 0 | - |
| HEALTH SERVICES DEVELOPMENT | DHS | 4,943,100 | 80.0 | 0 | - | 0 | - |
| DISASTER PREPAREDNESS | DPP | 11,300 | .2 | 0 | - | 0 | - |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 1,205,900 | 19.6 | 925,000 | 100.0 | 0 | - |
| ENVIRONMENTAL HEALTH | | 35,500 | .6 | 0 | - | 0 | - |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 35,500 | .6 | 0 | - | 0 | - |
| MATERNAL AND CHILD HEALTH | | 375,400 | 6.1 | 0 | - | 0 | - |
| DIARRHEAL DISEASES | CDD | 375,400 | 6.1 | 0 | - | 0 | - |
| COMMUNICABLE DISEASES | | 783,500 | 12.7 | 925,000 | 100.0 | 0 | - |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 197,300 | 3.2 | 0 | - | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 361,100 | 5.9 | 360,000 | 38.9 | 0 | - |
| MALARIA | MAL | 225,100 | 3.6 | 565,000 | 61.1 | 0 | - |
| HEALTH PROMOTION | | 11,500 | .2 | 0 | - | 0 | - |
| OCULAR HEALTH | PBD | 11,500 | .2 | 0 | - | 0 | - |
| GRAND TOTAL | | 6,171,800 | 100.0 | 925,000 | 100.0 | 0 | |

* LESS THAN .05 PER CENT

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 1,001,300 | 2 | 0 | 115 | 437,300 | 30,100 | 76 | 152,000 | 206,700 | 57,900 | 0 | 117,300 |
| WHO - WR | 1,232,300 | 3 | 3 | 170 | 671,400 | 32,600 | 60 | 120,000 | 78,900 | 46,600 | 0 | 282,800 |
| TOTAL | 2,233,600 | 5 | 3 | 285 | 1,108,700 | 62,700 | 136 | 272,000 | 285,600 | 104,500 | 0 | 400,100 |
| % OF TOTAL | 100.0 | | | | 49.6 | 2.8 | | 12.2 | 12.8 | 4.7 | .0 | 17.9 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 1,129,400 | 2 | 1 | 82 | 525,300 | 72,900 | 20 | 40,000 | 225,600 | 80,400 | 0 | 185,200 |
| WHO - WR | 1,430,700 | 3 | 3 | 150 | 797,100 | 46,300 | 48 | 96,000 | 78,200 | 114,600 | 0 | 298,500 |
| TOTAL | 2,560,100 | 5 | 4 | 232 | 1,322,400 | 119,200 | 68 | 136,000 | 303,800 | 195,000 | 0 | 483,700 |
| % OF TOTAL | 100.0 | | | | 51.6 | 4.7 | | 5.3 | 11.9 | 7.6 | .0 | 18.9 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 1,243,900 | 2 | 1 | 82 | 564,200 | 82,700 | 20 | 40,000 | 255,900 | 91,100 | 0 | 210,000 |
| WHO - WR | 1,573,100 | 3 | 3 | 150 | 867,500 | 52,500 | 48 | 96,000 | 88,600 | 130,000 | 0 | 338,500 |
| TOTAL | 2,817,000 | 5 | 4 | 232 | 1,431,700 | 135,200 | 68 | 136,000 | 344,500 | 221,100 | 0 | 548,500 |
| % OF TOTAL | 100.0 | | | | 50.9 | 4.8 | | 4.8 | 12.2 | 7.8 | .0 | 19.5 |

## HEALTH SITUATION ANALYSIS

### Demography

1. Although the populations of the French Departments of Martinique, Guadeloupe and French Guiana are all relatively young, there is a marked difference in the population densities. French Guiana has a very low population density, 1.03 km², while that of Guadeloupe and Martinique in 1990 was 201 and 312 per km², respectively. The 1990 estimates of total population for French Guiana, Guadeloupe and Martinique are 95,540, 339,672 and 337,101, respectively.

### Health status indicators

2. The life expectancy at birth is estimated at 68 years for men and 75 years for women in Guadeloupe, 72 years for men and 76 years for women in Martinique, and 65 years for men and 74 years for women in French Guiana. All three territories show an increase in the birth rate: French Guiana is 31.04 per 1,000 population, Guadeloupe 21 per 1,000 and Martinique 19.0 per 1,000.

3. The infant mortality rate however have decreased in all instances in 1988: 24.6 per 1,000 in French Guiana; 8.6 per 1,000 in Martinique, and 12.9 per 1,000 in Guadeloupe. Although there is a decrease in infant mortality rate (IMR), analysis has shown that the major causes are within the perinatal period. Among the children 0-14 years, accidents and pediatric AIDS are major concerns.

4. Infectious diseases continue to pose serious health threats, dengue fever in particular, and malaria. Dengue is endemic in French Guiana and in that territory, the incidence of malaria increased with 3,000 chloroquine resistant cases in 1988.

5. The main causes of morbidity in the adult population are cardiovascular disease, hypertension and diabetes, cancer and disorders due to alcoholism and accidents.

6. Sexually transmitted diseases, including AIDS, continue to be of public health concern. AIDS is becoming a major concern with 537 cases in the region as of the 31 March 1990, an incidence of 68.8 per 100,000. The majority of the cases are within the 30-39 year age group with the mode of transmission being primarily heterosexual.

### Factors affecting health status

7. The population in these territories are served by a wide range of primary care and secondary care services but certain groups, specifically the immigrant populations of St. Martin and Guadeloupe administrated by French Guiana are not covered by the social security system.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

8. Inspection Regionale de la Sante des Antilles Guiana has identified these major priority areas for technical cooperation: development of human resources for tertiary care; promotion of health lifestyles; reduction of transmission of the HIV virus; and greater coordination of activities with neighboring states.

### National priorities for technical cooperation from PAHO/WHO

9. PAHO/WHO will support the attachment of health personnel from the French Territories to English-speaking Caribbean institutions and other extraregional training facilities when appropriate. In the area of health promotion, PAHO will assist with the development of culturally relevant educational materials, specifically for the immigrant population.

## PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

### Health services development (DHS)

10. The purpose of this project is to increase the capacity to meet the health needs of the local population. To achieve this purpose it will be necessary to distribute health promotion material and appropriate social communication; develop suitable health promotion and social communication strategies; and utilize training opportunities to develop human resources.

## PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 153,800 | 100.0 | 169,000 | 100.0 | 185,700 | 100.0 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 153,800 | 100.0 | 169,000 | 100.0 | 185,700 | 100.0 |
| HEALTH SERVICES DEVELOPMENT | DHS | 153,800 | 100.0 | 169,000 | 100.0 | 185,700 | 100.0 |
| GRAND TOTAL | | 153,800 | 100.0 | 169,000 | 100.0 | 185,700 | 100.0 |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT $ | PERSONNEL PROF. POSTS | PERSONNEL LOCAL POSTS | PERSONNEL CONS. DAYS | PERSONNEL AMOUNT $ | DUTY TRAVEL AMOUNT $ | FELLOWSHIPS MONTHS | FELLOWSHIPS AMOUNT $ | SEMINARS AND COURSES $ | SUPPLIES AND EQUIPMENT $ | GRANTS $ | OTHER $ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 80,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 80,000 |
| WHO - WR | 73,800 | 0 | 0 | 30 | 20,500 | 8,000 | 18 | 36,000 | 5,400 | 3,900 | 0 | 0 |
| TOTAL | 153,800 | 0 | 0 | 30 | 20,500 | 8,000 | 18 | 36,000 | 5,400 | 3,900 | 0 | 80,000 |
| % OF TOTAL | 100.0 | | | | 13.3 | 5.2 | | 23.4 | 3.5 | 2.5 | .0 | 52.1 |
| 1994-1995 | | | | | | | | | | | | |
| WHO - WR | 169,000 | 0 | 0 | 30 | 22,500 | 9,100 | 18 | 36,000 | 6,100 | 4,500 | 0 | 90,800 |
| TOTAL | 169,000 | 0 | 0 | 30 | 22,500 | 9,100 | 18 | 36,000 | 6,100 | 4,500 | 0 | 90,800 |
| % OF TOTAL | 100.0 | | | | 13.3 | 5.4 | | 21.3 | 3.6 | 2.7 | .0 | 53.7 |
| 1996-1997 | | | | | | | | | | | | |
| WHO - WR | 185,700 | 0 | 0 | 30 | 24,400 | 10,300 | 18 | 36,000 | 6,900 | 5,100 | 0 | 103,000 |
| TOTAL | 185,700 | 0 | 0 | 30 | 24,400 | 10,300 | 18 | 36,000 | 6,900 | 5,100 | 0 | 103,000 |
| % OF TOTAL | 100.0 | | | | 13.1 | 5.5 | | 19.4 | 3.7 | 2.7 | .0 | 55.6 |

## HEALTH SITUATION ANALYSIS

### Demography

1. Grenada, Petit Martinique and Carriacou had a population in 1992 of 90,691 with a growth rate of 0.3%.

### Indicators of health status

2. The life expectancy at birth was 66.7 years and 73.1 years for males and females respectively in 1980. The crude death rate has remained at 10 per 1,000 population - Infant mortality is 18%.

3. The leading causes of overall mortality in 1992 were diabetes mellitus, disease of the pulmonary circulation, acute myocardial infarction, bronchitis, emphysema, hypertensive disease, diseases of the digestive system. Within the 0-5 age groups, perinatal conditions, pneumonia and gastroenteritis are the principal causes of death. The number of low birth weight babies varied between 5%-9%.

### Factors affecting health status

4. The delivery of health care at the St. Georges Hospital continues to be a concern. Problems with the equipment continue to plague the Ministry and affecting health care. The environmental health situation also continues to be a dominant concern, particularly in the area of sewerage disposal, notwithstanding the improvement of the system. In some rural communities all areas of environmental health remain a priority. With the cholera epidemic being present, food protection and the food handling by itinerant vendors and food handlers in large institutions are also a concern. In addition, the situation is compounded by a fiscal deficit. The Government began a structural adjustment program which called for manpower rationalization, thus affecting health severely.

5. The health system continues to maintain its coverage. A number of rehabilitative studies were done which provided options for the St. Georges Hospital, but no decisions have been made. In addition, the Princess Alexandra Hospital needs improved organization and management. The Hillsborough hospital has been rehabilitated, but with the restraint in spending, the institution has not been fully staffed and is not able to serve Carriacou and Petit Martinique effectively. The importance of planning and programming within this stringent economic environment is vital. Studies in relation to a cost-recovery program for St. Georges Hospital were provided, but no decision has been made.

### Plans and priorities for national health development

6. The Ministry continues to embrace the Caribbean Cooperation in Health initiative (CCH) and has developed its plans in accordance with the Goals and Targets. The priorities for the Ministry are those for the CCH and are summarized below.

7. In the critical area of human resources or manpower development, the Government will embark upon an organized approved training of health care workers (including physicians). The purpose is to equip them with such advanced knowledge and skills as to enhance their capabilities to deal with the increasing complexities of health care. Furthermore, the creation locally of such a cadre of health professionals is likely to assist in meeting our manpower needs and to stem the "brain drain" from the health sector.

8. The physical environment is crucial to the maintenance of a viable ecosystem. The Government, therefore, attempts to ensure that development activities will not destroy this balance and will enforce regulations to ensure and maintain a sanitary, pollution-controlled, and healthy environment and will strengthen national efforts at coordinating and managing environmental initiatives.

9. Recognizing the advantages of regional efforts, the Government will support regionalization of health services, in areas such as surveillance, diagnosis, treatment and rehabilitation of specific and predetermined cases. In particular, the Government will support the principle of sharing of services among the Organization of Eastern Caribbean States (OECS) through the proposed OECS health desk. The Government will seek to establish a vibrant and innovative health education policy. The Government, accepting that the maintenance of health is the key to productivity in the enhancement of family life, to the overall quality of life and to its national image, will also provide incentives for health personnel and communities to be involved in health promotion, maintenance and rehabilitation within their local health systems. The Government wishes to continue to develop a functional and computerized health information system that will provide support for the various activities and management decisions related to "Health for All".

10. The Government is committed to disaster preparedness including the design of buildings based on structural standards recommended by the Caribbean Uniform Building Code (CUBIC). While acknowledging both global and local impact of HIV infection and AIDS, the Government will continue to collaborate with efforts consistent with WHO strategies; and by mobilization of financial, human and other resources from local and overseas agencies work towards the prevention and control of this deadly disease. Recognizing the threats that work-related hazards pose to the safety and health of workers, the Government will implement and enforce regulations that will protect workers' health and ensure their safety at all work sites. Substance abuse, including alcohol and cigarette smoking, have contributed to the destruction of human lives. The Government will therefore utilize multi-sectoral and multi-disciplinary approaches to prevent and control these conditions, as well as provide treatment and rehabilitative services as needed. The Government will continue to give priority in the provision of health services to vulnerable and high-risk groups such as the poor, children, expectant and nursing mothers, the elderly, the chronically ill, drug addicts and disabled persons.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

11. As a result of the Joint Evaluation Meeting in 1991, the following areas have been identified for external assistance: development of operational research into areas such as neonatal jaundice, sickle cell anaemia, rheumatic fever; analysis of the functioning of the district health system including information and managerial aspects; development of solid waste master plan and sanitary landfill; increased coverage in potable water and sewerage; development of the education program for vector control and a study in the resistance of Aedes Aegypti to insecticides; development of a lifestyle program with emphasis on health promotion in relation to AIDS, hypertension and diabetes; establishment of a quality assurance program for hospitals; mobilization of resources for the prevention and control of AIDS and other sexually transmitted diseases; involvement of NGOs and establishment of linkages with other NGOs; development of a strategic health plan with the strengthening of the planning process; support the human resource development needs; strengthen the food protection program; development of an adolescent program, including school health; and support efforts to reduce perinatal mortality rate.

12. The French Government has provided personnel with expertise in the area of epidemiology and communicable diseases. In addition support is being given in the improvement in the physical infrastructure. Through OLADE and UNDP the water supply systems in the hospitals in Grenada are being improved.

### National priorities for technical cooperation from PAHO/WHO

13. The priority areas for technical cooperation from PAHO/WHO during the biennium are the seven priority areas of the Caribbean Cooperation in Health. It was decided that the community health services and the improvement in the management of St. Georges Hospital are important priorities, in addition to the environment and human resource development.

14. In addition to the projects under the regular budget, extrabudgetary resources were mobilized for the following projects within the Caribbean Cooperation in Health: the management of the community health information system funded by the Inter-American Development Bank; projects are supported by the Italian Government in the following areas: maternal and child health; community based vector control and community based rehabilitation. A project for the prevention and control of cancer of the cervix is funded by the French Government. USAID has also approved a project which seeks to address financing, policy formulation and management of the system and UNDCP will be supporting activities relating to drug abuse.

## PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

### Community water supply and sanitation (CWS)

15. The purpose of the project is to increase the national capacity to address problems in environmental health. To achieve this purpose it will be necessary to expand the food protection program; conduct studies on the resistance of Aedes Aegypti to insecticides; support the development of a solid waste master plan; and develop educational material for vector control.

### Health services development (DHS)

16. The purpose of this project is to improve the quality of health care services. Achieving this purpose will require a review of the functioning of the district health system and recommendations for improvements; health promotion programs which focus on diabetes and hypertension in the first instance; the introduction of quality assurance systems in hospitals; improvements in the planning process; and training in critical areas.

### Growth, development and human reproduction (MCH)

17. The purpose of the project is to increase the national capacity to management MCH programs. To achieve this it will be necessary to provide training in midwifery, perinatal care and adolescent health; collect data relating to child abuse and neglect; and support the development of programs geared to the needs of adolescents.

## PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 124,200 | 79.0 | 129,800 | 78.1 | 135,600 | 77.2 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 124,200 | 79.0 | 129,800 | 78.1 | 135,600 | 77.2 |
| HEALTH SERVICES DEVELOPMENT | DHS | 124,200 | 79.0 | 129,800 | 78.1 | 135,600 | 77.2 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 33,000 | 21.0 | 36,300 | 21.9 | 40,000 | 22.8 |
| ENVIRONMENTAL HEALTH | | 25,200 | 16.0 | 27,500 | 16.6 | 30,000 | 17.1 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 25,200 | 16.0 | 27,500 | 16.6 | 30,000 | 17.1 |
| MATERNAL AND CHILD HEALTH | | 7,800 | 5.0 | 8,800 | 5.3 | 10,000 | 5.7 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 7,800 | 5.0 | 8,800 | 5.3 | 10,000 | 5.7 |
| GRAND TOTAL | | 157,200 | 100.0 | 166,100 | 100.0 | 175,600 | 100.0 |

## PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| III. HEALTH SCIENCE AND TECHNOLOGY | | 115,200 | 100.0 | 101,600 | 100.0 | 0 | |
| COMMUNICABLE DISEASES | | 105,300 | 91.4 | 101,600 | 100.0 | 0 | |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 105,300 | 91.4 | 101,600 | 100.0 | 0 | |
| HEALTH PROMOTION | | 9,900 | 8.6 | 0 | - | 0 | - |
| OCULAR HEALTH | PBD | 9,900 | 8.6 | 0 | - | 0 | - |
| GRAND TOTAL | | 115,200 | 100.0 | 101,600 | 100.0 | 0 | |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL AMOUNT | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 157,200 | 0 | 0 | 60 | 17,200 | 9,300 | 39 | 78,000 | 24,300 | 16,800 | 0 | 11,600 |
| TOTAL | 157,200 | 0 | 0 | 60 | 17,200 | 9,300 | 39 | 78,000 | 24,300 | 16,800 | 0 | 11,600 |
| % OF TOTAL | 100.0 | | | | 10.9 | 5.9 | | 49.6 | 15.5 | 10.7 | .0 | 7.4 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 166,100 | 0 | 0 | 60 | 18,000 | 10,500 | 39 | 78,000 | 27,600 | 19,000 | 0 | 13,000 |
| TOTAL | 166,100 | 0 | 0 | 60 | 18,000 | 10,500 | 39 | 78,000 | 27,600 | 19,000 | 0 | 13,000 |
| % OF TOTAL | 100.0 | | | | 10.8 | 6.3 | | 47.1 | 16.6 | 11.4 | .0 | 7.8 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 175,600 | 0 | 0 | 60 | 18,200 | 11,900 | 39 | 78,000 | 31,300 | 21,500 | 0 | 14,700 |
| TOTAL | 175,600 | 0 | 0 | 60 | 18,200 | 11,900 | 39 | 78,000 | 31,300 | 21,500 | 0 | 14,700 |
| % OF TOTAL | 100.0 | | | | 10.4 | 6.8 | | 44.4 | 17.8 | 12.2 | .0 | 8.4 |

## HEALTH SITUATION ANALYSIS

### Demography

1. The estimated population of Guatemala in 1993 is 10,055,401. The population is predominantly rural (67%), and widely scattered. Indigenous groups make up 58% of the population. Altogether they speak 23 languages and numerous dialects, with a high degree of monolingualism. The children group under 15 years of age makes up 64% of the total population, and women of childbearing age comprise 23% of the total population.

2. The fertility rate (5.6), birth rate (37 per 1,000) and the natural growth of the population (3.0% annual) are among the highest in Latin America. The current trend means that the population doubles every 23 years, with all the consequences that such growth implies for the delivery of social services.

### Health status indicators

3. The health conditions of Guatemala are among the most deficient in the Region, comparable to the least developed countries. This is reflected in high mortality rates: infant (57 per 1,000), preschool child (10 per 1,000) and maternal (27 per 1,000), with 60% of the causes of deaths preventable and treatable with low-cost technologies.

4. Life expectancy at birth was 59.1 years for men and 63.8 years for women in 1989 and increased to 60.2 and 65.9, respectively, in 1991.

5. The total death rate in 1990 was 7.67 per 1,000 population. Deaths among children under 5 years old represented 41% of all deaths.

6. The highest death rates were reported in the under-5 and over-65 age groups.

7. The leading causes of death in 1990 were: Intestinal infectious diseases; Pneumonia; signs, symptoms, and ill-defined conditions; Measles; certain conditions originating in the perinatal period; nutritional deficiencies; various forms of heart disease.

8. For that same year, the leading causes of seeking health services were: Acute respiratory infections; acute diarrhea; malnutrition; measles.

9. Chronic noncommunicable diseases are an important problem in urban areas. Heart and cerebrovascular diseases are among the leading causes of death there.

10. Tuberculosis, malaria, dengue, onchocerciasis, and AIDS stand out as the main infectious diseases of growing importance in recent years, affecting the most deprived population groups.

11. The food and nutrition situation of the Guatemalan population is reflected in the prevalence of malnutrition in 33.6% of children between 6 and 36 months and in the chronic deficiency found in 37.4% of schoolchildren with low height-for-age. In addition, specific deficiencies of iron, vitamin A, and iodine affect vulnerable groups, including schoolchildren and adolescents. The direct cause of this situation is the extreme poverty that affects 64.5% of the population, as a result of which they do not have access to basic foods, much less to basic services.

### Factors affecting health status

12. Only a third of the population is considered economically active. The levels of poverty and extreme poverty, currently 89% and 65%, respectively, have doubled in the past decade. Women and indigenous groups still face discrimination in the distribution of goods and services.

13. Only 42% of the dwellings have water and 46% have latrines. In addition, there is a severe general shortage of housing (in quality and quantity). 58% of the population is illiterate, and access to education is limited.

14. An estimated 5% of wastewater receives some treatment. Solid waste disposal is deficient; the capital city produces 1,000 tons a day, which are disposed of without any treatment. Other cities in the country lack an urban sanitation system. In the metropolitan area (Guatemala City), environmental deterioration has increased due to an excess of industrial contaminants.

15. Since 1982, the Expanded Program on Immunization (EPI) has been gradually implemented in the country. In 1985 vaccination coverage for the different biologicals for infants under 1 year old had not reached 10%, but by 1990 these figures had increased to more than 60%. Similarly, morbidity and mortality due to diseases preventable by vaccination have declined significantly, without any reported cases of secondary paralytic poliomyelitis from wild poliovirus since September 1990 or any cases of diphtheria since 1991.

16. In order to cover the population with health services, the country has 50,000 people, including personnel with health training, administrative personnel, and volunteers (community health workers) in the public, private, and community sectors. This figure does not include self-employed health professionals.

GUATEMALA (Cont.)

17. Drugs are mainly marketed in a network of public and private pharmacies that include 818 first-class pharmacies, 762 second-class ones, and 760 drug retail outlets in the private sector. In the public sector, without including the service assistance network, the retail distributors include 53 state-run pharmacies and 104 municipal drug outlets. The domestic pharmaceutical market in 1989 generated US$ 100 million, 24% corresponding to public sector purchases (by the Ministry of Public Health and the Guatemalan Institute of Social Security), according to local industry estimates. From this figure, it may be inferred that per-capita spending on drugs is US$ 11.90. However, there are large sectors of the population that still do not have access to drugs.

18. The quality of food expended and consumed in the country is often deficient. In 1992, the Ministry of Health analyzed a total of 1,566 samples of all types of food for quality control. The physical-chemical analysis showed that only 56% was acceptable microbiologically and 84% from the point of view of chemical and biological contaminants. For milk and food products sold by street vendors, only 50% of the samples met quality standards.

19. Since 1988, when a program for rabies control began, the incidence of rabies in dogs has decreased from 456 to 62 cases in 1992, representing a decline of 86.4%.

20. The epidemiological situation of malaria in the country indicates that for the past 15 years Guatemala has presented an annual averages of 57,829 cases of malaria. In 1991, despite increases in the Malaria Division's budget, there were 16,118 more cases than had been diagnosed in 1990. The malaria program works as a vertical program, with little participation from the health services. With the appearance of dengue in Guatemala in 1978, not only has there been an increase in the number of cases, but also in the number of serotypes, existing at present serotypes 1, 2, and 4. There is no laboratory for viral isolation and identification, or for seroepidemiologic studies.

21. Approximately 50% of the population lacks access to health services, and the quality of the services is very deficient. The annual average number of medical consultations per inhabitant is 0.5, indicating a low level of utilization of the existing services. Nearly half of the population lacks potable drinking water and basic health services, which translates into high morbidity and mortality due to water-borne infections. In rural areas and in the indigenous population (more than half the total population), health conditions are even more deficient, with greater rates of morbidity and mortality, 80% of which could be prevented.

22. The 1990 budget of the Ministry of Health is 8.3% of public spending and 1.0% of the GDP, a lower share than most Central American countries. Per-capita spending on health is approximately US$ 8 per year, of which 80% is for curative medicine. On average, US$ 1.60 is spent on primary care, despite its high cost-effectiveness. The sector's human and financial resources show a high concentration in urban areas, especially in the Metropolitan Region, which has 2.5 times more professionals than the national average and 6 times more than the region with least resources. The resources of the Ministry of Health are supplemented by contributions from bilateral, multilateral, and nongovernmental organizations which provide more than half of the funds allocated to primary and preventive care.

23. By 1992, the accumulated social deficit had reached unprecedented levels. The main problems facing the Government in the short and medium term, as indicated in its 1992-1996 Social Development Plan of Action, are: the increase in poverty (63% of the population in 1980, rising to 89% in 1989, according to official figures); open and concealed unemployment; the deterioration in nutrition; the insufficiency in education; the marginalization of women; the especially difficult situation of young people; environmental deterioration; and the precariousness of health conditions.

24. Several achievements in the past biennium that have indicated the concern of the sector to strengthen its health management capacity in the country should be underscored:

25. The dissemination and execution by health authorities of policy guidelines and strategies in order to give guidance and to support ministerial management and its leadership of the sector, including the Institutional Development Plan and the 1993 Annual Plan of Operations (POA 1993 MSPAS).

26. The work of the National Health Council, an advisory organ of the Ministry of Health, which has concentrated on the formulation of a National Health Plan. This plan is intended to be an instrument of political leadership for reorienting the actions of the health sector and seeking interaction with other sectors, especially education and agriculture, for the purpose of finding solutions to the country's health problems. A first step has been the preparation of a National Policy of the Health Sector, which includes the policy on human resources. A process of reassessment of the health care model has also been initiated as a basis for planning and programming.

27. In early 1992, the National Health Council prepared the document "National Policy of the Health Sector," which sets out the specific actions of the sector: to strengthen the strategy of local health systems development; to organize the health system by levels of care, to improve the system's response capability, and to establish a policy for the expansion of coverage, and to emphasize actions in the areas of water and environment, financing of the health sector, food security, development of human resources, and strengthening of the social security system.

28. For 1993-1995, the Ministry of Public Health and Social Welfare (MSPAS) has defined the following policies of action: Expansion of health service coverage to vulnerable groups, especially the poorest; institutional and service

development, based on the principles of efficiency, effectiveness, and equity; forecasting the availability and rational utilization of material and financial resources.

29. Enhancing the functioning of the installed infrastructure in the health service network; strengthening the strategic development of human resources; multisectoral and interinstitutional approach and coordination in the area of health; promotion of appropriate dietary practices, controlling product quality and the nutritional status of the population; provision of drinking water and environmental sanitation for the high-risk and poorest populations.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

30. The national priorities for technical cooperation in health, for which PAHO/WHO cooperation has been requested in all cases, are the following:

31. To strengthen the formulation, direction, and coherence of health policies at the national level, based on constitutional and institutional principles.

32. To establish a functional interrelationship between preventive and curative medicine, bolstering the former through primary care and support and strengthening of health centers and stations.

33. To achieve comprehensive development of the hospital system in order to improve the quality of services and their outreach to the community.

34. To lay institutional and managerial foundations over the medium term that will permit the transformation and adaptation of health services in view of national conditions over the medium term.

35. To give continuity to the process of decentralization, regionalization, and deconcentration of health services, prioritizing preventive measures and supporting the self-management and incorporation of community-based forms of health care.

36. To prioritize primary health care at all levels, participatory strategic planning, technological adaptation, and the reconceptualization of the health-disease phenomenon, as well as social and community participation.

37. The Inter-American Development Bank (IDB) has approved a technical cooperation project for US$ 2.2 million for 1993-1994, aimed at strengthening the National Commission on the Environment (CONAMA) and establishing an environmental program. Funds from other sources are expected to continue reaching NGOs that work in the health sector. PAHO/WHO will continue to coordinate with the agencies that handle the projects in order to avoid duplications and maximize their impact on national health development.

38. The Ministry of Health has issued its policy for expanding primary care coverage and developing the local health systems in prioritized regions, with emphasis on vulnerable groups (mothers, children, migrants, repatriates, and refugees). Efforts are under way to reorganize the Ministry of Health and improve administrative effectiveness, with support from IDB and the World Bank. A work program is being coordinated with the General Secretariat of the National Plan for Economic Planning (SEGEPLAN) and the Ministry of Finance. The change in the model of health care model involves the effort of the entire country, from the National Health Council down to the service-delivery institutions, including the private sector, especially FUNDAAZUCAR on the Southern Coast. USAID is strengthening the administrative development of health areas, and "health managers" have been named recently at the local level.

39. Health care for migrants is a priority. The Ministry of Health is arranging a loan of US$ 20 million from the Central American Bank for Economic Intergration (BCIE) for a project aimed at improving the productivity of agroindustry as well as living conditions of migrant workers and their families on farms and in the highlands. Care for the refugee population is a political priority and is endorsed within the government's peace proposal. Over the next few years, the return of 45,000 people is expected, and they will require health services, education, environmental sanitation, and development projects.

40. The Health in Development programs, oriented toward priority regions and high-risk groups, are the main focus of priorities for planning agencies.

41. However, serious difficulties are being confronted, as in the case of the Social Investment Fund (FIS). The FONAPAZ programs have been launched with national resources, and serious negotiations for the pre-investment fund in environment and health are under way. This initiative will be linked to the development of local health systems. The role of the Congress, the Ministry of Finance, SEGEPLAN, and the sectoral planning office is vital for the approval of 1994-1995 PIP/POA investment proposals. It is also urgent to strengthen the capacity for execution of the social investment in the local systems in order to guarantee effective resources and community participation through municipalities and urban and rural development councils.

42. Technical cooperation among the Central American countries is being strengthened through the PSCDG and TCC initiatives, as in the case of Nicaragua and Guatemala for the development of local health systems.

## PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Community water supply and sanitation (CWS)
Control of environmental health hazards (CEH)

43. The purpose of cooperation will be the expansion of water and sanitation services and the control of environmental hazards.

44. Cooperation will be provided to strengthen the management capacity of institutions in the health sector, the development of national capabilities to prepare investment proposals, the promotion of community participation, and the development of appropriate technologies.

45. Special support will be given for the expansion of coverage and the improvement of the quality of public water supply and sanitation services. Special importance will also be given to the sanitary disposal of excreta and wastewater.

46. To contain environmental health hazards, cooperation will be provided in air pollution control, pesticide management, waste disposal, and protection of water sources for human consumption.

Health services development (DHS)

47. The purpose of this project is the development of local health systems and the transformation of the model of health care model.

48. The experience acquired with the support of intensified WHO technical cooperation in Region VII will be extended to Regions VI, II, and I in order to strengthen local programming and mechanisms of promotion and community participation in order to achiev increased coverage, effectiveness, efficiency and equity of services.

49. Efforts to develop the Southern Coast will continue facilitating the expansion of Social Security services with the support of the Ministry of Health and the private sector.

50. The mechanisms of manpower training required by changes in the model of health care model will be strengthened, as will the development of local management.

51. An effort will be made to modernize the administrative systems jointly with other cooperation agencies.

52. Development of the capacity of the network of hospital and ambulatory services in health centers and stations will be the focus of work oriented toward improving the efficiency and quality of services. Comprehensive action by the programs on management, drugs, maintenance, laboratory, and nutrition will be promoted to establishing standards and procedures that strengthen local administration of services and improve management capacity.

53. The incorporation of investment projects that support health and development, as well as the improvement of environmental health programs in the development of the local health systems, will be a priority for cooperation. The strengthening of sectoral analysis and analysis of the problems regarding financing of the health sector will continue.

54. Support will be given for the design and execution of operations research on service usage, quality, efficiency, and equity, in conjunction with academic institutions.

Immunization (EPI)

55. The purpose of this project is the control and elimination of diseases preventable by vaccination and the maintenance and increase of coverage for the biologicals included under the EPI among infants and women of childbearing age.

56. The principal strategies utilized will be support for local programming and promotion, decentralization of financial resources, and coordination with public and private institutions inside and outside of the health sector, in addition to strengthening community participation for comprehensive development of local health systems, in which an epidemiological information and surveillance system will be maintained.

Food safety (FOS)

57. The purpose of this project is to strengthen the national capacity for surveillance and quality control of the foods processed, sold, and consumed nationally.

58. Cooperation will be provided for the formulation of interinstitutional plans of action for food protection at the district and area levels and the installation of regional laboratories for the analysis of food and water.

59. In addition, support will be given for the creation and operation of the Interinstitutional Commission of Food Protection with participation by representatives from health, agriculture, economy, and municipalities; and at the local level, the organization of workshops will be endorsed.

60. Activities will be organized to improve hygiene in food handling by street vendors as well as in homes and food establishments throughout the country; and there will also be support to the National Committee of the Codex Alimentarius.

Scientific and technical information dissemination (HBD)

61. The purpose of this project is to maximize the potential of mass communication in order to contribute to health development.

62. Support will be provided for the dissemination of technical and scientific information to the sectors that are responsible for educating and guiding the public (mass media and health promoters).

63. Local training activities for journalists and media personnel will continue, and incentives will be devised for journalists interested in public health issues.

Human resources education (HRE)

64. The purpose of this project is to facilitate joint sectoral planning with the strategic approach to achieve the availability of sufficient qualified human resources, as well as their management, adapted to the new model of health care.

65. Cooperation will be provided in the management of human resources in the health sector, focusing on regionalization, and with emphasis on performance research and on national and local information systems as the foundation for evaluation and decision-making. The efficiency and management of the human resource units in counterpart institutions will be strengthened.

Health situation and trend assessment (HST)

66. The purpose of this project is to support the use and/or application of epidemiological knowledge and techniques in the planning, execution, monitoring, and evaluation of activities of the healthsector.

67. Cooperation will be provided to strengthen the epidemiological capacity of the health services with methodologies for the monitoring, evaluation and prospective analysis of health activities. Epidemiological research and training will be fostered and supported.

68. The systems of epidemiological surveillance will be strengthened, and cooperation will be provided for the identification, documentation, and dissemination of technical information for administrative-managerial levels of national counterparts.

Growth, development and human reproduction (MCH)

69. The purpose of this project is to reduce the risks and magnitude of the prevalent problems in the maternal and child population.

70. Support will be given for the establishment of food and nutrition surveillance system in priority areas.

71. Cooperation will be provided to improve the quality of care during delivery and the care of newborns at the departmental and local level.

72. Support will also be provided for the development of the programs on acute respiratory infections and diarrheal disease control, at the various stages (training, implementation of the different levels of care, evaluation, and epidemiological surveillance at service-delivery and resource-training institutions, state level, and private at the community level).

73. The preparation of a multidisciplinary and intersectoral comprehensive health care program for adolescents will be supported.

Managerial support for national health development (MPN)

74. The purpose of this project is to consolidate the processes of development of the PAHO/WHO Representative Office in the Country in its technical, administrative, and political capacity in order to provide the cooperation required for health development.

75. The process of continuing education of all staff at the PAHO Country Office will be strengthened. Administrative and technical-scientific information processes at the Representative office will be automated. The capacity for analysis of the national and sectoral context will be improved in order to enhance the process of delivery of technical cooperation.

Health promotion and prevention and control of noncommunicable diseases (NCD)

76. The purpose of this project is to incorporate health promotion as a fundamental strategy in all health programs on national institutions, at the operational level in local health systems, and in all components of the PAHO cooperation program in the country.

77. Cooperation will be provided for the evaluation of current standards and the mobilization of participation by other groups and sectors in the formulation of national programs for prevention and control.

78. In coherence with the decentralization process and the establishment of priority health areas, PAHO/WHO technical cooperation will be focused in certain geographical areas (departments) selected by the national authorities with a view to strengthening their ability to analyze the health situation; to program locally according to the local health situation, priorities, and availability of resources; to monitor the evolution of the situation and interventions; and to evaluate the impact on the population's health.

GUATEMALA (Cont.)

General communicable disease prevention and control activities (OCD)

79. The purpose of this project is to strengthen the national capacity for the execution of programs of communicable disease prevention and control which are technically viable, economically feasible, and socially acceptable.

80. Cooperation will be provided to facilitate the effective decentralization of prevention and control actions. The focalization of actions on risk groups will be based on epidemiological stratification, which will be a fundamental element for orienting specific intervention measures.

81. Within the broad framework of the concept of health promotion, emphasis will be placed on the improvement of housing and its surroundings, and on environmental sanitation. The principal target population will be women and school-age children.

82. Mass communication efforts will concentrate on disseminating and promoting relevant information geared toward different audiences, utilizing mass communication media and health education.

Technical cooperation among countries (TCC)

83. The purpose of this project is strengthen cooperation between Guatemala and neighboring countries with common problems.

84. Support will be provided for institutional strengthening of the Office for Coordination of International Affairs (OCAI). Logistical and secretarial support will be provided for the formulation of agreements and the organization of border projects (trinational).

85. Cooperation will be given for the mobilization of national and international resources to support the current and potential processes of technical cooperation among Central American countries.

Women, health and development (WHD)

86. The purpose of this project is to help to improve the health conditions of women and their families through the identification and elimination of gender-related factors that result in discrimination against women in terms of opportunities, access, and use of health care resources, and the modification of the social conditions that determine this situation.

87. The formation of networks of exchange and cooperation will be promoted, as will the formulation of technical cooperation projects to maximize external resources.

88. Information will be disseminated on issues relating to women, gender, health, and development, and support will be provided for the publication and dissemination of scientific and technical material.

89. The formulation and evaluation of laws, policies, programs, and models of comprehensive care for women will be supported, and human resources will be developed in the fields of gender, women's health, and development studies.

90. Efforts will be aimed at fostering and developing scientific research from a gender perspective and its linkage with development processes.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 2,821,200 | 71.1 | 2,879,100 | 66.2 | 3,205,200 | 66.5 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 1,075,500 | 27.1 | 1,248,400 | 28.7 | 1,409,100 | 29.2 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 1,075,500 | 27.1 | 1,248,400 | 28.7 | 1,409,100 | 29.2 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 117,300 | 3.0 | 133,000 | 3.1 | 150,800 | 3.1 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 117,300 | 3.0 | 133,000 | 3.1 | 150,800 | 3.1 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 368,800 | 9.3 | 421,600 | 9.7 | 462,000 | 9.6 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 368,800 | 9.3 | 421,600 | 9.7 | 462,000 | 9.6 |
| HEALTH POLICY DEVELOPMENT | | 0 | - | 25,100 | .6 | 28,400 | .6 |
| WOMEN, HEALTH AND DEVELOPMENT | WHD | 0 | - | 25,100 | .6 | 28,400 | .6 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 1,136,700 | 28.6 | 865,900 | 19.8 | 948,200 | 19.7 |
| HEALTH SERVICES DEVELOPMENT | DHS | 1,136,700 | 28.6 | 781,000 | 17.9 | 851,900 | 17.7 |
| ESSENTIAL DRUGS AND VACCINES | EDV | 0 | - | 84,900 | 1.9 | 96,300 | 2.0 |
| HUMAN RESOURCES DEVELOPMENT | | 122,900 | 3.1 | 124,900 | 2.9 | 139,200 | 2.9 |
| HUMAN RESOURCES EDUCATION | HRE | 122,900 | 3.1 | 124,900 | 2.9 | 139,200 | 2.9 |
| HEALTH INFORMATION SUPPORT | | 0 | - | 60,200 | 1.4 | 67,500 | 1.4 |
| SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION | HBD | 0 | - | 60,200 | 1.4 | 67,500 | 1.4 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 1,142,200 | 28.9 | 1,477,700 | 33.8 | 1,614,900 | 33.5 |
| ENVIRONMENTAL HEALTH | | 342,300 | 8.7 | 498,600 | 11.4 | 542,300 | 11.3 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 267,900 | 6.8 | 415,800 | 9.5 | 452,700 | 9.4 |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 74,400 | 1.9 | 82,800 | 1.9 | 89,600 | 1.9 |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| MATERNAL AND CHILD HEALTH | | 130,300 | 3.3 | 193,900 | 4.4 | 216,100 | 4.5 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 130,300 | 3.3 | 131,600 | 3.0 | 145,500 | 3.0 |
| IMMUNIZATION | EPI | 0 | - | 62,300 | 1.4 | 70,600 | 1.5 |
| COMMUNICABLE DISEASES | | 340,500 | 8.6 | 422,100 | 9.7 | 462,700 | 9.6 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 340,500 | 8.6 | 422,100 | 9.7 | 462,700 | 9.6 |
| HEALTH PROMOTION | | 45,400 | 1.1 | 54,000 | 1.2 | 59,400 | 1.2 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 45,400 | 1.1 | 54,000 | 1.2 | 59,400 | 1.2 |
| VETERINARY PUBLIC HEALTH | | 283,700 | 7.2 | 309,100 | 7.1 | 334,400 | 6.9 |
| FOOD SAFETY | FOS | 283,700 | 7.2 | 273,500 | 6.3 | 294,600 | 6.1 |
| ZOONOSES | ZNS | 0 | - | 35,600 | .8 | 39,800 | .8 |
| GRAND TOTAL | | 3,963,400 | 100.0 | 4,356,800 | 100.0 | 4,820,100 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 2,239,600 | 56.9 | 739,500 | 42.5 | 0 | |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 15,700 | .4 | 0 | - | 0 | |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 15,700 | .4 | 0 | - | 0 | |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 22,600 | .6 | 0 | - | 0 | - |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 22,600 | .6 | 0 | - | 0 | - |
| HEALTH POLICY DEVELOPMENT | | 24,900 | .6 | 61,500 | 3.5 | 0 | - |
| WOMEN, HEALTH AND DEVELOPMENT | WHD | 24,900 | .6 | 61,500 | 3.5 | 0 | - |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 2,173,400 | 55.2 | 678,000 | 39.0 | 0 | - |
| HEALTH SERVICES DEVELOPMENT | DHS | 1,888,700 | 48.0 | 678,000 | 39.0 | 0 | - |
| ESSENTIAL DRUGS AND VACCINES | EDV | 275,700 | 7.0 | 0 | - | 0 | - |
| DISASTER PREPAREDNESS | DPP | 9,000 | .2 | 0 | - | 0 | - |
| HEALTH INFORMATION SUPPORT | | 3,000 | .1 | 0 | - | 0 | - |
| PUBLIC INFORMATION | HBF | 3,000 | .1 | 0 | - | 0 | - |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 1,703,000 | 43.1 | 1,000,600 | 57.5 | 0 | - |
| ENVIRONMENTAL HEALTH | | 51,200 | 1.3 | 0 | - | 0 | - |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 51,200 | 1.3 | 0 | - | 0 | - |
| MATERNAL AND CHILD HEALTH | | 534,000 | 13.5 | 0 | - | 0 | - |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 48,700 | 1.2 | 0 | - | 0 | - |
| IMMUNIZATION | EPI | 4,300 | .1 | 0 | - | 0 | - |
| DIARRHEAL DISEASES | CDD | 481,000 | 12.2 | 0 | - | 0 | - |
| COMMUNICABLE DISEASES | | 1,117,800 | 28.3 | 1,000,600 | 57.5 | 0 | - |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 218,800 | 5.5 | 0 | - | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 668,100 | 16.9 | 435,600 | 25.0 | 0 | - |
| MALARIA | MAL | 230,900 | 5.9 | 565,000 | 32.5 | 0 | - |
| GRAND TOTAL | | 3,942,600 | 100.0 | 1,740,100 | 100.0 | 0 | |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 3,336,700 | 6 | 8 | 960 | 1,553,700 | 57,000 | 77 | 154,000 | 540,500 | 176,100 | 0 | 855,400 |
| WHO - WR | 626,700 | 2 | 1 | 155 | 419,300 | 16,800 | 17 | 34,000 | 50,700 | 32,500 | 0 | 73,400 |
| TOTAL | 3,963,400 | 8 | 9 | 1115 | 1,973,000 | 73,800 | 94 | 188,000 | 591,200 | 208,600 | 0 | 928,800 |
| % OF TOTAL | 100.0 | | | | 49.8 | 1.9 | | 4.7 | 14.9 | 5.3 | .0 | 23.4 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 3,637,700 | 4 | 12 | 826 | 1,599,700 | 59,800 | 79 | 158,000 | 525,300 | 199,400 | 0 | 1,095,500 |
| WHO - WR | 719,100 | 2 | 1 | 175 | 510,300 | 18,900 | 16 | 32,000 | 56,600 | 35,900 | 0 | 65,400 |
| TOTAL | 4,356,800 | 6 | 13 | 1001 | 2,110,000 | 78,700 | 95 | 190,000 | 581,900 | 235,300 | 0 | 1,160,900 |
| % OF TOTAL | 100.0 | | | | 48.4 | 1.8 | | 4.4 | 13.4 | 5.4 | .0 | 26.6 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 4,037,000 | 4 | 12 | 826 | 1,747,400 | 67,800 | 79 | 158,000 | 595,700 | 225,900 | 0 | 1,242,200 |
| WHO - WR | 783,100 | 2 | 1 | 175 | 550,600 | 21,400 | 16 | 32,000 | 64,200 | 40,700 | 0 | 74,200 |
| TOTAL | 4,820,100 | 6 | 13 | 1001 | 2,298,000 | 89,200 | 95 | 190,000 | 659,900 | 266,600 | 0 | 1,316,400 |
| % OF TOTAL | 100.0 | | | | 47.7 | 1.9 | | 3.9 | 13.7 | 5.5 | .0 | 27.3 |

## HEALTH SITUATION ANALYSIS

### Demography

1. The estimated population continues to decline steadily. From 756,100 (1986) to 739,553 in 1991. Emigration still represents a major drain on the younger and more educated sector of the population. For the year 1991, 4,478 persons (2,200 males and 2,278 females) left the country permanently to reside abroad. In 1991 there was a total of 13,235 births showing a steady decline since 1988 when the total was 18,158. Of these births, 98.2% were live births. There was a still birth rate of 18.2 per 1,000 births. The total number of low birth weights in 1991 reached (17.9%). This may even be underestimated because of inadequate recording of birth weights. On the other hand, the number of deaths have increased from 4,050 in 1988 to 4,775 in 1990. The crude death rate was 7.9 per 1,000 in 1989, and the infant mortality rate was 45 per 1,000 live births (1989).

### Health status indicators

2. Data for 1990 shows that the ten main causes of mortality accounted for 66,6% of all deaths. These were: cerebrovascular diseases (16.4%) ischemic heart disease (7,9%), diseases of pulmonary circulation and other forms of heart diseases (7,9%), diseases of other parts of the digestive system (6,2%), endocrine and metabolic diseases, immunity disorders (5,9%), other diseases of the respiratory system (5,9%), hypertensive diseases (5,6%), certain conditions originating in the perinatal period (3,5%), intestinal infectious diseases (3,4%), other accidents including late effects (2,7%). The number of AIDS cases had increased to 390 by the end of 1992. The total cases for 1992 was 160, a 69,5% increase over the cumulative figure of cases as at December 1991. The number of tuberculosis cases continue to rise with 182 cases in 1992. The total number of malaria cases still remain very high with 35,340 cases recorded for the period January - November 1992. This program suffered in 1992 with the withdrawal of the International NGO Medecins Sans Frontières which had been supporting malaria operations for a long time. Acute Diarrhoeal diseases (ADD) and Acute Respiratory Infections (ARI) continue to be among the leading causes of morbidity and mortality in children under five years. The dramatic arrival of cholera in the country in November 1992 in the administrative region close to the Venezuelan border, created new demands on the health sector which has been aggressively trying to contain the spread of the disease. As at 31st December 1992 there were 556 suspected cases with 5 deaths.

### Factors affecting health status

3. The election of a new Government to office in Guyana in October 1992 is by far the most significant development in the political life of the country for the past decade. These elections were the focus of attention for the international community and were monitored by observers from the commonwealth countries and the Carter Center. The new government is pursuing in principle the same basic policies established by the previous Government. Adherence to the International Monetary Fund Guidelines are continuing. The structural adjustments policies of reduction in public expenditure, and stimulation of private sector to play an increasingly important role in the national development process are critical strategies in this process. The exchange rate for the Guyana dollar has remained stable for the past two year at G$ 126.00 = US$ 1.00. Over the past year the inflation rate was reduced from a level of 20% to 13%-14%. However, the salaries paid to the majority of the working population still remain inadequate for the provision of basic food and shelter. In December 1992 the average nutrient cost of a 2.400 kilocalories diet was $101 per day. This was beyond the reach of most wage earners. Nevertheless, the country experienced economic growth of 7.7% during 1992 and foreign exchange has been easily available as a result of the structural adjustment policies put in place.

4. The year 1992 has witnessed very little improvement in the environmental health infrastructures (drinking water, wastewater, solid waste, sewerage and excreta disposal) of the country. The exception to this is in Plaisance and Sparendaam communities where the water supply system has been improved and new sanitary facilities provided to the school population, and in Region #4, where of 500 VIP latrines have been installed, mainly in the schools. In New Amsterdam, a new water treatment plant has been built. However, the population is still suffering from lack of water due to the poor state of the piping system. The new wells that were installed in Farm Village on the West Bank, Soesdyke on the East Bank, Ogle and Mahaica on the East Coast and Line Path and Rose-Hall on the Corentyne still suffer from lack of appropriate pumps and the poor state of the piping system. The sector has continued to be deprived of its most qualified personnel who either migrate or join the private sector in search of better working conditions.

5. The emigration of health manpower, as part of the general trend of people leaving the country, poses serious problems for the staffing of the health sector. This situation is further aggravated by the low salaries paid to health professionals in relation to the cost of living, making it difficult for the Government to attract and retain those health professionals that are available.

6. The quality of services offered suffers from this shortage of health staff. The Government is however responding to this challenge by training their own professionals i.e nurses, physicians, pharmacists, medical technologist, medical extensionists, environmental health officers, dental technicians, health services managers and health tutors. These are contracted to remain within the Government system and help to mitigate the shortage of staff. As yet the Government has not been able to articulate a health manpower policy and plan to address the situation and give coherence to the number of manpower initiatives taking place.

7. Improving the management of the health services is still a major priority of the Government. There is need for a health policy and plan to guide the management process. The role of the central level of the Ministry of Health needs to be clearly defined, particularly in relation to the service delivery field units

most of which come under another ministry, Regional Development. The lack of up-to-date information affects the planning and management of health programs.

8. The shortage of supplies and equipment to provide health services seriously affects the quality of these services. This is compounded by the scarcity of competent leaders within the health sector to maximize the use of those limited resource available.

Plans and priorities for national health development

9. The Health sector comprises the Ministry of Health, the Ministry of Regional Administration; the Guyana Agency for Health Sciences Education, the Environment and Food Policy (GAHEF); the Guyana Water Authority (GUYWA) and the Ministry of Labor (Occupational Health). Coordination among these agencies is a major challenge for the new Government in achieving a comprehensive document outlining its policies and strategies to be pursued in health. Nevertheless the indications are that strengthening the health services at the regional (local) levels will be a major strategy to relieve the pressure for service delivery at the main hospitals, particularly the Public Hospital Georgetown.

10. The broad objectives for the national health system are: improve the delivery of health services; reduce the mortality and morbidity rates (especially maternal and child mortality) and increase life expectancy; reorganize the administrative structure and system; improve the planning capacity, and the information systems; undertake human resources development, reduce the incidence of communicable diseases and eradicate those where the incidence is very low; improve the nutritional status of the population on the whole; improve and extend dental health services (especially preventive aspects); bring the benefit of improved environmental sanitation to communities; establish an effective insect vector control program; develop veterinary public health programs, particularly in the light of the national agriculture thrust; develop a program of health education and community participation; improve and expand diagnostic, treatment and rehabilitative services and facilities; provide services of psychiatric coverage to the population.

11. Reorganization of the health system is envisaged to facilitate the effective delivery of health services at all levels of the system concurrently with the improvement of the physical facilities. The central directorate of regional health services and the regional health administration units headed by a regional health officer, were established in 1986. Management support sub-systems are in a critical condition and PAHO/WHO has been requested to provide support in manpower and drug supply management, improvement of the management information system within selected hospitals, strengthening of the health information system and of the local health systems.

12. A priority focus has been on medical education as evidenced by first, the creation of a special Ministry and now an Agency (GAHEF), to deal with this matter. The medical education program is designed to suit the country's needs, be community based and innovative, in its approach to bridge the professional gap and to reduce the brain drain. Scientific excellence and research is being stressed as well as problem based learning.

13. The Faculty of Health Sciences carries out Allied Health training programs in radiography, pharmacy, medical technology and environmental health. The Medical Extensionists (MEDEX) program, now fully established and government supported, is being conducted by GAHEF. The health service managers and health sciences tutors are offered as certificate programs by the faculty. A center for health educational technology, established in 1986, produces teaching materials to support education for health and training. It is allied with the Medical School and organizes many in-service and public seminars, courses and workshops. This center is part of GAHEF.

14. In the environment, the indiscriminate use of pesticides, the improper disposal of wastewater, solid waste, hazardous hospital and industrial waste constitute health hazards and will be addressed by the government.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

National priority areas for technical cooperation

15. Based on the above plans and priorities the national priorities for technical cooperation for the health sector are in the following areas: strengthening the health policy, planning/programming implementation and evaluation process; support to the decentralization process with emphasis on improving the physical facilities and management systems at rural health facilities; improvement of the health information system as it relates to service delivery data and resource management (including health manpower data) to improve the decision-making process within the health sector; strengthening of environmental health services in the rural and urban communities giving priority to the most vulnerable communities; improvement of services to the mother and child with emphasis on immunization services, nutrition, ante-natal and post-natal services, diarrhoeal diseases and acute respiratory infections; development of the management process and expansion of coverage of the vector control program particularly in relation to malaria, dengue fever and filaria; strengthen the capacity of the health and education sectors to produce in adequate numbers the quality and quantity of human resources needed to staff the health sector; improvement of veterinary public health services with emphasis on food hygiene, public education, animal health surveillance and improvement of the management of selected animal health programs e.g. rabies, bovine tuberculosis and brucellosis; strengthening the management of selected communicable disease programs e.g malaria, AIDS, with increasing emphasis on changing behavior and lifestyles; and health promotion through health education and community participation as a basic strategy for reduction and control of selected illnesses e.g. diabetes, hypertension etc.

16. Important projects are being pursued in the water and sanitation sector. These include a master plan study for water, wastewater and sewerage in Georgetown which will last until 1994, funded by IDB with provisions for capital works. An

interim water rehabilitation program for Georgetown is scheduled to start in 1993 and is also funded by Inter-American Development Bank (IDB). The institutional strengthening of the Guyana Water Authority (GUYWA) which will be followed by a rehabilitation program for the rural water supply systems located on the coastal areas is funded by the World Bank. The successful implementation of these projects will depend on the negotiations now taking place between the government and funding agencies on pre-conditions for the disbursement of the loans.

National priorities for technical cooperation from PAHO/WHO

17. During the biennium (1994-1995) PAHO/WHO is being asked to provide technical cooperation in the following program areas:- management and organization of health services; maternal and child health; communicable disease control; human resources development; environmental health; food and nutrition, technical cooperation among countries and managerial support for national health development. These priorities are in keeping with those outlined in the strategic orientations and program priorities (SOPP) for PAHO/WHO during the quadriennium 1991-1994. These priority areas have been agreed upon in discussions with the national authorities.

18. In addition to the projects supported by its regular budget, PAHO/WHO also manages an HIV project which focuses on reducing the impact of the AIDS epidemic on the general population. The Canadian Public Health Association has also provided funds to PAHO/WHO for the implementation in Guyana of an Expanded Immunization Programme (EPI) as part of the Global EPI Programme. This is a three year project covering the period August 1992 - July 1995.

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Community water supply and sanitation (CWS)

19. The purpose of the project is to improve the environmental health situation in the country in the areas of public health, sanitation, water supply, sewerage sectors, control of health hazards in the hospitals and improvement of occupational health and safety in the country. During the biennium, the environmental health program will focus attention on the strengthening of the Environmental Health Services in the country so that better control could be exercised on the observance of established standards. Attention will also be paid to the provision of drinking water and basic sanitation to scattered hinterland population as well as selected marginal urban and rural areas. This will include the promotion of community-based solid waste management programmes utilizing health education and community participation as basic strategies.

Health services development (DHS)

20. The purpose of the project is to support the health management process in the health services through the strengthening of: the health planning process; health management at the central and regional (local) levels; the management of hospital services; the management of pharmaceutical supplies; disaster preparedness and management; mobilization of resources through project preparation. Emphasis will be placed on the development of the health information system covering health service delivery and management of human resources. The use of information for decision making will be emphasized. Such information will be computerized, where appropriate, and fed into the health planning and management process at central and local levels including hospitals. The structure and function of the Ministry of Health will be reviewed utilizing mission statements and objectives to guide the planning and budgeting process. Team building and the development of managerial skills at all levels of the system will be a priority activity. So too will be the mobilization of resources to support public sector efforts. It will also be necessary to strengthen the management systems in the Ministry of Health as well as the management skills of top and middle level managers and to strengthen the management of the major national hospitals to ensure that resources are optimally used.

Human resources education (HRE)

21. The purpose of the project is to improve health manpower management through development of a manpower policy and plan; strengthening of health training institutions and programs; and more efficient utilization of manpower resources. The focus will be on the development of a health manpower plan and policy to incorporate plans from those agencies that are involved in human resources training and development, and those that utilize human resources. Inter-agency coordination also should address the urgent and growing infrastructural demands for learning/teaching materials, methodologies and aids to ensure a continuous improvement of the training programs. University curricula will be revised using a problem-based learning approach and strengthened to ensure the development of enough qualified and specialized professionals to cover both teaching and service needs in Guyana in the medical and paramedical specialties. Community oriented multidisciplinary research will form part of the training programs. This will ensure that the Faculty of Health Sciences (FHS) remains close to the realities of the country and become a very active element in the education component of the local health system development in Guyana.

Growth, development and human reproduction (MCH)

22. The purpose of the project is to improve the national MCH program through the determination of standards for the delivery of services, extension of coverage in keeping with these standards, and training and development of staff. Specific attention will be paid to diarrhoeal diseases especially cholera, where the emphasis will be on the effective management of the disease. To achieve this purpose, the development and utilization of a manual of norms and procedures to strengthen managerial delivery of MCH services will be emphasized. Staff will be trained to utilize these norms and standards in implementing MCH services. Information systems for the management of MCH services will be computerized and the data used in decision making. Based on an assessment of adolescent health and acute respiratory infections, programs will be developed to address these critical areas.

GUYANA (Cont.)

Managerial support for national health development (MPN)

23. The purpose of the project is to facilitate and provide leadership for the planning, implementation and evaluation of PAHO/WHO technical cooperation program. To achieve this purpose, the project will aim to strengthen collaboration between the PAHO/WHO Guyana Office and the relevant government agencies in planning, implementation and evaluation of PAHO/WHO Technical Cooperation program in Guyana. The government will be supported in its efforts to mobilize resources to strengthen the national health services in keeping with Caribbean Cooperation in Health (CCH) initiative and the plan of investment for health development and the environment. The capacity of the PWR's office to support the delivery of the technical cooperation program will be improved through the strengthening of the office management system and procedures. The public image of PAHO/WHO will promoted through publications and broadcasts (radio, television) and news releases. The media will be encourage to publish articles and prepare other material for public information on health issues of national importance. The documentation center in the PAHO/WHO office will be supported in its goals to function as a resource center for use by students and professionals to update their knowledge.

Nutrition (NUT)

24. The purpose of the project is to support the implementation of the food and nutrition policy with emphasis on food security, food safety, animal health surveillance, the management of selected veterinary public health programs, food and nutrition surveillance and the management of nutrition related chronic diseases e.g. diabetes and hypertension. The development and implementation of a food safety plan with components of legislation, surveillance, lab services, public education will be a major thrust for the biennium. Strengthening the management of selected animal health/veterinary public health programs such as bovine tuberculosis, brucellosis and animal rabies will also be given priority attention. The implementation of a national food and nutrition surveillance system will be supported. So too will be the implementation of community based programs for the management of nutrition related chronic diseases such as diabetes and hypertension. These will be based on survey data on target population and public education material to support the adoption of healthy lifestyle.

General communicable disease prevention and control activities (OCD)

25. The purpose of the project is to strengthen epidemiological services in the health sector through the collection and use of epidemiological data in the planning, programming, implementation and evaluation of health services. Selected communicable diseases will be addressed, with emphasis on malaria, to improve the management of this program at central and local levels. To achieve this purpose, training will be provided to bring key national, regional and other officials up-to-date in the following aspects: The use of surveillance methods, and an epidemiological approach to aid the planning and programming process; management of preventative and control programs for selected communicable diseases; public education programs utilizing appropriate health education techniques; diagnosis, treatment and follow-up of selected communicable diseases. Standardized methods for gathering, processing and disseminating health information will be developed as well as methods for the screening, diagnosis, treatment and follow-up of selected communicable diseases. Health education materials will be prepared to strengthen the planning, implementation and evaluation of selected communicable diseases programs with emphasis on malaria, filaria, leprosy and tuberculosis. The participation of the private sector and Non Governmental Organizations (NGOs) in supporting selected preventative and control programs will be actively pursued. Resources will be mobilized to facilitate the acquisition and dissemination of health education materials and resources to strengthen the epidemiological services and surveillance system. Research will be supported through epidemiological field studies of vector-borne diseases and other communicable diseases relevant to the country health situation.

Technical cooperation among countries (TCC)

26. The purpose of the project is to establish Technical Cooperation programs between the Guyana Health Services and other countries so that they can learn from the Guyanese experience and provide support for the Guyanese health services. This project will support government's efforts to establish linkages with other countries for the development of the health sector in Guyana and in those other countries. Strong ties already exist with the government of Cuba and the program will maintain these ties in selected health areas, particularly the strengthening of the teaching programs for health personnel. The continuation of border meetings with Brazil and Venezuela on vector control issues and with Suriname on a list of priority health programs (cholera, AIDS, leprosy, vector control etc.) will be supported. So too will the program on water and sanitation between Guyana and Trinidad and Tobago where the water and sewerage authorities in both countries will collaborate in specific areas for their mutual benefit.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 874,500 | 63.2 | 996,400 | 63.9 | 1,097,500 | 64.3 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 391,300 | 28.4 | 474,000 | 30.4 | 527,800 | 30.9 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 391,300 | 28.4 | 474,000 | 30.4 | 527,800 | 30.9 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 50,500 | 3.6 | 57,300 | 3.7 | 65,000 | 3.8 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 50,500 | 3.6 | 57,300 | 3.7 | 65,000 | 3.8 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 329,700 | 23.8 | 360,500 | 23.1 | 391,800 | 23.0 |
| HEALTH SERVICES DEVELOPMENT | DHS | 329,700 | 23.8 | 360,500 | 23.1 | 391,800 | 23.0 |
| HUMAN RESOURCES DEVELOPMENT | | 103,000 | 7.4 | 104,600 | 6.7 | 112,900 | 6.6 |
| HUMAN RESOURCES EDUCATION | HRE | 103,000 | 7.4 | 104,600 | 6.7 | 112,900 | 6.6 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 510,000 | 36.8 | 562,800 | 36.1 | 609,500 | 35.7 |
| FOOD AND NUTRITION | | 57,400 | 4.1 | 62,200 | 4.0 | 67,300 | 3.9 |
| NUTRITION | NUT | 57,400 | 4.1 | 62,200 | 4.0 | 67,300 | 3.9 |
| ENVIRONMENTAL HEALTH | | 305,800 | 22.1 | 337,700 | 21.7 | 362,300 | 21.2 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 305,800 | 22.1 | 337,700 | 21.7 | 362,300 | 21.2 |
| MATERNAL AND CHILD HEALTH | | 51,100 | 3.7 | 56,200 | 3.6 | 61,200 | 3.6 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 51,100 | 3.7 | 56,200 | 3.6 | 61,200 | 3.6 |
| COMMUNICABLE DISEASES | | 95,700 | 6.9 | 106,700 | 6.8 | 118,700 | 7.0 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 95,700 | 6.9 | 106,700 | 6.8 | 118,700 | 7.0 |
| GRAND TOTAL | | 1,384,500 | 100.0 | 1,559,200 | 100.0 | 1,707,000 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 18,500 | 4.7 | 0 | - | 0 | |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 15,100 | 3.8 | 0 | - | 0 | |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 15,100 | 3.8 | 0 | - | 0 | |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 3,400 | .9 | 0 | - | 0 | - |
| HEALTH SERVICES DEVELOPMENT | DHS | 3,400 | .9 | 0 | - | 0 | - |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 374,200 | 95.3 | 288,200 | 100.0 | 0 | - |
| ENVIRONMENTAL HEALTH | | 97,100 | 24.7 | 0 | - | 0 | - |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 97,100 | 24.7 | 0 | - | 0 | - |
| COMMUNICABLE DISEASES | | 270,100 | 68.8 | 288,200 | 100.0 | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 270,100 | 68.8 | 288,200 | 100.0 | 0 | - |
| HEALTH PROMOTION | | 7,000 | 1.8 | 0 | - | 0 | - |
| OCULAR HEALTH | PBD | 7,000 | 1.8 | 0 | - | 0 | - |
| GRAND TOTAL | | 392,700 | 100.0 | 288,200 | 100.0 | 0 | |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 390,900 | 1 | 0 | 30 | 234,400 | 13,300 | 6 | 12,000 | 15,900 | 32,500 | 0 | 82,800 |
| WHO - WR | 993,600 | 2 | 4 | 370 | 510,600 | 25,300 | 45 | 90,000 | 69,300 | 83,400 | 0 | 215,000 |
| TOTAL | 1,384,500 | 3 | 4 | 400 | 745,000 | 38,600 | 51 | 102,000 | 85,200 | 115,900 | 0 | 297,800 |
| % OF TOTAL | 100.0 | | | | 53.7 | 2.8 | | 7.4 | 6.2 | 8.4 | .0 | 21.5 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 413,400 | 1 | 0 | 30 | 243,900 | 15,100 | 8 | 16,000 | 18,000 | 31,200 | 0 | 89,200 |
| WHO - WR | 1,145,800 | 2 | 4 | 325 | 598,900 | 28,300 | 48 | 96,000 | 82,100 | 108,300 | 0 | 232,200 |
| TOTAL | 1,559,200 | 3 | 4 | 355 | 842,800 | 43,400 | 56 | 112,000 | 100,100 | 139,500 | 0 | 321,400 |
| % OF TOTAL | 100.0 | | | | 54.1 | 2.8 | | 7.2 | 6.4 | 8.9 | .0 | 20.6 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 452,500 | 1 | 0 | 30 | 262,400 | 17,100 | 8 | 16,000 | 20,400 | 35,400 | 0 | 101,200 |
| WHO - WR | 1,254,500 | 2 | 4 | 325 | 647,300 | 32,100 | 48 | 96,000 | 93,100 | 122,700 | 0 | 263,300 |
| TOTAL | 1,707,000 | 3 | 4 | 355 | 909,700 | 49,200 | 56 | 112,000 | 113,500 | 158,100 | 0 | 364,500 |
| % OF TOTAL | 100.0 | | | | 53.2 | 2.9 | | 6.6 | 6.6 | 9.3 | .0 | 21.4 |

HAITI

## HEALTH SITUATION ANALYSIS

### Demography

1. The population of Haiti is currently estimated at about 6.6 million United Nations Development Program (UNDP) as compared with 5.0 million in 1982. The average annual rate of increase is estimated at 2% United Nations Population Fund (UNFPA). With 71% living in rural zones, rural population density per square kilometer of arable land is about 500. Migratory movements have always been very substantial but a consequence of the September 30th 1991 military coup has been an exodus of an undetermined portion of the Port-au-Prince population to rural areas. This counteracted the underlying rapid rate of urbanization with Port-au-Prince marginal areas growing annually at 8.6% projected to bring its population to 2 million by 2,000. The crude birth rate is about 36 per 1,000 population with only about 9.6% of rural women found to be using some form of modern contraception. Children under 15 years of age make up 40% of the population, 17% are under 5 years of age. The elderly (over age 64) comprise about 5% of the population.

### Health status indicators

2. Life expectancy at birth is estimated at 55 years (1985-1990). The crude death rate is 16.5 per 1,000 population. Infant mortality is estimated at 92 to 107 per 1,000 live births although individual studies range from 35 to over 200 depending on the socio-economic group and access to medical care. Preliminary data from the 1991 maternal mortality survey showed a mortality ratio of 236 per 100,000.

3. The major causes of childhood mortality remain malnutrition, diarrheal diseases and acute respiratory infections, with chronic malnutrition (stunting) reported in one third of the child population, and 17% of newborns weighing less than 2.5 kgs at birth. With an estimated annual tuberculosis incidence rate of five cases per 1,000 inhabitants, Haiti has one of the highest rates in the world. The problem is highly complicated by the appearance of the AIDS/tuberculosis disease correlation. Since the discovery of Acquired Immune Deficiency Syndrome (AIDS) in 1981, this disease has become a public health concern along with other sexually transmitted diseases. By the end of 1990 3,086 cases had been officially reported with an estimated 5% of the sexually active population seropositive for human immune deficiency virus (HIV) in urban areas. The malaria situation remains unclear and malaria statistics are notoriously incomplete, but malaria incidence is considered very high throughout the country. In 1991 from hospitals alone 101 deaths due to malaria were reported.

### Factors affecting health status

4. With an annual Gross National Product (GNP) per capital of $360 (UNDP, 1991), Haiti is one of the poorest countries in the world. Rural farmers have an estimated annual income of less than $100 and, in the capital, the formal unemployment rate for the active population has increased to over 60%. Illiteracy is high, reaching 47% among adults (UNDP, 1990). In 1991 potable water was available to 60% of the urban population and only 33.5% of rural zones. Only 16% of the rural population have latrines as compared with 43% in urban zones. UNDP estimated the human development index for 1992 at 0.276, and Haiti was ranked 124 of 160 countries listed.

5. About 540 facilities, run by the Government and/or the private sector provide the institutional base for the national medical services. The State University Hospital (HUEH) in the capital is often filled to overflowing, while many rural hospitals, even with a relatively low number of beds vis-a-vis their catchment areas, do not attain 50% occupancy rates. The number of health professionals remains extremely limited: 1.7 physicians per 10,000 population; 0.2 dentists per 10,000 population; 1.4 nurses per 10,000 population, 3.7 auxiliaries per 10,000 population, and six matrons per 10,000 population.

6. In 1990, an estimated 60% of the population had geographic access to modern care. In 1991 and 1992, the public sector was almost paralyzed, but the non governmental sector which benefitted from humanitarian assistance remained stable, continuing to deliver services to an increasing segment of the population through its institutions and community health programs.

7. Urban curative services are favored in allocation of budget and personnel, with Port-au-Prince (20% of population) receiving over 60% of health budget and served by 50% of health personnel. The 1992-1993 budget of the Ministry of Health was around G189 millions (15% of Government's budget and 1.3% of GDP) and that over 90% of this budget is required to cover salaries, thereby leaving no room for operating expenses.

8. Virtually everyone in rural as well as marginal urban areas uses traditional healers, be it birth attendants, herbalists or voodoo priests. There are also thousands of "piquristes" providing injections of allopathic medicine, a form of indigenous medicine.

9. Indicators of primary health care (PHC) services suggest that one of two pregnant women receives at least two prenatal visits. Fifty per cent of deliveries are attended by personnel with modern training (30% by professional medical personnel and 20% by traditional birth attendants with upgraded basic skills and a cord cutting kit). Immunization coverage of children was greatly improved through an Expanded Program on Immunization (EPI), including national vaccination days in 1988 and 1989 followed by institutional strengthening and local programming in 1990. Complete coverage at age one was estimated to be at 60% in 1990 nationwide with wide regional variations, followed by drastic falls

in coverage in 1991 and 1992. The Commission to certify eradication of paralytic poliomyelitis has been constituted and no cases have been confirmed in recent years.

Plans and priorities for national health development

10. The principles of PHC that evolved from Alma-Alta in 1978 have been supported in national planning exercises. In 1982, the Ministry of Public Health and Population (MSPP) issued a major policy document: "New Orientations", reaffirming health as an individual right and calling for a reform of the health delivery system, involving planning and identification of priority programs aimed at the most vulnerable groups, improving decision-making and efficiency through decentralized management, and encouraging communities to share responsibilities for the health of their members. In 1991 a draft Health Policy was prepared by the elected government, but never submitted to Parliament.

11. The last National Program and Budget for the development of health services, (1987-1991), contains two major elements. The first is the improvement and extension of health facilities to increase access to services and decentralization of decision-making. The second element is the definition of seven priority health programs: the control of diarrheal diseases; an expanded program on immunization; a nutritional program for children under five; improved maternal and child care and family planning services; the control of endemic diseases (malaria), the control of tuberculosis; the fight against sexually transmitted diseases, particularly AIDS. Leprosy, acute respiratory infections and prevention of blindness were later included ad hoc in the priority program approach, as outlined above.

12. There are three major components of the diarrheal diseases control program: oral rehydration, encouragement of breastfeeding, potable water and sanitation. Since 1981, the Government has subscribed to and participated in the goals of the program of the International Drinking Water Supply and Sanitation Decade notably with the creation of an interministerial council of Water and Sanitation, National Committee for the Water and Sanitation Decade (CONADEPA). An evaluation of the Decade and its results was published late 1990. The National Program for the Control of Diarrheal Diseases and Maternal Alimentation (PRONACODIAM) was begun in 1983.

13. The Government has followed WHO guidelines for the expanded Expanded Program on Immunization (EPI) since 1979 and officially launched a national program in 1985. No wild poliovirus has been isolated since 1989 and Neonatal Tetanus cases have decreased since 1985. The Program objective is universal immunization, with polio eradication, measles eradication and the elimination of neonatal tetanus also adapted as national objectives in 1991. The strategy includes the decentralization of specific targeted work plans, the integration of immunization into all health institutions and special intensive immunization days, on a local or national basis.

14. Nutrition surveillance for early detection of problems is being increased, with the adoption of a Road to Health-growth chart as a monitoring instrument for all priority programs. There is a consensus that a better understanding of malnutrition and its determinants is necessary to orient an integrated nutrition program, as well as to promote acute malnutrition surveillance by using new indicators as weight for height.

15. In the priority area of maternal health and family planning, the objectives set for 1994 called for 60% of pregnant women to receive prenatal care and tetanus immunization and 40% to be assisted in delivery by trained personnel in order to reduce maternal mortality. At least 20% of couples would be using effective contraception and the infant mortality rate was to be reduced from 124 to 90 per 1,000 live births. By end 1990 an initiative was developed to present an integrated maternal and child health program focusing on coverage and quality of care using the risk approach.

16. A main endemic disease of concern is malaria, with at least 60% of the population living in malarious zones. With the breakup in 1988 of the semiautonomous National Service for Major Endemic Disease (SNEM), malaria control, with UNDP support, is being integrated in PHCS and executed in a decentralized fashion, with first attention to appropriate diagnosis and treatment followed by epidemiological analysis of available data.

17. In the area of sexually transmitted diseases, AIDS is of particular concern, with 3,086 cases officially reported by the end of 1990 and acknowledged wide under reporting. The objectives and strategies adopted aim to: reduce sexual and perinatal transmission; have a safe blood supply; install standardized case definition, management and treatment; research on transmission; reduce social and economic impact of AIDS on Haitian communities; strengthen epidemiological surveillance, reduce sexually transmitted diseases transmission. A major part of the Control Program relies on information and education campaigns aimed at specific high risk groups, and training for better case management and psycho-social support. No formal evaluation of the 1988 medium term plan was carried out.

18. For tuberculosis the objective is to reduce abandonment rates and improve cure rates for diagnosed cases. No formal control programs are yet in place for leprosy and/or acute respiratory infections but they are being addressed as priority health problems. Cancer, diabetes and hypertension are becoming public health problems for which no formal strategies have as yet been adopted.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

19. Based on the major priorities identified, the government has decided to ask for technical cooperation in the following priority areas:

20. Analysis of the health sector and further development of policies and implementation aiming at increased efficiency in the use of resources and identification and mobilization of a higher level of resources from national and international sources, including the possibility of a Haiti Health Initiative.

21. Support for the decentralization process in the areas of gathering and analysis of information and management of local health systems and services.

22. Support for the process of coordination and, where possible, integration of the different institutions that comprise the health sector including, the Ministry of Public Health, other national institutions, NGOs and international cooperation to achieve increased coverage, better quality of services and better use of resources.

23. Improvement of the environment through increased coverage of potable water and particularly sewerage. Implementation of national policies regarding environmental health including design of training and introduction of appropriate technology; establishment of norms and standards for solid waste disposal; coordination of international support to the environmental health sector.

24. Strengthening of the capacity for epidemiological analysis, aiming at identifying causes, establishing reliable surveillance systems and contributing to the design of priority program interventions to reduce inter alia: maternal mortality; AIDS and other communicable diseases as malaria and tuberculosis; infant and perinatal mortality; as well as focusing on priority vulnerable groups.

25. Analysis of the health work force (structure, distribution, utilization) and development of national policies pertaining to their training and utilization. Identification of the issues in which gender plays a significant role.

26. Support the development of appropriate policy and adequate legislation on essential drugs. Support the supply of essential drugs and other medical supplies as well as the promotion of local production of generics and the use of medicinal plants. Promote the rational use of drugs and medical supplies. Support the training of health workers in the field of essential drugs and in pharmacy in general.

27. Most of the major external donors are involved in varying degrees in one or more of the priority program areas. In addition, within Haiti, there are numerous nongovernmental organizations, some indigenous, others linked with foreign parent groups, working in priority areas. The need for more effective mechanisms for coordination is gradually being addressed, as it is estimated there are 300 NGO's active in the health field alone.

28. In recent years cooperation between the Government and several non-governmental organizations was strengthened, with the government contracting NGO's to take full responsibility for delivery of health services to defined populations or geographical territories. In some cases the NGO's also take on management responsibility for state-owned health facilities as well as public service personnel. As part of their commitment the NGO's promise to undertake at least the national priority health programs. There has been scant attention to issues of organization, financing and/or management of the health sector, leaving room for wide experimentation and variation in this regard by private as well as public sector groups.

29. There is currently no single national health council. However, national intersectoral coordinating committees have been developed in response to program planning and implementation needs of different national priority programs. Examples are diarrheal diseases, the Expanded Program on Immunization, AIDS, and MCH/Family Planning. From these, the strategy which has evolved is that virtually every priority program has one or several "multisectoral" committees to oversee general policy, programming, operations and evaluation. Donor agencies are heavily represented in these interagency coordinating committees (ICC).

### National priorities for technical cooperation from PAHO/WHO

30. In support of the MSPP emphasis on the implementation of priority programs paying careful attention to the important issues of effectiveness, equity and efficiency, the PAHO/WHO country program will concentrate its technical cooperation on health infrastructure development necessary to implement specific subprogram interventions. PAHO/WHO, with its mission in the management of knowledge, will accord priority to health interventions and program implementation where Ministry and other operational resources are sufficient for sustained action, where targeted objectives have been defined and where a substantial health impact can be anticipated. PAHO/WHO activities will increasingly be brought to bear in support of the development of institutions and particularly on the health systems infrastructure components of the decentralization process, following an orientation of local health systems (SILOS). This will include adequate attention to health as an intersectoral process and an essential part of development, including the role of women in health and development.

31. A key role in the country program will be accorded to those activities which serve to assist in the coordination and mobilization of national and international resources for health program implementation. National and regional strategies to encourage more coordination and integration between public and private sector health institutions, especially non-governmental organizations, will receive priority attention by PAHO/WHO.

32. Health manpower development and training will continue to be a primary intervention strategy of the PAHO/WHO country program in Haiti. In the coming two bienna priority will be accorded to national training workshops, seminars and courses to develop appropriate skills needed for primary health care interventions and where the national health systems has an evident capacity to use effectively newly trained and motivated manpower. Long-term foreign fellowships will continue to be supported only in specific areas of necessity. In all training programs, priority will be given to training of trainers where an enhanced multiplier effect can be expected.

33. Supplies and materials provided in the country program will continue to be limited and tied to critical needs directly associated with other PAHO/WHO technical cooperation.

34. Special attention will be given in PAHO/WHO's Country Program to promote technical cooperation among countries (TCC), in order to facilitate contacts and access to expertise in neighboring countries.

35. In addition to using the regular funds assigned to Haiti, PAHO will also manage a number of resources from other donor agencies and multilateral organizations, such as UND, UNDP and UNFPA in MCH; USAID, EEC, France and Holland, and CIDA in essential drugs; France, Holland, the Swiss, UNDP, and WHO in AIDS, Germany, CIDA and France for cholera prevention and control; and others. These resources are utilized in accordance with established agreements and are designed to address and strengthen activities which are already supported through the regular program.

## PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

### Managerial support for national health development (MPN)

36. The purpose of this project is to promote an interface on policy dialogue and technical cooperation development with national authorities. It is proposed in this project that the PAHO/WHO Country Office continue its representation and management structure to interface with the MSPP on policy development and coordination. It will also interact with all other national and international actors to position health in/and development. The office of the Representative will seek to coordinate the country program in a fashion to meet essential program and infrastructure development needs of the MSPP programs in conformity with the global, regional and subregional goals and strategies of PAHO/WHO as well as priorities set forth in the SOPP for PAHO during the quadrennium 1991-1994. It will also be the responsibility of this project to oversee the appropriate development of the country office including the essential function of a documentation center. This documentation center will provide access to Haiti health professionals of a complete collection of PAHO and WHO books and documents, as well as selected public health literature. It will also build a collection of reference material, published and unpublished on Haiti health problems and programs.

### Technical cooperation among countries (TCC)

37. The purpose of this project is to promote technical cooperation among countries. It will be the effort of the PWR to assist the MSPP to identify potentials for TCC, as they may present themselves in technical programs in the future. Potential areas are epidemiological surveillance and malaria and AIDS control with the Dominican Republic, as well as integration of Haiti into the general programming of the Caribbean Community (CARICOM) Health Section and promotion of subregional project linkages with the CCH initiative and the Central American Bridge for Peace Initiative.

### Health services development (DHS)

38. The purpose of this project is to provide technical cooperation in the planning, programming, and development of national programs to extend and improve personal health care delivery services and the referral system, concentrating on their organization, financing and management. PAHO/WHO will assist in the identification and development of critical infrastructure components of national program activities and particularly as regards the decentralization process including cooperation between public and private sector for effective and efficient delivery of health services. Policy dialogue and technical cooperation on issues of organization, financing and management of health services will be the broad focus of the project. An appropriate training program will be developed as well as technical consultation, material and supplies for catalytic support. PAHO/WHO will address technical cooperation needs as defined for the essential drugs sector where PAHO/WHO will continue to carry out activities towards the mobilization of extrabudgetary resources to support the adoption of an appropriate essential drugs policy for the country.

Community water supply and sanitation (CWS)

39. The purpose of this project is to provide technical cooperation for the development, institutional strengthening and coordination of the national and non-governmental institutions active in the Community Water Supply and Sanitation (CWSS) sector, concentrating on: planning and programmingp of human resources development and management of existing facilities. In view of the extensive support from national and external assistance agencies to Haiti's national program, the PAHO/WHO technical cooperation will especially work to assure effective coordination of policies through the CONADEPA as well as in effective and efficient program implementation; it will assist in select training programs to meet both the manpower training needs and to promote community participation. The Organization will provide expertise for the organization and conduct of operational research, and for the introduction of appropriate technology.

Health situation and trend assessment (HST)

40. The purpose of this project is to provide technical cooperation to the development of adequate epidemiological capacity in the country, concentrating on manpower and information system development. PAHO/WHO will assist with the process of identifying priority health problems, the definition of appropriate control programs, as well as their evaluation. This process will be based on principles of epidemiology as well as economic analysis (e.g. cost effectiveness and cost-benefit). PAHO/WHO will continue to execute its field epidemiology training programs as well as the provision of both local and external expertise, fellowships, in-country training, supplies and materials. These will address malaria, tuberculosis, AIDS as well as the different elements of a maternal and child health program presented in a separate project. The process to strengthen epidemiological capacity as well as the process to promote local health systems as a fundamental strategy for disease control will be adopted more specifically in a subproject to control malaria and other infectious diseases.

Growth, development and human reproduction (MCH)

41. The purpose of this project is to provide technical and financial cooperation to the improvement of the services delivery of the MCH Program within a framework of integrated, decentralized and community based services. PAHO/WHO will provide support to assist with the process of integrating different aspects of existing priority programs as EPI, CDD, FP, ARI in a national program of maternal and child health.

Acquired immunodeficiency syndrome (HIV)

42. The purpose of this project is to provide technical and financial cooperation in support to the national AIDS/STD prevention and control program, concentrating on Epidemiology, training, management and coordination. The Organization will also concentrate on its mandate to coordinate international assistance for AIDS Prevention and Control.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 3,069,200 | 70.5 | 2,837,900 | 60.7 | 3,160,700 | 60.8 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 717,300 | 16.5 | 777,700 | 16.6 | 875,000 | 16.8 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 717,300 | 16.5 | 777,700 | 16.6 | 875,000 | 16.8 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 167,000 | 3.8 | 189,400 | 4.0 | 214,800 | 4.1 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 167,000 | 3.8 | 189,400 | 4.0 | 214,800 | 4.1 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 1,058,700 | 24.3 | 962,500 | 20.7 | 1,061,800 | 20.5 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 1,058,700 | 24.3 | 962,500 | 20.7 | 1,061,800 | 20.5 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 1,126,200 | 25.9 | 908,300 | 19.4 | 1,009,100 | 19.4 |
| HEALTH SERVICES DEVELOPMENT | DHS | 1,126,200 | 25.9 | 908,300 | 19.4 | 1,009,100 | 19.4 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 1,287,600 | 29.5 | 1,842,500 | 39.3 | 2,032,700 | 39.2 |
| ENVIRONMENTAL HEALTH | | 915,700 | 21.0 | 905,400 | 19.3 | 990,400 | 19.1 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 915,700 | 21.0 | 905,400 | 19.3 | 990,400 | 19.1 |
| MATERNAL AND CHILD HEALTH | | 371,900 | 8.5 | 713,100 | 15.2 | 792,700 | 15.3 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 371,900 | 8.5 | 713,100 | 15.2 | 792,700 | 15.3 |
| COMMUNICABLE DISEASES | | 0 | - | 224,000 | 4.8 | 249,600 | 4.8 |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 0 | - | 224,000 | 4.8 | 249,600 | 4.8 |
| GRAND TOTAL | | 4,356,800 | 100.0 | 4,680,400 | 100.0 | 5,193,400 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 3,430,800 | 36.4 | 0 | - | 0 | |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 3,430,800 | 36.4 | 0 | - | 0 | |
| HEALTH SERVICES DEVELOPMENT | DHS | 100,400 | 1.1 | 0 | - | 0 | |
| DISASTER PREPAREDNESS | DPP | 3,330,400 | 35.3 | 0 | - | 0 | - |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 5,971,600 | 63.6 | 2,387,200 | 100.0 | 0 | - |
| MATERNAL AND CHILD HEALTH | | 4,431,800 | 47.2 | 1,118,300 | 46.8 | 0 | - |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 2,816,300 | 30.0 | 1,118,300 | 46.8 | 0 | - |
| IMMUNIZATION | EPI | 1,589,400 | 16.9 | 0 | - | 0 | - |
| DIARRHEAL DISEASES | CDD | 26,100 | .3 | 0 | - | 0 | - |
| COMMUNICABLE DISEASES | | 1,520,100 | 16.2 | 1,268,900 | 53.2 | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 660,100 | 7.0 | 1,012,700 | 42.4 | 0 | - |
| MALARIA | MAL | 692,400 | 7.4 | 250,000 | 10.5 | 0 | - |
| SEXUALLY TRANSMITTED DISEASES | VDT | 167,600 | 1.8 | 6,200 | .3 | 0 | - |
| HEALTH PROMOTION | | 19,700 | .2 | 0 | - | 0 | - |
| OCULAR HEALTH | PBD | 19,700 | .2 | 0 | - | 0 | - |
| GRAND TOTAL | | 9,402,400 | 100.0 | 2,387,200 | 100.0 | 0 | |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 3,185,300 | 4 | 5 | 600 | 1,278,400 | 55,800 | 60 | 120,000 | 466,300 | 354,000 | 0 | 910,800 |
| WHO - WR | 1,171,500 | 2 | 1 | 240 | 516,200 | 35,800 | 110 | 220,000 | 151,500 | 122,800 | 0 | 125,200 |
| TOTAL | 4,356,800 | 6 | 6 | 840 | 1,794,600 | 91,600 | 170 | 340,000 | 617,800 | 476,800 | 0 | 1,036,000 |
| % OF TOTAL | 100.0 | | | | 41.2 | 2.1 | | 7.8 | 14.2 | 10.9 | .0 | 23.8 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 3,193,100 | 5 | 5 | 300 | 1,402,800 | 104,000 | 50 | 100,000 | 356,900 | 309,000 | 0 | 920,400 |
| WHO - WR | 1,487,300 | 2 | 1 | 420 | 585,000 | 0 | 20 | 40,000 | 485,200 | 207,400 | 0 | 169,700 |
| TOTAL | 4,680,400 | 7 | 6 | 720 | 1,987,800 | 104,000 | 70 | 140,000 | 842,100 | 516,400 | 0 | 1,090,100 |
| % OF TOTAL | 100.0 | | | | 42.5 | 2.2 | | 3.0 | 18.0 | 11.0 | .0 | 23.3 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 3,547,600 | 5 | 5 | 300 | 1,530,800 | 117,800 | 50 | 100,000 | 404,800 | 350,400 | 0 | 1,043,800 |
| WHO - WR | 1,645,800 | 2 | 1 | 420 | 628,000 | 0 | 20 | 40,000 | 550,200 | 235,200 | 0 | 192,400 |
| TOTAL | 5,193,400 | 7 | 6 | 720 | 2,158,800 | 117,800 | 70 | 140,000 | 955,000 | 585,600 | 0 | 1,236,200 |
| % OF TOTAL | 100.0 | | | | 41.5 | 2.3 | | 2.7 | 18.4 | 11.3 | .0 | 23.8 |

HONDURAS

## HEALTH SITUATION ANALYSIS

### Demography

1. According to the 1989 census, the estimated population of Honduras will be nearly 6 million inhabitants for the biennium, with an annual growth of 3.1%. With an area of 115,000 Km², it will have a population density of 52 inhabitants per km², with 45% of the population concentrated in urban areas, although its capital, the largest city, will still not have a million inhabitants during the biennium.

### Health status indicators

2. At the start of the decade, life expectancy was 63 years for men and 67 years for women, with a crude birth rate of 38 per 1,000 and a death rate of 7 per 1,000. Infant mortality was 64 per 1,000 live births. Health services include 46 hospitals, which gave a ratio of 110,957 inhabitants per hospital.

3. The main problems for the beginning of the decade, and these trends are expected to continue through the biennium, are: sexually transmitted diseases, especially AIDS on the northern Caribbean coast; vector-borne diseases, like malaria and dengue which are localized in those areas of internal migration toward the export agriculture areas on the Caribbean coast of San Pedro Sula and La Ceiba; and diarrheal diseases. Among children, acute respiratory diseases constitute the greatest problem throughout the country, and chronic deficiencies, like malnutrition, affect emigration corridors, as in the West on the border with El Salvador and Guatemala.

4. The country has made important achievements in the health sector. Increased vaccination coverage has drastically diminished the incidence of measles. There were no reported deaths due to measles in the past two years and no cases of poliomyelitis in the past four years. As in the case of the cholera epidemic, a notably adequate control was attained, partially due to the improvement in basic health infrastructure in rural areas.

5. These primary care measures carried out in the prevention of immunizable diseases and in cholera control show that the human resources and health infrastructure at the primary care level are dependable and permit a dynamic articulation among the local, regional, and central levels.

### Factors affecting health status

6. For Central America and particularly Honduras, the early 1990s brought first the possibility, and then the certainty, of a new period of stability, peace, and development. The mid-1990s should promise increased production, reduced unemployment, and lower inflation although these tendencies do not necessarily mean an improvement of the skewed distribution of personal income. The past decade's profile, as summarized by the U.N. Economic Commission for Latin America and the Caribbean (ECLAC), remains valid: the poorest 50% of the population received only 17% of national income, and this group included 20% in a situation of extreme poverty and another 10% considered as indigent.

7. The effects of the economic stabilization policy and the modernization of the state, which the Government of President Rafael L. Callejas initiated in 1990, will only be clearly evident in the second half of the decade when the social compensation measures, aimed at mitigating the impact of the policies on the most impoverished groups, are evaluated. Although several new hospitals recently initiated activities in several regions of the country, health service infrastructure is still deficient. There is little possibility for improvement, considering the high costs and the impossibility of private initiative or the social security system shouldering the problem, especially in traditionally underserved regions such as the eastern Nicaraguan border area with Misquita (native American) or Garífuna (black Caribbean) populations.

### Plans and priorities for national health development

8. The Government of the Republic has developed a process of modernization of the State in which the reorganization and reorientation of the National Health System are proposed. The fundamental procedures of this initiative seek universal access to health care; the incorporation of municipalities into the health system; technical, administrative, and financial decentralization; the development of community participation and control in decision-making in health; the strengthening of the management capacity of the system, especially at the local level; and the recovery of human resources.

9. The government's plan states the need to expand health insurance coverage to the entire population, maintaining the comprehensive nature of service networks.

10. For this purpose, a presidential health commission has been organized and has the support of a technical group in which the PAHO/WHO participates. A proposal has been drafted, and is being negotiated with the various social forces and actors of the country. Some of the proposal's points have already been incorporated in the 1993 program of action for the Ministry of Health and the Honduran Institute of Social Security. PAHO/WHO is firmly committed to this initiative.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

11. The Government has identified three large groups of national priorities for technical cooperation in health, which are stated below; in all these areas PAHO cooperation is expected:

12. Local, decentralized, strategic management, made up of the following principal components; the standardization of health care services; the

development of health resources; the role of health regions and their constituent areas; food safety; the role of health services as related to women's problems.

13. The control of the environment, made up of the following principal components: Availability of drinking water, supporting the responsible institutions in urban areas and relevant projects in the rural area; the Center of Studies of Toxic and Polluting Substances (CESSCO); the National Council on the Environment (CONAMA) and the PAHO/WHO Project MASICA; the work microenvironment in occupational health; natural disasters as serious human and environmental problems.

14. Health problems and needs, which point to the need for a vigorous development of epidemiology through health situation analyses and epidemiological surveillance; although the main areas of work are described below, these all require a comprehensive epidemiological, decentralized approach.

15. Cholera and diarrheal diseases; acquired immunodeficiency syndrome (AIDS) and other sexually transmitted diseases; diseases preventable by vaccination; vector-borne diseases; health of women, encompassing prevention and control of cancer of the cervix; acute respiratory infections; drug abuse; violence.

16. In turn, these priorities are coordinated horizontally within three large strategic lines of work:

17. The development of scientific research that would consist of bringing together the Honduran scientific community regularly, promoting its production and exchange, and supporting the achievement of greater excellence, as well as sponsoring and disseminating its work and facilitating the formation of various schools of interdisciplinary thought over the long term.

18. The development of technical cooperation among countries, not only with those that border Honduras and share common problems, but with other countries of the Region to enable a greater exchange of experiences and examples.

19. The development of external cooperation that would basically consist of analysis of the sources, institutions, and procedures of external cooperation, the development of a Ministry of Health unit that would dynamically handle a portfolio of projects, mechanisms for converting external debt into health projects, and coordination with, and policy on nongovernmental organizations involved in health activities.

20. In addition to developing the set of projects with PAHO/WHO regular funds, as described in the following point, PAHO/WHO will continue to mobilize national and external resources within the framework of the Central American Initiative, which in the case of Honduras includes activities in the following technical areas: environment and health; women, health, and development; prevention and control of malaria and dengue; prevention and control of AIDS; health equipment maintenance.

21. In addition, it will continue to provide technical cooperation in the area of food and nutrition through INCAP.

## PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

### Services of public water supply and sanitation (CWS)

22. The purpose of this Project is to develop processes for the environmental control and to improve the water supply and the solid waste disposal services, mainly in rural communities and marginal urban neighborhoods.

23. To this end, cooperation in coordinating actions between water supply institutions in the cities and national centers and institutions concerned about the environment will be provided. In rural areas, greater community participation in the administration of water and sanitation services will be sought in the framework of local health systems, promoting the participation of local governments and coordination with Health Regions and Areas.

### Health services development (DHS)

24. The purpose of this project is to develop local health systems through a process of decentralization and community participation.

25. Cooperation will continue in preparing health standards, with a dual approach: in addition to the indispensable generation and application of standards at the national level, other standards requiring local application will be drafted with the participation of the concerned population. Mass communication and interdisciplinary work groups will be promoted for introducing specialized programs at the level of Health Region and Areas. Health Region and Area teams will be strengthened through managerial training and instruction in epidemiology. In addition, interinstitutional articulation of the national health system will be supported and developed, and cooperation in the integration of the service component in the process of modernization of the state will be provided.

### Preparations for disasters (DPP)

26. The purpose of this project is to integrate the health component into the National Emergency Program. To this end, technical cooperation will be provided for preparing the National Emergency Plan in Health, regional teams will be trained to face situations of natural disasters, and the formation and operation of intersectoral teams for the prevention and mitigation of disasters will be promoted.

### Dissemination of scientific and technical information (HBD)

27. The purpose of this project is to establish processes so that the scientific community increases the quality of its scientific production and the publication of its results, as well as the development of ties in order to take advantage of external cooperation and technical cooperation among countries.

28. Technical coordination will be provided in order to consolidate the scientific community and to foster its production, coordinating among various institutions, both nationally and internationally. Investigators of the most appropriate research units for carrying out studies relevant to national health development will continue to be supported. Teams of investigators will be trained to produce their own research publications. In addition, the PAHO/WHO Documentation Center and the health information network will be technically strengthened.

Analysis and development of health policies (HDP)

29. The purpose of this project is to contribute to the process of modernization of the State and in particular the health sector, pursuing the policy goal of achieving equity, effectiveness, and efficiency. To this end, cooperation on technical, administrative, and financial decentralization will continue to be provided for the review of legislation, the development of administrative procedures, and managerial training at the national level. The development of local health systems will continue to be supported with the participation of the Ministry of Health, the Honduran Institute of Social Security, and municipal governments.

Human resources education (HRE)

30. The purpose of this project is to develop training programs to increase the technical response capability of human resources in the face of priority problems identified by the population and the health services.

31. To this end, technical support will be provided to the sector for establishing a continuing education program in eight selected health areas. The program will bolster the technical and management capability of human resources, as an integral part of local administrative development. Programs for human resource education in critical areas will continue to be supported to develop a national plan for human resources. Cooperation will also be provided to strengthen the development of a human resources management capability.

Health situation assessment and its trends (HST)

32. The purpose of this project is to establish an integrated process for the development of epidemiology to enable the corresponding situation analyses and surveillance both at the central and local levels. To this end, cooperation will continue to be provided to coordinate actions of the specific projects of communicable and noncommunicable diseases, at the central, regional, and health area levels. The integration of teaching and service activities will be promoted for training in epidemiology and statistics.

Growth, development, and human reproduction (MCH)

33. The purpose of this project is to reduce maternal and child morbidity and mortality by increasing access to health care and employing a risk approach. To this end, cooperation will continue to be provided for the strengthening and systematization of epidemiological surveillance of maternal and child health problems. Training in the application of the Reproductive Risk Approach (contraception and pregnancy and delivery care at a level of complexity according to the degree of risk) will continue. Cooperation in the implementation of specific strategies, including the training and supervision of midwives and the establishment of birthing centers, will aim to diminish maternal and child mortality. Technical cooperation will be provided to strengthen community treatment of children with pneumonia and diarrhea and to strengthen the first referral level.

Managerial support for national health development (MPN)

34. The purpose of this project is to optimize the delivery of PAHO technical cooperation. To this end, political and diplomatic activities will be carried out to enable a high-level exchange between the national health authorities and the PAHO counterparts at the central level. The technical capabilities of the PAHO/WHO Representative's Office will continue to be developed and the technical resources of centers and regional programs will be mobilized for the delivery of technical cooperation in each of the projects. In addition, efficient administrative systems will be developed to facilitate technical cooperation.

Health promotion and noncommunicable disease prevention and control (NCD)

35. The purpose of this project is to develop a health promotion program directed toward dealing with the principal problems of noncommunicable diseases. To this end, cooperation will be provided in order to identify, both at the sectoral and extrasectoral levels, the key actors at the central and regional levels in order to design and establish a community program to control violence. Cooperation in developing the capacity of processing cytologies for the detection of uterocervical cancer will continue.

General Communicable Disease Prevention and Control Activities (DCD)

36. The purpose of this project is to improve the management of communicable disease control programs. To this end, the national epidemiology group will continue to be strengthened, and the restructuring of the Epidemiological Surveillance System will be promoted. In addition, cooperation will bolster the decentralization of disease control programs, favoring, in as much as possible, the technical development of the regions.

Technical cooperation among countries (TCC)

37. The purpose of this project is to contribute to the mobilization of resources through cooperation among countries. To this end, support will continue for the program of cooperation with Mexico, Ecuador, and Belize wich promotes the development of scientific research.

Vector-borne diseases (VBC)

38. The purpose of this project is the control of vector-borne diseases, particularly malaria and dengue on the Pacific and Atlantic coasts. To this end, cooperation will continue to bolster the program of community participation and the decentralization of control programs toward Health Regions. In addition, cooperation in technical, administrative coordination will be focused at the level of Health Regions with the different actors whose actions can have an impact on the control of these diseases.

Women, health, and development (WHD)

39. The purpose of this project is to reorient the policies, programs, and actions aimed at the female population to give them a gender approach in order to guarantee access to social benefits with equity, efficiency, effectiveness, and social participation.

40. To this end, the participation of women in the care and protection of their own health will continue to be promoted and based on strengthening of their self-esteem and on individual and collective practices aimed to resolve the health problems of women and to facilitate their incorporation in the sustained development of the country. Cooperation will be provided in the reorientation of policies, programs, and actions aimed at women, using a gender approach in order to achieve intersectoral and interinstitutional, articulated and comprehensive action and improve the access of women to health with equity, efficiency, effectiveness, and social participation.

41. The review and reform of laws using gender approaches will be supported in order to avoid measures that obstruct the fair access of women to social benefits. Research projects with a gender perspective will be promoted to help to explain women's problems.

42. Actions of formation, retraining and development of institutional and non-institutional human resources of civilian society will be carried out to raise awareness about the problem of women and to contribute to comprehensive and humanized care.

Zoonosis (ZNS)

43. The purpose of this project is to coordinate the mobilization of resources in support of zoonosis programs in different locations. Cooperation will continue in the coordination of actions between the Ministry of Health and the Ministry of Agriculture to achieve the control of rabies and the improvement of veterinary public health.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 1,771,000 | 65.7 | 2,026,300 | 66.2 | 2,245,200 | 66.4 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 556,200 | 20.6 | 652,600 | 21.4 | 737,200 | 21.8 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 556,200 | 20.6 | 652,600 | 21.4 | 737,200 | 21.8 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 33,200 | 1.2 | 37,600 | 1.2 | 42,600 | 1.3 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 33,200 | 1.2 | 37,600 | 1.2 | 42,600 | 1.3 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 195,700 | 7.3 | 315,500 | 10.3 | 347,800 | 10.3 |
| HEALTH SITUATION AND TRENO ASSESSMENT | HST | 195,700 | 7.3 | 315,500 | 10.3 | 347,800 | 10.3 |
| HEALTH POLICY DEVELOPMENT | | 94,200 | 3.5 | 103,900 | 3.4 | 113,900 | 3.3 |
| HEALTH POLICY ANALYSIS AND DEVELOPMENT | HDP | 47,800 | 1.8 | 51,600 | 1.7 | 55,200 | 1.6 |
| WOMEN, HEALTH AND DEVELOPMENT | WHD | 46,400 | 1.7 | 52,300 | 1.7 | 58,700 | 1.7 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 640,800 | 23.8 | 650,900 | 21.2 | 708,100 | 20.9 |
| HEALTH SERVICES DEVELOPMENT | DHS | 626,900 | 23.3 | 635,100 | 20.7 | 690,200 | 20.4 |
| DISASTER PREPAREDNESS | DPP | 13,900 | .5 | 15,800 | .5 | 17,900 | .5 |
| HUMAN RESOURCES DEVELOPMENT | | 133,100 | 4.9 | 128,700 | 4.2 | 138,000 | 4.1 |
| HUMAN RESOURCES EDUCATION | HRE | 133,100 | 4.9 | 128,700 | 4.2 | 138,000 | 4.1 |
| HEALTH INFORMATION SUPPORT | | 117,800 | 4.4 | 137,100 | 4.5 | 157,600 | 4.7 |
| SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION | HBD | 117,800 | 4.4 | 137,100 | 4.5 | 157,600 | 4.7 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 927,600 | 34.3 | 1,036,000 | 33.8 | 1,137,100 | 33.6 |
| ENVIRONMENTAL HEALTH | | 377,500 | 14.0 | 433,100 | 14.1 | 473,400 | 14.0 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 377,500 | 14.0 | 433,100 | 14.1 | 473,400 | 14.0 |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| MATERNAL AND CHILD HEALTH | | 75,400 | 2.8 | 85,600 | 2.8 | 97,100 | 2.9 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 75,400 | 2.8 | 85,600 | 2.8 | 97,100 | 2.9 |
| COMMUNICABLE DISEASES | | 336,600 | 12.4 | 365,000 | 11.9 | 399,900 | 11.8 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 116,700 | 4.3 | 328,200 | 10.7 | 359,800 | 10.6 |
| VECTOR-BORNE DISEASES | VBC | 219,900 | 8.1 | 36,800 | 1.2 | 40,100 | 1.2 |
| HEALTH PROMOTION | | 116,500 | 4.3 | 128,000 | 4.2 | 139,800 | 4.1 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 116,500 | 4.3 | 128,000 | 4.2 | 139,800 | 4.1 |
| VETERINARY PUBLIC HEALTH | | 21,600 | .8 | 24,300 | .8 | 26,900 | .8 |
| ZOONOSES | ZNS | 21,600 | .8 | 24,300 | .8 | 26,900 | .8 |
| GRAND TOTAL | | 2,698,600 | 100.0 | 3,062,300 | 100.0 | 3,382,300 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 331,700 | 10.6 | 0 | - | 0 | |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 11,300 | .4 | 0 | - | 0 | |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 11,300 | .4 | 0 | - | 0 | |
| HEALTH POLICY DEVELOPMENT | | 5,500 | .2 | 0 | - | 0 | - |
| WOMEN, HEALTH AND DEVELOPMENT | WHD | 5,500 | .2 | 0 | - | 0 | - |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 314,900 | 10.0 | 0 | - | 0 | - |
| HEALTH SERVICES DEVELOPMENT | DHS | 299,100 | 9.5 | 0 | - | 0 | - |
| DISASTER PREPAREDNESS | DPP | 15,800 | .5 | 0 | - | 0 | - |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 2,800,800 | 89.4 | 1,012,500 | 100.0 | 0 | - |
| ENVIRONMENTAL HEALTH | | 440,500 | 14.1 | 0 | - | 0 | - |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 397,800 | 12.7 | 0 | - | 0 | - |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 42,700 | 1.4 | 0 | - | 0 | - |
| MATERNAL AND CHILD HEALTH | | 357,800 | 11.4 | 0 | - | 0 | - |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 16,000 | .5 | 0 | - | 0 | - |
| DIARRHEAL DISEASES | CDD | 341,800 | 10.9 | 0 | - | 0 | - |
| COMMUNICABLE DISEASES | | 1,998,300 | 63.8 | 1,012,500 | 100.0 | 0 | - |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 387,700 | 12.4 | 0 | - | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 561,000 | 17.9 | 447,500 | 44.2 | 0 | - |
| MALARIA | MAL | 1,049,600 | 33.5 | 565,000 | 55.8 | 0 | - |
| HEALTH PROMOTION | | 4,200 | .1 | 0 | - | 0 | - |
| OCULAR HEALTH | PBD | 4,200 | .1 | 0 | - | 0 | - |
| GRAND TOTAL | | 3,132,500 | 100.0 | 1,012,500 | 100.0 | 0 | |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 1,916,700 | 3 | 5 | 465 | 790,900 | 62,600 | 87 | 174,000 | 332,000 | 223,200 | 0 | 334,000 |
| WHO - WR | 781,900 | 2 | 0 | 270 | 400,800 | 17,400 | 36 | 72,000 | 183,300 | 64,300 | 3,500 | 40,600 |
| TOTAL | 2,698,600 | 5 | 5 | 735 | 1,191,700 | 80,000 | 123 | 246,000 | 515,300 | 287,500 | 3,500 | 374,600 |
| % OF TOTAL | 100.0 | | | | 44.1 | 3.0 | | 9.1 | 19.1 | 10.7 | .1 | 13.9 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 2,125,100 | 3 | 5 | 480 | 909,300 | 71,100 | 53 | 106,000 | 369,700 | 257,100 | 0 | 411,900 |
| WHO - WR | 937,200 | 2 | 0 | 219 | 456,700 | 14,500 | 34 | 68,000 | 246,200 | 98,300 | 0 | 53,500 |
| TOTAL | 3,062,300 | 5 | 5 | 699 | 1,366,000 | 85,600 | 87 | 174,000 | 615,900 | 355,400 | 0 | 465,400 |
| % OF TOTAL | 100.0 | | | | 44.6 | 2.8 | | 5.7 | 20.1 | 11.6 | .0 | 15.2 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 2,356,800 | 3 | 5 | 480 | 992,400 | 80,600 | 53 | 106,000 | 419,200 | 291,500 | 0 | 467,100 |
| WHO - WR | 1,025,500 | 2 | 0 | 219 | 489,700 | 16,400 | 34 | 68,000 | 279,300 | 111,400 | 0 | 60,700 |
| TOTAL | 3,382,300 | 5 | 5 | 699 | 1,482,100 | 97,000 | 87 | 174,000 | 698,500 | 402,900 | 0 | 527,800 |
| % OF TOTAL | 100.0 | | | | 43.8 | 2.9 | | 5.1 | 20.7 | 11.9 | .0 | 15.6 |

JAMAICA

## HEALTH SITUATION ANALYSIS

### Demography

1. As of April 1991, the preliminary census report gives the population of Jamaica as 2,366,067 which is quite close to the 1991 end of year estimate of 2,435,800. The estimated growth rate of the population for 1991 was 0.9% and the decrease due to external movements amounted to 25,900. The crude birth rate and crude death rate were 24.7 and 5.5 per 1,000, respectively.

2. Caution is urged in the utilization of some of these data as reliable indicators of national vital events, due to the chronic problem of under-reporting and under-registration. Notwithstanding, there is a narrowing base to the population pyramid which suggests a declining fertility and an aging population. This has policy and program implications. The age group under 14 years account for 33% of the population; the labor force (i.e. 15 - 64 years) account for 58.6%, while the 65 years and over account for 7.5% and the over 60 years old for 10% of the population.

### Health status indicators

3. There were no serious epidemics during 1991. However, Jamaica was put on and has remained on Cholera alert because of the epidemic in Latin America. At the same time, the unusually high numbers of rubella and chicken pox cases reported in 1991 suggest that there were epidemics of both rubella and chicken pox.

4. Trauma caused by accidents and violence was the leading cause of morbidity among the population in general, and second among children 1 - 4 years old; while the incidence of cardiovascular diseases, genito-urinary diseases and cancer increased significantly. The most prevalent neoplasms were those of the cervix, uterus, stomach, breast and lungs.

5. The incidence of gastro-enteritis as a leading cause of admission among children 1-4 years old decreased between 1989 and 1990 and may be attributable to success with the use of oral rehydration therapy. There is growing evidence of malnutrition among children 0-5 years old in select high risk communities.

6. In 1989, life expectancy at birth was 70.8 years (male/female). The leading causes of death for all ages in 1990 were malignant neoplasms, heart disease, cerebrovascular disease, hypertension and diabetes mellitus; while for the under one year old age group these were: intestinal diseases, conditions originating in the perinatal period, nutritional deficiencies, congenital abnormalities, pneumonia and influenza.

7. The number of reported cases and deaths from AIDS has risen significantly. To the end of November 1992, a total of 419 AIDS cases was reported (64% males and 46% females) and 70% of these have died. Of the total pediatric of 39, 70% have died. The male/female ratio is now 1.9:1 among adults. Confirmed HIV infected persons, excluding those with AIDS, number 1,005 (619 male). An intensive surveillance program continued during 1992 and the national HIV/sexually transmitted diseases control program has maintained a relatively high public profile with the launching of a intensive media campaign and condom marketing program. The prevalence of HIV and certain other STDs remain a cause for concern.

8. The maternal mortality rate derived from Government hospitals - where approximately 80% of live births occur - was estimated at 10.9 per 10,000 live births in 1991 which reversed the gains made in 1990 when the rate was 5.6% per 10,000. The perinatal mortality rate for 1991 was estimated at 25.5 per 1,000 live births, while that for 1990 was estimated to be 29.8.

### Factors affecting health status

9. The inability of the Ministry of Health (MOH) to respond to the increase in demand for its services generally results from underfinancing. Although the overall budget of the MOH for 1991-1992 increased by 10% over 1990-1991, the recurrent budget for Primary Health Care was less in 1991-1992 than in 1990-1991, while the Secondary Care budget was increased in the latter budget year. However, in view of the depreciation of the Jamaican dollar by 60.9% in 1991, the subsequent rise in the cost of pharmaceuticals, medical supplies and other basic commodities, the increase in the budget was inadequate. Budgetary constraints and the impact of devaluation were primarily responsible for the delay in planned projects and programs.

10. Another problem is the scarcity of human resources. The acute shortage of nurses resulted, among other things, in the closure of wards and/or amalgamation of wards; reduction in elective surgery; unattended deliveries; high incidence of absenteeism and low morale; poor quality of nursing care and consequent adverse reaction from the public. The attrition of nurses slowed somewhat in 1991 and was further mitigated by recruitment from abroad. Significant shortages still persist among pharmacists and public health inspectors. Manpower planning activities during the last biennium were virtually non-existent; and yet there is a need for this, having regard to the complement of personnel employed by the MOH; some 12,000 - 13,000. This has been recognized by the Ministry and plans are in hand to address this area as a priority. There are also initiatives to mitigate the worst effects of the loss of personnel from the MOH to other institutions and via migration.

11. New and innovative management strategies continue to be put in place for the improvement of services. Decentralization of the health services still remains a high priority and activities to further this policy initiative are continuing apace, including the identification and training of personnel. It is envisaged that through this continued structural/functional rearrangement of service delivery, the health service coverage for both Primary Health Care and Secondary/Tertiary care will be improved, thus providing for equity in accessibility of the services. In this regard, some rationalization of secondary services has taken place, reducing the number of secondary institutions by four hospitals, and is expected to continue.

12. The environmental health program is mainly carried through the MOH as a regulatory agency. However, other Government agencies play important roles in this area, either as regulatory or as implementing ones, namely: The Natural Resources Conservation Authority, the Underground Water Authority, the Ministry of Development, Planning and Production, the National Water Commission and the Ministry of Local Government.

13. The incidence of respiratory tract infections, gastro-enteritis, typhoid, and skin diseases is generally closely allied to unsatisfactory environmental conditions. The high incidence of cardiovascular diseases, diabetes, psychiatric disorders, drug abuse and motor vehicle accidents is pointing to increasing stress within the society and in so doing, indicate the need for a less stressful lifestyle. As regards drug abuse, available data (1991) suggest that consumption of all drugs on a national scale has declined since 1989. However, it appears that the use of cocaine and crack has increased in the urban centers while a decline is indicated in rural areas.

Plans and priorities for national health development

14. The Government health services are operated mainly by the Ministry of Health. The Five-Year Health Plan (1990-1995) became effective in 1990. The Ministry of Health's policy as enunciated in the National Five-Year Plan 1990-1995 is "to seek to provide comprehensive, efficient and acceptable health services which incorporate both the public and private sectors and provide at least a basic level of health care for all people, with facilities for easy transfer of people to all levels of care as necessary".

15. The strategies for achieving the policy objectives include: finding new initiatives for financing health care; expanding and improving the quality of family planning, counselling and general services in collaboration with the National Family Planning Board, to facilitate the achievement of National Population Policy target; raising the management and support services to the same high level of competence and to provide physical facilities and equipment which will encourage high standards of care.

16. The following activities are geared towards achieving the third priority: establishing a comprehensive health information system to support central management systems and the decentralized administration of the health services; phasing in of the decentralized structure for the MOH which began in 1991; setting up four regional authorities to strengthen the parish public health services and development of local health systems offering integrated primary and secondary services; upgrading of physical infrastructure in the primary, secondary and tertiary services; testing and incorporating disaster plans at all levels as a component of basic training programs, including simulation exercises; identifying high risk mothers and developing regional maternity clinics for the management of high risk cases, and strengthening of domiciliary services; improving nutrition status with the focus on specific vulnerable and high risk groups; promoting oral health through public education which emphasizes preventive measures, particularly in school children; integrating mental health into Primary Health Care services; addressing the chronic lifestyle diseases which are responsible for much of the morbidity among the older population, including diabetes and hypertension and a cancer screening program; promoting food safety and protection.

17. The sustainable management of the natural resource based economy is also a basic policy goal. It requires that the environmental health and natural resources be managed in such a way that they do not compromise the welfare of present or future generations. The priorities of the MOH are to: improve the drinking water quality by proper monitoring, reporting and by setting standards; minimize the pollution of water, both surface and underground, by improper excreta/sewage disposal; reduce the impact of air pollutants on the human environment, especially infectious and hazardous wastes; and improve the working conditions of factory and farm workers. Activities to achieve the objectives include: decentralizing the environmental health activities; promoting community participation in the detection and solution of environmental health problems; establishing a strong monitoring program of raw water, drinking water, air and soil; developing an environmental health management information system; public education, both formal and informal; institutional development, both in terms of human resources and equipment; enacting laws and regulations, and introducing new economic and financial mechanisms.

18. Finally, strengthening of epidemiological surveillance systems is being emphasized in the areas of STD, HIV, Dengue, Hepatitis B, typhoid fever and food borne diseases, tuberculosis, Hansen's disease and cholera. These programs remain centralized because they require specialized manpower which is scarce.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

National priority areas for technical cooperation

19. Based on the priorities identified above, the Government will seek external assistance in the following areas: support for improvement to the management information system and upgrading of management capacity to further the implementation of a decentralized health service; support for the planning process to include manpower planning for, inter alia, the more efficient use of resources and for the further development of local health systems to incorporate the delivery of an integrated service with adequate referral between tiers of service delivery;analysis of the health facilities maintenance program and support for the upgrading and sustained enhancement of that program; support for the reorganization of the Ministry of Health headquarters and for the development and structuring of the regional services; health promotion to include social marketing and health education aimed at lifestyle changes and modifications that affect health status, changes in attitudes relating to community and individual responsibility for care, alternative methods of health care financing and rational drug use, improvement to food safety and protection and gender issues; strengthening the epidemiological surveillance program to include the special problems of women and children; improvement to water quality monitoring, reduction in ground water pollution and air pollution, rationalization of solid/toxic waste disposal and improvement to workers' health; support for intersectoral coordination to further develop partnerships between the public and private sectors and government and non-governmental organizations; and support for strengthening the secondary and tertiary care services.

20. In its effort to increase access to health, the Ministry of Health has pledged to work in collaboration with the private sector and NGOs. This strategy is supporting latest research (1989) which points to the fact that 55% of the population seek medical treatment from private practitioners. Non-Governmental Organizations also play an important role particularly in the treatment and control of some of the chronic diseases (e.g. Jamaican Cancer Society, Heart Foundation and the Diabetic Association). Currently, approximately 50 NGOs contribute invaluable services to health care of the population. Projects are also underway which enjoy the support of USAID, IDB and U.S. Public Law 480: Health Sector Initiatives Project for the further strengthening of the health services is being supported by USAID with a projected cost of US$ 973,000; IDB is funding a hospital restoration project, the capital cost of which is US$ 92 million; there is a technical cooperation element for institutional strengthening of US$5.9 million; under US Public Law 480, an amount of J$ 17 million (or approximately US$ 773,000) is being provided through the United Nations Development Program (UNDP) for environmental improvement in Westmoreland. PAHO is providing technical assistance to several of these projects.

National priorities for technical cooperation from PAHO/WHO

21. PAHO/WHO's technical cooperation has been delivered as an integral part of the Ministry of Health's effort to improve health care delivery. Consequently, although emphasis will be placed on some priority areas, the MOH does not wish to exclude PAHO/WHO's assistance in others, as these latter may require technical cooperation inputs over the biennium. The areas are consistent with priorities as expressed in the Strategic Orientation and Program Priorities (SOPP). PAHO/WHO technical cooperation will therefore be targeted principally towards: environmental sanitation; continued reorganization and strengthening of the management of the health services, to include planning, decentralization and the further strengthening of the district health system; development of human resources, to include health manpower planning; women health and development; epidemiological analysis; maternal and child health; health promotion, and health facilities maintenance.

22. In addition to the projects supported by PAHO/WHO regular funds, there will be projects supported by extrabudgetary funds in: DHS, activities will focus on resource mobilization to improve financial and personnel management systems with funding from the USAID Health Sector Initiatives Project and WHO/ICO; HIV, where resources from WHO are expected to combat AIDS; LEP, where resources come from the Leprosy Relief Work (Switzerland) and MCH, where resources come from Rotary International. In addition, projects have been submitted to the Italian Government for environment control, and to the Dutch Government for the strengthening of local health systems. The regional programs are expected to continue supporting the national immunization program significantly.

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Community water supply and sanitation (CWS)

23. The purpose of the project is to strengthen the units of the MOH (MOH) involved in the environmental sector through the development of human resources and mechanisms of intra- and inter-sectoral collaboration for a more effective delivery of service. To achieve this purpose, direct technical cooperation will be given to units of the MOH to strengthen their operational and technical capacity; the Pan American Center for Sanitary Engineering and Environmental Sciences (CEPIS) and the Division of Health and Environment (HPE) will collaborate in respect of a survey for hazardous waste disposal in Jamaica. Other activities will be aimed at creating public awareness of environmental health issues through basic documentation from the sector and the establishment of an environmental health profile and a national environmental health information system; training efforts will include in-service courses and seminars; and assistance to the Ministries of Health and Labor for the preparation and implementation of a National Plan for Workers' Health and reinforcement of relevant regulations and for the integration of environmental health requirements in the National Resources Conservation Authority's guidelines for environmental impact assessment.

Health services development (DHS)

24. The purpose of the project is to support the continuing decentralization of the management of the health services and promote development of local health systems and restructure the MOH to bring its organizational arrangements in line with the functional requirements of a decentralized service. By 1994, four regional health authorities are expected to have been established and technical cooperation will focus on the development of plans and mobilization of resources for projects supporting the decentralization process and the staff training. Following the integration of the management of the primary and secondary care services, support will be provided for the development of local health systems. Technical cooperation will be provided by in-country staff for the reorganization exercise while external consultations will be provided for the areas of planning and manpower planning. Resources will continue to be mobilized through the promotion and marketing to external donors for extra-budgetary assistance. The technique of social marketing will be used to inform the public about the new developments and changes. Fellowships will be used to develop and strengthen personnel skills in organizational development, management, administration and generally in current public health issues including oral health. The upgrading of physical facilities is underway through various projects and assistance will be required with the development of policies and procedures for these facilities and the improvement of the maintenance system through resource mobilization and training. Support will be given to ensure a continued state of readiness in the health sector in the event of disasters. Resources will be mobilized to promote and support field activities for Women Health and Development (WHD). Nationals will be kept informed on WHD issues and provided with the opportunity for sharing in regional and sub-regional activities on the subject.

Food safety (FOS)

25. The purpose of the project is to improve food protection, reduce the prevalence of zoonotic diseases and maintain a foot and mouth disease free status. To achieve this purpose training will be effected in food safety surveillance methods, evaluation of bovine brucellosis procedures and control of leptospirosis; collaborative efforts with the National Food Protection Committee, through which government agencies and the private sector involved in food production/processing will coordinate activities; a Food Safety Plan of Action will be prepared and a National Food Protection Safety Committee established to monitor the quality control of milk; and animal health program management will be enhanced.

Human resources education (HRE)

26. The purpose of the project is to strengthen the institutional capacity of local health training institutions and the manpower planning capacity of the MOH. To support this, training will be made available through technical assistance to tertiary institutions and through the provision of faculty support by PAHO/WHO staff; PAHO/WHO will collaborate with the MOH and local training institutions to identify areas of need and to give support to the strengthening of institutions to meet identified needs; the institutional capacity of local training institutions will be strengthened with emphasis on faculty and program development and the operational capacity of the MOH in the assessment of its manpower needs and the development of MOH training policy and procedures.

Health situation and trend assessment (HST)

27. The purpose of the project is to improve the capability and capacity for the MOH to acquire, process, analyze, disseminate and use health information. To achieve this purpose, it will be necessary to provide direct technical assistance, training, and the acquisition of hard- and software will be required to improve the capacity of the MOH to better collect, process and use a wide variety of data related to health services, epidemiology and vital events. PAHO/WHO will provide support through staff or consultants to develop appropriate manual or automated systems to address the need for a wide variety of currently unavailable or cumbersome, inefficient/ineffective systems for use nationally, regionally and locally. The training component of the project will include the provision of fellowship support at the post-secondary level for medical records officers and other mid-level MOH staff who are responsible for handling, processing and using data related to health and health services and also the staging of in-service training courses and seminars for appropriate staff. Appropriate equipment and supplies will be acquired to support the systems developed in the technical assistance component and the locally staged courses and seminars.

Growth, development and human reproduction (MCH)

28. The purpose of this project is to improve health care to women within child-bearing ages and to children attending public health facilities, to improve immunization coverage, to reduce morbidity/mortality due to diarrhoeal diseases and Acute Respiratory Infections (ARI), and to give special emphasis to other high risk groups, especially to adolescent. To achieve this purpose, health care providers will be trained in the use of manuals pertaining to maternal and child health care, management of diarrhoea and respiratory diseases so as to be able to detect high risk pregnancies, encourage early attendance at antenatal clinics, increase immunization coverage, manage diarrhoea and respiratory diseases and promote/encourage proper home care.

Management support for national health development (MPN)

29. The purpose of this project is to provide technical, managerial and administrative support for the delivery of technical cooperation projects in Jamaica, Bermuda and Cayman Islands as indicated in the annual program budget for these countries. It will be necessary for the PWR and other staff members to work closely with national authorities. It will also be necessary to focus on promoting Caribbean Cooperation in Health (CCH) and Technical Cooperation among Countries (TCC) and the Organization's Plan of Investment; developing the administrative and information processing capabilities of the country office and monitoring the delivery of technical cooperation to ensure consistency with the SOPP. This will necessitate the conducting of frequent meetings between the MOH/PAHO as well as with other international development agencies for the purpose of collaboration and resource mobilization.

Health promotion and prevention and control of non-communicable diseases (NCD)

30. The purpose of this project is to develop and implement programs designed to promote healthy lifestyles, prevention of chronic non-communicable diseases and cancer, improve nutrition and in general effect responsible health behavior. To achieve this purpose, health care providers will be trained to impart messages on healthy lifestyles in an effort to promote good nutritional habits with the effect of controlling hypertension, diabetes, obesity and certain cancers; and a study will be conducted to ascertain the true prevalence of chronic diseases in the country, as well as habits and practices of these patients.

General communicable disease prevention and control activities (OCD)

31. The purpose of this project is to improve the capacity of the health sector in surveillance of communicable diseases through strengthening of laboratory services, investigation and data collection. To achieve this purpose, the surveillance system will be strengthened to ensure timely reporting at all levels from all parishes to national level and vice versa. Prompt investigations of cases and contacts and reporting from the private sector will also be strengthened. The transportation of samples to the laboratory within specified time periods is also to be improved.

Technical cooperation among countries (TCC)

32. The purpose of this project is to mobilize and share resources among countries in respect of common problems and to support the sub-regional initiative. This purpose will be achieved through dissemination of information, visits and attachments; skills will be shared among Jamaica, Bermuda and Cayman Islands nationals; and resources will be sought to support participation in meetings.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 1,749,800 | 70.9 | 1,929,500 | 70.4 | 2,139,800 | 70.7 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 742,400 | 30.0 | 787,500 | 28.7 | 888,800 | 29.3 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 742,400 | 30.0 | 787,500 | 28.7 | 888,800 | 29.3 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 83,600 | 3.4 | 94,800 | 3.5 | 107,500 | 3.6 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 83,600 | 3.4 | 94,800 | 3.5 | 107,500 | 3.6 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 128,900 | 5.2 | 142,600 | 5.2 | 157,700 | 5.2 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 128,900 | 5.2 | 142,600 | 5.2 | 157,700 | 5.2 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 697,300 | 28.3 | 796,200 | 29.0 | 865,400 | 28.6 |
| HEALTH SERVICES DEVELOPMENT | DHS | 697,300 | 28.3 | 796,200 | 29.0 | 865,400 | 28.6 |
| HUMAN RESOURCES DEVELOPMENT | | 97,600 | 4.0 | 108,400 | 4.0 | 120,400 | 4.0 |
| HUMAN RESOURCES EDUCATION | HRE | 97,600 | 4.0 | 108,400 | 4.0 | 120,400 | 4.0 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 716,600 | 29.1 | 810,000 | 29.6 | 883,700 | 29.3 |
| ENVIRONMENTAL HEALTH | | 280,600 | 11.4 | 333,100 | 12.2 | 361,900 | 12.0 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 280,600 | 11.4 | 333,100 | 12.2 | 361,900 | 12.0 |
| MATERNAL AND CHILD HEALTH | | 132,400 | 5.4 | 145,900 | 5.3 | 161,200 | 5.3 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 132,400 | 5.4 | 145,900 | 5.3 | 161,200 | 5.3 |
| COMMUNICABLE DISEASES | | 147,700 | 6.0 | 160,400 | 5.9 | 174,400 | 5.8 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 147,700 | 6.0 | 160,400 | 5.9 | 174,400 | 5.8 |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| HEALTH PROMOTION | | 109,100 | 4.4 | 118,900 | 4.3 | 129,400 | 4.3 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 109,100 | 4.4 | 118,900 | 4.3 | 129,400 | 4.3 |
| VETERINARY PUBLIC HEALTH | | 46,800 | 1.9 | 51,700 | 1.9 | 56,800 | 1.9 |
| FOOD SAFETY | FOS | 46,800 | 1.9 | 51,700 | 1.9 | 56,800 | 1.9 |
| GRAND TOTAL | | 2,466,400 | 100.0 | 2,739,500 | 100.0 | 3,023,500 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 899,700 | 72.6 | 76,000 | 17.4 | 0 | |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 899,700 | 72.6 | 76,000 | 17.4 | 0 | |
| HEALTH SERVICES DEVELOPMENT | DHS | 899,700 | 72.6 | 76,000 | 17.4 | 0 | |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 338,900 | 27.4 | 360,000 | 82.6 | 0 | - |
| MATERNAL AND CHILD HEALTH | | 69,100 | 5.6 | 0 | - | 0 | - |
| ACUTE RESPIRATORY INFECTIONS | ARI | 69,100 | 5.6 | 0 | - | 0 | - |
| COMMUNICABLE DISEASES | | 269,800 | 21.8 | 360,000 | 82.6 | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 249,800 | 20.2 | 360,000 | 82.6 | 0 | - |
| LEPROSY | LEP | 20,000 | 1.6 | 0 | - | 0 | - |
| GRAND TOTAL | | 1,238,600 | 100.0 | 436,000 | 100.0 | 0 | |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| **1992-1993** | | | | | | | | | | | | |
| PAHO - PR | 731,600 | 1 | 0 | 125 | 235,900 | 31,500 | 48 | 96,000 | 134,600 | 75,700 | 0 | 157,900 |
| WHO - WR | 1,734,800 | 3 | 6 | 220 | 886,700 | 36,800 | 68 | 136,000 | 195,300 | 109,100 | 0 | 370,900 |
| TOTAL | 2,466,400 | 4 | 6 | 345 | 1,122,600 | 68,300 | 116 | 232,000 | 329,900 | 184,800 | 0 | 528,800 |
| % OF TOTAL | 100.0 | | | | 45.5 | 2.8 | | 9.4 | 13.4 | 7.5 | .0 | 21.4 |
| **1994-1995** | | | | | | | | | | | | |
| PAHO - PR | 844,600 | 1 | 0 | 96 | 284,600 | 39,800 | 49 | 98,000 | 148,400 | 85,200 | 0 | 188,600 |
| WHO - WR | 1,894,900 | 3 | 6 | 189 | 915,400 | 43,500 | 70 | 140,000 | 215,800 | 128,900 | 0 | 451,300 |
| TOTAL | 2,739,500 | 4 | 6 | 285 | 1,200,000 | 83,300 | 119 | 238,000 | 364,200 | 214,100 | 0 | 639,900 |
| % OF TOTAL | 100.0 | | | | 43.8 | 3.0 | | 8.7 | 13.3 | 7.8 | .0 | 23.4 |
| **1996-1997** | | | | | | | | | | | | |
| PAHO - PR | 926,500 | 1 | 0 | 96 | 304,600 | 45,100 | 49 | 98,000 | 168,300 | 96,600 | 0 | 213,900 |
| WHO - WR | 2,097,000 | 3 | 6 | 189 | 1,005,100 | 49,300 | 70 | 140,000 | 244,700 | 146,100 | 0 | 511,800 |
| TOTAL | 3,023,500 | 4 | 6 | 285 | 1,309,700 | 94,400 | 119 | 238,000 | 413,000 | 242,700 | 0 | 725,700 |
| % OF TOTAL | 100.0 | | | | 43.3 | 3.1 | | 7.9 | 13.7 | 8.0 | .0 | 24.0 |

## HEALTH SITUATION ANALYSIS

### Demography

1. The 1990 national census indicated a total population of 81,249,645 inhabitants, with 38.3% under 15 years of age and 5.0% over 65. The annual growth rate between 1980 and 1990 was 2.3%. The total fertility rate (women 15 to 49) is 3.8 children per 1,000 women of childbearing age and is higher in rural areas (5.9) than in metropolitan areas (3.0).

2. By 1995 the estimated total population will be 89 million inhabitants, assuming that the annual growth rate is 1.9% during the present decade.

### Health status indicators

3. Life expectancy was 66.45 years for men and 76.08 for women in 1990; this represents an increase of three years for men and six years for women, with respect to the 1980 values.

4. The total death rate per 100,000 population was 521.1 in 1990. The leading causes were: heart disease, malignant neoplasms, accidents, diabetes mellitus, certain conditions originating in the perinatal period, pneumonia and influenza, intestinal infectious diseases, cerebrovascular diseases, cirrhosis of the liver, and homicide. In rural municipalities with predominantly indigenous populations, the leading killers were infectious and parasitic diseases.

5. The infant mortality rate was 24.1 per 1,000 reported live births. In this group the leading cause of mortality is certain conditions originating in the perinatal period, followed by intestinal infectious diseases, pneumonia and influenza, and nutritional deficiencies.

6. The mortality rate in the 1-4 age group was 243.6 per 100,000 in 1990, the principal causes being: intestinal infectious diseases, measles, accidents, pneumonia and influenza, and nutritional deficiencies.

7. In 1988 the overall prevalence of malnutrition in children under 5 (Waterlow Index, National Survey of Nutrition) was 29.2%, ranging widely from 17.1% in Mexico City to 30.9% in the central region of the Country.

8. During the productive years (15 to 64), the mortality rate in 1990 was 307.4 per 100,000 population in that group, 407.1 for men and 210.6 for women. Accidents are the principal cause of death among men, followed by homicides and injury purposely inflicted by other persons, cirrhosis and other diseases of the liver, heart disease, and malignant neoplasms, while among women the latter are the leading cause of death, followed by heart disease, diabetes mellitus, accidents, and cerebrovascular disease.

9. With respect to the patterns of mortality in the 1970s, it was observed that in the 1980s chronic and degenerative diseases have displaced infectious diseases as the prevailing cause of death among adults, but not among children.

10. Information on mortality from the states reveals a list of causes of death similar to the national list, although in 4 of the 32 states Accidents are the leading cause of death in the overall population.

11. Maternal mortality in 1990 was 5.4 per 10,000 reported live births, the principal causes being hemorrhages of pregnancy and childbirth, toxemia of pregnancy, and complications of the puerperium.

12. With regard to morbidity from communicable diseases, according to information as of week 45 of 1991 and the same week in 1992, cholera, which was first detected in mid-1991, caused a total of 2,029 cases that year and 6,991 in 1992. As for AIDS, the number of cases declined from 2,883 cases in 1991 to 2,271 in 1992; Mexico has the second highest number of cases of this disease in Latin America. The number of measles cases declined from 4,389 to 538, and for the second straight year there were no confirmed cases of polio or diphtheria. Rabies cases dropped from 46 to 29 cases. With respect to diarrheal diseases, the number of cases declined from 3.2 million to 2.5 million, and the number of ARI cases also decreased, from 8.2 million to 6.2 million. As regards malaria, the number of cases fell from 21,289 to 13,206 cases.

13. The chronic diseases are not subject to systematic national surveillance, but given their growing importance in the public health panorama, a household survey was begun in November 1991, with personal interviews and laboratory tests, in order to ascertain the true magnitude of diabetes mellitus and cardiovascular disease in the general population and that of chronic illnesses among the elderly; the corresponding information is currently being processed.

14. The National Nutrition Survey of 1988 showed that 24.8% of non-pregnant women from 12 to 49 years of age were overweight, with 14.6% characterized as obese.

15. According to the National Addictions Survey of 1990, 28% of the respondents from 12 to 65 years of age said that they used tobacco, and 25% mentioned that they smoked at one time but no longer did; smoking was more than twice as prevalent among men as among women. Regular heavy drinkers make up 6.8% of the respondents, 14.2% among men and less than 1% among women. A total of 4.8% of the respondents said that they have consumed drugs at some time; only 1% admitted use during the past month.

### Factors affecting health status

16. According to the 1990 census, occupied private dwellings had an average of 5 inhabitants; 10.5% of dwellings consisted of a single room, with the consequent problems stemming from overcrowding.

17. The percentage of dwellings with non-dirt floors rose from 50% in 1970 to 80% in 1990. The coverage of running water increased from 61% in 1970 to 79.4% in 1990, while that of sewerage rose from 45.5% to 63.6% between these years. The availability of electric power rose from 58.9% to 87.5%. The populations not covered by these services live in rural localities, mainly widely scattered ones, which also have less access to formal health care.

18. It is estimated that the indigenous population approaches 6 million, some of whom do not speak the Spanish language. There is great concern among the authorities to ascertain in detail the health and services related problems of this group, so that actions that meet their specific needs can be carried out.

19. The potential coverage of health services is 94% of the Mexican population. The population not covered by formal services resorts to traditional therapists (healers, herbal healers, bonesetters, lay midwives, faith healers, etc.), who have been recognized by the official sector and received the corresponding credentials. There has been progress in experiments to bring these therapists into the formal systems to carry out primary health care activities.

20. Environmental pollution is severe in the most heavily industrialized urban areas, particularly Mexico City, where it reached critical danger levels during 1992. Studies are being conducted among schoolchildren and the elderly in order to detect the effects of pollution on health and to plan preventive measures.

21. Illiteracy among those over the age of 15 stood at 12.4% in 1990, with a lower rate among men (9.6%) than among women (15%), a fact which needs to be taken into account in programs for health promotion.

22. The economy showed gradual improvement from the beginning of the 1990s; inflation reached a level close to 10% in 1992. The fiscal deficit disappeared, and the economy was in surplus. Rapid growth was observed in investment and exports.

23. The negotiations for the North American Free Trade Agreement with Canada and the United States of America were concluded. The initiative of the Ibero-American summit in Guadalajara was consolidated, with progress toward integration with Latin America, Spain, and Portugal. There were gains in commercial relations with Chile, Colombia, Venezuela, Bolivia, and Central America. Discussions with MERCOSUR were initiated.

24. The rate of unemployment in urban areas stood at around 2.7% in 1991 and 1992. Decentralization processes have been strengthened, privatization has continued, and the State has assumed a growing regulatory responsibility.

25. Social expenditures grew, mainly under the National Solidarity Program, which extended its coverage to thousands of low-income communities and districts around the country, with actions benefiting more municipalities and families and support for the construction of solidarity services and companies. Property rights to ejido or community lands were defined.

26. Despite these advances, the distribution of income is unequal, and major differences still exist between the rural and marginalized urban population sectors and those that have benefitted the most from economic growth. Consequently, there is a need to apply measures aimed at achieving greater equity in health services by strengthening actions at the level of the local health systems, decentralizing services, and implementing the agreements established at the World Summit for Children.

Plans and priorities for national heath development

27. The National Health System is made up of the health and social welfare services of the agencies of the public sector; it includes federal, state, and municipal services, and those provided by the social and private sectors that are incorporated into the system through inducements and consensus. Under Mexican law, the Ministry of Health coordinates the system and performs normative functions through advisory services and evaluation. The potential coverage of health services is 94% of the Mexican population. The Ministry of Health covers 34.4%. Under the social security system, the IMSS covers 46.9% of the population, and the ISSSTE 10.5%.

28. Under the national agreement for the productive improvement of living standards, the 1989-1994 National Development Plan establishes the broad goals for health, assistance, and social security policy. The 1990-1994 National Health Program has as its general objective to promote protection for all Mexicans, by offering timely, effective, equitable, and humanitarian services and benefits that will truly help to improve their conditions of social well-being, with the cooperation of the communities and the three levels of government as an effective means of obtaining the necessary resources.

29. The following policies have been defined to achieve the aforementioned objective and to carry out health-care activities: promotion of a culture of health; universal access to equitable, high-quality health services prevention and control of diseases and accidents; protection of the environment and basic sanitation; contribution to the regulation of population growth; and the promotion of social welfare.

30. The following strategies have been defined for the 1990-1994 period: functional coordination of the national health system, by adapting the legal framework and establishing mechanisms of coordination in the use of resources; consolidation of the National System of Information on the infrastructure, productivity, control, and impact of the services; strengthening of the local health systems as an operational strategy of primary care; community participation and decision-making at the first level of care; decentralization of health services and health regulation so as to enhance managerial and decision-making capabilities; administrative modernization and simplification in order to carry out a dynamic adjustment of the national health system and reduce, streamline, and clarify its procedures and formalities; intersectoral coordination in order to strengthen the organization and operation of the services of the national health system under the current multicausal concept of health, its determinants, and the various factors involved in the solution of health problems; and community participation in order to promote the success of health programs especially in the areas of research into problems; the planning, pursuit, and supervision of actions; and self-care.

31. The policies and strategies defined in the health program are applied through the following programs: health education; nutrition and health; campaign against addictions; medical care; maternal and child care; health promotion and health care for schoolchildren; rehabilitation; oral health; extension of coverage; prevention and control of parasitic and infectious diseases; control of chronic degenerative diseases; accident prevention; health care in the event of natural disasters; mental health; environmental health, and health regulation and surveillance; regulation of population growth; family planning; and social welfare. The pivotal elements in the national effort are the acceleration of the epidemiological transition and the modernization of health regulations. Technical cooperation among countries is encouraged, particularly with those along the southern border (Belize and Guatemala) and to the north with the United States of America. The health sector interacts with the sectors of agriculture and social development in nutrition and environmental enhancement programs.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

32. In the framework of the 1990-1994 National Health Program of Mexico, the Joint Evaluation of PAHO/WHO Technical Cooperation 1988-1989 and 1990-1991, and the Strategic Orientations and Program Priorities for the Pan American Health Organization during the Quadrennium 1991-1994, technical cooperation during the 1994-1995 biennium will be provided on a priority basis in the following areas: (1) support for the health sector in order to improve its capacity for analysis, by more accurately identifying high-risk groups and the most important factors that condition or modify the health status of the Mexican population; (2) increase in the participation of the health sector in the country's development in order to achieve protection for all Mexicans, by delivering timely, effective, equitable, and priority services for the true improvement of social well-being; (3) strengthening of the National Health Information System, especially at the local and state level in order to promote better utilization of information in support of the programs for prevention and control of priority health problems; (4) promotion of a culture of health by encouraging educational activities and promoting self-care, family and community health, and the protection of the environment; emphasis will be placed on preventing AIDS and sexually transmitted diseases, drug-dependency, and smoking and on accident prevention and prevention of cancer; (5) strengthening of epidemiological surveillance systems to make it possible to improve information about and the prevention and control of infectious, parasitic, and chronic degenerative diseases, accidents, disasters, and the factors that constitute a major public health problem in the country, as well as to reduce malaria, acute diarrheal diseases, and acute respiratory infections, and eliminate leprosy; (6) actions of the health sector related to the protection of the environment, including support for the increased availability of drinking water and greater coverage for the sanitary disposal of excreta and waste; (7) sanitary protection of food products in order to reduce the diseases transmitted by this route and to facilitate the marketing of these products domestically and internationally; (8) spurring the functional coordination of the National Health System, for the purpose of making better use of resources and achieving their greater mobilization within the sector, as well as coordination among the institutions that deliver social welfare services; (9) management of knowledge, by strengthening the training and updating of human resources, thus improving and expanding the availability and dissemination of health information; (10) support for the health sector in following up the process of commercial integration under the free trade agreement and collaboration in carrying out the activities for which it is responsible; and (11) consolidation of technical cooperation among countries with regard to incentives for scientific, technical, and financial collaboration in areas of interest to the region, particularly the production and quality control of biologicals and drugs, reference analysis services, research, and training of personnel.

33. During the biennium the country hopes to expand support from the World Bank and the IDB, mainly through the execution of projects in the area of drinking water and improvement of the environment. In addition, the UNDP will strengthen its areas of cooperation, prominent among which are the battle against poverty, health, indigenous peoples, and nutrition. Within the country, and through the mobilization of internal funds allocated for the social expenditures, it is hoped that in the biennium the expenditures of the National Solidarity Program (PRONASOL) allocated to the area of health will increase considerably, as has been the trend in recent years. Moreover, it is expected that the North American Free Trade Agreement (NAFTA) that has just been signed by the governments of the United States, Canada, and Mexico will have favorable implications for the mobilization of resources for the entire health sector, particularly in border areas.

### Plans and priorities for national health development

34. The national authorities have recognized that in defining the priority areas for technical cooperation it is necessary to take into account the existing infrastructure, human resources, and response capability of the country, in order to improve the health conditions of the population and fulfill the general objective and the policies established under the national health program. Accordingly, cooperation should be oriented toward: (1) human resources development, through training and the supply of scientific and technical information to health personnel, especially at the state and local level; (2) an analysis of health conditions and greater familiarity with diseases and with the factors that cause higher morbidity and mortality rates in the different priority population groups; (3) the strengthening of local health systems (health jurisdictions) as one of the priority strategies for PAHO/WHO cooperation, focusing on marginalized urban areas; and (4) use of the mass media as mechanisms of support for health promotion and for the different prevention and control programs, especially concerned with AIDS and STDs, drug abuse and smoking, accidents, and childhood diseases.

35. PAHO/WHO will serve as a catalyst and promote intersectoral coordination and integration in support of health plans. Actions will be carried out to promote the mobilization of economic resources and achieve community participation in protecting the environment and improving basic sanitation services, especially in the most vulnerable sectors.

36. In addition to the country projects financed with regular funds, PAHO/WHO will carry out projects supported with extrabudgetary funds in areas considered priorities. In this way, the funds allocated to the control of AIDS will be maintained or increased, with activities geared towards preventing HIV infection. It is hoped that support will be received from the PAHO Regional Program on MCH for the development of human resources, policies, plans, and standards in the area of maternal and child health and for community training; financing may also be received from the UNFPA for research on family planning. In order to meet the targets outlined in the program to control diseases preventable by vaccination, the support of national and international agencies will be arranged. Commitments have been obtained from the JICA of Japan and AID of the United States, and there is the possibility of continuing to coordinate actions and financing with UNICEF and, at the national level, with Rotary International of Mexico and other nongovernmental organizations. This financing will complement the funds of the regional EPI program for vaccination campaigns. In relation to the project to control communicable diseases, it is expected that support will be received from the regional OCD program for activities aimed at the control of acute diarrheal diseases and others that are considered priority, such as leprosy, cholera, malaria, and onchocerciasis.

37. Through the formulation of specific research projects and programs to train researchers, there will be continued financing for the regional initiatives on tropical diseases, safe motherhood, and human reproduction, and for PAHO research grants program.

## PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

### Control of environmental health hazards (CEH)

38. The purpose of this project is to support national efforts to prevent, evaluate, and control physical, chemical, biological, and psychosocial risks, with the objective of improving the health conditions of the population, especially the population at highest risk. In order to achieve this, support will be given to the General Environmental Health Agency (DGSA), the Ministry of Health, and the Department of Social Development for the programs for the control of environmental hazards, through the dissemination of information, training, and the formulation of standards. Work will be undertaken with the DGSA on solid waste and hygiene in the home. There will be support for the programs of drinking water, sanitation, and control of water resources, of which the National Water Commission is in charge. Workers' health and Preparation for Natural and Technological Disasters will entail intersectoral efforts and efforts with national institutions and other agencies of the United Nations. Technical cooperation in environmental health will be promoted along the southern border with Belize and Guatemala, and with Canada and the United States under the North American Free Trade Agreement. There will be continued support for the programs between Brazil and Mexico on environmental hazards. There will be cooperation with the Mexican Association of Sanitary and Environmental Engineering, the Association for Hazardous Waste Control, and universities and schools of public health in training and research activities to predict and control risks.

### Health services development (DHS)

39. The purpose of this project is to strengthen local health systems in order to improve the quality of health services, with emphasis on primary care. The Strategic Project to Develop Model Health Jurisdictions is a specific action designed to strengthen the local health systems and consequently to consolidate the National Health System. By the 1994-1995 biennium, the consolidation stage will have begun, which will enable Mexico to have true local health systems. During this period it will be vital to disseminate information concerning the actions that the health sector will be pursuing in a coordinated manner with other sectors to achieve family welfare and the welfare of the community as a whole, with a view towards their active participation in support of these actions. Timely plans will be designed to streamline the activities that the various institutions of the federal, state, and municipal government alike will be called on to perform for the benefit of the community. The training program will be directed both to health personnel and to those persons who are directly or indirectly involved in health care. Research will be promoted both within the health sector and in other sectors in order to define actions and, if need be, adapt or strengthen programs of action and prioritize activities.

### Food safety (FOS)

40. The purpose of this project is to support the development of integrated programs for food protection, the strengthening of analytical and sanitary testing services, epidemiological surveillance of FBDs, and education for consumer protection. To this end, the creation of intersectoral commissions will be promoted at the national and state level and in the principal cities and geographical regions of interest to tourists in order to develop integrated programs for food protection. The training of personnel in sanitary testing will be supported. The systems of epidemiological surveillance of FBDs will be strengthened. Personnel in analysis laboratories will be trained. Technical information on food protection will be provided. There will be support for the systems of mass communication and community education in the sanitary handling of food.

### Human resources education (HRE)

41. The purpose of this project is to develop the national capacity for human resources planning, regulation, and education by consolidating research on the work force and modernizing the dissemination of scientific and technological know-how. Resources will be mobilized in order to bolster the joint efforts of institutions of higher learning in the areas of medicine, nursing, public health, and veterinary medicine or among professionals in the different areas, for the purpose of enriching their development through the exchange of knowledge and experiences. Specific problems will be investigated or suggested strategies of

intervention for solving them will be evaluated. Priority will also be attached to activities related to decision-making. There will be actions aimed at consolidating the human resources system by political-administrative levels, with the adoption of standards for the distribution and utilization of the health personnel who enter the labor market. The program will continue to support lines of training that are consistent with national priorities in the area of technician training and public health education. Through the full operation of the PAHO/WHO information and documentation network in Mexico and the broad-based promotion and sale of scientific publications and PALTEX material, substantive support will continue to be given to the training and development of human resources in health care.

Health situation and trend assessment (HST)

42. The purpose of the project is to expand knowledge of Mexico's health situation by deepening the analysis according to living conditions and specific population groups in order to promote the planning of health activities and enable them to be evaluated. Cooperation will aim at utilizing the existing data bases in order to identify correlations between health conditions and the different socioeconomic and environmental determinants among specific groups (the indigenous population, the marginalized urban population, workers, etc.). The findings of this analysis will be disseminated widely among decision-makers. The impact of the epidemiological transition on health services will be studied. The training of instructors and coders for the utilization of the 10th Revision of the International Classification of Diseases (ICD-10) will continue. Mexico will be the first country to utilize the standards of the ICD-10 when it begins the coding of 1993 mortality in 1994. Resources will be mobilized in order to produce a compact disk (CD-ROM) that contains the three volumes of the ICD-10 so that they can be utilized widely in coding causes of death and disease and be consulted by researchers.

Human reproduction, growth, and development (MCH)

43. The purpose of this project is to help improve the health of women, children, and adolescents, mainly among rural and marginalized urban populations. Coordination will be strengthened among the General Bureaus of Maternal and Child Care, Preventive Medicine, Epidemiology, and Family Planning, which handle the different components of the HPM program. The preparation of joint plans and standards for comprehensive health care for women, children, and adolescents will be promoted with a view towards the functional integration of the aforementioned agencies in an effort to bolster the existing resources in the country and avoid duplicating efforts. Active participation of the different programs in the development and strengthening of local health systems will be encouraged. The gender perspective will be integrated into all activities. The active participation of all institutions that are involved in fostering the health of women, children, and adolescents will be promoted: the Ministry of Health, social security institutions, nongovernmental organizations, and private sector groups. Joint projects with bilateral and multilateral agencies will be promoted. Knowledge in this field of endeavor will continue to be disseminated both to health personnel and to the community. In addition, information, education, and mass communication aimed at priority populations will be strengthened, seeking active community participation in the process.

Managerial support for national health development (MPN)

44. The purpose of this project is to efficiently manage the resources of the Organization allocated for technical cooperation with the Government of Mexico and ensure that the purposes and principles of the Organization are present in the technical cooperation program, particularly the Strategic Orientations and Program Priorities for the quadrennium 1991-1994, as well as the points set forth in the Regional Plan for Investment in the Environment and Health. In order to achieve this end, it will be necessary to establish the appropriate mechanisms for providing the managerial support needed to deliver technical cooperation on the basis of administrative development and the streamlining and growth of the information processes of the PAHO/WHO Representative Office. It will be necessary to monitor and coordinate the projects of the PAHO/WHO Representative Office with a view to implementing and coordinating the National Health Program of the Government of Mexico with the Strategic Orientations and Program Priorities of the Organization. The quality of the Representative Office's material and human resources will be continually enhanced.

Health promotion and prevention and control of noncommunicable diseases (NCD)

45. The purpose of this project is to lay the institutional, population, and individual groundwork in order to make health an objective and a social concern. To this end, activities will be pursued to spur policies and programs of health promotion, and interventions will be undertaken to modify lifestyles and risk factors for the major chronic diseases: smoking, alcoholism, drug addiction, sedentary lifestyles, poor diet, aggressive behavior, and other psychosocial factors. There will be support for strengthening the services geared towards addressing this type of problem, as well as for the services that seek to prevent and control chronic noncommunicable diseases. The program contents will be disseminated widely, and research into the distribution of this type of pathology among the population will be encouraged.

General activities for the prevention and control of communicable diseases(OCD)

46. The purpose of this project is to strengthen the ability of the health services to prevent, control, and eliminate infectious and parasitic diseases. Technical cooperation under the project will be oriented towards the problems originated by: vectors, tropical diseases, leprosy, malaria, tuberculosis, AIDS,

sexually transmitted diseases, and acute respiratory infections. Efforts will be directed toward strengthening the local health systems, training personnel at the operational levels, and enhancing the effectiveness of the programs, with the support of epidemiological surveillance and research.

Technical cooperation among countries (TCC)

47. The purpose of this project is to promote and support the activities of technical cooperation among the countries of the region, mainly bordering countries. In order to achieve this goal, activities will be carried out to encourage better relations and greater cooperation with the other countries of the region and especially with the border health associations in the north and south of the country. Bilateral or multilateral agreements and epidemiological information of common interest will be disseminated. Research that will further the technological development of the countries or lead to improved knowledge of common health problems will be promoted. The technical advisory services needed to perform the proposed tasks will be provided.

Zoonoses (ZNS)

48. The purpose of this project is to consolidate the program for the elimination of urban rabies and to support the programs for the control and elimination of priority zoonoses: bovine TB, brucellosis, taeniasis, and cysticercosis. Technical cooperation will be geared towards improving medical care for individuals exposed to rabies; strengthening the systems of epidemiological surveillance and diagnosis of this zoonosis; eliminating bovine TB along the northern border; strengthening the programs to control caprine brucellosis and to develop models for preventing and controlling taeniasis cysticercosis; promoting intersectoral and interinstitutional coordination at all levels; strengthening the systems of surveillance in order to prevent the introduction of exotic diseases; training professionals at the state and local levels to prevent and control the major zoonoses in the various countries; and improving public health education in institutions of veterinary medicine and in schools.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 2,768,700 | 55.2 | 3,233,300 | 56.0 | 3,614,300 | 56.4 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 1,214,600 | 24.2 | 1,519,900 | 26.3 | 1,716,700 | 26.7 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 1,214,600 | 24.2 | 1,519,900 | 26.3 | 1,716,700 | 26.7 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 123,800 | 2.5 | 140,400 | 2.4 | 159,200 | 2.5 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 123,800 | 2.5 | 140,400 | 2.4 | 159,200 | 2.5 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 213,300 | 4.3 | 242,500 | 4.2 | 262,100 | 4.1 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 213,300 | 4.3 | 242,500 | 4.2 | 262,100 | 4.1 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 930,000 | 18.5 | 974,300 | 16.9 | 1,075,300 | 16.8 |
| HEALTH SERVICES DEVELOPMENT | DHS | 930,000 | 18.5 | 974,300 | 16.9 | 1,075,300 | 16.8 |
| HUMAN RESOURCES DEVELOPMENT | | 287,000 | 5.7 | 356,200 | 6.2 | 401,000 | 6.3 |
| HUMAN RESOURCES EDUCATION | HRE | 287,000 | 5.7 | 356,200 | 6.2 | 401,000 | 6.3 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 2,249,300 | 44.8 | 2,538,000 | 44.0 | 2,783,300 | 43.6 |
| ENVIRONMENTAL HEALTH | | 534,600 | 10.7 | 532,500 | 9.2 | 584,100 | 9.1 |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 534,600 | 10.7 | 532,500 | 9.2 | 584,100 | 9.1 |
| MATERNAL AND CHILD HEALTH | | 206,100 | 4.1 | 571,000 | 9.9 | 624,000 | 9.8 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 206,100 | 4.1 | 571,000 | 9.9 | 624,000 | 9.8 |
| COMMUNICABLE DISEASES | | 789,100 | 15.7 | 645,400 | 11.2 | 715,100 | 11.2 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 789,100 | 15.7 | 645,400 | 11.2 | 715,100 | 11.2 |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| HEALTH PROMOTION | | 347,900 | 6.9 | 397,300 | 6.9 | 432,900 | 6.8 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 347,900 | 6.9 | 397,300 | 6.9 | 432,900 | 6.8 |
| VETERINARY PUBLIC HEALTH | | 371,600 | 7.4 | 391,800 | 6.8 | 427,200 | 6.7 |
| FOOD SAFETY | FOS | 112,300 | 2.2 | 99,500 | 1.7 | 109,900 | 1.7 |
| ZOONOSES | ZNS | 259,300 | 5.2 | 292,300 | 5.1 | 317,300 | 5.0 |
| GRAND TOTAL | | 5,018,000 | 100.0 | 5,771,300 | 100.0 | 6,397,600 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 56,000 | 4.2 | 0 | - | 0 | - |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 56,000 | 4.2 | 0 | - | 0 | - |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 56,000 | 4.2 | 0 | - | 0 | - |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 1,273,300 | 95.8 | 1,328,700 | 100.0 | 112,900 | 100.0 |
| ENVIRONMENTAL HEALTH | | 195,200 | 14.7 | 54,900 | 4.1 | 58,700 | 52.0 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 195,200 | 14.7 | 54,900 | 4.1 | 58,700 | 52.0 |
| MATERNAL AND CHILD HEALTH | | 260,300 | 19.6 | 193,700 | 14.6 | 54,200 | 48.0 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 260,300 | 19.6 | 193,700 | 14.6 | 54,200 | 48.0 |
| COMMUNICABLE DISEASES | | 817,800 | 61.5 | 1,080,100 | 81.3 | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 817,800 | 61.5 | 1,080,100 | 81.3 | 0 | - |
| GRAND TOTAL | | 1,329,300 | 100.0 | 1,328,700 | 100.0 | 112,900 | 100.0 |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 3,978,500 | 4 | 15 | 1105 | 1,642,000 | 67,100 | 114 | 228,000 | 631,100 | 344,800 | 78,100 | 987,400 |
| WHO - WR | 1,039,500 | 4 | 0 | 45 | 792,000 | 38,500 | 6 | 12,000 | 29,200 | 17,800 | 0 | 150,000 |
| TOTAL | 5,018,000 | 8 | 15 | 1150 | 2,434,000 | 105,600 | 120 | 240,000 | 660,300 | 362,600 | 78,100 | 1,137,400 |
| % OF TOTAL | 100.0 | | | | 48.4 | 2.1 | | 4.8 | 13.2 | 7.2 | 1.6 | 22.7 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 4,888,100 | 4 | 15 | 712 | 2,033,200 | 81,800 | 161 | 322,000 | 1,172,600 | 370,100 | 0 | 908,400 |
| WHO - WR | 883,200 | 3 | 0 | 35 | 670,700 | 66,300 | 5 | 10,000 | 50,200 | 13,600 | 0 | 72,400 |
| TOTAL | 5,771,300 | 7 | 15 | 747 | 2,703,900 | 148,100 | 166 | 332,000 | 1,222,800 | 383,700 | 0 | 980,800 |
| % OF TOTAL | 100.0 | | | | 46.8 | 2.6 | | 5.8 | 21.2 | 6.6 | .0 | 17.0 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 5,435,300 | 4 | 15 | 712 | 2,241,100 | 92,700 | 161 | 322,000 | 1,329,700 | 419,800 | 0 | 1,030,000 |
| WHO - WR | 962,300 | 3 | 0 | 35 | 722,600 | 75,200 | 5 | 10,000 | 56,900 | 15,500 | 0 | 82,100 |
| TOTAL | 6,397,600 | 7 | 15 | 747 | 2,963,700 | 167,900 | 166 | 332,000 | 1,386,600 | 435,300 | 0 | 1,112,100 |
| % OF TOTAL | 100.0 | | | | 46.3 | 2.6 | | 5.2 | 21.7 | 6.8 | .0 | 17.4 |

## HEALTH SITUATION ANALYSIS

### Demography

1. The Netherlands Antilles had an estimated population of 191,311 inhabitants in 1992, not including a large population of illegal immigrants, estimated at between 20,000 and 30,000, on the island of St. Maarten. Aruba has an estimated population of 68,897 inhabitants.

### Health status indicators

2. The life expectancy of the population of Curaçao has been estimated at 71.13 years for men and 75.75 for women. The birth rate in the Netherlands Antilles was 19 per 1,000, and the mortality rate 6.4 per 1,000 in 1990; 26% of the population is under 15 years of age. In Aruba 8% of the population is above 65 years of age, while in the Netherlands Antilles only 6.9% is.

3. The major health problems in the Netherlands Antilles are chronic noncommunicable diseases, cardiovascular diseases, cancer, and diabetes.

4. A national health survey was carried out in Aruba in 1990; the most common diseases were hypertension, which affects 9.8% of the populations and diabetes, which affects 4.3%. The latter finding is consistent with another study that found that 60% of Aruba residents between 15 and 75 years of age were overweight. Excessive alcohol consumption is estimated at 10%.

5. Annual mortality in Aruba is estimated at 6.3/1,000. A total of 401 people died in 1990, 136 from cardiovascular problems, 79 from cancer, 43 from ill-defined symptoms and diseases, 38 from accidents, 26 from endocrine problems, and 22 from diseases of the respiratory system. Infant mortality is 9 per 1,000, with a birth rate of 16 per 1,000.

6. AIDS is a major public health problem in the Netherlands Antilles. Since 1986, 110 cases have been recorded, a rate of 57 per 100,000 population, and there were 507 seropositives as of 15 August 1992, 222 women and 285 males; in Aruba 59 cases have been recorded, a rate of 86 per 100,000 population.

### Factors affecting health status

7. Per capita income on the island of Aruba, which in 1986 was US$ 6,000, was estimated in 1989 at US$ 8,000 and reportedly hit US$ 11,000 in 1990. It has continued to rise gradually over the last two years. The population growth rate for Aruba stands at more than 1.5% a year, unlike the Netherlands Antilles, where the growth rate on most of the islands except St. Maarten is negative. On St. Maarten the population is growing, and it is estimated that by virtue of the flourishing tourist industry there are between 20,000 and 30,000 illegal immigrants. As a result, it is expected that there will be an upswing in communicable diseases, which will necessitate the strengthening of programs such as the Expanded Program on Immunization, among others, and easier access to services, which is difficult because of the illegal status of these immigrants.

8. There has been a high incidence of AIDS in recent years, also due to the tourist flow and the heavy movement of people between Caribbean islands.

9. In Aruba the health budget is estimated at between 75 and 80 million guilders, which is currently equivalent to 6% of GDP. The government of Curaçao invests $89 million (4.7% of government expenditures), 8% of this budget being spent on administration, 11% on primary health care, and the remaining 81% on medical care. Given that 93% of hospitalizations, in the case of Aruba, occurred on this island, it is estimated that per capita expenditures on health, both in the Netherlands Antilles and in Aruba, are very high, which means that spending on health must be optimized.

10. The findings of the health survey show a high incidence of diabetes and hypertension, as 4.3% of the inhabitants of Aruba suffer from diabetes, compared with 1.9% in Holland; this is related to the very high prevalence of overweight and is a serious public health problem.

11. Both in the Netherlands Antilles and in Aruba, 95% of the children born are seen by the child health services from birth up to between 5 and 6 years of age; the pattern then changes as only 50% of children are seen periodically, but they are examined again later in schools. The people who have no income receive social benefits, water and electricity subsidies, and free medical coverage through the social services departments. Some 13,000 people on the island of Curaçao make use of these benefits.

12. Social security provides medical care to people who have incomes below 600 guilders and partial medical coverage to those whose monthly incomes are between 600 and 1,500 guilders. There is, in addition, social security that gives assistance to the elderly, the homeless, the handicapped, unemployed young people, and pregnant teenagers. Special courses are being developed for the latter group through community centers. In Curaçao these community centers are very well developed organizationally, enabling them to make local community decisions that have resolved problems, for example, in the Cerro Fortuna neighborhood in Curaçao, which used to have a high incidence of drug abuse.

NETHERLANDS ANTILLES (Cont.)

13. In Curaçao more than 90% of the population has access to drinking water and electricity, and the great majority of dwellings are connected to a sewerage system, where wastewater is treated in treatment plants before being discharged.

14. In Aruba and in Curaçao there are oil refineries that cause problems of environmental pollution. In St. Eustatius an oil storage tank that will supply the nearby islands with fuel is being built.

15. Rapid development, accompanied by unrestrained modernization, has caused a degradation of marine environments, of the atmosphere, and of the soil.

16. The flourishing tourist industry also contributes to environmental deterioration. In Curaçao, for example, the hope is to add 3,700 hotel rooms in the coming years, which means that, as was the case in Aruba and St. Maarten, the intention is to bring about a boom in the tourist industry on this island. Problems are likely to result, however, from the rapid growth of the population and the failure to adapt public services and urban infrastructure, which leads to unhealthful, overcrowded living conditions.

17. The literacy rate for the Netherlands Antilles is estimated at 95%, with equal access to all schools and equal educational opportunities for men and women alike.

18. The highest rates of unemployment are in Curaçao, 24.4%, Bonaire 10.8%, St. Maarten 8.4%, St. Eustatius 10.7%, and Saba 1.6%, and the level of education of the unemployed population is lower than that of the employed population.

Plans and priorities for national health development

19. The system of health care in the Netherlands Antilles has grown enormously over the last few decades in terms of volume, cost, and health-care centers. As a consequence, the management of the system is extremely expensive. It is common knowledge, both to the Government and to health professionals, that unless appropriate measures are taken, there is a danger that the system itself will cease to exist. Total spending on health is US$ 200 million per year, of which 70% is absorbed by the Government. Of the total government expenditures in the different island territories that make up the Netherlands Antilles, spending on health accounts for 13% in the case of St. Maarten, 18% in Curacao, and 20% in Saba.

20. The Government formulated a health policy in 1991, in which it established its general strategies and priorities. The National Health Plan is based on the principles of efficiency, effectiveness, and coherence in the system. In addition, the system has to be accessible to the entire population, while the high quality of services must be assured by the Government. Cooperation with other sectors that have an influence on the area of health is also considered necessary. The priority areas defined by the Government are: health services development; health manpower planning; financing of health care; quality control in medical care; epidemiology, and health education. health legislation is being reviewed and updated in order to cope with the changes that the times demand.

21. The Government is also aware of the importance of a healthy environment for the health of the population. The United Nations Conference on Environment and Development gave the Government the opportunity to pay more attention to this matter. As a consequence, it is preparing the National Environmental Plan, on which it is working closely with the Government of the Netherlands.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

National priority areas for technical cooperation

22. The Government has defined health care strategies in a general, long-term plan. Implementation of this plan requires greater knowledge of the health care situation in the Netherlands Antilles; the problems need to be defined and analyzed and solutions to them sought.

23. So far, special attention has been paid to manpower planning in the health sector, to AIDS, to mental health problems, to the disabled (both mental and physical), and to the financing of the health care sector. The Government has already written or published reports on these topics.

24. However, the Government lacks the human resources and expertise needed to integrate the different issues into a single, overall policy. As a result, the Government will request technical cooperation from the Pan American Health Organization to achieve the aforementioned objectives in the following priority fields: optimization of spending on health through the development and strengthening of the local health systems; support for the development and strengthening of the epidemiology structure and the establishment of the systems of epidemiological surveillance to identify vulnerable groups; support for the maternal and child program in strengthening the utilization of the epidemiological method, the processing of its information, and its utilization in decision-making; support for the program of health promotion, with regard to oral health, through epidemiological studies and the execution of programs to promote oral health among schoolchildren and in the population at large; support for health promotion in connection with the problems of such chronic diseases as diabetes, cancer prevention through the tobacco and health program, mental health, and cardiovascular diseases (with emphasis on the participation of women); health promotion in relation to cholera; support for the program to control environmental health hazards through legislation, the mass media, education, community participation, and the integrated development of environmental programs; development of contingency plans for emergencies and disasters and strengthening

of the occupational health program; support for the development of integrated programs of food protection; support for the program of vector and rodent control; support for the control and prevention of morbidity from HIV/AIDS in the islands; and support for technical cooperation between Venezuela and the Netherlands Antilles and between the islands of the Netherlands Antilles and Aruba.

External cooperation for the health sector

25. Most of the needs and resources for dealing with health problems come from the Government of the Netherlands, and as a result there are no sizable additional resources for these islands. The Government of Aruba has received a US$ 416,900 subsidy from the Government of the Netherlands to develop and strengthen epidemiology and has requested PAHO technical cooperation for this project.

Extrabudgetary resources managed by the PAHO/WHO representative office

26. Financing is expected to continue for the NEA/HIV Projects on the Prevention and Control of AIDS in the Netherlands Antilles for the 1994-1995 biennium, since the donors of the funds have committed themselves to continue lending support to the programs launched in Curacao, Bonaire, Aruba, Saba, and St. Eustatius, which have been carried out successfully by governmental agencies and the National Commission on AIDS.

27. Likewise, bilateral support will continue between Venezuela and the Netherlands Antilles in mutually advantageous areas of the health sector.

National priorities for technical cooperation from PAHO/WHO

28. The Governments of the Netherlands Antilles and Aruba have identified as their priorities: reduction of excessive spending on health; control of environmental health hazards; vector and rodent control; maternal and child health; the health of schoolchildren; oral health; epidemiology; health promotion with an emphasis on chronic diseases and mental health; women, health, and development; food protection; AIDS; technical cooperation among the islands; and technical cooperation with Venezuela, in an effort to optimize spending on health by strengthening local health systems and improving their systems of epidemiological surveillance, with an emphasis on the analysis of morbidity for the preparation of local health profiles in order to utilize the risk approach through the primary health care strategy, thus fostering health promotion to solve local problems with full community participation.

29. In addition to the regular resources that PAHO/WHO allocates to the Netherlands Antilles under its program, the Organization also devotes a great deal of time and resources from its program in Venezuela. It is also anticipated that the Organization, with funds from the Global Program on AIDS, will carry out a project to control this disease. It will also provide support through the specialized centers of PAHO/WHO.

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Control of environmental health hazards (CEH)

30. The purpose is to establish systems and programs for environmental assessment, including research on environmental health hazards and the impact of development processes on the environment. To this end there will be direct technical cooperation in the development of policies, plan, and standards for the control of environmental health hazards, occupational health, and hygiene of the work environment; emergency and disaster preparedness, vector and rodent control, and promoting the use of information systems in the prevention environmental health hazards; the training of human resources will be promoted in the areas of environmental health and control of emergencies; and research will continue into the development of a program for the biological control of vectors.

Health services development (DHS)

31. The intention is to establish local participatory programming in a decentralized model in Curaçao and to consider the possibility of extending it to other islands. In order to fulfill the purpose of the project, the intention is to encourage the island governments and the central government to define policies, plans, and standards that will permit decentralization and decision-making at the level of each island; to identify local developments in order to mobilize national resources among the islands and thus strengthen the process of establishing local health systems, and exchange experiences with Venezuela, the Andean countries, and the Caribbean in this area; to train health personnel and the personnel of other involved agencies in the well-being of the community and in the different aspects of the health promotion strategy, as well as facilitators and women from the communities in topics related to development and health promotion; in addition, the personnel involved in the process of restructuring psychiatric care within community work in general, through the strategies of health promotion and mass health education; strengthening the systems of epidemiological surveillance of morbidity, as well as the utilization of the simplified perinatal clinical history and the monitoring of growth and development to identify vulnerable groups and focus health actions in order to achieve equity. This last strategy will be carried out primarily through direct technical cooperation from CLAP, CAREC, and the PAHO/WHO Representative Office and by training resources in the use of the epidemiological approach.

Food safety (FOS)

32. The purpose of the project is to support the development of integrated programs of food protection. The lines of action consist of promoting the definition of policies, plans, and standards to encourage the participation of governmental and nongovernmental organizations in the development of integrated food protection programs and their incorporation into the health area and tourism; to cooperate in the development of an information system on food protection and the epidemiological surveillance of food-borne diseases and of a health education project to prevent cholera and other food-borne diarrheal diseases; to promote applied research using the methodology of hazard analysis critical control point evaluation and to disseminate information on risks associated with the importation of animals and animal by-products.

## PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 142,000 | 74.8 | 156,900 | 74.5 | 172,400 | 74.4 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 142,000 | 74.8 | 156,900 | 74.5 | 172,400 | 74.4 |
| HEALTH SERVICES DEVELOPMENT | DHS | 142,000 | 74.8 | 156,900 | 74.5 | 172,400 | 74.4 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 47,900 | 25.2 | 53,500 | 25.5 | 59,500 | 25.6 |
| ENVIRONMENTAL HEALTH | | 27,000 | 14.2 | 30,000 | 14.3 | 33,200 | 14.3 |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 27,000 | 14.2 | 30,000 | 14.3 | 33,200 | 14.3 |
| VETERINARY PUBLIC HEALTH | | 20,900 | 11.0 | 23,500 | 11.2 | 26,300 | 11.3 |
| FOOD SAFETY | FOS | 20,900 | 11.0 | 23,500 | 11.2 | 26,300 | 11.3 |
| GRAND TOTAL | | 189,900 | 100.0 | 210,400 | 100.0 | 231,900 | 100.0 |

## PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| III. HEALTH SCIENCE AND TECHNOLOGY | | 35,600 | 100.0 | 53,900 | 100.0 | 0 | |
| COMMUNICABLE DISEASES | | 35,600 | 100.0 | 53,900 | 100.0 | 0 | |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 35,600 | 100.0 | 53,900 | 100.0 | 0 | |
| GRAND TOTAL | | 35,600 | 100.0 | 53,900 | 100.0 | 0 | |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 97,900 | 0 | 0 | 30 | 8,000 | 0 | 1 | 2,000 | 18,100 | 6,900 | 0 | 62,900 |
| WHO - WR | 92,000 | 0 | 0 | 45 | 12,000 | 1,200 | 8 | 16,000 | 29,000 | 12,800 | 0 | 21,000 |
| TOTAL | 189,900 | 0 | 0 | 75 | 20,000 | 1,200 | 9 | 18,000 | 47,100 | 19,700 | 0 | 83,900 |
| % OF TOTAL | 100.0 | | | | 10.5 | .6 | | 9.5 | 24.8 | 10.4 | .0 | 44.2 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 53,500 | 0 | 0 | 32 | 8,900 | 3,000 | 0 | 0 | 19,900 | 5,700 | 0 | 16,000 |
| WHO - WR | 156,900 | 0 | 0 | 90 | 25,000 | 4,600 | 8 | 16,000 | 90,800 | 11,400 | 0 | 9,100 |
| TOTAL | 210,400 | 0 | 0 | 122 | 33,900 | 7,600 | 8 | 16,000 | 110,700 | 17,100 | 0 | 25,100 |
| % OF TOTAL | 100.0 | | | | 16.1 | 3.6 | | 7.6 | 52.7 | 8.1 | .0 | 11.9 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 59,500 | 0 | 0 | 32 | 8,900 | 3,400 | 0 | 0 | 22,600 | 6,500 | 0 | 18,100 |
| WHO - WR | 172,400 | 0 | 0 | 90 | 25,000 | 5,200 | 8 | 16,000 | 103,000 | 12,900 | 0 | 10,300 |
| TOTAL | 231,900 | 0 | 0 | 122 | 33,900 | 8,600 | 8 | 16,000 | 125,600 | 19,400 | 0 | 28,400 |
| % OF TOTAL | 100.0 | | | | 14.6 | 3.7 | | 6.9 | 54.2 | 8.4 | .0 | 12.2 |

## HEALTH SITUATION ANALYSIS

### Demography

1. The Republic of Nicaragua had a population of approximately 4.2 million in 1992, with an annual growth rate of 3.3%, whose distribution has the following characteristics:

2. The Pacific region, with 15% of the national territory, is home to about 65% of the population; the central region, with 29% of the national territory, has about 30% of the population; and the Atlantic region, with 56% of the national territory, accounts for 8% of the population.

3. The last population survey (1985) showed a slightly greater predominance of the urban population over the rural; by sex, there were 93.8 men for every 100 women; and the age cohort of 0 to 14 accounted for 47% of the total population. The general fertility rate was 5.8 children per woman.

### Health status indicators

4. The total mortality rate is 10.08 per thousand population. Close to 25% of all deaths are estimated to be due to communicable diseases, while at the same time deaths from cardiovascular diseases and malignant neoplasms are on the rise and deaths from war injuries are declining.

5. Infant mortality still runs high, being estimated at 71.8 per 1,000 live births in 1990. The leading causes are: intestinal infectious diseases, certain conditions originating in the perinatal period, and acute respiratory infections, which together account for 81.3% of the total. The leading causes of death in children aged 1-4 are also intestinal infectious diseases and acute respiratory infections.

6. Maternal mortality is approximately 16 per ten 1,000 live births. The most frequent causes are hemorrhage, sepsis, and hypertension in pregnancy. Abortion is another major cause.

7. Morbidity is characterized by a high incidence of infectious and contagious diseases linked with deficient hygiene and sanitation conditions. The leading causes are old age and acute respiratory infections.

8. Cholera struck Nicaragua last year and is now present in 14 of its 17 departments.

9. The most frequent reportable diseases are: scabies, mumps, gonococcal infections, pulmonary tuberculosis, viral hepatitis, syphilis, and typhoid fever. There are also high rates of vector-borne diseases, such as malaria, dengue, and leishmaniasis.

10. Statistical reports from the Ministry of Health (MINSA) reveal that 21% of the children under age 6 treated in health services suffer from moderate malnutrition and 18%, from severe malnutrition.

### Factors affecting health status

11. Water supply system coverage continues to be inadequate. It was calculated at 53% of the total population in 1989, 78% of the urban population and 18% of the rural population. Water quality problems also prevail, since 59% of the wastewater is not treated. There are also problems with refuse and waste disposal. Only 32% of the population has sanitary sewerage service and only 16% of the rural population has sanitation service. Only 45% of the solid waste is collected and final solid waste disposal does not meet established standards.

12. The economic situation has worsened, as shown by unemployment and underemployment rates, which have increased from 33% of the economically active population in 1989 to 53% in 1992, with a concomitant increase in the size of the informal sector. The fiscal sector remains in deficit, which is offset by contributions from international cooperation agencies. Armed conflicts and tensions persist in the northern region of the country, resulting in social instability and abandonment of productive activities in that region. Although the economy did not grow in 1992, at least there was no negative growth as in previous years. Wages have been frozen for two years, although inflation was less than 10% in 1992. The overall illiteracy rate is 24% and it is estimated that 28% of the school-age population has no access to primary education.

13. Health service coverage is good, although there are pockets of population without access to basic health care. Specialized medical practices are concentrated in the capital and some regional capitals, and there is no tertiary-level hospital in Nicaragua. There is a shortage of nurses and middle-level technicians. There is also lack of motivation and dissatisfaction among medical personnel owing to low wages and poor working conditions. There was an acute shortage of many pharmaceuticals last year, which lowered the effectiveness of the units and the credibility of the system. More than 40% of the installed medical equipment is reported to be in poor condition or in need of replacement and the buildings of a large proportion of units are in need of repair. MINSA does not have the budgetary resources to accomplish all this.

### Plans and priorities for national health development

14. The health sector basically comprises MINSA, which is responsible for organizing health promotion, protection, recovery and rehabilitation efforts

through public programs and services. There are also medical care services that are under the jurisdiction of the Ministry of Government and the army. Social security does not provide any health services directly, but is currently examining the implementation of a system for buying services for the insured. Private practice is limited mainly to outpatient care.

15. In 1992, MINSA launched a process to decentralize and strengthen the local level. Nineteen Local Comprehensive Health Care Systems (SILAIS) were established, so that currently the health system is organized into two administrative levels. These are:

15.1 The central level: made up of national departments and divisions in charge of formulating policies, and regulating and evaluating national programs.

15.2 The SILAIS level: the basic administrative unit of the system, where operational relations of intersectoral coordination exist for the delivery of health care.

16. The policies and strategies of the Ministry of Health are set forth in the 1991-1996 master health plan, proposing three simultaneous lines of intervention: one of an institutional nature, to develop and strengthen the sector within the framework of broad coordination within and among sectors; a second one, designed to organize and strengthen the services, increasing the coverage and quality; and a third one, of a social nature, which promotes active participation by society in safeguarding the health of its members.

17. The main strategies that are outlined in the master plan and are currently being implemented are:

17.1 Development of a vigorous process of decentralization to the SILAIS, entrusting their management staff with organizing and directing the health process in their territory, and executing directly a large part of the health budget. Plans call for increasing financial decentralization still further and, starting in 1992, extending it to the hospitals.

17.2 Reorganization of the services in each SILAIS in accordance with their individual installed capacity, defining two levels: the first one covering outpatient care and the second one covering hospital care, endeavoring to find effective solutions to the main health problems and complementarity between the two levels.

17.3 Study of the possibilities of supplementary financing to MINSA's ordinary budget. Implementation of the charging of fees for services and separate health care for the insured, paid for by the INSSBI.

17.4 Special attention to vulnerable groups, particularly mothers and children, the disabled and socially disadvantaged groups. A steady increase in vaccination coverage and measles eradication is proposed.

17.5 Improvement of the physical infrastructure, assigning a very important role to the mobilization of external cooperation resources, stressing recovery of installed capacity and maintenance.

17.6 Implementation of a process to develop the skills of the labor force, particularly management training for local health leaders. Establishment of human resource management and control systems to help correct the discrepancies in their distribution.

17.7 Development of the management skills aimed at improving control and rationalization in the health system, by developing strategic planning and local programs, strengthening the legal framework of health, introducing a management information system, measuring costs and applying organizational development methods.

17.8 Development of a policy for providing supplies, including the establishment of a basic list of pharmaceuticals, planning and distribution by SILAIS and units, improved purchasing through public bidding, control and distribution systems in hospital pharmacies, and strengthening drug quality control.

17.9 Control of health-related environmental factors, by improving water supply coverage and quality, providing sewerage systems and proper excreta disposal methods, to which end MINSA will work jointly with INAA and the mayoralties in finding extrabudgetary funds and will increase advisory services and control on the environment.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

18. Based on the national priorities defined in the 1991-1996 master health plan and an analysis of institutional resources, the following priority fields for technical cooperation have been identified:

18.1 Institutional development of the local comprehensive health care systems. aimed at strengthening the local networks of services and ensuring efficient administration of health care facilities, particularly hospitals.

18.2 Mobilization of resources from the local governments, nongovernmental organizations, and international cooperation agencies for the health sector. Analysis of health financing and implementation of procedures for recovering fees and collecting payments for medical services.

18.3 Strengthening the capacity for epidemiological analysis and for identifying and monitoring social risks associated with the health process, with a view to organizing more comprehensive interventions on the major local health problems.

18.4 Development of processes of quality assurance of the health care provided in the health services. Support for activities relating to hospital accreditation, the establishment of treatment standards, and the tertiary health care level in the country.

18.5 Health promotion through individual and family education and their active participation in: health self-care and domestic hygiene practices; community hygiene; and modification of lifestyles associated with the leading causes of mortality and morbidity.

18.6 Promotion of a more favorable health environment, particularly improvement and increased coverage of water supply and solid waste disposal systems. Strengthening of the institutional capacity for protecting ecosystems.

18.7 Development of health resources, with emphasis on administration and strategic development in accordance with Nicaragua's health practice model. Support for the processes of university education and dissemination of scientific information within the national health system.

19. Nicaragua is making significant efforts to obtain international financial resources for improving the national health system as a part of national reconstruction and recovery.

20. Accordingly, during this period the multilateral and bilateral agencies are expected to establish projects for comprehensive development of the SILAIS aimed at improving the areas of infrastructure, institutional strengthening, human resource development, attention to priority problems, and community participation.

21. Progress has been made in designing and developing these projects, primarily with the World Bank and the Inter-American Development Bank. The Nordic countries, Japan, Italy, Germany, the Netherlands, and the United States have also expressed interest in continuing to support or increasing their cooperation in the health sector.

22. The Ministry of Health is also developing activities to improve the cooperation of nongovernmental organizations and agencies operating in Nicaragua.

National priorities for technical cooperation from PAHO/WHO

23. PAHO/WHO will provide technical cooperation on the seven priorities identified jointly with the national health authorities: institutional development of the SILAIS; mobilization of resources and financial analysis of the sector; epidemiological analysis and interventions on priority problems; quality assurance of health care; health promotion and community participation; environment and health; and human resource development.

24. It has been agreed with the Ministry of Health that PAHO's technical cooperation in Nicaragua will support the institutional efforts aimed at: improving the efficiency of the services, especially hospital services, developing effective systems of control of resources and funds; increasing the quality of medical care in health centers and hospitals; establishing alternative sources of financing for secondary and tertiary health care by charging for services; carrying out situation analysis and pinpointing risks in order to organize efficient interventions on health problems; developing mechanisms for community participation in planning and evaluating health management; improving the coverage and quality of the domestic water supply; and improving the dissemination of scientific information within the sector and to the people.

25. Agreement has been reached with the Nicaraguan Social Security and Welfare Administration (INSSBI) to cooperate in evaluating and supervising the quality of medical care provided to the insured and in cost and rate studies.

26. Besides carrying out, with PAHO/WHO regular funds the group of projects described in the following section, PAHO/WHO will continue the process of mobilizing national and external resources, launched within the framework of the Central American Initiative, which, in the case of Nicaragua, includes activities in the following technical areas: development of the Local Comprehensive Health Care Systems; rehabilitation of the disabled; environment and health; women, health, and development; malaria prevention and control; AIDS prevention and control; and health equipment maintenance.

27. These projects will be carried out with technical cooperation from the Organization and financial support from the Nordic countries, AID, and the Netherlands. The amounts assigned to these projects constitute nearly 80% of the funds administered by the PAHO/WHO Representative Office.

28. It is hoped that during this biennium extrabudgetary funding for cooperation activities will remain at levels that are similar to or greater than those of the previous biennium.

29. INCAP will continue to work actively in the areas of food, preventive nutrition, and food protection, with regular funds and with funds from the Nordic countries, Switzerland, Great Britain, France, and AID.

## PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Diarrheal diseases (CDD)

30. Health promotion through individual and family education and active participation in: health self-care and domestic hygiene practices; community hygiene; and modification of lifestyles associated with the leading causes of mortality and morbidity.

31. Promotion of a more favorable health environment, particularly improvement and increased coverage of water supply and solid waste disposal systems. Strengthening the institutional capacity for protecting ecosystems.

Control of environmental health hazards (CEH)

32. The purpose of this project is to improve the knowledge of and control over community and environmental hygiene of government institutions and social organizations, and to improve the quality of domestically consumed water.

NICARAGUA (Cont.)

33. Technical cooperation will continue to be granted in the areas of water quality, proper waste disposal, and protection and rational use of natural resources without affecting the surroundings and human settlements. This cooperation will be given to MINSA, the Water Supply and Sewerage Administration (INAA), the Municipal Development Administration (INIFOM), and the Natural Resources and Environment Administration (IRENA). Cooperation will also be provided in developing social awareness of the importance of the environment in health and information will be given on protective measures and health promotion.

Health services development (DHS)

34. The purpose of this project is to strengthen the organization and operation of the SILAIS and ensure efficient management in the major health units.

35. The cooperation will focus on developing programs of health care quality assurance, applying procedures for improving the reliability of the health and management information compiled in health care units and establishing national standards on fees for services. Health Services research will have to be carried out to determine what progress has been made on the quality of health care and the management area to confirm the rates and use of service charges. Management training for local and health care unit leaders will continue in coordination with the human resource project.

Essential drugs and vaccines (EDV)

36. Institutional development of the local comprehensive health care systems aimed at strengthening the local networks of services and ensuring efficient management of health care facilities, particularly hospitals.

37. Development of processes of quality assurance of the health care provided in the health services. Support for activities relating to hospital accreditation, the establishment of treatment standards, and the tertiary health care level in the country.

Health policy analysis and development (HDP)

38. The purpose of this project is to improve knowledge of health financing and strengthen Nicaragua's health laws.

39. Cooperation will be offered in monitoring health spending and measuring costs by activities so that the information thus derived can be used by health leaders in the decision- making process. The data base for drawing up laws and resolutions on public health will be supported within MINSA and the national assembly. The health leaders at the national level and within the SILAIS will have to be trained on sector financing and health policies.

Human resources training (HRC)

40. The purpose of this project is to strengthen human resource management capacity in MINSA.

41. The training of the management staff of the SILAIS and the most important health care units so that they can strategically manage the resources in their respective areas will be one of the priority activities. The establishment of technical and legislative conditions for implementing careers in health will be supported. In these efforts it will be necessary to work with universities, polytechnic and public health schools, as well as with trade and professional associations operating in the health sector. Cooperation will be provided in enhancing the national medical library in the areas of process automation and connection to international information networks.

Growth, development and human reproduction (MCH)

42. The purpose of this project is to develop the local capability for analysis and control of the leading causes of infant and maternal mortality.

43. Technical cooperation will be given to standardize institutional practices and procedures with midwives and NGOs on care during pregnancy, delivery, and the puerperium, and to strengthen health care capabilities. Programs for training personnel from the community and disseminating information to the people and local authorities on family planning and child growth and development will need to be maintained.

Managerial support for national health development (MPN)

44. The purpose of this project is to provide managerial support to MINSA in strengthening its control and supervision capability and in formulating and evaluating cooperation projects.

45. The Representative and experienced consultants will participate in the analysis of information and implementation of technical procedures, advising the national and local authorities on managing the health process. The PAHO project unit will provide ongoing information and will participate in preparing, negotiating, and evaluating projects together with the upper management of MINSA.

Health promotion and prevention and control of noncommunicable diseases (NCD)

46. The purpose of this project is to strengthen the capacity for epidemiological analysis on noncommunicable diseases and their prevention in the community.

47. Programs will be required to train national and local staff members on measuring and controlling noncommunicable diseases, with emphasis on cardiovascular diseases, cancer, accidents, and alcoholism and drug addiction. Cooperation will be provided in promoting healthy lifestyles, through mass communications techniques. Procedures will be established for gathering information and monitoring the situation analysis units in the SILAIS.

General communicable disease prevention and control activities (OCD)

48. The purpose of this project is to improve the local capability to compile and analyze epidemiological data on communicable diseases and to schedule control activities.

49. The SILAIS management and statistics staff will have to be trained in operating situation analysis rooms and organizing effective control of foci of communicable diseases. Cooperation will be provided in standardizing practices to compile, process, and disseminate information on communicable diseases.

Technical cooperation among countries (TCC)

50. The purpose of this project is to concentrate resources in order to deal with health problems in border areas.

51. Cooperation will be given in standardizing the collection and processing of epidemiological information, and in supplementing health care for the inhabitants of border areas. There will also be cooperation in training professionals and technicians, exchanging staff according to the skills and needs of each country at the southern border.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 1,855,100 | 77.9 | 2,074,400 | 75.5 | 2,313,500 | 75.4 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 762,000 | 31.9 | 975,200 | 35.6 | 1,076,500 | 35.2 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 762,000 | 31.9 | 975,200 | 35.6 | 1,076,500 | 35.2 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 146,200 | 6.1 | 165,800 | 6.0 | 188,000 | 6.1 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 146,200 | 6.1 | 165,800 | 6.0 | 188,000 | 6.1 |
| HEALTH POLICY DEVELOPMENT | | 100,000 | 4.2 | 113,300 | 4.1 | 128,400 | 4.2 |
| HEALTH POLICY ANALYSIS AND DEVELOPMENT | HDP | 100,000 | 4.2 | 113,300 | 4.1 | 128,400 | 4.2 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 503,200 | 21.2 | 539,500 | 19.6 | 605,000 | 19.6 |
| HEALTH SERVICES DEVELOPMENT | DHS | 503,200 | 21.2 | 448,900 | 16.3 | 502,300 | 16.3 |
| ESSENTIAL DRUGS AND VACCINES | EDV | 0 | - | 90,600 | 3.3 | 102,700 | 3.3 |
| HUMAN RESOURCES DEVELOPMENT | | 343,700 | 14.5 | 280,600 | 10.2 | 315,600 | 10.3 |
| HUMAN RESOURCES TRAINING | HRC | 343,700 | 14.5 | 280,600 | 10.2 | 315,600 | 10.3 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 522,500 | 22.1 | 674,000 | 24.5 | 758,800 | 24.6 |
| ENVIRONMENTAL HEALTH | | 111,000 | 4.7 | 168,500 | 6.1 | 188,900 | 6.1 |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 111,000 | 4.7 | 168,500 | 6.1 | 188,900 | 6.1 |
| MATERNAL AND CHILD HEALTH | | 54,500 | 2.3 | 225,500 | 8.2 | 255,800 | 8.3 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 54,500 | 2.3 | 107,900 | 3.9 | 122,400 | 4.0 |
| DIARRHEAL DISEASES | CDD | 0 | - | 117,600 | 4.3 | 133,400 | 4.3 |
| COMMUNICABLE DISEASES | | 280,900 | 11.9 | 169,500 | 6.2 | 191,500 | 6.2 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 253,500 | 10.7 | 169,500 | 6.2 | 191,500 | 6.2 |
| MALARIA | MAL | 27,400 | 1.2 | 0 | - | 0 | - |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| HEALTH PROMOTION | | 46,400 | 2.0 | 110,500 | 4.0 | 122,600 | 4.0 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 46,400 | 2.0 | 110,500 | 4.0 | 122,600 | 4.0 |
| VETERINARY PUBLIC HEALTH | | 29,700 | 1.2 | 0 | - | 0 | - |
| FOOD SAFETY | FOS | 29,700 | 1.2 | 0 | - | 0 | - |
| GRAND TOTAL | | 2,377,600 | 100.0 | 2,748,400 | 100.0 | 3,072,300 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 5,395,600 | 59.4 | 5,424,000 | 85.4 | 0 | |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 9,100 | .1 | 0 | - | 0 | |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 9,100 | .1 | 0 | - | 0 | |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 28,300 | .3 | 0 | - | 0 | - |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 28,300 | .3 | 0 | - | 0 | - |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 5,358,200 | 59.0 | 5,424,000 | 85.4 | 0 | - |
| HEALTH SERVICES DEVELOPMENT | DHS | 4,163,700 | 45.9 | 4,294,000 | 67.6 | 0 | - |
| DISASTER PREPAREDNESS | DPP | 117,000 | 1.3 | 0 | - | 0 | - |
| REHABILITATION | RHB | 1,077,500 | 11.8 | 1,130,000 | 17.8 | 0 | - |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 3,718,800 | 40.6 | 925,000 | 14.6 | 0 | - |
| FOOD AND NUTRITION | | 58,200 | .6 | 0 | - | 0 | - |
| NUTRITION | NUT | 58,200 | .6 | 0 | - | 0 | - |
| ENVIRONMENTAL HEALTH | | 85,900 | .9 | 0 | - | 0 | - |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 85,900 | .9 | 0 | - | 0 | - |
| MATERNAL AND CHILD HEALTH | | 1,830,800 | 20.0 | 0 | - | 0 | - |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 1,188,700 | 13.0 | 0 | - | 0 | - |
| ACUTE RESPIRATORY INFECTIONS | ARI | 265,200 | 2.9 | 0 | - | 0 | - |
| IMMUNIZATION | EPI | 55,500 | .6 | 0 | - | 0 | - |
| DIARRHEAL DISEASES | CDD | 321,400 | 3.5 | 0 | - | 0 | - |
| COMMUNICABLE DISEASES | | 1,743,900 | 19.1 | 925,000 | 14.6 | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 441,800 | 4.8 | 360,000 | 5.7 | 0 | - |
| MALARIA | MAL | 1,302,100 | 14.3 | 565,000 | 8.9 | 0 | - |
| GRAND TOTAL | | 9,114,400 | 100.0 | 6,349,000 | 100.0 | 0 | |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 1,448,900 | 1 | 0 | 135 | 287,000 | 27,800 | 10 | 20,000 | 410,300 | 332,500 | 0 | 371,300 |
| WHO - WR | 928,700 | 1 | 2 | 80 | 257,700 | 8,700 | 0 | 0 | 203,600 | 180,000 | 0 | 278,700 |
| TOTAL | 2,377,600 | 2 | 2 | 215 | 544,700 | 36,500 | 10 | 20,000 | 613,900 | 512,500 | 0 | 650,000 |
| % OF TOTAL | 100.0 | | | | 22.9 | 1.5 | | .8 | 25.8 | 21.6 | .0 | 27.4 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 1,530,100 | 1 | 0 | 180 | 335,500 | 34,000 | 20 | 40,000 | 407,900 | 260,600 | 0 | 452,100 |
| WHO - WR | 1,218,300 | 1 | 2 | 76 | 354,100 | 8,500 | 0 | 0 | 229,600 | 213,500 | 0 | 412,600 |
| TOTAL | 2,748,400 | 2 | 2 | 256 | 689,600 | 42,500 | 20 | 40,000 | 637,500 | 474,100 | 0 | 864,700 |
| % OF TOTAL | 100.0 | | | | 25.1 | 1.5 | | 1.5 | 23.2 | 17.3 | .0 | 31.4 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 1,706,300 | 1 | 0 | 180 | 357,100 | 38,600 | 20 | 40,000 | 462,500 | 295,500 | 0 | 512,600 |
| WHO - WR | 1,366,000 | 1 | 2 | 76 | 385,900 | 9,600 | 0 | 0 | 260,400 | 242,100 | 0 | 468,000 |
| TOTAL | 3,072,300 | 2 | 2 | 256 | 743,000 | 48,200 | 20 | 40,000 | 722,900 | 537,600 | 0 | 980,600 |
| % OF TOTAL | 100.0 | | | | 24.2 | 1.6 | | 1.3 | 23.5 | 17.5 | .0 | 31.9 |

## HEALTH SITUATION ANALYSIS

### Demography

1. Bermuda. The estimated population at the end of 1991 was 58,460. The annual growth rate is approximately 1% and 67% of the population is over age 21.

2. Cayman Islands. The Cayman Islands are comprised of three islands with a combined population of 25,400. These islands are located about 500 miles south of Miami, Florida. Life expectancy at birth is 77.1 years.

### Health status indicators

3. Bermuda. In 1990, the overall mortality rate was 7.5 per 1,000 population and the infant mortality rate 7.8 per 1,000 live births. The birth rate was 15.2 with life expectancy of 76 years for females and 69 years for males. Ninety-six percent of newborns weighed over 2,500 grams at birth and 90% of children have adequate weight for age. Immunization coverage for children in 1991 was 80% DPT, 80% OPV, 75% measles. Alcoholism, respiratory illness and accidents were major causes of morbidity while cardiovascular diseases, cancer, accidents, violence and respiratory disease were major causes of mortality. Obesity, alcoholism, drug abuse, AIDS and accidents are significant public health problems. Toxoplasmosis is a zoonosis of national significance.

4. Cayman Islands. The leading causes of death are diseases of the circulatory system, accidents, poisoning, diseases of the respiratory system, malignancy and diseases of the digestive system. The exact prevalence of diabetes and hypertension is not known but it has been estimated that 1 in 4 adults attending clinics has either or both of these conditions. The overall number of accidents occurring in the country is not known. It is estimated that most are due to increased road traffic accidents, many of which are alcohol related. Increasingly alcohol and drug abuse are recognized as related factors in mental health cases. Sexually transmitted diseases - particularly gonorrhoea and syphilis are a significant problem. The incidence of gastroenteritis in children under 5 years of age is very high. In 1992, immunization coverage for children was 97% OPV, 99% measles, mumps, rubella, 80% BCG and 97% DPT.

### Factors affecting health status

5. Bermuda. A quality of life survey conducted in 1984 indicated an overall satisfaction with the health services. The impact of these services is evidenced by the low infant mortality rate indicated above and the life expectancy rate. In the area of environmental health, there is growing concern over oil pollution of beaches, ground and water pollution by pesticides and automobile and airplane emissions. Drinking water is obtained from individual roof catchment water collection and storage systems - other sources of water are the Government-controlled fresh water reservoirs and hotel desalination plants. Individual household cesspits, septic tanks and aeration plants are the main types of excreta disposal systems. Pollution control regulations are under review. Collection and disposal of solid wastes are carried out by the Public Works Department. Nutrition education programs are at present being instituted in primary and secondary schools. A preventive dental care program provides fluoride treatment for children. The health services are considered to be adequate, available and accessible to all the population. Hospital insurance is compulsory for all. Costs are borne equally by employers and employees. Health care is provided by the Government and the private sector. Population groups designated for special attention include mothers and infants, school-age children and the elderly. School children receive free treatment and hospitalization of persons over age 65 is 75%-100% subsidized. Following identification of areas of need, the Government initiated a program to provide services for the elderly and evaluated the public schools program.

6. Cayman Islands. In the area of environmental health, a collection and disposal of solid waste system is in operation. Package treatment plants for large scale establishments and septic tanks and latrines for smaller residential units are the methods used for excreta disposal. Sanitary conditions and water quality in restaurants and other food handling establishments are routinely monitored. Animals slaughtered for local consumption are examined ante- and post-mortem. In the area of maternal and child health, the Government carries out a rigorous immunization program offering DPT, oral polio, TB and measles vaccines. Health education on immunization is given at pre- and post-natal clinics as well as through the media.

### Plans and priorities for national health development

7. Bermuda. The National Health Policy emphasizes maternal and child health, health of the school-age child, community nursing for the elderly, dental health, control of communicable diseases, mental health and alcohol and drug abuse. The Ministry of Health and Social Services has adopted "Health for All by the Year 2000" as a major goal and is pursuing policies congruent with the regional strategies for attaining this goal. The Ministry of Health and Social Services has responsibility for health planning, programming, budgeting and evaluation. A Ministerial Joint Planning Committee reviews all major expenditures for public health hospitals and social services programs. There is, however, no central planning agency. The budgeting process has been decentralized to involve program managers more fully. The Department of Health is responsible for public health, disease prevention and health promotion services. There is a significant private and semi-private sector consisting of general practitioners and hospital services. The health information system is being expanded and attempts are being made to integrate all information sub-systems, including the development of central case registers. The Department of Health has participated in a number of inter-disciplinary committee activities on health education, water supply, sewage,

health care costs and program development. Inter-Ministry projects on youth health education and child development are ongoing. The strategy of community participation still needs to be developed more significantly. The Government supports technical cooperation among countries.

8. Cayman Islands. The Ministry of Health is responsible for all health services provided by the Government. The health policy of the country is based on the recognition that access to good health is a fundamental universal right. The objective is to provide adequate, available and appropriate health services to the entire population by the year 2000. Strategies to attain these goals include expanding primary health care services and emphasizing preventive services, community care and health education, and increasing the levels of training for health personnel. Priority will increasingly be given to care of the elderly, the mentally ill and those with alcohol and drug problems as well as to the acutely ill. All this is carried through a vigorous national health promotion program which is quite pervasive. Although there is no social security system in the Cayman Islands, within the Department of Social Services there is a general welfare system that provided free medical care for welfare cases. Services are geographically accessible to all, through an integrated primary-secondary care network that includes a central hospital and outreach clinics in each district. A wide variety of community groups are involved in health programs. Similarly, health education activities in the communities are arranged in consultation with church groups, voluntary agencies and community groups. The Government gives some attention to health manpower development by granting ad hoc training scholarships and making assistance available to employees seeking further education. Alternative methods of financing the public health services now being considered are direct payment by patient or a national health insurance plan, or a combination of both.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

9. Bermuda. Based on the priorities of the Government, external assistance will be sought for the strengthening of the following areas: epidemiological surveillance; manpower development; health information system; and disaster preparedness.

10. Cayman Islands. Based on the priorities defined, the Government will seek external assistance in the following areas: manpower development, through training by fellowships, courses and seminars; environmental health, through direct technical assistance such as consultants; and health promotion, through development of resources and technical assistance.

### National priorities for technical cooperation from PAHO/WHO

11. Bermuda. PAHO is being asked to provide technical cooperation in the following areas: epidemiological surveillance; manpower development; health information system; disaster preparedness. There have been no extra-budgetary funds.

12. Cayman Islands. Technical cooperation is required by the Government in the following areas: manpower development; environmental health activities; and health promotion.

13. PAHO technical cooperation will therefore be targeted significantly towards providing support for development and enhancement of health manpower; providing consultations in environmental health; and for health promotion activities. The AIDS program has benefitted from WHO/GPA funding. However, the future continuity of this arrangement is in doubt.

## PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

### Health services development (DHS)

14. Bermuda. The purpose of the project is to strengthen health services delivery through training of health personnel locally and overseas, health promotion, disease surveillance and management of knowledge through dissemination of information. To achieve this purpose, it will be necessary to direct technical cooperation activities mainly to the promotion of Caribbean Cooperation in Health (CCH) and TCC in investigating disease outbreaks through CAREC; provide computer assistance in immunization programs; disseminate information aimed at creating public awareness of disease trends; provide training in the areas of community health nursing, STD training, applied epidemiology and dental health; and provide support for evaluation of dental health programs.

15. Cayman Islands. The purpose of the project is to strengthen health services delivery through training of health personally locally and overseas; to enhance environmental health and disease surveillance, and support health promotion through development of resources and dissemination of information. To achieve this purpose it will be necessary to promote CCH and TCC activities and facilitate disease surveillance through CAREC; share documentation, promote meetings between the British Dependent Territories and support attendance of nationals at regional and sub-regional events; training will be carried out through fellowships and seminars in the priority areas; and provide technical assistance in the strengthening of the health programs and health promotion activities.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 87,500 | 100.0 | 95,300 | 100.0 | 103,400 | 100.0 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 87,500 | 100.0 | 95,300 | 100.0 | 103,400 | 100.0 |
| HEALTH SERVICES DEVELOPMENT | DHS | 87,500 | 100.0 | 95,300 | 100.0 | 103,400 | 100.0 |
| GRAND TOTAL | | 87,500 | 100.0 | 95,300 | 100.0 | 103,400 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| III. HEALTH SCIENCE AND TECHNOLOGY | | 20,000 | 100.0 | 215,900 | 100.0 | 0 | |
| COMMUNICABLE DISEASES | | 20,000 | 100.0 | 215,900 | 100.0 | 0 | |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 20,000 | 100.0 | 215,900 | 100.0 | 0 | |
| GRAND TOTAL | | 20,000 | 100.0 | 215,900 | 100.0 | 0 | |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 87,500 | 0 | 0 | 65 | 17,400 | 15,300 | 15 | 18,000 | 17,400 | 7,100 | 0 | 12,300 |
| TOTAL | 87,500 | 0 | 0 | 65 | 17,400 | 15,300 | 15 | 18,000 | 17,400 | 7,100 | 0 | 12,300 |
| % OF TOTAL | 100.0 | | | | 19.9 | 17.5 | | 20.5 | 19.9 | 8.1 | .0 | 14.1 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 95,300 | 0 | 0 | 55 | 15,300 | 17,300 | 10 | 20,000 | 19,800 | 8,100 | 0 | 14,800 |
| TOTAL | 95,300 | 0 | 0 | 55 | 15,300 | 17,300 | 10 | 20,000 | 19,800 | 8,100 | 0 | 14,800 |
| % OF TOTAL | 100.0 | | | | 16.1 | 18.2 | | 20.9 | 20.8 | 8.5 | .0 | 15.5 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 103,400 | 0 | 0 | 55 | 15,300 | 19,600 | 10 | 20,000 | 22,500 | 9,200 | 0 | 16,800 |
| TOTAL | 103,400 | 0 | 0 | 55 | 15,300 | 19,600 | 10 | 20,000 | 22,500 | 9,200 | 0 | 16,800 |
| % OF TOTAL | 100.0 | | | | 14.8 | 19.0 | | 19.3 | 21.8 | 8.9 | .0 | 16.2 |

## HEALTH SITUATION ANALYSIS

### Demography

1. According to data from its 1990 population census, Panama has 2,329,329 inhabitants, with an annual population growth rate of 2.5%, and it is estimated that by the year 2000 it will have nearly 3 million inhabitants. Of these, 54% live in urban areas, and 46% of the total population is concentrated in the province of Panama. The country has an area of 75,512 km², and an average population density of 31 inhabitants/km², with variations ranging from 4,860.5 inhabitants/km² to 1.6 inhabitants/km². The average number of persons per household is 4.4, and for each 102 men there are 100 women, 22% of whom are heads of household. The median age of the population is 22 years; 34,61% is under 15 years of age and 12.8% is under 5 years of age.

### Health status indicators

2. Life expectancy at birth was 72.44 years in 1990. For that year, registered infant mortality was 18.9, and adjusted infant mortality, 23.9, with a neonatal rate of 11.5 and a postnatal rate of 6.2. Mortality in children 1-4 years of age is 1.4 per 1,000 live births. Maternal mortality is 0.5 per 1,000 live births. Total mortality is 4 per 1,000 live births. In 1992, severe malnutrition affected 7.1% of the children 1-5 years of age, and 31.1% suffered from some degree of malnutrition. In 1988, 24.4% of first-grade schoolchildren exhibited physical growth retardation. Micronutrient deficiencies are also a serious problem: the prevalence of nutritional anemia is 18.6% in preschool children and between 22% and 38.6% in pregnant women. Endemic goiter affects 13.2% of the population, and there is one region where this figure is 23.2%. Vitamin A deficiency (<30 mcg/dl) is 29.4%. The leading causes of infant mortality are: perinatal causes, congenital anomalies, diarrhea, pneumonia, and malnutrition. Cardiovascular problems, myocardial infarction, arterial hypertension, accidents, cancer, and other chronic conditions are the most prominent on the list of the 10 leading causes of death in the general population. To date there have been 393 cases of AIDS, and in recent years there has been an increase in cases among heterosexuals. Of the total cases, 186 have died. The incidence of HIV seropositivity is unknown, but there are signs that it is increasing, and it is expected that by 1995--as a conservative estimate--more than 20,000 persons will be infected.

3. Aedes aegypti infestation is confined to less than 5% of households in the principal urban centers. In 1992 there was an increase in cases of malaria, with two principal foci: one in the Region of Darien and another in the Region of Bocas del Toro.

4. Cholera broke out on 10 September 1991, causing 1,180 cases that year, with 292 hospitalizations and 31 deaths. In 1992, 2,418 cases occurred, with 1,262 hospitalizations and 49 deaths.

### Factors affecting health status

5. Water supply and sanitation conditions are good on the average: of the 524,284 inhabited private dwellings, 18.5% have dirt floors, 83% have drinking water, and 72.8% have electric lighting. Nevertheless, there are segments of the population considered to be at high health risk in terms of excreta disposal and water quality; in locales of less than 500 inhabitants, there is practically no purification of the water used for human consumption. The emergence of cholera has put pressure on authorities to rapidly develop plans to correct these problems.

6. Unemployment is 20%. With regard to nutrition, information contained in the food balance sheets shows the growth of caloric and protein availability from 1960 to 1985 to be even higher than international recommendations; but between 1986 and 1989, this trend was reversed, with a drop in the availability of calories (-20%) and of proteins (-15%). The basic food basket has an average monthly cost of US$214 for a family of 5, a figure which exceeds the minimum wage (US$175). This means that, for 50% of the population, basic needs for food, housing, education, health, etc., are not being met, and that for 27% not even dietary needs are being covered (critical poverty level).

7. In 1992, there was unprecedented economic growth, at an annual rate of 9.5%, but no positive changes have yet been reported in the social indicators, such as unemployment and poverty.

8. Maternal and child health programs have shown low coverage, especially among preschoolers, schoolchildren, and adolescents and in prenatal care, with little participation from the community or from the nongovernmental sector and with limited coordination with other institutions of the public sector.

9. General health service coverage for the population is on the average high (approximately 50% of the population is covered by Social Security Fund services); however, due to a scarcity of resources and problems in the organization of services, the quality of care is far from ideal. The same is true of the coverage of water supply and excreta disposal services.

### Plans and priorities for national health development

10. The national policy document drafted in 1990 establishes modern theories with regard to the objectives, targets, and strategies for health care and health systems, emphasizing comprehensive care, prioritization of the highest-risk groups, equity, community participation, health education, the development of services, the expansion of health and sanitation coverage in accordance with global development strategies, the updating of health and environmental legislation, the strengthening of relations and coordination with universities, manpower development, and interinstitutional coordination with the private sector and with international cooperation agencies.

11. To achieve these goals, the health sector has established two basic strategies: to strengthen the operating capacity of the Local Health Systems, mainly by modernizing and developing local management and management training systems; and to develop community ability to participate in health activities, especially those of prevention and self-care. These strategies have been in effect for some time now and will continue to be used, despite the fact that it has not been possible to implement them on a large-scale basis, due to political and administrative constraints.

12. Another express objective of the policies and plans has been to improve qualitatively and quantitatively the coverage of the immunization program and the production of nutritionally enhanced foods for pregnant women and schoolchildren.

13. In the environmental area, a series of targets and programs of great importance have been formulated, which are aimed in particular at comprehensive environmental protection, basic comprehensive sanitation, and the elimination of cholera risks through the purification of water and the sanitary disposal of excreta in rural areas. The problem of metropolitan sewerage and the consequent contamination of the Bay of Panama have grown worse, and no specific solution has been formulated, athough the matter has led to a mobilization of political and technical forces, which is a very positive development for the environmental future of the country.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National Priority Areas for Technical Cooperation

14. The Government has quite clearly identified several strategic areas requiring priority technical cooperation. These are:

14.1 Support for the strengthening of local health systems with emphasis on managerial development.

14.2 Support for health promotion, with emphasis on self-care as a special strategy in each health region, including the organization and operation of basic local libraries of health information for health and community personnel.

14.3 Support for the programs on control of cholera, AIDS, STDs, tuberculosis, and diarrheal diseases.

14.4 Development of comprehensive maternal and child health programs and environmental protection programs, with emphasis on water quality and total coverage for sanitary disposal of excreta.

### National priorities for technical cooperation from PAHO

15. At the request of the government, PAHO/WHO will endeavor to extend coverage in the priority areas indicated in the previous section. Indeed, these are the areas that are of greatest importance and cover the broadest spectrum for the health of Panamanians; moreover, they coincide to a great extent with the Strategic Orientations and Program Priorities of the Organization.

16. In addition to carrying out the series of projects described below with PAHO/WHO regular funds, the organization will continue to mobilize national and external resources within the framework of the Central American Initiative. In the case of Panama, activities are planned in the following technical areas: diarrheal disease prevention and control, with a special focus on cholera; maintenance of health equipment and facilities; AIDS prevention and control; human resources development; malaria prevention and control; environment and health; and women, health, and development.

17. In addition, through INCAP, it will continue to furnish technical cooperation in the area of food and nutrition.

## PROJECTS SUPPORTED WITH REGULAR PAHO/WHO FUNDS

### Community water supply and sanitation (CWS)

18. The purpose of this project is to improve the management of water and sanitation institutions, with emphasis on the identification of problems and the formulation of projects.

19. The improvement of the managerial capacity of staff members at all levels will be achieved by training them through courses focused on the daily problems faced by the institutions and by applying participatory methodologies. There is a need for mobilization of resources to finance the basic studies required for the formulation of projects on water supply and sanitation; active participation in these studies will come from universities, nongovernmental organizations, and professional groups and associations. The following will also be promoted: the adoption of sectoral water supply plans, monitoring of water quality, removal and treatment of liquid and solid wastes, and other pertinent actions--a process in which interinstitutional coordination will be strengthened as the appropriate mechanism for the formulation of comprehensive projects for the subsector. There will be cooperation in the preparation of manuals and guidelines and in the promotion of the intensive use of REPIDISCA, among other information sources. Another technical cooperation activity will be the establishment of a managerial information system, at all levels of the organizations, on the development of the subsector. An understanding of the true state of the subsector will be achieved with the promotion of research, with the participation of universities, nongovernmental organizations, and water and sanitations institutions.

### Health services development (DHS)

20. The purpose of this project is to develop the response capacity of the local health systems (including the capacity to plan, develop, conserve, and manage physical resources), as well as the capacity for community participation in health activities.

21. Managerial systems will be developed, and their proper utilization and handling will be emphasized through managerial training. The development of health care models, due to their novelty, will require intense technical cooperation and utilization of TCC. An information system for planning, development, and management of physical infrastructure will be established; the lack of such a system is currently the greatest obstacle to the generation of development projects. Finally, major efforts will focus on health promotion, which will be the dominant factor in health actions.

22. There will be continued cooperation in the development of maintenance policies, and these policies will gradually become an integral part of the national system of planning, management, and development of physical infrastructure. Technical cooperation among countries at the Central American level will be an essential component in this process, especially for the implementation of a comprehensive computerized information system.

23. The new guidelines for the Oral and Dental Health Program will be disseminated among all responsible personnel at the regional and local levels; oral health actions will be added to the programs as one of their basic components. Through courses and workshops, training will be provided for the local personnel responsible for carrying out these actions. At the local level, there will be support for the processes of negotiation and consensus-building among health services, teachers, and parents in order to mobilize resources for the prevention and prompt care of dental caries in the preschool and school-age population. Research will be facilitated at the local level so as to make it possible to evaluate the impact of these actions.

Human resources training (HRC)

24. The purpose of this project is to support the Ministry of Health in the coordination of human resource planning and development with a strategic approach in support of the process of decentralization in the context of the local health systems.

25. Strategic development of human resources for health will be supported, drawing on the contributions of research on the work force as a means of bridging the gap between the training and utilization of health personnel.

26. There will be support for the development of health leadership at all levels, promoting the development of public health as the way to the ethical practice in health care.

27. Special emphasis will be directed toward continuing education, concentrating on the work process and on innovations in the practice of health care to meet the needs of the population, in light of new socio-epidemiological profiles and technological progress, striving for the transformation of health services.

Managerial support for national health development (MPN)

28. The purpose of this project is to channel the potential of technical cooperation in order to make maximum use of it to achieve national health development objectives.

29. There will be a continued mobilization of resources for the development of programs and projects of physical infrastructure and institutional development, and the development of local health systems and health promotion, and the capacity of the Country Representative's Office to support the health programs will be strengthened. Panama's participation in regional and subregional health forums will also be supported.

Health promotion and prevention and control of noncommunicable diseases (NCD)

30. The purpose of this project is to incorporate health promotion, as an effective defense strategy of all health programs.

31. Interprogram plans will be formulated to facilitate implementation of the health promotion strategy at the local level, as well as the evaluation of its impact, without generating competition or conflicts with regard to technical jurisdiction. The organization and structure of the health programs and their respective standards will be reviewed and updated in order to make them consistent with new models or guidelines; to that end, the policy-level technical and supervisory personnel of the programs will be trained in the design and evaluation of programs of disease control and technical standards. Operative research will be promoted as a means of evaluating the impact of this strategy on the population and the programs. In order to secure the commitment of the community (on an individual and collective basis), this entire process will be oriented within the framework of implementation of the local health systems, which will be utilized in order to facilitate the mobilization of local resources.

General activities communicable disease prevention and control (OCD)

32. The purpose of this project is to increase the efficiency and effectiveness of communicable disease control programs and the impact of their actions.

33. Studies and current situation analyses will be performed with regard to those communicable diseases considered to be of priority status in the country or in one region in particular, as well as with regard to appropriate control measures. The results will be disseminated among health personnel at all levels who are involved in the planning or execution of their actions. To that end, the policy-level technical and supervisory personnel of these programs will be trained in the design and evaluation of programs of disease control and technical standards. These programs will be incorporated into plans for the integration of the the health promotion strategy. A process of updating and adjusting these

programs will be carried out, and it is expected that this reformulation will make for their easy incorporation into the process of local health systems development.

Workers' health (OCH)

34. The purpose of this project is to increase the coverage of actions for the prevention and reduction of occupational risks.

35. Follow-up and support will be furnished for the implementation of the National Worker's Health Plan formulated by the National Commission, as well as for the process of negotiation and consensus-building on specific occupational health policies and plans, and for the mobilization of commercial, union, and trade organizations. These plans will be incorporated into the process of local health system development. In order to guarantee faithful execution of the plans, personnel from the institutions and organizations involved in the identification, prevention, and control of occupational risks will be trained. Epidemiological and operational research will be facilitated in order to design or make appropriate adjustments to the plans.

Technical cooperation among countries (TCC)

36. The purpose of this project is to increase the binational capacity for combined health development along the Costa Rica - Panama border (800 $km^2$/80,000 inhabitants, 106 communities).

37. Binational action will be coordinated through mechanisms of joint action, as well as through the development of health information systems for common use and the development of standards, plans, and strategies of binational action.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 1,679,700 | 88.8 | 1,839,200 | 88.6 | 2,019,000 | 88.6 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 646,400 | 34.2 | 747,500 | 36.0 | 840,400 | 36.9 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 646,400 | 34.2 | 747,500 | 36.0 | 840,400 | 36.9 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 47,300 | 2.5 | 53,600 | 2.6 | 60,800 | 2.7 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 47,300 | 2.5 | 53,600 | 2.6 | 60,800 | 2.7 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 907,300 | 47.9 | 952,300 | 45.9 | 1,024,000 | 44.9 |
| HEALTH SERVICES DEVELOPMENT | DHS | 907,300 | 47.9 | 952,300 | 45.9 | 1,024,000 | 44.9 |
| HUMAN RESOURCES DEVELOPMENT | | 78,700 | 4.2 | 85,800 | 4.1 | 93,800 | 4.1 |
| HUMAN RESOURCES TRAINING | HRC | 78,700 | 4.2 | 85,800 | 4.1 | 93,800 | 4.1 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 212,700 | 11.2 | 235,200 | 11.4 | 259,500 | 11.4 |
| ENVIRONMENTAL HEALTH | | 98,600 | 5.2 | 107,000 | 5.2 | 116,100 | 5.1 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 69,800 | 3.7 | 74,400 | 3.6 | 79,200 | 3.5 |
| WORKERS' HEALTH | OCH | 28,800 | 1.5 | 32,600 | 1.6 | 36,900 | 1.6 |
| COMMUNICABLE DISEASES | | 52,600 | 2.8 | 59,800 | 2.9 | 67,800 | 3.0 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 52,600 | 2.8 | 59,800 | 2.9 | 67,800 | 3.0 |
| HEALTH PROMOTION | | 61,500 | 3.2 | 68,400 | 3.3 | 75,600 | 3.3 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 61,500 | 3.2 | 68,400 | 3.3 | 75,600 | 3.3 |
| GRAND TOTAL | | 1,892,400 | 100.0 | 2,074,400 | 100.0 | 2,278,500 | 100.0 |

## PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 124,000 | 11.9 | 0 | - | 0 | |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 29,400 | 2.8 | 0 | - | 0 | |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 29,400 | 2.8 | 0 | - | 0 | |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 94,600 | 9.1 | 0 | - | 0 | - |
| HEALTH SERVICES DEVELOPMENT | DHS | 94,600 | 9.1 | 0 | - | 0 | - |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 916,100 | 88.1 | 790,100 | 100.0 | 0 | - |
| ENVIRONMENTAL HEALTH | | 48,900 | 4.7 | 0 | - | 0 | - |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 48,900 | 4.7 | 0 | - | 0 | - |
| MATERNAL AND CHILD HEALTH | | 493,600 | 47.5 | 0 | - | 0 | - |
| ADOLESCENT HEALTH | ADH | 240,800 | 23.2 | 0 | - | 0 | - |
| DIARRHEAL DISEASES | CDD | 252,800 | 24.3 | 0 | - | 0 | - |
| COMMUNICABLE DISEASES | | 373,600 | 35.9 | 790,100 | 100.0 | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 223,500 | 21.5 | 225,100 | 28.5 | 0 | - |
| MALARIA | MAL | 150,100 | 14.4 | 565,000 | 71.5 | 0 | - |
| GRAND TOTAL | | 1,040,100 | 100.0 | 790,100 | 100.0 | 0 | |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 809,700 | 1 | 0 | 275 | 297,200 | 14,000 | 73 | 146,000 | 200,000 | 10,300 | 0 | 142,200 |
| WHO - WR | 1,082,700 | 3 | 4 | 80 | 861,800 | 18,600 | 0 | 0 | 0 | 22,400 | 0 | 179,900 |
| TOTAL | 1,892,400 | 4 | 4 | 355 | 1,159,000 | 32,600 | 73 | 146,000 | 200,000 | 32,700 | 0 | 322,100 |
| % OF TOTAL | 100.0 | | | | 61.3 | 1.7 | | 7.7 | 10.6 | 1.7 | .0 | 17.0 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 911,000 | 1 | 0 | 301 | 354,100 | 15,900 | 61 | 122,000 | 187,200 | 17,700 | 0 | 214,100 |
| WHO - WR | 1,163,400 | 3 | 4 | 80 | 912,900 | 21,100 | 0 | 0 | 0 | 25,500 | 0 | 203,900 |
| TOTAL | 2,074,400 | 4 | 4 | 381 | 1,267,000 | 37,000 | 61 | 122,000 | 187,200 | 43,200 | 0 | 418,000 |
| % OF TOTAL | 100.0 | | | | 61.0 | 1.8 | | 5.9 | 9.0 | 2.1 | .0 | 20.2 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 986,400 | 1 | 0 | 301 | 371,500 | 18,000 | 61 | 122,000 | 212,200 | 20,000 | 0 | 242,700 |
| WHO - WR | 1,292,100 | 3 | 4 | 80 | 1,008,100 | 23,900 | 0 | 0 | 0 | 28,900 | 0 | 231,200 |
| TOTAL | 2,278,500 | 4 | 4 | 381 | 1,379,600 | 41,900 | 61 | 122,000 | 212,200 | 48,900 | 0 | 473,900 |
| % OF TOTAL | 100.0 | | | | 60.6 | 1.8 | | 5.4 | 9.3 | 2.1 | .0 | 20.8 |

## HEALTH SITUATION ANALYSIS

### Demography

1. The population of Paraguay rose from 3.03 to 4.1 million between 1982 to 1992 according to provisional figures from the 1992 census, with 3.1% annual growth during this period. The urban population rose from 43% to 51%. By the year 2000 the population is expected to be 5.1 million.

2. The age structure has shown no major changes; those 15 years of age and younger account for 40.1% of the population; those from 15 to 64, 56.2%; and those older than 65, 3.7%. Women of childbearing age account for 24.2% of the population. The estimated birth rate for 1990-1995 is 33.04 per 1,000 live births and the fertility rate is 4.34 children.

### Health status indicators

3. Life expectancy at birth is increasing steadily, the current figure being 67.29 years (65.15 for men and 69.53 for women).

4. The epidemiological profile is consistent with a developing country. The leading causes of disease and death are infectious and parasitic diseases and nutritional deficiencies among children and chronic and degenerative diseases among adults.

5. In 1991, total mortality was 6.38 deaths per 1,000 population. The infant mortality rate was 24.02 per 1,000 live births; and the rate in the 1-4 year age group 1.46 per 1,000. The principal causes of death overall are heart disease, cerebrovascular disease, tumors, and accidents among young adults. Among children under 5, they are diarrheal diseases, accute respiratory infections (ARI), and nutritional deficiencies. Prematurity, birth trauma, and infectious diseases are the most common causes of death among newborns. Among mothers, the leading causes of death are toxemia and hemorrhage of pregnancy, sepsis, abortion, and other complications.

6. Diarrheal diseases, acute respiratory infections, and diseases preventable by vaccination are the major causes of morbidity, and even though they have declined moderately, they are the leading causes of hospitalization in the group of children under 5. Malaria (5,000 cases a year), leishmaniasis (200 cases in 1992), and dengue (of which there is a high risk of outbreaks) are the most important VBDs. AIDS, with 60 current cases and 170 seropositives, increased by nearly 45% from 1991 to 1992.

7. Information remains incomplete due to the marked underreporting of vital statistics. The frequent adjustments to the information system have not succeeded in overcoming deficiencies.

8. Zoonoses are also a serious problem, especially urban rabies, foot-and-mouth disease, brucellosis, and bovine tuberculosis, due to the damage that they cause to the population and to the national economy.

### Factors affecting health status

9. Health status is strongly influenced by the low coverage of water services and sanitary systems for the final disposal of excreta and refuse; only 30% of the population has basic water service and only 15%, sewerage service; in rural areas these services are practically nonexistent.

10. Pollution of the water and soil is a steadily growing problem due to the use of toxic substances, especially in the agricultural sector, and to the deficient coverage of health care services. The possibilities for increasing services are significantly limited by budgetary and administrative constraints. The fragmentation of the sector creates duplication that has not been overcome despite the efforts carried out by the institutions through the National Council and the Regional Health Councils. It is estimated that only 35% of the population receives the direct health care services. The health programs have not managed to extend basic health protection, promotion, and recovery activities to all groups at risk, and community participation is very limited.

11. Health personnel show deficiencies in training for the administration of the services, and there is a scarcity of trained nursing auxiliaries and technicians, especially in the services in the interior of the country. Pre- and post-degree training programs are not geared towards the health problems of the population, and in-service training is a process that has only just begun.

12. Another important factor is deficient primary and health education. Illiteracy stands at more than 20%, and functional illiteracy is very common, as many people go to work in agriculture at an early age.

13. The budget of the Ministry of Public Health over the last three years has increased sharply in general, but the purchasing power of the guarani, the national currency, has deteriorated. The external debt, although small, and the world economic recession have affected the economic situation of the country, generating moderate but sustained inflation (20% a year) that has been particularly hard on low-income groups.

### Plans and priorities for national health development

14. The country has a broad health services network, structured by levels of complexity and divided between two principal institutions, the Ministry of Health and the Institute of Social Welfare, which together cover 80% of the population. The National Health System was established under the Political Constitution of 1992, and all efforts in the future will be geared towards the development and consolidation of this system.

15. The Strategic Health Sector Plan of 1991 establishes as its principal lines of action the decentralization of technical-administrative processes to the health regions (local health systems); interinstitutional coordination; attention to the major health problems affecting the population; improvement of the quality of care; attention to environmental health; and improvement of the management of

the sector. These lines of action will be implemented at the level of the local systems and the national health system. Community participation is being promoted through the formation of the health councils of the local health systems and the local health subsystems (regions and districts).

16. In order to implement these lines, it will be necessary to enhance administrative systems; train personnel; develop the management information system; consolidate local programming; strengthen teaching and the use of epidemiology in identifying the risk factors and groups; and adapt the services so that they meet the real needs of the population.

17. The priority risk groups are: the indigenous population and rural inhabitants, mothers, children, adolescents, workers, and the elderly, and health actions aimed at these groups will be intensified. It is very important to increase coverage against diseases preventable by vaccination.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

18. In accordance with the national priorities of the sector, the government is requesting technical cooperation to: develop the national health system; implement the process of decentralization at the level of the local health systems (health regions); develop managerial processes by incorporating the concept of strategic local administration; strengthen the organization and improve the infrastructure of health services in order to succeed in increasing efficiency and effectiveness; improve disease control programs with an emphasis on AIDS, diseases preventable by vaccination, diarrheal diseases and acute respiratory infections, vector-borne diseases, the major chronic, degenerative diseases, and the main zoonoses; carry out studies in order to improve knowledge of aspects that will permit the reallocation and best utilization of the financial resources of the sector; improve the programs for the ongoing training of human resources; extend the coverage of health and social security to unprotected groups; increase the provision of basic services of water, sewerage, and refuse collection; promote health through social participation and education to transform living conditions; develop the capacities for the use of epidemiology in diagnosis, planning, management, and evaluation of health programs and actions; and register, monitor, and control the quality of drugs, biologicals, and similar products.

19. Increasing the coverage of waste-disposal and drinking-water-supply services is a high priority for the Ministry of Health, which intends to obtain national and foreign funding to strengthen the actions geared towards this goal. Technical Cooperation Among Countries, especially in the framework of MERCOSUR, is being given special attention, as is the building of closer ties with the agencies of the United Nations system and other multilateral and bilateral agencies. Increasing emphasis is being placed on the participation of grass-roots organizations and NGOs in actions for the comprehensive improvement of health.

20. The following are under way: a project on environmental sanitation geared to the development of the Regulatory Plan of Asunción, which has US$ 70 million in financing, $45 million of which are being contributed by IDB and $8 million by the Sanitary Works Corporation (CORPOSANA); a project that is just getting started, with total funding of $36 million, $23 million of which is being contributed by IBRD and $13 million by Regional Funds for basic sanitation in rural areas. Both projects are expected to continue for more than three years. The following projects are being negotiated: a project with the European Economic Community for a total of $20 million, non-reimbursable, for excreta disposal in outlying areas of Asunción; a $50 million project with IDB to supply water for Asunción; a $30 million project, also with IDB, for water and sewerage in the interior of the country; a $50 million project with IBRD for sewerage in Asunción; a $5.3 million project with IBRD under the FONPLATA Project for sanitation in 33 district capitals; a $55.3 million project with IDB for integrated rural development that includes agriculture, education, health care, and public works. In addition, a three-year Institutional Development Project of the Ministry of Public Health and Social Welfare, which has $1.5 million in financing from AID, is currently under way.

### National priorities for technical cooperation from PAHO/WHO

21. In accordance with the Strategic Orientations and Program Priorities of the Organization, and in response to the request for cooperation from the government based on its priorities, PAHO will give technical cooperation to the country, with particular emphasis on the following areas: sectoral analysis and development of the National Health System; improving the operation and administration of the services through the decentralization and development of the local health systems; improving the programs to train human resources; improving the systems of epidemiological surveillance to control the principal diseases and problems related to the environment; strengthening the national capacity to enhance the efficiency of actions to protect the environment and the coverage of basic health services; and improving the services and coverage of the social security system.

22. In addition to the projects supported with regular funds there are projects supported with funds from outside the Organization. For example, under the MCH project, the hope is to continue support for the training of human resources, for the development of a model of comprehensive care, and for the dissemination of materials to educate parents in how to care for their children. With regard to HIV and AID, activities designed to protect the population will continue.

## PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

### Community water supply and sanitation (CWS)

23. The purpose of this project is to improve the technical-operational capacity of the national institutions responsible for water supply and excreta and refuse disposal services. In order to achieve this end, information about and the implementation of actions envisaged under the Regional Plan for Investment in the Environment and Health will be promoted, and the mobilization of national and external resources for its financing will be supported. Personnel will be trained in techniques for the design, construction, and operation of basic services of

water supply and excreta and refuse disposal. Research will be supported for optimum utilization of water sources and for information about environmental pollution. Plans and standards will be formulated for the coordination of services in basic actions to increase coverages for rural and marginalized urban populations; information will be disseminated in an effort to teach the populace to adopt behaviors conducive to the safeguarding of environmental health; and scientific and technical information will be disseminated to health sector personnel.

Health services development (DHS)

24. The purpose of this project is to develop the National Health System by strengthening the local health systems and by decentralizing. In order to achieve this end, standards, and procedures will be prepared in an effort to continue developing the local health systems, which will in turn serve as elements for the transformation of the National Health System; the teaching and implementation of local strategic administration will continue; the management information system will be developed; the concepts of community participation will be disseminated to encourage the population to become involved in health issues in accordance with the principles of decentralization; resources from the health sector and from other sectors in the country and overseas will be mobilized in order to transform the health system.

Foot-and-mouth disease (FMD)

25. The purpose of this project is to improve the technical and administrative infrastructure of the National Program for the Control and Eradication of Foot-and-mouth Disease. In order to achieve this purpose, the utilization of the mass media and of scientific and technological innovations will be encouraged in disseminating information on the eradication program to the public at large and to specialized groups; human resources will be trained and kept up to date on current scientific and technological changes in the field; resources from the sectors and institutions involved in livestock will be mobilized to help achieve the goal of eradication; continuation of the Technical Cooperation Agreement for the Eradication of Foot-and-Mouth Disease from the La Plata Basin and the Agreement with Bolivia will be fostered; biologicals and reagents will be supplied; technical advisory services will be provided to improve the production capacity of oil-adjuvant FMD vaccine and to start up and operate the cell culture laboratory.

Food safety (FOS)

26. The purpose of this project is to ensure that national food quality assurance activities are carried out in a coordinated manner by the various institutions that are involved. In order to achieve this end, models of shared participation and responsibility in the efforts aimed at food protection will be promoted. Technical support will be provided for the formulation of a national policy for the sanitary control of food and for the formulation of plans and standards to implement it and to coordinate the actions of institutions. Training will be provided to the personnel involved in production, processing, distribution, marketing, inspection, and laboratory diagnosis. The public in general will be given guidance on basic hygiene and health standards for food, the signing of an agreement with the INPPAZ for the sanitary control of food will be promoted.

Human resources education (HRE)

27. The purpose of this project is to develop the capacity of the institutions to adapt the process of human resources development to the requirements of the National Health System. In order to bring about a true transformation of health manpower, the coordinated participation of training centers and service institutions is necessary in an effort to redefine the profiles of the different health professions and make the necessary modification in academic programs, as well as the adaptation of the processes of training and in-service training. It is also necessary to define a National Health Policy and models for the training and utilization of professionals and technicians, and to pursue a process of continuing education. Research will be conducted to expand knowledge of the labor market.

Growth, development and human reproduction (MCH)

28. The purpose of this project is to strengthen the maternal and child health services of the Ministry of Public Health. In order to achieve this, operations research will be conducted to ascertain the efficiency of the services and the magnitude and structure of maternal and child morbidity and mortality rates at the level of the local health systems; plans will be formulated to improve the organization of the services, so as to increase the coverage of delivery care and care for newborns and to improve its quality. Information will be disseminated to modify knowledge, skills, and practices with regard to maternal and child health risks and to promote increased coverage of vaccination and the control of acute respiratory and diarrheal diseases. Personnel in the services at the primary and secondary levels and community health workers will be trained in techniques of delivery and newborn care and vaccination.

Managerial support for national health development (MPN)

29. The purpose of this project is to ensure the programming and delivery of PAHO technical cooperation in accordance with the principles of the Organization and the needs of the country. In order to achieve this end, the following will be disseminated and promoted: the incorporation of the principles and Strategic Orientations and Program Priorities of the Organization into national programs and plans; the pursuit of the actions arising from subregional, regional, and global commitments; and the coordination and mobilization of national resources towards the comprehensive improvement of health. The strategic lines that will guide the government on how to improve the country's health will be defined. Internally, an effort will be made to develop and enhance organization, administrative processes, and personnel training in order to optimize the management of the technical cooperation program and the delivery of program resources to the

country. A joint evaluation meeting will be held during the first year of every biennium. Interim evaluations will be conducted at least twice a year in order to adjust the annual program.

Health promotion and prevention and control of noncommunicable diseases (NCD)

30. The purpose of this project is to improve the national ability to promote and safeguard health by addressing the leading causes of death and the problem of drug dependency. The development and implementation of plans and standards will center on the early diagnosis and treatment of breast and cervical cancer, cardiovascular disease, and drug abuse. These efforts will include a heavy component of mass communication, which will be a major factor in reducing the risks associated with these problems. The personnel at the different levels of services will be trained in the techniques of diagnosis and treatment, and educational programs at schools will attempt to reduce the prevalence of drug use. Information will be disseminated to the public on risks and methods of prevention through lifestyle changes.

General communicable disease prevention and control activities (OCD)

31. The purpose of this project is to create conditions for the use of the epidemiological method in ascertaining the different health realities and in applying appropriate intervention measures. Personnel training will be aimed at familiarizing health professional with the epidemiological method and its application through national courses and fellowships for study abroad, with the participation of professionals at the local, regional, and central levels; this will enable studies and research to be carried out in order to identify the problems at each level of service. The application of epidemiological stratification will make it possible to identify risk groups and to take action geared to these vulnerable population groups. The formulation of standards and plans for the implementation and development of epidemiological surveillance at the local level will be a factor that strengthens decentralization and the local health services. The dissemination of research findings and epidemiological analyses, as well as of information to health personnel and to the population, will be an important element in reducing risks to health and in transforming living conditions.

Technical cooperation among countries (TCC)

32. The purpose of this project is to carry out coordinated actions to control common problems in border regions with neighboring countries. In order to achieve this end, standards and plans will be developed to implement systems of sanitary surveillance, epidemiological surveillance, and services coordination in the shared border areas; research will be carried out to identify the principal health problems and their determinants in the shared areas, with a view towards developing new joint programs or towards strengthening existing ones; and resources will be mobilized to fulfill the commitments made under bilateral agreements and agreements of the Ministers of Health of the Southern Cone, and to reactivate or intensify actions that are currently under way.

Zoonoses (ZNS)

33. The purpose of this project is to improve operational conditions in the country for the control and eradication of zoonoses in the areas at greatest risk. In order to achieve this purpose, multisectoral and community participation will be promoted for the prevention and control of zoonoses; a national policy for the control of zoonoses will be developed; sector human resources will be trained and updated, especially in the areas of laboratory, epidemiological, and field diagnosis; continuation of the health agreements between countries for the elimination of rabies and other zoonoses will be fostered; the utilization of the mass media will be encouraged to disseminate information on zoonoses to the public in general; specific projects in the area of Veterinary Public Health will be formulated with the School of Veterinary Sciences of the National University; and there will be support for epidemiological and operations research in the area of zoonoses with a view to contributing to political, strategic, and operational decision-making.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 1,272,400 | 62.3 | 1,462,300 | 64.3 | 1,617,200 | 64.4 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 443,100 | 21.8 | 626,200 | 27.5 | 703,400 | 28.0 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 443,100 | 21.8 | 626,200 | 27.5 | 703,400 | 28.0 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 54,800 | 2.7 | 62,100 | 2.7 | 70,400 | 2.8 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 54,800 | 2.7 | 62,100 | 2.7 | 70,400 | 2.8 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 647,300 | 31.6 | 664,600 | 29.3 | 726,000 | 28.9 |
| HEALTH SERVICES DEVELOPMENT | DHS | 647,300 | 31.6 | 664,600 | 29.3 | 726,000 | 28.9 |
| HUMAN RESOURCES DEVELOPMENT | | 127,200 | 6.2 | 109,400 | 4.8 | 117,400 | 4.7 |
| HUMAN RESOURCES EDUCATION | HRE | 127,200 | 6.2 | 109,400 | 4.8 | 117,400 | 4.7 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 764,700 | 37.7 | 816,000 | 35.7 | 893,300 | 35.6 |
| ENVIRONMENTAL HEALTH | | 316,900 | 15.6 | 325,300 | 14.3 | 354,400 | 14.1 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 316,900 | 15.6 | 325,300 | 14.3 | 354,400 | 14.1 |
| MATERNAL AND CHILD HEALTH | | 22,000 | 1.1 | 48,800 | 2.1 | 51,800 | 2.1 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 22,000 | 1.1 | 48,800 | 2.1 | 51,800 | 2.1 |
| COMMUNICABLE DISEASES | | 318,900 | 15.7 | 331,100 | 14.5 | 364,100 | 14.5 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 318,900 | 15.7 | 331,100 | 14.5 | 364,100 | 14.5 |
| HEALTH PROMOTION | | 40,000 | 2.0 | 37,100 | 1.6 | 41,500 | 1.7 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 40,000 | 2.0 | 37,100 | 1.6 | 41,500 | 1.7 |
| VETERINARY PUBLIC HEALTH | | 66,900 | 3.3 | 73,700 | 3.2 | 81,500 | 3.2 |
| ZOONOSES | ZNS | 66,900 | 3.3 | 73,700 | 3.2 | 81,500 | 3.2 |
| GRAND TOTAL | | 2,037,100 | 100.0 | 2,278,300 | 100.0 | 2,510,500 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| III. HEALTH SCIENCE AND TECHNOLOGY | | 708,700 | 100.0 | 338,800 | 100.0 | 16,300 | 100.0 |
| MATERNAL AND CHILD HEALTH | | 414,800 | 58.5 | 14,700 | 4.3 | 16,300 | 100.0 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 414,800 | 58.5 | 14,700 | 4.3 | 16,300 | 100.0 |
| COMMUNICABLE DISEASES | | 292,400 | 41.3 | 324,100 | 95.7 | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 292,400 | 41.3 | 324,100 | 95.7 | 0 | - |
| HEALTH PROMOTION | | 1,500 | .2 | 0 | - | 0 | - |
| OCULAR HEALTH | PBD | 1,500 | .2 | 0 | - | 0 | - |
| GRAND TOTAL | | 708,700 | 100.0 | 338,800 | 100.0 | 16,300 | 100.0 |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| **1992-1993** | | | | | | | | | | | | |
| PAHO - PR | 1,351,600 | 3 | 2 | 285 | 715,500 | 47,600 | 27 | 54,000 | 196,900 | 110,700 | 0 | 226,900 |
| WHO - WR | 685,500 | 2 | 0 | 315 | 460,100 | 8,000 | 16 | 32,000 | 141,200 | 4,300 | 0 | 39,900 |
| TOTAL | 2,037,100 | 5 | 2 | 600 | 1,175,600 | 55,600 | 43 | 86,000 | 338,100 | 115,000 | 0 | 266,800 |
| % OF TOTAL | 100.0 | | | | 57.8 | 2.7 | | 4.2 | 16.6 | 5.6 | .0 | 13.1 |
| **1994-1995** | | | | | | | | | | | | |
| PAHO - PR | 1,485,400 | 3 | 2 | 195 | 776,300 | 47,500 | 19 | 38,000 | 165,100 | 106,300 | 0 | 352,200 |
| WHO - WR | 792,900 | 2 | 0 | 264 | 495,600 | 9,500 | 26 | 52,000 | 172,400 | 29,400 | 0 | 34,000 |
| TOTAL | 2,278,300 | 5 | 2 | 459 | 1,271,900 | 57,000 | 45 | 90,000 | 337,500 | 135,700 | 0 | 386,200 |
| % OF TOTAL | 100.0 | | | | 55.7 | 2.5 | | 4.0 | 14.8 | 6.0 | .0 | 17.0 |
| **1996-1997** | | | | | | | | | | | | |
| PAHO - PR | 1,646,700 | 3 | 2 | 195 | 847,800 | 53,800 | 19 | 38,000 | 187,200 | 120,500 | 0 | 399,400 |
| WHO - WR | 863,800 | 2 | 0 | 264 | 533,600 | 10,800 | 26 | 52,000 | 195,500 | 33,300 | 0 | 38,600 |
| TOTAL | 2,510,500 | 5 | 2 | 459 | 1,381,400 | 64,600 | 45 | 90,000 | 382,700 | 153,800 | 0 | 438,000 |
| % OF TOTAL | 100.0 | | | | 55.1 | 2.6 | | 3.6 | 15.2 | 6.1 | .0 | 17.4 |

## HEALTH SITUATION ANALYSIS

### Demography

1. The population of Peru is estimated at 22,453,000 for 1992 and at 23,360,000 for 1994. It is quite a young population, with approximately 48% under 20 years of age and only 3.9% over 65. The demographic indicators estimated for 1992 show a total death rate of 7.6 per thousand and a birth rate of 29.1 per thousand population, with a total fertility rate of 3.5 children per woman and a population growth rate of 2.0% per year, all are which are on a downward trend. Rural-to-urban migration has produced the rapid development of human settlements on the fringes of the large cities, modifying the spatial distribution of the population. The country's rural population is currently estimated at 30%. Lima, the capital, has 6.5 million inhabitants in its metropolitan area (29% of the national population).

2. There are serious problems of underregistration of vital statistics; for example, it is estimated that only 50% of all deaths are registered. In addition, of these registered deaths, on the average only 64% are physician-certified. The last national census was taken in 1981, and another one is scheduled for 1993.

3. According to data from the 91/92 ENDES (Demographic and Family Health Survey), 90.3% of urban dwellings and only 19.6% of rural ones have electricity (70.1% in total). The availability of running water in dwellings is 75.2% in the urban areas and only 18.0% in the rural areas (58.9% in total), and 9.1% of urban dwellings and 63.4% of rural ones (24.6% in total) do not have any sanitary services--neither private nor common ones. The floors in 21.3% of urban dwellings and 74.9 of rural ones (36.6% in total) are dirt or sand.

4. Between 1985 and 1990, the growth of the country's total population was 13.3%, while the increase in the number of hospital beds was only 6.5%. As a consequence, the availability of beds per 1,000 population fell from 1.57 to 1.47.

### Health status indicators

5. For 1992, total mortality is estimated at 7.6 per 1,000 population, and life expectancy at birth is estimated at 64 years of age--66 for women and 62 for men. Owing to registry problems, it is impossible to calculate infant mortality directly based on those data. For this reason, estimates of infant mortality for the period 1990-1992 vary, from 55 per 1,000 live births up to 80. The National Council on Population estimates infant mortality in Peru to be 76.1, with the highest figure set at approximately 114 per 1,000 live births (in the Inca Region) and the lowest, at 51 (in the Lima Region).

6. With regard to daily consumption of calories per capita, from 1980 to 1990 there was a drop from 2,074 to 1,978 (under 4.6%), while protein intake has been reduced from 52.2 grams daily to 46.2 grams (under 11.5%). Data from the 91/92 ENDES show that 37% of children under 5 suffer from chronic malnutrition (size for age ratio). These figures have remained at the same level as those confirmed in the 1984 ENDES. The major differences that exist among the various regions of the country should be mentioned: The level of overall rural malnutrition is triple the urban level, and in the jungle almost 6 times higher than in Metropolitan Lima, with the proportion of undernourishment 10 times higher in children whose mothers are not educated than in children whose mothers have advanced degrees.

7. In regard to communicable diseases, it has been possible to increase vaccination coverage by more than 70% at the national level. There is a general downward trend in diseases preventable by vaccination; the last confirmed case of poliomyelitis occurred in August 1991. Measles outbreaks continue to occur, however, and there are unresolved problems such as leprosy, yellow fever, dengue, viral hepatitis, and AIDS, with reports of cases increasing every year. Many of the above diseases and others are frequently transmitted by blood, as a consequence of limited control of blood banks and blood transfusion in the country. Two other major public health problems are tuberculosis (approximately 49,000 reported cases in 1992 - preliminary data) and malaria (approximately 40,000 cases per year), with the reappearance of cases caused by P. falciparum.

8. With regard to mortality, there is a high incidence of deaths from avoidable and typically poverty-related causes, such as infectious diseases associated with malnutrition and high infant and maternal mortality rates. Also associated with this type of poverty situation are chronic degenerative diseases and those originating in urban lifestyles and behavior, such as alcoholism, accidents, violence, cardiovascular disease, and drugs, which diversify and complicate the status and solution of health problems.

9. In the Peruvian epidemiological profile, however, the most noteworthy event since 1991 has been the occurrence of cholera which, beginning in late January of that year, accounted for the most explosive epidemic in modern health history. From the coast of Peru, the disease swept through the entire Western Hemisphere. An accumulated total of more than 530,000 cases, with around 200,000 hospitalizations and approximately 3,620 deaths, was reported in the country in 1991 and 1992. The 1992 weekly incidence curve is identical to that of 1991, with the greatest occurrence of cases in the first quarter and a marked reduction starting in April.

### Factors affecting health status

10. Peru is experiencing the most profound and prolonged crisis - of a generalized nature - in its history. With its roots in the second half of the 1970s, it became acute starting in 1988. Some of the clearest indicators of this crisis are the following: A 2.7% drop in the GDP from 1991 to 1992; a fiscal deficit, reflected in the reduction of central government revenues from 14.1% of the GDP in 1985 to only 7.9% in 1991, an amount not sufficient to cover the minimum financial needs of the government; a drastic reduction in public spending on social resources (from US$ 45 per capita in 1981 to US$ 13 in 1989), which seriously affects the quality, quantity, and timeliness of the services offered to the population. There is great financial and commercial isolation from the foreign market, with export difficulties that have become increasingly acute in

the past two years. Although inflation has been reduced considerably, starting in 1991, it persists at residual levels (between 2% and 5% a month, with an accumulated rate of 56.3% in 1992), and the economy is strongly dependent on the dollar which results in a high cost of living. The low valuation of U.S. currency on the internal exchange market has caused, among other problems, export difficulties, with a deficit in the balance of trade. The foreign debt was already over 20,000 million dollars in 1991.

11. In addition to its impact on health, cholera has had important economic implications, especially with regard to reduced exports of products derived from fishing and from fruit and plant cultivation; the payment of increased tariffs owing to the quarantine of products in foreign ports; reduced domestic consumption of these same products; reduced internal productivity owing to the effect on the EAP; and expenditures on the treatment of cholera cases and on prevention. In 1991 alone, it is estimated that approximately 500 million dollars was lost as a consequence of the cholera epidemic.

12. The coverage of basic health services has increased in the 85-90 period, however. At the national level, there was a health post available for every 6,710 inhabitants in 1990, as opposed to every 11,135 inhabitants in 1985, and a health center available for every 26,741 inhabitants in 1990, as opposed to 32,185 in 1985. The health service system continues to have a high degree of institutional dispersion, with limited coordination, which contributes to the system's low decision-making capacity. There are still major, inequities in the delivery of final services, which give an unfair advantage to Lima and the urban areas, especially the large cities, to the detriment of the rural population. In spite of the increase in the quantity available, the utilization of health resources by the public sector has declined owing to incentives to resign, low wages, and cuts in working hours, which increasingly affect the health system's response capability. Refuse collection is lacking in most of Peru's cities, and its final disposal is not performed in accordance with sanitary methods. One of the most critical problems of the health service system is its failure to give the population access to pharmaceuticals and the lack of availability thereof. Maintenance of the physical plant of health establishments under the Ministry of Health continues to be deficient: it is estimated that 40% of all hospital equipment is out of order.

13. Economic resources earmarked for the social sectors have declined since 1985. The expenditure by the Ministry of Health has dropped from 2.1% of the GDP in 1985 to 0,91% in 1989; in 1987, 21,89% of the budget administered by the central government was allocated for education, a percentage which dropped to 16,97% in 1990 and to only 5.40% of the budget programmed in 1991. The health sector was allocated 5.75% of the 1988 budget and 4.48% of the 1990 budget, with this figure falling to only 4.03% of the budget programmed in 1991.

Plans and priorities for national health development

14. One of the principal priorities is to undertake more in-depth development of the comprehensive care models, incorporating the areas of promotion, prevention, and recuperation. This would allow for an integrated response, with the participation of the various public and private sectors and institutions, and would thus lay the groundwork for the construction and development of a regionalized national and integrated health system, with a view to reaching political agreements and coordinating actions with all components of the sector and with other sectors at the national, regional, and local levels. From the beginning the government has drafted national policies and strategies to face the difficult task of watching over the health of the country. The government has identified ten (10) significant priority areas in which to achieve its principal objectives in the sector. They are: Comprehensive Health; Health as the Responsibility of All; Decentralization and Regionalization; Prioritization of the Local Level; Reassessment of Human Resources; Scientific Development and Technological Production; Pharmaceuticals as a Social Good; Recovery of the Health Establishments; Coordination and Consensus with the Peruvian Social Security Institute; and Reorientation of Technical Cooperation.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

National priorities for technical cooperation

15. The strategies that the government has formulated for the achievement of its political objectives in the field of health are the following: Dissemination and social mobilization for health; social consensus for change in the health sector; strengthening and legitimization of the regulatory role of the Ministry of Health; intensification of the process of decentralization in health; betterment of working conditions and reclassification of human resources; refocusing of health actions; dissemination and sharing of knowledge and experiences regarding health; and redirection of financing for the achievement of equity.

16. In order to carry out all its activities in the field of health, the Government will have the support of different sources, in addition to its own resources. These will include a project supported by the Inter-American Development Bank in the field of health services; a project of environmental sanitation with support from the European Community; USAID support for a range of projects, including some in drug control and drug abuse; some Italian resources for the development of local health services; and activities of the World Bank in the field of environmental health.

National priorities for technical cooperation from PAHO/WHO

17. PAHO/WHO has been asked to collaborate in: the regionalization and integration of the national health system; the development and strengthening of programs and services; the strengthening of food and nutrition programs; comprehensive health care of women, infants, schoolchildren, and adolescents; and environmental services for health.

18. In addition to its regular resources, PAHO/WHO will utilize some resources from other sources in order to develop its program of activities. It is expected that some resources will come from IDB for health services, from the European Community for environmental health, and from Italy for the program of the local health systems. There will be also resources for disasters, immunization, AIDS, essential drugs, and maternal and child health. Furthermore, it is anticipated that an appreciable quantity of Ministry resources will continue to be handled through FONCODES.

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Community water supply and sanitation (CWS)

19. It is proposed that action be taken to improve environmental conditions associated most closely with the principal health problems affecting Peru's population.

20. Work will be done on public water supply and sanitation by promoting expanded coverage of safe services of water supply and of sanitary collection and disposal of wastewater and excreta, as well as by promoting enhanced efficiency and effectiveness of services; work will also be done to promote programs for unconventional solutions to the problems of water supply and elimination of excreta in marginal urban areas and rural areas. In solid wastes: to promote and support the expansion and improvement of coverage for the collection and elimination of solid wastes in the principal cities of the country; institutional strengthening, which will include development of human, legal, organizational, and technological resources, facilitating the channeling of external and internal financial resources. Attention will be paid to environmental education and media actions to guide or motivate the community vis-a-vis issues of the environment and health. There has been cooperation in the formulation and development of the National Plan for Investment in the Environment and Health, as well as in the implementation of strategies for execution of the Plan in the framework of the Regional Plan for Investment in the Environment and Health.

Health services development (DHS)

21. The purpose is to redirect the processes of planning, programming, evaluation, and management of health services toward Networks of Establishments occupying a defined geographical space, for the care of the societal groups residing temporarily or permanently therein.

22. The actions will be: To help intensify the national process of regionalizing the political, economic, and social life of the country; to institutionalize local health management, through the ZONADIS [Zones of Comprehensive Health Development], in the search for health care models that are more consistent with the needs of the community; to promote coordination of the institutions of the public and private health and education sectors for the development and consolidation of the process of accreditation of hospitals and other establishments of the country's health service networks, and to raise the quality of care; to prioritize, as part of the administration of health establishment supplies, the provision, conservation, and adequate use of essential drugs, supporting the Social Drug Programs (community emergency kit program and others); to promote and facilitate the articulation of public and private capacities, in order to meet needs for conservation and maintenance of the physical infrastructure and of health equipment; to seek new ways for Social Security to participate in the sectoral activities of health promotion and prevention of disease and disability; to publicize the dangers of irresponsible attitudes regarding the use and supply of blood and blood products and to promote among blood donors, users, and health services, an awareness of the need for a greater commitment to society, with a view to ensuring safety and security in the delivery of this vital resource; and to articulate with the education sector the promotion and prevention of oral disease and with the private sector the use of fluoridated salt to help prevent dental caries.

Disaster preparedness (DPP)

23. This project is aimed at training human resources and improving the response capability of national health institutions and other institutions such as the Ministry of Foreign Affairs, Civil Defense, the regional and municipal governments, CISMID, APIS, universities, and agencies of assistance, with a view to reducing morbidity and mortality caused by disasters and to improving the administration of supplies in emergency situations.

24. The project emphasizes the training of human resources through in-school education of specialists in Emergency Medicine and Disaster Preparedness at the university level; the incorporation of emergency and disaster topics into undergraduate curricula; the training of investigators in various areas of this specialty; human resources education in intermediate-level technology (in preparation for careers as emergency technicians); in-service training of health personnel (physicians, nurses, and other personnel) and environmental health personnel; the institutionalization of a plan of operations through the implementation of nosocomial and institutional preparedness in prevention-mitigation and assistance in disasters. In addition, it is expected that important advances will be made in the implementation of the plan of operations in the institutions responsible for the environmental health and basic sanitation of the country. Another important area is operational integration for intra- and intersectoral response.

Immunization (EPI)

25. The aim is to perform work in the following areas by carrying out activities designed to ensure the adequate, ongoing, and timely distribution of biologicals and program supplies; to strengthen the surveillance system in order to ensure 100% reporting of cases of acute flaccid paralysis, neonatal tetanus, and measles so that timely action may be taken and so that the objective of eradicating polio and controlling neonatal tetanus may be achieved. Further activities would be: supervision, research, and evaluation of the program; performance of follow-up for the program of in-service training on various technical aspects of the program; research on hazardous areas of neonatal tetanus; research on polioviruses in the environment; performance of continuous and ongoing evaluation of immunization coverage. Finally, the program seeks to furnish training in, and disseminate, the EPI technical standards, with emphasis on epidemiological surveillance of diseases preventable by vaccination and on the cold chain at the regional and local levels.

Food safety (FOS)

26. The purpose of the project is to promote national and international actions which will help lead the country to adopt policies, strategies, and technologies to improve the situation of food protection with a view to reducing human morbidity and mortality caused by food-borne diseases; to reduce losses and other harms in the production and marketing of food; to improve Peru's competitive

standing in the international market for foodstuffs; and to reduce rejections by the importing countries, and to support the country in formulating policies, strategies, and technologies that will make it possible to enhance the protection of food for consumption.

27. The project will be aimed at supporting: the organization of the integrated national program for food protection, the strengthening of laboratory services, the strengthening of inspection services, the development of the system of epidemiological surveillance of food-borne diseases (ESFBD), and the promotion of food protection through community participation.

Public information (HBF)

28. The purposes of this project are to support health promotion and the strengthening of levels of individual and collective knowledge about health care, to increase the space devoted to the subject in the mass media, and to focus the media on disease prevention.

29. The actions will lead to the production of information on health in the mass media, directed basically toward disease prevention. These actions will be carried out through the weekly publication of a supplement called "Vida" [Life], the production of three short weekly television programs called "Let's Talk About Health", the production of a daily newspaper column called "PAHO Responds" and the production of a series of graphics called "Health is..." for 80% of daily newspapers, the provision of technical cooperation in the field of communications to the Ministry of Health through direct support to its programs, publication of special issues "Vida," and support for the formulation of health projects in the field of communications. Also contemplated are: the training of journalists in health promotion with education about better reporting techniques through courses for radio, television, and press journalists; the distribution of published materials to MINSA [the Ministry of Health], other State institutions, and the NGOs that work to improve the health of the population; and advisory services and technical support in communications to governmental institutions and NGOs working in the area of health prevention.

Health policy analysis and development (HDP)

30. This project will support the High-level Bureau and the Office of International Cooperation of the Ministry of Health in health policy management and will articulate policies, strategies, and national and regional health plans through the establishment of permanent mechanisms of negotiation, conciliation, and consensus between the Ministry of Health and the country's regional and subregional health authorities.

31. The focus of the work will be on the strengthening of the leadership capacity and policy authority of the Ministry of Health at the central, regional, and local levels; the transformation of the Zones of Comprehensive Health Development [ZONADIS] into one National Health System, in accordance with equitable principles; the development of negotiation mechanisms for the achievement of social consensus among the central and regional governments, including the articulation of planning, budgeting, and management, with a strategic approach undertaken at the regional and subregional levels; the development of capacities for the formulation, monitoring, and evaluation of projects; the promotion of, and search for, new sources of sectoral financing, including updated legal standards and regulations for the mobilization of national and international resources; the development of systems of self-management and self-financing for systematized and evaluated health services; the enhancement of health legislation so that it incorporates the sectoral changes approved by the Executive and Legislative branches and is promulgated; the systematization and sharing of participatory experiences; the development of capacities for local strategic administration of the ZONADIS, including basic instruments developed for Local Strategic Administration; the training of institutional and community human resources of the ZONADIS; and the articulation of the ZONADIS with the Regional Health Systems.

Acquired immunodficiency syndrome (HIV)

32. The purpose of the project is to strengthen activities for AIDS prevention and control, with support for the Special Program for AIDS Control (PECOS), in the areas of administration, epidemiology, education, and laboratory work.

33. Work will be done to develop the capacity for articulation and technical coordination of the National Program with the agencies and institutions that carry out AIDS activities and to conduct training of human resources in the clinical, epidemiological, and administrative aspects of the program. Actions will include direct technical advisory services; strengthening of the laboratory capacity for the diagnosis of HIV infection; review of legislation on blood and blood products; and support for the production and dissemination of educational, scientific, and technical materials.

Human resources training (HRC)

34. The purpose of the project is to promote the formulation of a human resources development policy to guide the training, distribution, and utilization of health resources, in accordance with the regional realities, and to develop a model of education-health care integration in one region of the country.

35. The actions to be considered by the project are: to develop a national council and regional councils on human resources that will operate as agencies of intersectoral consensus; to articulate research policies and human resources development in the Andean Subregion, generating integrated training mechanisms, subregional events, and scientific production and information networks; to support curriculum enhancement in technical and professional training, including the teaching sciences, in the articulation of basic knowledge with the active participation of institutions using human resources; to strengthen the formation of highly qualified middle-level technicians, through the accreditation of training institutions and the development of institutions in the sector; to utilize continuing education as a strategy for the transformation of health services with work/study-type projects and to generate a regionalized system of training for the health personnel of the ZONADIS; to strengthen systems for the

collection and dissemination of scientific information, through the development of the Peruvian Network of Health Libraries, "REPEBIS"; and to support the development of documentation centers and specialized libraries, university institutions, trade and scientific organizations, and health services, with scientific publications and the Expanded Textbook Program, "PALTEX".

Health situation and trend assessment (HST)

36. The purpose of the project is to develop a system of "health intelligence", as a fundamental element for the follow-up and monitoring of the temporal-spatial variations of the health profiles at the national, regional, and local levels, and to incorporate it at the Latin American and the world levels.

37. The aim is to promote the strengthening of the use of epidemiology as a guiding and integrating focus for the planning, programming, and administration of health services and health activities; to train human resources in epidemiology and statistics; to promote studies and investigations on the health situation, especially with regard to living conditions; to disseminate scientific and technical information through epidemiological bulletins and through other mechanisms; and to support the processes of decentralization and regionalization of health, with the development of the health services' capacity for analysis and response and the mobilization of resources.

Growth, development and human reproduction (MCH)

38. The purpose of the project is to improve the comprehensive health of women, children, and adolescents through a system of services, and to identify priorities based on the risk approach.

39. The aim is to maintain a continuous system of updating of national standards and their implementation in the services, with the participation in activities of all entities of the sector; to strengthen the response capability of maternal and child health care services in accordance with local needs under the ZONADIS strategy; to continue the training of health personnel, intensifying efforts for coordination with the human resources training institutions and prioritizing in-service training; to cooperate with the local levels in the development of strategies that allow for the active participation of all community organizations; and to support the education and dissemination of health information on critical maternal and child problems, through the mass media; to promote a situation whereby women take leading roles in health actions within the maternal and child area.

Managerial support for national health development (MPN)

40. The purpose of the project is to utilize technical cooperation in order to strengthen the capacity for mobilization of financial, technical, and human resources; to prepare technical standards and procedures in order to improve efficiency, effectiveness, and equity in the health sector; to disseminate scientific and technical knowledge about health; and to prepare programs for the development of the sector in the medium and long terms.

41. The project actions are: to lend managerial support for National Health Development; to promote, analyze, and implement the resolutions of the Governing Bodies, to program the requirements of cooperation within the framework of the 1991-1994 SOPPs and the 1993-2004 Regional Plan for Investment in the Environment and Health; to mobilize the institutions of the health sector, the legislature, and human resource training institutions in the direction of health promotion and the management of scientific health knowledge; to support policy administration for the mobilization of financial resources inside and outside the country; to optimize the joint programs of cooperation of the Ministry of Health and other institutions of the sector, focusing multidisciplinary and pluralistic action, with active community participation, on health; to mobilize national technical resources and intercountry technical resources; to strengthen subregional and intercountry actions, including Andean cooperation in health; to strengthen required scientific research through the utilization of the Centers of PAHO and the World Health Organization; to strengthen the managerial capacity for cooperation with a view to fulfilling the purposes of AMPES; to support the Andean initiative in health through the Hipolito Unanue Agreement; to improve administrative management through the application of new managerial techniques and through the intensification the process of technical-administrative rationalization of PWR procedures for the effective delivery of technical cooperation; to strengthen the monitoring and evaluation of financial management with a view to promoting the efficient and timely utilization of budgetary resources; to intensify the process of training of PWR personnel, with a view to strengthening the development of PWR; to reduce operational costs through the implementation and development of modern systems of communications and information and other systems that allow for proper rationalization of resources and time; to promote the participatory work of personnel by means of quality circle techniques; and to ensure the security of the people and the goods of the Organization by adjusting to the situation of the country and to the standards of the United Nations Security Plan for Agencies of the System.

Health promotion and prevention and control of noncommunicable diseases (NCD)

42. The purpose is to support the formulation of national programs for handling the improper use of drugs, alcohol, and tobacco; for the prevention of violence to children and women; and for the training of health personnel in the management of strategies of the national programs in mental health and primary mental health care.

43. Work will be done on the strengthening of national mental health programs, the treatement of drug abuse and the prevention of violence to children and women, and on the strengthening of the system for cervical and uterine cancer screening.

Nutrition (NUT)

44. The project supports the implementation of policies and programs contemplating the organizational structure and temporary nature of dietary assistance directed toward high-risk populations.

45. The project will promote the strengthening of educational programs in food and nutrition for personnel of the education, agriculture, fishing, health, and population sectors; seek a change in attitudes and values with regard to harmful dietary habits and patterns; promote adequate feeding, nutrition, and health; strengthen institutions through the formulation of policies and strategies that will make it possible to direct interventions concerning nutrition and food security toward the high-risk groups and the poorer sectors of society; develop nutritional surveillance systems that will allow for continuous analysis of national-regional-local situations for action as needed; prevent and control the most prevalent specific nutritional deficiencies, such as iron, iodine, and vitamin A, through food supplementation or fortification with these nutrients; and support the ZONADIS, seeking an intersectoral approach, and active, conscious, and responsible participation among the organized population.

General communicable disease prevention and control activities (OCD)

46. The project seeks to strengthen the systems of epidemiological surveillance of communicable diseases and the response capability of the health system for the control of these diseases.

47. The actions will be: integration of the programs for the development of the Zones of Comprehensive Health Development; training of human resources in the areas of epidemiological surveillance and management and administration of health programs; the decentralization of technical capacities; strengthening of the network for diagnostic laboratories through the training of human resources and the provision of basic inputs; facilitated procurement and distribution of inputs for the prevention and treatment, and control of communicable diseases; direct technical advisory services; and the mobilization of resources.

Workers' health (OCH)

48. The purpose of this project is to help strengthen and improve, especially with regard to prevention, the programs and services furnished by the principal national agencies responsible for Workers' Health.

49. To that end, the project assists in: the development of health criteria for the protection of workers from physical, chemical, and biological occupational risks and the implementation of measures to reduce these risks in the workplace; the promotion, coordination, and mobilization of resource planning by joining forces with public and private agencies, as well as with various social groups and workers' health institutions, for the evaluation and control of occupational risks of a physical, chemical, and biological nature; the focusing of the actions of the various agencies on common objectives through articulated and integrating policies and plans, in the framework of a National Workers' Health Plan; the strengthening of the technical capability of the institutions and intensification of their human resources development; the incorporation in the local health systems of an ongoing capacity for workers' health care, specially targeted to the needs of workers in the informal sector.

Research promotion and development (RPD)

50. The purpose is to support the implementation of the National Research Policy in Health, strengthening the National Institute of Health and other public and private institutions, and
to disseminate the relevant scientific output of the past decade so that it may be utilized, while promoting the development of research on the country's various regions.

51. The aim is to promote, support, and systematize essentially that research that is related to the use of new knowledge; to support joint work among research institutions, such as the National Institute of Health, the Nutritional Research Institute, universities, and CONCYTEC; to promote and support the formation of nuclei of investigators in institutions at the country's regional level; to strengthen and institutionalize the Advisory Research Group, which began operations in 1991 (PAHO/CONCYTEC) as an authority for the promotion and catalysis of health research; to investigate health problems and the factors that aggravate them (the economy, anthropology, local management, local health systems, community participation); to educate health personnel and the personnel of other sectors; and to disseminate important scientific output targeted for the population in general and the scientific community in particular.

Technical cooperation among countries (TCC)

52. The purpose is to facilitate technical cooperation among countries, particularly for the border countries and for those with which that Peru has traditionally engaged in TCC actions, such as Argentina and Cuba.

53. The aim will be to structure projects of cooperation among the countries bordering Peru, Argentina, and Cuba, for health priorities of common interest.

Zoonoses (ZNS)

54. The purpose is to strengthen zoonotic disease prevention and control programs, especially those for urban rabies.

55. The project focuses its actions on: the control of urban rabies; the strengthening of programs for the elimination and eradication of bacterial and parasitic zoonoses; the control and eradication of foot-and-mouth disease; the protection of areas free from foot-and-mouth disease; the strengthening of epidemiological surveillance of vesicular diseases, and the development of programs for natural areas and areas under control.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 3,227,300 | 72.3 | 3,980,900 | 76.5 | 4,471,100 | 76.8 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 1,009,900 | 22.6 | 1,322,500 | 25.4 | 1,510,200 | 26.1 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 1,009,900 | 22.6 | 1,322,500 | 25.4 | 1,510,200 | 26.1 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 115,200 | 2.6 | 130,600 | 2.5 | 148,100 | 2.5 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 115,200 | 2.6 | 130,600 | 2.5 | 148,100 | 2.5 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 429,200 | 9.6 | 440,400 | 8.5 | 485,800 | 8.3 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 429,200 | 9.6 | 440,400 | 8.5 | 485,800 | 8.3 |
| HEALTH POLICY DEVELOPMENT | | 279,700 | 6.3 | 234,500 | 4.5 | 261,000 | 4.5 |
| HEALTH POLICY ANALYSIS AND DEVELOPMENT | HDP | 279,700 | 6.3 | 234,500 | 4.5 | 261,000 | 4.5 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 1,000,300 | 22.4 | 1,187,100 | 22.8 | 1,303,000 | 22.3 |
| HEALTH SERVICES DEVELOPMENT | DHS | 975,900 | 21.9 | 1,150,000 | 22.1 | 1,261,000 | 21.6 |
| DISASTER PREPAREDNESS | DPP | 24,400 | .5 | 37,100 | .7 | 42,000 | .7 |
| HUMAN RESOURCES DEVELOPMENT | | 258,000 | 5.8 | 407,900 | 7.8 | 471,300 | 8.1 |
| HUMAN RESOURCES TRAINING | HRC | 258,000 | 5.8 | 407,900 | 7.8 | 471,300 | 8.1 |
| HEALTH INFORMATION SUPPORT | | 19,700 | .4 | 175,800 | 3.4 | 199,300 | 3.4 |
| PUBLIC INFORMATION | HBF | 0 | - | 175,800 | 3.4 | 199,300 | 3.4 |
| SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION | HBD | 19,700 | .4 | 0 | - | 0 | - |
| RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT | | 115,300 | 2.6 | 82,100 | 1.6 | 92,400 | 1.6 |
| RESEARCH PROMOTION AND DEVELOPMENT | RPD | 115,300 | 2.6 | 82,100 | 1.6 | 92,400 | 1.6 |

## PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| III. HEALTH SCIENCE AND TECHNOLOGY | | 1,235,500 | 27.7 | 1,226,100 | 23.5 | 1,368,300 | 23.2 |
| FOOD AND NUTRITION | | 71,500 | 1.6 | 61,100 | 1.2 | 66,500 | 1.1 |
| NUTRITION | NUT | 71,500 | 1.6 | 61,100 | 1.2 | 66,500 | 1.1 |
| ENVIRONMENTAL HEALTH | | 397,700 | 8.9 | 437,000 | 8.4 | 483,400 | 8.2 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 363,100 | 8.1 | 402,900 | 7.7 | 445,800 | 7.6 |
| WORKERS' HEALTH | OCH | 34,600 | .8 | 34,100 | .7 | 37,600 | .6 |
| MATERNAL AND CHILD HEALTH | | 377,700 | 8.4 | 416,800 | 8.0 | 470,600 | 8.0 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 220,900 | 4.9 | 194,200 | 3.7 | 218,100 | 3.7 |
| IMMUNIZATION | EPI | 156,800 | 3.5 | 222,600 | 4.3 | 252,500 | 4.3 |
| COMMUNICABLE DISEASES | | 228,900 | 5.2 | 196,200 | 3.7 | 218,700 | 3.7 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 213,200 | 4.8 | 178,500 | 3.4 | 198,700 | 3.4 |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 15,700 | .4 | 17,700 | .3 | 20,000 | .3 |
| HEALTH PROMOTION | | 73,900 | 1.7 | 43,600 | .8 | 49,400 | .8 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 73,900 | 1.7 | 43,600 | .8 | 49,400 | .8 |
| VETERINARY PUBLIC HEALTH | | 85,800 | 1.9 | 71,400 | 1.4 | 79,700 | 1.4 |
| FOOD SAFETY | FOS | 85,800 | 1.9 | 29,600 | .6 | 32,300 | .6 |
| ZOONOSES | ZNS | 0 | - | 41,800 | .8 | 47,400 | .8 |
| GRAND TOTAL | | 4,462,800 | 100.0 | 5,207,000 | 100.0 | 5,839,400 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 6,193,400 | 86.5 | 662,200 | 48.8 | 413,000 | 66.9 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 502,000 | 7.0 | 391,000 | 28.8 | 413,000 | 66.9 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 502,000 | 7.0 | 391,000 | 28.8 | 413,000 | 66.9 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 5,691,400 | 79.5 | 271,200 | 20.0 | 0 | - |
| HEALTH SERVICES DEVELOPMENT | DHS | 5,261,900 | 73.4 | 271,200 | 20.0 | 0 | - |
| ESSENTIAL DRUGS AND VACCINES | EDV | 68,300 | 1.0 | 0 | - | 0 | - |
| ORAL HEALTH | ORH | 3,600 | .1 | 0 | - | 0 | - |
| DISASTER PREPAREDNESS | DPP | 357,600 | 5.0 | 0 | - | 0 | - |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 964,500 | 13.5 | 695,100 | 51.2 | 204,500 | 33.1 |
| FOOD AND NUTRITION | | 71,700 | 1.0 | 0 | - | 0 | - |
| NUTRITION | NUT | 71,700 | 1.0 | 0 | - | 0 | - |
| ENVIRONMENTAL HEALTH | | 32,500 | .4 | 0 | - | 0 | - |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 15,100 | .2 | 0 | - | 0 | - |
| WORKERS' HEALTH | OCH | 17,400 | .2 | 0 | - | 0 | - |
| MATERNAL AND CHILD HEALTH | | 580,200 | 8.2 | 191,000 | 14.1 | 204,500 | 33.1 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 433,300 | 6.1 | 191,000 | 14.1 | 204,500 | 33.1 |
| DIARRHEAL DISEASES | CDD | 146,900 | 2.1 | 0 | - | 0 | - |
| COMMUNICABLE DISEASES | | 280,100 | 3.9 | 504,100 | 37.1 | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 280,100 | 3.9 | 504,100 | 37.1 | 0 | - |
| GRAND TOTAL | | 7,157,900 | 100.0 | 1,357,300 | 100.0 | 617,500 | 100.0 |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| **1992-1993** | | | | | | | | | | | | |
| PAHO - PR | 2,934,100 | 4 | 10 | 305 | 1,377,300 | 63,500 | 26 | 52,000 | 429,600 | 262,900 | 0 | 748,800 |
| WHO - WR | 1,528,700 | 2 | 3 | 545 | 690,900 | 66,100 | 36 | 72,000 | 203,400 | 149,000 | 0 | 347,300 |
| TOTAL | 4,462,800 | 6 | 13 | 850 | 2,068,200 | 129,600 | 62 | 124,000 | 633,000 | 411,900 | 0 | 1,096,100 |
| % OF TOTAL | 100.0 | | | | 46.3 | 2.9 | | 2.8 | 14.2 | 9.2 | .0 | 24.6 |
| **1994-1995** | | | | | | | | | | | | |
| PAHO - PR | 3,711,800 | 4 | 11 | 300 | 1,765,600 | 47,400 | 21 | 42,000 | 688,500 | 228,300 | 0 | 940,000 |
| WHO - WR | 1,495,200 | 2 | 3 | 205 | 681,200 | 31,000 | 41 | 82,000 | 309,300 | 100,900 | 0 | 290,800 |
| TOTAL | 5,207,000 | 6 | 14 | 505 | 2,446,800 | 78,400 | 62 | 124,000 | 997,800 | 329,200 | 0 | 1,230,800 |
| % OF TOTAL | 100.0 | | | | 47.0 | 1.5 | | 2.4 | 19.2 | 6.3 | .0 | 23.6 |
| **1996-1997** | | | | | | | | | | | | |
| PAHO - PR | 4,176,900 | 4 | 11 | 300 | 1,975,400 | 53,800 | 21 | 42,000 | 780,800 | 259,000 | 0 | 1,065,900 |
| WHO - WR | 1,662,500 | 2 | 3 | 205 | 750,400 | 35,200 | 41 | 82,000 | 350,700 | 114,300 | 0 | 329,900 |
| TOTAL | 5,839,400 | 6 | 14 | 505 | 2,725,800 | 89,000 | 62 | 124,000 | 1,131,500 | 373,300 | 0 | 1,395,800 |
| % OF TOTAL | 100.0 | | | | 46.7 | 1.5 | | 2.1 | 19.4 | 6.4 | .0 | 23.9 |

PUERTO RICO

1. The Commonwealth of Puerto Rico joined PAHO as an Associate Member in September 1992. As a result, Puerto Rico will participate in and benefit from PAHO's programs of technical cooperation.

## HEALTH SITUATION ANALYSIS

2. Puerto Rico has a population of 3.5 million and is growing at the rate of 1.2% per year.

3. The economy of Puerto Rico has expanded rapidly in recent years, with the gross domestic product growing at an annual rate of 3.2% from 1984 to 1991. Per capita income was US$5,901 in 1990, although unemployment did increase to 15.2% in 1991.

4. Puerto Ricans enjoy a relatively high health status with life-expectancy for women being 78 years and for men 72 years. Infant mortality has declined to 10 deaths per 1000 live births and maternal mortality to 19.5 deaths per 100,000 live births.

5. In 1990, the five leading causes of death in the general population were heart diseases, malignant neoplasms, diabetes mellitus, cerebrovascular diseases, and pneumonia and other infections. Among infants, the sequelae of low birth weight, prematurity and respiratory diseases were the principal causes of mortality. Accidents, AIDS and pneumonia were the leading causes of death among pre-school children (ages 1-4).

6. The incidence of communicable diseases has declined sharply in Puerto Rico in the last 30 years in all age-groups except for those over 45. However, AIDS has now emerged as a leading cause of mortality among women, aged 20-39 years, and among men aged 25-44. AIDS is also having an impact on pre-school mortality, for whom 10% of the deaths are due to the disease.

7. Health policy in Puerto Rico is oriented toward preventive medicine and to the use of ambulatory clinics instead of hospital based care.

8. The health care delivery system is a mixed public-private system with Commonwealth citizens benefitting from health care financing programs administered by the Government of the United States of America, albeit at lower levels of funding than on the continent.

9. A 1988 study of health services showed that utilization was independent of the level of family income. Sixty-four percent of visits were made to private providers. Of those using the private sector, 87% had incomes of over US$20,000.

10. On the average, each Puerto Rican makes 4.5 ambulatory care visits to a medical doctor every year. Children under six years and persons over 65 years of age make 6.7 visits/year. During each year, 78% of the population, both in rural and urban areas, make at least one visit to a physician.

11. Hospital utilization is approximately 85 patient days per 1000 persons. The average length of stay is 6.5 days for in-patients, although for those over 65 years, the average is 10.5 days.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

12. The program of technical cooperation, established in 1993, will gain momentum during the 1994-1995 biennium. The strategy will focus on fully including Puerto Rico and its health care institutions in the life of the Organization, opening new avenues for cooperation, particularly with Member Governments in and around the Caribbean.

13. Opportunities will be provided for consultation in the continued development of the health care delivery system, in the prevention of communicable and non-communicable diseases, and in environmental health. Fellowships also will be made available to meet international training needs.

## PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

### Health services development (DHS)

14. The purpose of this project is to provide technical cooperation in the continued development of Puerto Rico's health system, addressing issues of current concern for improvement of the health status of the people of the Commonwealth.

## PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 0 | | 199,000 | 100.0 | 210,000 | 100.0 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 0 | | 199,000 | 100.0 | 210,000 | 100.0 |
| HEALTH SERVICES DEVELOPMENT | DHS | 0 | | 199,000 | 100.0 | 210,000 | 100.0 |
| GRAND TOTAL | | 0 | | 199,000 | 100.0 | 210,000 | 100.0 |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL PROF. POSTS | PERSONNEL LOCAL POSTS | PERSONNEL CONS. DAYS | PERSONNEL AMOUNT | DUTY TRAVEL AMOUNT | FELLOWSHIPS MONTHS | FELLOWSHIPS AMOUNT | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 199,000 | 0 | 0 | 348 | 96,700 | 0 | 10 | 20,000 | 0 | 0 | 0 | 82,300 |
| TOTAL | 199,000 | 0 | 0 | 348 | 96,700 | 0 | 10 | 20,000 | 0 | 0 | 0 | 82,300 |
| % OF TOTAL | 100.0 | | | | 48.5 | .0 | | 10.1 | .0 | .0 | .0 | 41.4 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 210,000 | 0 | 0 | 348 | 96,700 | 0 | 10 | 20,000 | 0 | 0 | 0 | 93,300 |
| TOTAL | 210,000 | 0 | 0 | 348 | 96,700 | 0 | 10 | 20,000 | 0 | 0 | 0 | 93,300 |
| % OF TOTAL | 100.0 | | | | 46.1 | .0 | | 9.5 | .0 | .0 | .0 | 44.4 |

SAINT KITTS AND NEVIS

## HEALTH SITUATION ANALYSIS

### Demography

1. St. Kitts/Nevis had a population of 41,826 with the population of St. Kitts being 32,696 and Nevis 9,130. The total population is made up of 20,692 males and 21,134 females.

### Health status indicators

2. The life expectancy is 66.4 years and 75.4 for males and females respectively. The crude death rate is 11.5 and the infant mortality rate is 22.2. The leading causes of mortality are chronic non-communicable diseases and heart diseases. Among the infants conditions in the perinatal period are diarrheal diseases.

3. Among the children 1-5 years, gastroenteritis and malnutrition in some communities continue to present major problems. However, there has been a decline in gastroenteritis. Maternal mortality has continued to be low. Notification for sexually transmitted diseases is required.

### Factors affecting health status

4. The environment continues to be an area of concern for the Ministry of Health and Women's Affairs. There is concern for the treatment of the rural water system since the water being distributed to many rural communities is not treated. Likewise, excreta disposal in some of the rural communities is presenting problems. These problems stem from the difficult rocky terrain which does not contribute to easy construction of pit latrines. The exponential increase in itinerant vendors has created a cause for concern in relation to their food handling technique under the threat of Cholera. The availability of trained manpower for the delivery of programs is creating a problem. In a number of clinical specialties there are shortages of personnel.

5. The run-off from open drains in the city of Basseterre pollutes the sea water which could have adverse effects on tourism, fishing and the health of the population.

6. The Gross Domestic Product continued the upward trend and at 1991 was at 6.8%. Inflation was at 4.3% reflecting steep increases in food and clothing prices. The health system has a reasonable coverage. However, much of what comes to the JN France Hospital can be dealt with at the periphery. Although there is a policy statement re the district health services, there needs to be a rationalization of boundaries thereby permitting better concentration of the services. This will also permit better utilization of some personnel. The Psychiatric Service needs to be decentralized and the existing space for psychiatric patients at the JN France Hospital needs to be improved. Despite a study into the causes of perinatal mortality, many of the recommendations still remain to be implemented. In relation to the AIDS/STD program, there has been problems with the confirmation testing for HIV. There were a number of false positives and the situation is being investigated. At the main secondary care institution, there is a problem of adequate human resource for certain specialty services, hence cases are sent abroad for treatment.

### Plans and priorities for national health development

7. The health sector comprises the Ministry of Health and Women's Affairs. The Ministry of Health in addition to its commitment to "Health For All" is also committed to the Caribbean Cooperation in Health and has embraced the seven priority areas therein. Also included are the elderly, dental health and mental health.

8. With the thrust towards decentralization of services management at the central and local levels must be improved. The capacity to acquire and analyze information needed for effective management must be present at the local level. The development of human resources is to be approached through establishing manpower planning and rationalizing the use of scarce resources. With the extension of coverage, health care to vulnerable groups will be improved leading to a decrease in such areas as infant mortality and teenage pregnancy. Health education will be used to inform the community about health and government issues which affect the quantity and quality of health care so that informed decisions can be affected by the community. Specific issues that will be addressed through strategies are: support for the process of decentralization in which data gathering and analysis will form the bases for decision making and management of local health systems and services; improvement of the environment through increased coverage of quality of water in rural areas, the capacity to dispose of solid and hazardous waste and the development of an integrated approach to vector control; analysis of health manpower resources and development of national policies relating to categories mix and utilization and finding ways for retention of certain categories of workers;health promotion through health education and community participation aiming at changes in lifestyles that contribute to the leading causes of mortality, morbidity and disability; and support for the process of intersectoral coordination among Government and non-Governmental organizations to improve coverage, quality of services and appropriate use of resources.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

9. As a result of the Joint Review in 1991, the following areas have been identified for technical cooperation: Development of alternative mechanisms for financing; support for the rationalization of district boundaries and the development of guidelines for the functioning of the district health system; support the improved management of the secondary institution and the community health services through improved information systems; establishment of a community mental health program; support for program of pesticide control in relation to the

contamination of acquifiers and workers health; support in monitoring the pollution of the coasts and water quality control; support the development of solid waste master plan, program on food protection, appropriate technology for the construction of letrines on rocky ground; support the development of human resource to address the needs of the health care delivery system; support the development of health promotion program to address the change in lifestyles especially as it relates to diabetes, hypertension and HIV infection; and support the development of strategies deal with the emerging drug problem.

10. The European Economic Commission will continue to support the rehabilitation of the J.N. France Hospital. This will focus primarily on the improvement of the physical infrastructure and the management of the institution.

National priorities for technical cooperation from PAHO/WHO

11. The following areas have been identified for technical cooperation from PAHO/WHO: strengthening of health services; environmental health; human resource development; chronic non-communicable disease; maternal and child health; and AIDS/STD. In the area of strengthening of health services, PAHO/WHO is being requested to support the improvement in management of the services and the strengthening of the district health system. In the area of environment health, PAHO/WHO is being requested to support water quality monitoring, improvement in excreta disposal and food protection and vector control. In the area of chronic non-communicable disease, request is made for the development of a health promotion program specifically for changing lifestyles as it relates to diabetes, hypertension and HIV Infection. In the area of Human Resource Development, support is requested in a number of areas including Planning and Programming for the district staff, nursing administration and environmental health. In the area of AIDS/STD, support is requested in improving counselling, addressing the policies as it relates to immigration and work permits, training staff in improved laboratory techniques.

12. In addition to the projects under the regular budget, extrabudgetary resources were mobilized for the following projects within the Caribbean Cooperation in Health: management of the community health information system, funded by the Inter-American Development Bank; projects are supported by the Italian Government in the following areas: maternal and child health; community based vector control and community based rehabilitation. Another project for the prevention and control of cancer of the cervix is funded by the French Government. USAID has also approved a project which seeks to address financing, policy formulation and management of the system and UNDCP will be supporting activities relating to drug abuse.

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Community Water Supply and Sanitation (CWS)

13. The purpose of the project is to increase the capacity of the country to address environmental health problems. To achieve this purpose, it will be necessary to monitor and evaluate the MOGGOD Technology for purification of water in rural areas; develop an integrated vector control program; support a review of plans and policies in the food protection program; and upgrade liquid waste management.

Health services development (DHS)

14. The purpose of this project is to improve the quality of health care delivery. To achieve this purpose, it will be necessary to review the management of the health services and make recommendations for its improvement; support training in planning and programming practices for district staff; and support health promotion activities to influence changes in lifestyles with particular reference to diabetes and hypertension.

Growth, development & human reproduction (MCH)

15. The purpose of this program is to increase the capacity for management of MCH services. To achieve this purpose, it will be necessary to support training activities aimed at reducing perinatal mortality; improve management of acute respiratory infections; and develop adolescent health programs.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 116,900 | 76.8 | 124,600 | 76.4 | 132,700 | 76.2 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 116,900 | 76.8 | 124,600 | 76.4 | 132,700 | 76.2 |
| HEALTH SERVICES DEVELOPMENT | DHS | 116,900 | 76.8 | 124,600 | 76.4 | 132,700 | 76.2 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 35,300 | 23.2 | 38,500 | 23.6 | 41,600 | 23.8 |
| ENVIRONMENTAL HEALTH | | 21,900 | 14.4 | 23,200 | 14.2 | 24,300 | 13.9 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 21,900 | 14.4 | 23,200 | 14.2 | 24,300 | 13.9 |
| MATERNAL AND CHILD HEALTH | | 13,400 | 8.8 | 15,300 | 9.4 | 17,300 | 9.9 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 13,400 | 8.8 | 15,300 | 9.4 | 17,300 | 9.9 |
| GRAND TOTAL | | 152,200 | 100.0 | 163,100 | 100.0 | 174,300 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| III. HEALTH SCIENCE AND TECHNOLOGY | | 125,000 | 100.0 | 108,100 | 100.0 | 0 | |
| FOOD AND NUTRITION | | 9,000 | 7.2 | 0 | - | 0 | |
| NUTRITION | NUT | 9,000 | 7.2 | 0 | - | 0 | |
| COMMUNICABLE DISEASES | | 116,000 | 92.8 | 108,100 | 100.0 | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 116,000 | 92.8 | 108,100 | 100.0 | 0 | - |
| GRAND TOTAL | | 125,000 | 100.0 | 108,100 | 100.0 | 0 | |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 35,300 | 0 | 0 | 25 | 6,700 | 0 | 4 | 8,000 | 11,300 | 3,200 | 0 | 6,100 |
| WHO - WR | 116,900 | 0 | 0 | 60 | 17,700 | 9,300 | 24 | 48,000 | 14,500 | 5,800 | 0 | 21,600 |
| TOTAL | 152,200 | 0 | 0 | 85 | 24,400 | 9,300 | 28 | 56,000 | 25,800 | 9,000 | 0 | 27,700 |
| % OF TOTAL | 100.0 | | | | 16.0 | 6.1 | | 36.8 | 17.0 | 5.9 | .0 | 18.2 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 38,500 | 0 | 0 | 25 | 7,000 | 0 | 4 | 8,000 | 12,900 | 3,700 | 0 | 6,900 |
| WHO - WR | 124,600 | 0 | 0 | 60 | 18,600 | 10,500 | 24 | 48,000 | 16,400 | 6,600 | 0 | 24,500 |
| TOTAL | 163,100 | 0 | 0 | 85 | 25,600 | 10,500 | 28 | 56,000 | 29,300 | 10,300 | 0 | 31,400 |
| % OF TOTAL | 100.0 | | | | 15.7 | 6.4 | | 34.3 | 18.0 | 6.3 | .0 | 19.3 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 41,600 | 0 | 0 | 25 | 7,000 | 0 | 4 | 8,000 | 14,600 | 4,200 | 0 | 7,800 |
| WHO - WR | 132,700 | 0 | 0 | 60 | 18,900 | 11,900 | 24 | 48,000 | 18,600 | 7,500 | 0 | 27,800 |
| TOTAL | 174,300 | 0 | 0 | 85 | 25,900 | 11,900 | 28 | 56,000 | 33,200 | 11,700 | 0 | 35,600 |
| % OF TOTAL | 100.0 | | | | 14.9 | 6.8 | | 32.2 | 19.0 | 6.7 | .0 | 20.4 |

## HEALTH SITUATION ANALYSIS

### Demography

1. Saint Lucia has a population of 135,975 as of 1992, and based on the current projections, will have an annual growth rate of 1.2%. Fifty-six percent of the population is under the age of 25 years and approximately 47.8% under the age of 19 years.

### Health status indicators

2. The life expectancy increased from 65.1 in 1978 to 68.3 in 1989 for males, and from 73.0 to 73.9 for females. Crude mortality rates have fluctuated between 6.5 and 5.9 per 1,000 in 1987 and 1990. Ten principal causes of death are heart disease and disease of pulmonary circulation, cancers, cerebrovascular disease, conditions of perinatal mortality, accidents, hypertensive disease, pneumonia and influenza; diabetes mellitus, intestinal infectious disease; chronic liver disease and cirrhosis.

3. Among the children in the 0-5 population, the principal causes of death are conditions of perinatal mortality, congenital anomalies, accidents, intestinal infectious disease and pneumonia and influenza. Conditions of perinatal mortality account for along 50% of the deaths in the under 5.

4. Maternal mortality is low and with respect to their nutrition iron deficiency or anaemia among pregnant women and women in general continues to lend problems.

### Factors affecting health status

5. The completion of the Roseau Dam and the implementation of a surveillance system for schistosomiasis control remains critical. Thirty five percent of the population has no approved means of fecal waste disposal. Disposal of solid waste has been identified as a problem contributing to rodent problems.

6. With 47.8% of the population being under nineteen years and 15% of the population being unemployed which is indicative of a high rate of unemployment among the youth, coupled to this fact is the increase in the use of alcohol, marijuana and cocaine.

7. The economy of Saint Lucia continues to perform well - with a growth rate of 2.5% in 1991. The Banana production declined by 26% with a concomitant drop of 18% in exports. Tourism continues to do well with 12.8% increase stop-over tourist arrival and 49.7% increase in cruise ship arrivals. In 1991, the debt service ratio was estimated to be 31% and debt service payments estimated to 6% of Central Government's current revenue. Despite the good economic performance, unemployment continues to be at 20%. This is so since the labor market has a larger proportion of unskilled workers.

8. Despite the high coverage, the health service management of all institutions continues to be a priority. Government has decided to establish a hospital board and has commenced the introduction of cost recovery system at the Victoria Hospital. There has been some negative reaction to the announced rates for procedures, however, implementation is going apace. Human resource needs continue to be a problem and Government is exploring all areas for training.

### Plans and priorities for national health development

9. The Government of Saint Lucia continues to endorse the World Health Organization's (WHO) definition of health. The Government also subscribes to the philosophy of Health For All by the Year 2000, and interprets "Health for All" to mean basic health care for everyone. The Government regards health as a basic human right and essential for national development and proposes to prepare a new national health plan to respond strategically to new challenges brought about by a shift in mortality and morbidity patterns and by increases in the demands made on the secondary and tertiary care services. Other considerations are the need for new management strategies in response to shortage of resources.

10. The health policies to be enunciated will be consistent with the policies of WHO and PAHO/WHO and the Caribbean Cooperation in Health Goals and Targets. It is expected that the new health plan will give practical expression to the various policy statements made by the Government. These statements can be summarized as follows, the Government will: continue efforts to improve the health care system utilizing the primary health care approach, while simultaneously increasing the availability and quality of secondary and tertiary care services; take steps to improve inter-ministerial coordination and will strengthen cooperation with private sector organizations; continue to earmark a sizeable proportion of the annual budget for operating and improving the country's health care delivery system and seek ways and means of enhancing revenues from the health sector; strengthen the review and regulatory functions within the health sector; mobilize financial, human and other resources from local and foreign agencies towards the prevention and control of AIDS; emphasize the need for and acquisition of cost-effective, cost-benefit appropriate technology, medical supplies and drugs that together will enhance the quality of health services; recruit, develop and retain a cadre of highly trained, committed and motivated professional, administrative and technical staff; develop a sound management system that is accountable, progressive, communicative and functional; pursue a policy designed to control the growth of the country's population in order that an acceptable level of socio-economic development for all citizens be achieved; implement and enforce regulations that will protect workers' health and ensure their safety; ensure that development activities will not destroy the physical

environment; utilize multi-sectoral and multi-disciplinary approaches for the control of substance abuse; encourage community participation in the development of local health systems; and review the health laws.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation from PAHO/WHO

11. From the results of the Joint Review held in 1992, the Government will be seeking external assistance in the following areas: collaboration in the strengthening of Victoria Hospital Management; improvement of management skills for middle and top level supervisors; re-establishment of health teams; promotion of health system research among nationals in hospitals, nursing, and human resource development; disaster plans and simulation exercises for district hospitals; training in planning, statistics and epidemiology, psychiatric nursing, nursing administration, environmental health, ICU nursing, and nephrology nursing; development of a food quality laboratory; workers' health; solid waste management; liquid waste management; computer application systems; developing water resource protection policies strategies, including protection of water intakes, treatment plants, leak detection and water conservation programs; development of solid waste master plans taking into consideration, wastes from yachts, cruise ships, agricultural, clinical wastes, abattoirs and hazardous wastes; reduction, re-use and re-cycling of waste; mobilization of resources for the project on adolescent health; training of perinatal teams and the management of high risk programs; training of staff in health education and promotion; integration of NGO's into the AIDS/STD program; training counsellors for the AIDS/STD program; short term training for staff in areas relevant to STD.

12. The French Government will continue its support in the provision of health personnel and the strengthening of the management of the Victoria Hospital. The St. Jude's Hospital will be supported by a religious order of Catholic nuns in the management of the institution and the provision of specialized personnel. UNFPA will be supporting family planning activities.

### National priorities for technical cooperation

13. The seven priority areas of the Caribbean Cooperation in health have been identified as the areas for Technical Cooperation from PAHO/WHO. Specifically, the areas were resulted in the recently concluded Joint Evaluation Meeting. These areas are also in keeping with the SOPP. Continual emphasis will be placed on the improvement of management in the entire health systems. Also the improved functioning of the district health system will be given special focus through the improvement of the information system, and the development of operational guidelines for the system. The environment, of no less importance will be seeking to improve the surveillance as it relates to schistosomiasis. Solid waste management and food protection will also be addressed. The large percentage of adolescents together with the prevalence of diabetes, hypertension and AIDS have caused an increased focus to be given to health promotion as a strategic approach which will be included in the development of an adolescent health program.

14. In addition to the projects under the regular budget, extrabudgetary resources were mobilized for the following projects within the Caribbean Cooperation in Health: management of the community health information system, funded by the InterAmerican Development Bank; projects are supported by the Italian Government in the following areas: maternal and child health, community based vector control and community based rehabilitation. Another project for the prevention and control of cancer of the cervix is funded by the French Government. USAID has also approved a project which seeks to address financing, policy formulation and management of the system and UNDCP will be supporting activities relating to drug abuse.

## PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

### Community water supply and sanitation (CWS)

15. The purpose of this project is to improve the delivery of environmental health services. To achieve this end it will be necessary to: improve the operational efficiency of the solid waste disposal system; support the development of the food protection program and a food quality laboratory; assist in the development of occupational health and safety programs; and promote community participation in the integrated vector control program.

### Health services development (DHS)

16. The purpose of this project is to improve the efficiency of health care services. To achieve this purpose it will be necessary to: upgrade and strengthen Health Legislation; provide training; develop and implement health promotion strategies to modify lifestyles; improve the management at the Victoria Hospital; strengthen linkages with the primary health care systems; and support effort aimed at reducing the levels of substance abuse.

### Growth, development and human reproduction (MCH)

17. The purpose of this project is to improve the efficiency of the delivery of MCH services through research, management and resources development. To achieve this purpose it will be necessary to: support training activities to improve the management of MCH services, including adolescent health, child abuse, team building and leadership; and collect and analyze data on maternal mortality and morbidity.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 147,900 | 83.7 | 156,800 | 82.8 | 166,800 | 82.3 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 147,900 | 83.7 | 156,800 | 82.8 | 166,800 | 82.3 |
| HEALTH SERVICES DEVELOPMENT | DHS | 147,900 | 83.7 | 156,800 | 82.8 | 166,800 | 82.3 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 28,800 | 16.3 | 32,500 | 17.2 | 35,800 | 17.7 |
| ENVIRONMENTAL HEALTH | | 19,300 | 10.9 | 21,500 | 11.4 | 23,900 | 11.8 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 19,300 | 10.9 | 21,500 | 11.4 | 23,900 | 11.8 |
| MATERNAL AND CHILD HEALTH | | 9,500 | 5.4 | 11,000 | 5.8 | 11,900 | 5.9 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 9,500 | 5.4 | 11,000 | 5.8 | 11,900 | 5.9 |
| GRAND TOTAL | | 176,700 | 100.0 | 189,300 | 100.0 | 202,600 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 2,800 | 1.5 | 0 | - | 0 | |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 2,800 | 1.5 | 0 | - | 0 | |
| ESSENTIAL DRUGS AND VACCINES | EDV | 2,800 | 1.5 | 0 | - | 0 | |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 183,100 | 98.5 | 126,100 | 100.0 | 0 | - |
| FOOD AND NUTRITION | | 10,200 | 5.5 | 0 | - | 0 | - |
| NUTRITION | NUT | 10,200 | 5.5 | 0 | - | 0 | - |
| COMMUNICABLE DISEASES | | 172,900 | 93.0 | 126,100 | 100.0 | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 172,900 | 93.0 | 126,100 | 100.0 | 0 | - |
| GRAND TOTAL | | 185,900 | 100.0 | 126,100 | 100.0 | 0 | |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 19,300 | 0 | 0 | 0 | 0 | 0 | 2 | 4,000 | 4,900 | 5,800 | 0 | 4,600 |
| WHO - WR | 157,400 | 0 | 0 | 75 | 21,700 | 9,300 | 33 | 66,000 | 26,100 | 10,700 | 0 | 23,600 |
| TOTAL | 176,700 | 0 | 0 | 75 | 21,700 | 9,300 | 35 | 70,000 | 31,000 | 16,500 | 0 | 28,200 |
| % OF TOTAL | 100.0 | | | | 12.3 | 5.3 | | 39.6 | 17.5 | 9.3 | .0 | 16.0 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 21,500 | 0 | 0 | 0 | 0 | 0 | 2 | 4,000 | 5,600 | 6,600 | 0 | 5,300 |
| WHO - WR | 167,800 | 0 | 0 | 75 | 22,800 | 10,500 | 33 | 66,000 | 29,700 | 12,000 | 0 | 26,800 |
| TOTAL | 189,300 | 0 | 0 | 75 | 22,800 | 10,500 | 35 | 70,000 | 35,300 | 18,600 | 0 | 32,100 |
| % OF TOTAL | 100.0 | | | | 12.0 | 5.5 | | 37.1 | 18.6 | 9.8 | .0 | 17.0 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 23,900 | 0 | 0 | 0 | 0 | 0 | 2 | 4,000 | 6,400 | 7,500 | 0 | 6,000 |
| WHO - WR | 178,700 | 0 | 0 | 75 | 23,100 | 11,900 | 33 | 66,000 | 33,700 | 13,600 | 0 | 30,400 |
| TOTAL | 202,600 | 0 | 0 | 75 | 23,100 | 11,900 | 35 | 70,000 | 40,100 | 21,100 | 0 | 36,400 |
| % OF TOTAL | 100.0 | | | | 11.4 | 5.9 | | 34.5 | 19.8 | 10.4 | .0 | 18.0 |

## HEALTH SITUATION ANALYSIS

### Demography

1. St. Vincent and the Grenadines had a total population of 107,598 in 1992. This population comprised 52,977 males and 52,621 females. The population showed an increase of 9.12% over the enumerated population of 98,604 in 1980.

### Health status indicators

2. Life expectancy has been put at 69 years for males and 72 years for females. The crude death rate is 6.3 and the infant mortality rate 21.4. The leading causes of overall mortality are malignancies, ischemic heart disease, cerebrovascular disease, hypertensive disease, endocrine metabolic diseases and immunological disorders. Chronic diseases have emerged as the major causes of mortality. Maternal mortality has not recorded any increase and remains at less than 1 per 1,000. Among the 0-5 age group, the principal causes of mortality are perinatal conditions, respiratory infections and gastroenteritis.

### Factors affecting health status

3. Since the latter half of the 1980s to 1990, the Gross Domestic Product has experienced substantial growth. However, in 1991 the GDP declined from 7.1% in 1990 to 4.9 in 1991. Hence a high level of fiscal and domestic economic management in the public sector is important.

4. Notwithstanding the progress being made in all aspects of the health system, the environment continues to demand a special focus. The collection and disposal of solid waste remain a source of concern, since the present landfill at Arnos Vale needs to be developed and two additional sites need to be developed. There has been a rapid increase in food handling establishments, however, concern exists for the Ministry's ability in the area of food safety and food quality control. In addition, although the responsibility for monitoring water quality is with the Ministry, it lacks the equipment required to perform the function. Another area affecting the health status is the issue of human resource development. The main concern is the retention of trained staff, thus making it difficult to effectively deliver the programs.

5. The health system has continued to provide greater accessibility and coverage. District hospitals and health centers are being rehabilitated and constructed to address to the equity issue. The rate at which staff is trained is not keeping apace with the rate of physical development of the infrastructure. In addition, the issue of retention of national staff is even more pressing in sustaining any progress which is achieved. Dental health is an area of serious concern since this program has one responsibility for its direction and implementation. Likewise, mental health is not well organized with serious overcrowding in the institution, which was built in 1936 for a capacity of 90 patients and has now a daily occupancy of 175. More than 50% of the admissions are drug abuse.

### Plans and priorities for national health development

6. The Ministry of Health and Environment has reiterated its commitment to the seven priority areas of the Caribbean Cooperation in Health, along with dental health, mental health and the care of the aged. During the next biennium, special emphasis will continue to be given to the strengthening of health services with priority to the further development of local health system and the overall improvement in the managerial efficiency at the institutional and programmatic levels. Hence the thrust of improving the capability of planning and programming will continue together with the strengthening of the information systems at the hospital and district levels. Human resource development for St. Vincent and the Grenadines remains crucial in terms of retention of trained staff and the training of additional staff for a rapidly expanding system.

7. Environmental health will focus on solid waste disposal, excreta disposal for the rural communities, water monitoring and food protection. Special focus will be given to improved food handling of the rapidly growing crop of itinerant vendors. This activity together with improved water monitoring will facilitate the implementation of the preventative program for children.

8. Chronic non-communicable diseases especially diabetes, hypertension and malignancies have taken the forefront in the morbidity and mortality of the adult population. The Ministry will embark on an aggressive health promotion program for the improvement in the lifestyle of the population. Disaster preparedness is re-organized as an important priority and the Ministry will continue to integrate the disaster preparedness program with the development of local health system. In terms of infrastructural development, the third phase of the Kingstown Hospital is a priority which should be completed by the end of the biennium.

9. Vulnerable groups such as mothers, child and adolescents will continue to receive special attention. The Ministry will continue to work for the attainment of the subregional goal of eradication of polio, elimination of measles and the reduction of childhood morbidity from respiratory and diarrhoeal diseases. The Ministry with the purpose of improving population's lifestyle intends to extend the health promotion program on drug use and prevention of sexually transmitted diseases among adolescents. The reduction of the infant mortality will receive special attention by examining the causes of perinatal mortality and developing strategies for improving same. The other priority programs are dental health, mental health and care of the aged.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

10. Based on the priorities identified above, the Government will seek external assistance in the following areas: health information and education at all levels of the society as a critical means of influencing lifestyles and achieving positive behavior modification; comprehensive oral health care services to all children of schoolage; community mental health as a viable approach to the prevention of mental illness and the treatment and rehabilitation of the mentally ill; development of local health systems as an effective mechanism for the delivery of essential health care services; infrastructural development of the Kingstown General Hospital on a phased basis; improvement of the diagnostic capabilities of the pathology laboratory to undertake tests for banned substances, water quality control, rape and homicide cases; improvement of the management information system through the computerization of all hospital data; comprehensive health care services to women at the clinic level aimed at the achievement of healthy motherhood; programs aimed at improving the major health status indicators for infants and young children; food safety and food quality measures; dietary services at the various health institutions; health care needs of aged persons within the general population; special programs designed to respond to the special challenges of sexually transmitted diseases, including AIDS and HIV-infection; healthy lifestyles as the most essential component in the prevention and control of non-communicable diseases; drug abuse prevention and control programs at all levels of society; adequate health manpower resources; and a coherent and functional health information system linking all levels of the service so as to facilitate the decision-making and planning processes.

11. The European Economic Commission will be supporting the completion of phase II of the Kingstown Hospital. This include the improvement in the physical infrastructure and will also address the improvement in the management of the Institution. UNFPA will be supporting family planning activities. The Caribbean Society for the Blind will be supplying equipment for improvement in the area of ophthalmology.

### National priorities for technical cooperation from PAHO/WHO

12. Of the priorities identified for technical cooperation, PAHO/WHO is being asked to support the Ministry in the following areas: local health system development; improved management; improvement of the health information system; human resource development
maternal and child health; chronic non-communicable disease with special emphasis on health promotion; and environmental health. These priority areas are consistent with the priorities of the Caribbean Cooperation in Health and the SOPP.

13. It was agreed that the technical cooperation will be weighted on the strengthening of the health system, human resource development, environmental health and AIDS/STD. The other areas including maternal and child health and the information systems, although part of the technical cooperation, will be supported by extra budgetary resources.

14. In addition to the projects under the regular budget, extrabudgetary resources were mobilized for the following projects within the Caribbean Cooperation in Health: management of the community health information system, funded by the InterAmerican Development Bank; projects are supported by the Italian Government in the following areas: maternal and child health, community based vector control and community based rehabilitation. A project for the prevention and control of cancer of the cervix is funded by the French Government. USAID has also approved a project which seeks to address financing, policy formulation and management of the system and UNDCP will be supporting activities relating to drug abuse.

## PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

### Community water supply and sanitation (CWS)

15. The purpose of the project is to increase the capacity to address environmental health problems. To achieve this purpose, it will be necessary to provide training activities to improve food handling; improve solid and liquid waste management; develop system to monitor water quality; and promote intersectoral linkages to support an integrated vector and rodent control program.

### Health services development (DHS)

16. The purpose of the project is to increase the capacity to deliver quality health care. To achieve this purpose, it will be necessary to strengthen the capacity to assess and apply health promotion and social communication to modify lifestyles; develop a comprehensive oral health service focussing on children of school age; develop a community mental health program; promote the development of the local health system, emphasizing the inter-disciplinary approach, intersectoral coordination and community participation; and strengthen the management information system.

### Growth, development and human reproduction (MCH)

17. The purpose of this project is to improve the capacity to manage Maternal and Child Health (MCH) services. To achieve this purpose, it will be necessary to upgrade management skills relating to neonatal, maternal and adolescent health care and distribute the revised MCH strategy and promote of its use.

## PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 133,800 | 76.8 | 142,200 | 76.7 | 151,000 | 76.6 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 133,800 | 76.8 | 142,200 | 76.7 | 151,000 | 76.6 |
| HEALTH SERVICES DEVELOPMENT | DHS | 133,800 | 76.8 | 142,200 | 76.7 | 151,000 | 76.6 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 40,200 | 23.2 | 43,200 | 23.3 | 46,200 | 23.4 |
| ENVIRONMENTAL HEALTH | | 24,800 | 14.3 | 25,800 | 13.9 | 26,500 | 13.4 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 24,800 | 14.3 | 25,800 | 13.9 | 26,500 | 13.4 |
| MATERNAL AND CHILD HEALTH | | 15,400 | 8.9 | 17,400 | 9.4 | 19,700 | 10.0 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 15,400 | 8.9 | 17,400 | 9.4 | 19,700 | 10.0 |
| GRAND TOTAL | | 174,000 | 100.0 | 185,400 | 100.0 | 197,200 | 100.0 |

## PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| III. HEALTH SCIENCE AND TECHNOLOGY | | 128,300 | 100.0 | 76,200 | 100.0 | 0 | |
| MATERNAL AND CHILD HEALTH | | 7,500 | 5.8 | 0 | - | 0 | |
| ADOLESCENT HEALTH | ADH | 7,500 | 5.8 | 0 | - | 0 | |
| COMMUNICABLE DISEASES | | 120,800 | 94.2 | 76,200 | 100.0 | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 120,800 | 94.2 | 76,200 | 100.0 | 0 | - |
| GRAND TOTAL | | 128,300 | 100.0 | 76,200 | 100.0 | 0 | |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 149,200 | 0 | 0 | 60 | 18,000 | 9,300 | 30 | 60,000 | 20,000 | 13,300 | 0 | 28,600 |
| WHO - WR | 24,800 | 0 | 0 | 30 | 8,000 | 0 | 6 | 12,000 | 4,100 | 700 | 0 | 0 |
| TOTAL | 174,000 | 0 | 0 | 90 | 26,000 | 9,300 | 36 | 72,000 | 24,100 | 14,000 | 0 | 28,600 |
| % OF TOTAL | 100.0 | | | | 14.9 | 5.3 | | 41.5 | 13.9 | 8.0 | .0 | 16.4 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 159,600 | 0 | 0 | 60 | 18,900 | 10,500 | 30 | 60,000 | 22,700 | 15,000 | 0 | 32,500 |
| WHO - WR | 25,800 | 0 | 0 | 30 | 8,300 | 0 | 6 | 12,000 | 4,700 | 800 | 0 | 0 |
| TOTAL | 185,400 | 0 | 0 | 90 | 27,200 | 10,500 | 36 | 72,000 | 27,400 | 15,800 | 0 | 32,500 |
| % OF TOTAL | 100.0 | | | | 14.7 | 5.7 | | 38.8 | 14.8 | 8.5 | .0 | 17.5 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 170,700 | 0 | 0 | 60 | 19,200 | 11,900 | 30 | 60,000 | 25,700 | 17,000 | 0 | 36,900 |
| WHO - WR | 26,500 | 0 | 0 | 30 | 8,300 | 0 | 6 | 12,000 | 5,300 | 900 | 0 | 0 |
| TOTAL | 197,200 | 0 | 0 | 90 | 27,500 | 11,900 | 36 | 72,000 | 31,000 | 17,900 | 0 | 36,900 |
| % OF TOTAL | 100.0 | | | | 13.9 | 6.0 | | 36.6 | 15.7 | 9.1 | .0 | 18.7 |

## HEALTH SITUATION ANALYSIS

### Demography

1. Estimated mid year population for Suriname for 1991 was set at 404,000. The population density is highest in the district of Paramaribo City and Wanica, a relatively small district surrounding Paramaribo: 65% of the total population of Suriname lives in the Paramaribo-Wanica area.

2. The last census was done in 1980 and its numbers are hopelessly outdated. Relatively large groups have been migrating into, out or within Suriname, in part as a result of the socio-economic upheavals of the 1980s and the 1990s. Guyanese have been moving in and Surinamese have continued their long-term trend of emigration to the Netherlands. Roughly 200,000 Surinamese are now living in Holland. The bush war (1986-1992) in the interior of Suriname has pushed out several waves of refugees: about 15,000 people from Marowijne district and at least 5,000 from Sipaliwini and Brokopondo. The majority of the approximately 7,000 refugees who fled to French Guyana in 1986-1988 have returned to Suriname (Marowijne) in 1991-1992. The estimated 13,000 refugees in Paramaribo have not yet started to go back to their tribal lands in large numbers.

3. Suriname has a population characterized by a high degree of ethnic diversity. Five major languages are spoken. Dutch is the official language. Administratively, Suriname is divided into ten districts.

4. Approximately 70% of the population is under 30 years of age. About 6% of the population is over sixty.

### Health status indicators

5. Infant mortality rates and the vaccination coverage rates improved during the eighties, but the vaccination rate has started to slip in recent years, even in certain urban areas. The extraordinary efforts to maintain high coverage rates during the eighties are finally failing as a result of continued and increased losses of trained personnel from the public health services. Crude mortality rates have remained fairly constant in the past decade. Crude mortality rate was 6.9 per 1,000 in 1990 and 6.4 per 1,000 in 1991. Roughly one-third of medically certified mortality is attributed to heart disease, vascular disease, and diabetes mellitus.

6. Infant mortality was estimated at 20.9 per 1,000 live births in 1990. Major causes of infant mortality are praematuritas and obstetric complications. Malnutrition is increasing, according to surveillance figures of the Bureau of Public Health (B.O.G.). In 1991 B.O.G. found malnutrition in 28% of children 0-4 years of age in Amerindian villages near the Brazilian border. In Bushnegro villages in Brokopondo district, 11% of children had malnutrition (being below P3 of weight-for-height and/or height-for-age standards). The majority of cases in both groups were classified as acute. In both groups malnutrition was seen mainly in the 1 and 2 year olds. In the school year 1989-1990, first graders of 33 schools in Paramaribo were weighed and measured: 14% of first-graders aged 5-8 years had a weight-for-height below P3. In certain neighborhoods this percentage reached highs of 18%, 38% and 39%. Among children 1-4 years of age, the leading causes of death are diarrhoeal disease, acute respiratory infections and accidents.

7. Accidents, homicide and suicide are important causes of death among adults. Substance abuse and alcoholism are major causes of morbidity in adults. Suriname has high prevalence rates of cigarette smoking, much higher than Holland or the United States. Drug dealing and smuggling has become a major factor in the lives of many young Surinamese men and women. Whole villages in the interior and whole neighborhoods in Paramaribo seem to depend on drug-related income. The breakdown of traditional culture, internal war and increasing poverty, have set whole populations adrift, resulting in high mobility in geographic, economic and sexual terms. High incidence rates of sexually transmitted diseases, as reported by the STD-Clinic (Dermatologische Dienst), illustrate one of the many dangers threatening the health of young adults in Suriname.

8. Malaria is endemic in the interior and thousands of people are being effected. In 1992-1993 a major malaria epidemic developed along the Suriname-River. Schistosomiasis is still active in rural areas in the Saramacca district. Incidence of leprosy is declining, but there are still a few trouble spots in the interior. Typhoid fever epidemics are still common in the interior, but the national number of reported cases has been going down since 1986, when the bush war was started.

9. In February 1992, three confirmed cases of cholera were reported, all from the interior. The cases were limited to a few villages along the Marowijne river. Since this episode, no additional cases have been reported. Plague and yellow fever have not been reported for decades, but leptospirosis and dengue remain important infectious diseases.

10. According to an internal memo circulating in the public health department of the medical school, the major health problem in Suriname is not incidence of any particular disease, but the management crisis in the health care system: the manpower crisis, the financial crisis and the ideological crisis (theory versus practice in PHC).

11. The biennial program 1994-1995 of technical cooperation between PAHO/WHO and Suriname differs from the previous biennial program in that much more emphasis is placed on manpower development, management and promotion of the primary health care strategy.

Factors affecting health status

12. After a decade of serious socio-economic decline, the government and the non-government organizations in Suriname have been forced into action. Suriname has entered the stage of reconstruction, which is characterized by three processes: the democratization of politics and government resulting in free elections for national and local governing bodies in May 1991; the peace process, resulting in the Peace Treaty of August 1992, bringing a formal end to the bush war; and the structural adjustment of the economy. These processes have not resulted, however, in a reversal of the downward trend in the economy. Inflation was 26% in 1991 and much higher (46%) in 1992. Suriname is experiencing the effects of a decade of political and economic turmoil: large government deficits, hyperinflation, declining productivity, scarcity of foreign exchange, poverty, black market, capitalism and corruption. The incidence of violent acts resulting in deaths and injuries has been rising steadily in recent years according to statistics from the police and the Bureau of Public Health.

13. The peace process has brought 7,000 refugees back from the French Guiana. This has placed extra demands on the government and the people to rebuild the destroyed Marowijne District. The reconstruction of all government infrastructure in the interior is a national priority, but is hampered by a lack of consensus among policy makers and donor agencies, and by a lack of mechanisms to engage local communities in the process. An important problem remains the fact that large parts of the interior are not controlled by the central government, leaving bands of illegal gold miners and other groups free to terrorize local communities and pollute the environment at the same time.

14. At the end of 1992 the government had to take a number of painful measures which will result in even higher prices in 1993 and subsequent years. The parallel market rate for US$ 1 rose from Sf 25 in September 1992 to Sf 40 in February 1993. Financial aid from the Dutch for the productive sector has not been able to stop the decline in productivity and exports. The end of 1992 and the beginning of 1993 were marked by increased unrest in the labor market. Unions were demanding huge salary increases or even payment in US dollars.

15. While the economic picture is still bleak and while the country's organizations are still further deteriorating from continuing flight of skilled workers, there are reasons for guarded optimism considering the fact that Dutch development aid will begin to gather momentum in 1993-1994.

16. In the health sector, external aid has already helped to ease the shortages of essential drugs and some medical supplies, but the problem of skilled personnel leaving the hospitals and public health institutions has become even more acute in 1992-1993. The brain drain is damaging the very institutions needed to pull the country out of the present crisis.

17. In many parts of the interior, especially in the east, reconstruction of many government institutions is not keeping pace with the needs of returning refugees.

18. Mainly because of the high cost, low wages and low morale, water and sanitation, vector control and malaria eradication programs have not been able to reach adequate coverage rates. This leaves large sectors of the population vulnerable to epidemics as is evidenced by the 1992-1993 dengue epidemic. So far, the displacement of people from the interior into city slums has not caused the feared epidemics of such diseases as typhoid fever and cholera, but the danger still exists.

Plans and priorities for national health development

19. A major element of the national health strategy is the strengthening of the Ministry of Health as the central coordinating body in the national health care system, while at the same time decentralizing services to private (commercial) and semi-private (subsidized) institutions, such as the Regional Health Service (RGD) and the foundations running the former state hospitals. More than 75% of the health care system is in private hands.

20. Services are paid by the State Health Insurance Foundation for government workers and their families and by the Ministry of Social Affairs for the poor. Government policy is to expand the target population of the SZF to include the poor and groups in the private sector of the economy. This policy is part of a strategy expand health care coverage to the poor and to remove the abuses in the system.

21. The health sector has enormous financial problems. These problems are caused by inflation, open-ended financing of health care, and the lack of mechanisms to control quality and costs of health care. More than the incidence of any disease entity, it is organizational weaknesses of government and private institutions and the resulting managerial dysfunction on every level, which are considered the number one health problem in Suriname. National health strategies, policies and plans are being adapted in response to the deteriorating socio-economic situation.

22. Immediate steps must be taken to: prevent further weakening of the health care system; stop the brain drain of trained health workers both from the country and into the more profitable private sector; replace lost personnel and train new health sector personnel; and improve management, efficiency, cost control and intersectoral coordination in the health care system.

23. Given the continued problems of a disrupted and still declining economy; an enormous and debilitating brain drain; and chronic shortages of all kinds of basic materials, the Ministry of Health has highlighted the following priorities in its "Governments Policy Declaration 1988-1993": 1) complete coverage of all, irrespective of race, religion, political view or ability to pay which will be achieved through the full decentralization of the RGD and with the full participation of the local communities through their district health committees and congresses, and expansion of coverage by the SZF; 2) emphasis on the preventive and educational aspects of all programs, particularly the MCH and EPI programs, food safety and nutrition, STD/HIV; 3) the entire environmental health program; 4) intensified control of environment with emphasis on solid waste, water quality, housing, sanitation; 5) vector control and food safety; 6) nutrition, with special emphasis on vulnerable groups; 7) full coverage for the EPI program in the entire coastal region and full cooperation with the medical missions in their effort to cover the interior; 8) control of all sexually transmitted diseases in general through public health education and preventive and control measures, with special emphasis on preventing the further spread of HIV infection; 9) development of an emergency manpower plan in the light of the critical manpower shortage; 10) restoration of the physical health infrastructure in the interior which has been destroyed by internal conflict; 11) capital investment in the physical health infrastructure in the urban areas to prevent further deterioration of services; 12) mobilization of external resources to assist in the implementation of the five-year health development plan; and 13) renewed emphasis on collaborating with neighboring countries, through TCDC.

24. Once again, the major strategy to be used in implementing the above is through the strengthening of local health systems. Given the existing political/electoral districts in Suriname, intersectoral corporation, coordination and communication is part and parcel of daily life. There is also a long and accepted history of a vigorous community participation through non-government organizations.

25. Even though the population is small there are several hundred vocal and active NGOs flourishing in the country which have always shown a historical willingness to participate. All these will be mobilized through the district health congresses in an attempt to deliver the best quality mix of services to the community.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

26. In light of the Structural Adjustment Program and the economic and social deterioration, the national priority areas for technical cooperation are as follows. 1) Strengthening of the managerial capacity of all health institutions and programs, with particular emphasis on hospitals. 2) More rational use of PHC clinics in order to protect the hospitals whose budgets are eroding dangerously, through more emphasis on planning, prevention and participation at the local level. 3) Maintenance of adequate levels of essential health personnel at management and technical levels, while at the same time ensuring the most efficient and effective use of existing manpower resources. This will include a publicly stated commitment by the Ministry of Health to team-building and strengthening of resource planning. 4) Maternal and child health care has also been clearly marked as a national priority, with special emphasis on nutrition monitoring and surveillance, breast-feeding, development of educational materials and practical demonstration projects; control of diarrhoeal diseases, with special attention to the re-emergence of cholera; maintenance of the entire EPI program. 5) Environmental sanitation with emphasis on solid waste management and safe drinking water. Special emphasis will be placed on those areas which are considered particularly vulnerable due to several factors. 6) Control of malaria, dengue and other infectious diseases, as well as dealing with the emerging problems related to socioeconomic and environmental decay and stress. 7) Surveillance of various diseases and trends to alert decision makes to deteriorating situations. 8) Mobilization of resources.

27. The major player in the health of Suriname apart from PAHO/WHO is the Dutch. Other agencies play a role. The following projects are now underway. 1) The Dutch Government provides approximately 10 million Dutch Florins per year for the purchase of medicines reagents and laboratory equipment. 2) UNICEF has an annual budget of US$50,000 for several small projects. 3) The Belgian Government assists by placing several pharmacists at the disposal of the Ministry. It also provides some minor hospital equipment, and some fellowships in Belgium. 4) The IDB has a $9 million project for the expansion of the Nickerie Hospital of which one million is a technical cooperation grant for the development of a specialized bio-medical maintenance center and strengthening of managerial systems. This is a one time activity. 5) The United Nations High Commission for Refugees (UNHCR) has put approximately $60,000 into the purchase of hospital supplies and equipment to help rehabilitate the Albina (East Border) Hospital destroyed in the war. This would appear to be a one-time activity related to the return of 4000 bushnegro refugees from French Guiana.

### National priorities for technical cooperation from PAHO/WHO

28. In response to the stated national priorities for technical cooperation, PAHO/WHO has agreed to provide cooperation in six areas: development of health services under which a very wide area of technical cooperation is delivered; health manpower development; maternal and child health; community water supply and sanitation; disease control; and epidemiological surveillance and trend assessment.

29. The non PAHO/WHO regular funds managed by the local PWR office are: support for HIV/AIDS from the GPA; assistance from the French Government for upgrading the Albina Hospital; and Dutch grant for a cholera social communications project.

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Community water supply and sanitation (CWS)

30. The purpose of the project is to control and reduce water borne and faecal-borne diseases and to improve the quality of the occupational environment and the health status of workers. To achieve this purpose it will be necessary to increase the quantity of water supplied to Paramaribo; promote the use of chlorination for drinking water disinfection; implement design solutions to various faecal waste disposal problems developed in 1992 and 1993; investigate problems of faecal waste disposal and development of solutions in urban and rural areas; improve the storage, collection, treatment and disposal of solid waste; restructure the Environmental Health Division (EHD) of the BOG; train new managers in the restructured EHD; prepare and disseminate newsletters, factsheets, reports, etc. in Dutch and English; and mobilize resources through project identification and preparation.

Health services development (DHS)

31. The purpose of this project is to improve management capacity and organizational efficiency in national and local health care delivery systems and programs. Conduct regional health congresses in support of strengthening local health systems, building on the successes of the three congresses held 1992-1993; develop district health profiles; develop community based health information systems; plan and conduct special health surveys in support of ongoing programs or for solution of specific problems; update and revise health legislation and regulations; develop strong women and health components in all programs and projects; develop community based mental health programs integrated into the ongoing health services, including outreach services, counseling, basic treatment, and referral; continue the cooperation commenced in 1992-1993 between PAHO, EC, IDB, the French and Dutch governments to strengthen management and health information systems; renovate and reconstruct of the hospitals in Nickerie and Albina; and reconstruct health centers in the interior including the transport and communications infrastructure of the Medical Mission (MM).

Educación de recursos humanos (HRE)

32. The purpose of the project is to ensure that planning, production and utilization of manpower resources are adequate for maintaining and/or improving the delivery of basic health care services to the community. To achieve this purpose it will be necessary to: develop a short term human resources plan to address the impact of manpower flight arising from structural adjustment; train mid-level personnel to broaden their capabilities in such areas as management of mother and child care programs; provide fellowships; conduct training needs analysis; develop specific project proposals; establish accredited training courses for district health managers in epidemiology, health education, management, research, and data management; establish an MPH course at the University of Suriname in cooperation with the University of the West Indies; conduct workshops on team building; and conduct studies on operational efficiency parameters for hospitals.

Health situation and trend assessment (HST)

33. The purpose of this project is to maintain and strengthen health intelligence network systems, protocols and standards to facilitate policy formulation and implementation. This will require strengthening existing surveillance systems, and expand others, including the establishment of sentinel stations in all ten districts; establish a national nosocomial infection control program, including manuals and protocols for all major infectious diseases; training personnel in the epidemiology of nutritional diseases, chronic diseases, infectious diseases, accidents, violence, suicide, and injuries; development at both central and local levels of epidemiological research capacity and data management capacity; development and standardization of protocols for monitoring of epidemics and conducting case investigations; revamping the mortality surveillance system; establish a central registry (CENTRALE ENT REGISTRATIE) for all vaccinations in Suriname; and developing small project proposals in an attempt to mobilize resources in support of ongoing programs.

Growth, development and human reproduction (MCH)

34. The purpose of this project is to improve efficiency in the management of MCH programs and to maintain adequate levels of intervention particularly in the areas of perinatology, immunization and nutrition. This will require: recruiting personnel to fill the vacant positions in public health institutions; strengthening the perinatology component of the MCH program; improving coverage in the many sub-populations in which there has been a decline in recent years; strengthening of the "under five clinics" and broadening the range of services offered to include more developmental monitoring and more remedial services; and strengthening the CDD program and establishing an ARI component; strengthening the nutritional surveillance system with emphasis on the 0-5 age group and school children; training of school teachers in the use of growth charts which are being promoted nationally; public education campaigns and nutritional counseling on diabetes, hypertension, nutrition, and promotion of healthy lifestyles; use of food balance sheets; and strengthening of health education and extension services through 'ondroso' clinics at the community level.

Management support for national health development (MPN)

35. The purpose of this project is to maintain the PAHO/WHO country office at the most efficient and optimal levels in order to stimulate, guide and promote the Work Program consistent with National policies and priorities and Regional and Global goals and strategies. To achieve this purpose it will be necessary to carry out all administrative and managerial procedures in support of all ongoing programs of technical cooperation, which includes problem solving on a daily basis to building national commitment to the development of policies, plans, programs and services more responsive to the changing needs of a changing society; develop the capacity of the country office at both technical and administrative levels; this will focus on 4 areas. Firstly, every attempt will be made to recruit further technical and strengthen cooperation between other international donor and development agencies; and promote the continued integration of women in health at all levels and into all national health programs.

General communicable disease prevention and control activities (OCD)

36. The purpose of this project is to reduce the incidence of communicable diseases through effective prevention, control, treatment programs and to strengthen services in chronic diseases. This will require: decentralization of the vector control program, with heavy emphasis on surveillance within districts, and development of community based control programs; Strengthen community participation is disease control initiatives through the creation of "Milieubrigadiertjes" (environmental scouts) within all schools in Suriname; assistance in developing an ongoing training program for teachers and Milieubrigadiertjes; supporting the ongoing anti-malaria campaign in the form of rehabilitation to the health centers of the Medical Missions in the interior so that they can resume their surveys, mass treatment campaigns, and residual spraying; support for critical inputs of drugs and equipment; strengthen retraining and education campaigns; lab testing with special emphasis on capacity to evaluate resistance to drugs and pesticides; and establishing a diabetes and hypertension monitoring and control program.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 760,500 | 62.8 | 862,000 | 61.5 | 947,100 | 61.9 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 526,200 | 43.5 | 607,400 | 43.2 | 671,000 | 43.9 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 526,200 | 43.5 | 607,400 | 43.2 | 671,000 | 43.9 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 23,200 | 1.9 | 26,300 | 1.9 | 29,800 | 1.9 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 23,200 | 1.9 | 26,300 | 1.9 | 29,800 | 1.9 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 42,400 | 3.5 | 47,200 | 3.4 | 52,000 | 3.4 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 42,400 | 3.5 | 47,200 | 3.4 | 52,000 | 3.4 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 92,500 | 7.6 | 103,200 | 7.4 | 114,500 | 7.5 |
| HEALTH SERVICES DEVELOPMENT | DHS | 92,500 | 7.6 | 103,200 | 7.4 | 114,500 | 7.5 |
| HUMAN RESOURCES DEVELOPMENT | | 76,200 | 6.3 | 77,900 | 5.6 | 79,800 | 5.2 |
| HUMAN RESOURCES EDUCATION | HRE | 76,200 | 6.3 | 77,900 | 5.6 | 79,800 | 5.2 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 450,000 | 37.2 | 538,700 | 38.5 | 582,700 | 38.1 |
| ENVIRONMENTAL HEALTH | | 292,600 | 24.2 | 365,600 | 26.1 | 392,700 | 25.7 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 292,600 | 24.2 | 365,600 | 26.1 | 392,700 | 25.7 |
| MATERNAL AND CHILD HEALTH | | 50,100 | 4.1 | 55,800 | 4.0 | 61,800 | 4.0 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 50,100 | 4.1 | 55,800 | 4.0 | 61,800 | 4.0 |
| COMMUNICABLE DISEASES | | 107,300 | 8.9 | 117,300 | 8.4 | 128,200 | 8.4 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 107,300 | 8.9 | 117,300 | 8.4 | 128,200 | 8.4 |
| GRAND TOTAL | | 1,210,500 | 100.0 | 1,400,700 | 100.0 | 1,529,800 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 28,600 | 6.3 | 0 | - | 0 | |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 10,400 | 2.3 | 0 | - | 0 | |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 10,400 | 2.3 | 0 | - | 0 | |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 18,200 | 4.0 | 0 | - | 0 | - |
| HEALTH SERVICES DEVELOPMENT | DHS | 18,200 | 4.0 | 0 | - | 0 | - |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 430,700 | 93.7 | 629,900 | 100.0 | 0 | - |
| MATERNAL AND CHILD HEALTH | | 67,800 | 14.8 | 0 | - | 0 | - |
| DIARRHEAL DISEASES | CDD | 67,800 | 14.8 | 0 | - | 0 | - |
| COMMUNICABLE DISEASES | | 362,900 | 78.9 | 629,900 | 100.0 | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 310,600 | 67.5 | 629,900 | 100.0 | 0 | - |
| LEPROSY | LEP | 52,300 | 11.4 | 0 | - | 0 | - |
| GRAND TOTAL | | 459,300 | 100.0 | 629,900 | 100.0 | 0 | |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 788,200 | 1 | 1 | 110 | 428,500 | 22,800 | 32 | 64,000 | 71,100 | 32,000 | 0 | 169,800 |
| WHO - WR | 422,300 | 1 | 0 | 120 | 261,600 | 16,200 | 14 | 28,000 | 36,100 | 63,700 | 0 | 16,700 |
| TOTAL | 1,210,500 | 2 | 1 | 230 | 690,100 | 39,000 | 46 | 92,000 | 107,200 | 95,700 | 0 | 186,500 |
| % OF TOTAL | 100.0 | | | | 57.0 | 3.2 | | 7.6 | 8.9 | 7.9 | .0 | 15.4 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 893,200 | 1 | 1 | 110 | 494,100 | 25,900 | 32 | 64,000 | 80,600 | 36,300 | 0 | 192,300 |
| WHO - WR | 507,500 | 1 | 0 | 120 | 328,800 | 18,400 | 14 | 28,000 | 41,000 | 72,300 | 0 | 19,000 |
| TOTAL | 1,400,700 | 2 | 1 | 230 | 822,900 | 44,300 | 46 | 92,000 | 121,600 | 108,600 | 0 | 211,300 |
| % OF TOTAL | 100.0 | | | | 58.6 | 3.2 | | 6.6 | 8.7 | 7.8 | .0 | 15.1 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 982,500 | 1 | 1 | 110 | 538,400 | 29,400 | 32 | 64,000 | 91,400 | 41,200 | 0 | 218,100 |
| WHO - WR | 547,300 | 1 | 0 | 120 | 348,300 | 20,900 | 14 | 28,000 | 46,500 | 82,000 | 0 | 21,600 |
| TOTAL | 1,529,800 | 2 | 1 | 230 | 886,700 | 50,300 | 46 | 92,000 | 137,900 | 123,200 | 0 | 239,700 |
| % OF TOTAL | 100.0 | | | | 57.9 | 3.3 | | 6.0 | 9.0 | 8.1 | .0 | 15.7 |

## HEALTH SITUATION ANALYSIS

### Demography

1. According to the 1990 census, the population of Trinidad and Tobago stood at 1.23 million. The estimated total population for 1995 is 1.4 million. In 1980 the 0-15 year old constituted 34% of the population and by 1990 this had declined to 31%, while the contribution of the over 65 age group remained stable at around 5.5%. These statistics reflect emigration which reached a peak in 1988, and a birth rate which fell from 28/1000 in 1980 to 20.4/1000 in 1990. Two ethnic groups, African and East Indian, together comprise over 75% of the population in relatively equal proportions. Approximately 65% of the population in 1990 lived in urban areas, and this is expected to marginally increase to about 69% by 2000.

### Health status indicators

2. Life expectancy at birth was 64.1 years for males and 68.1 for females in 1970. By 1991, this had increased to 71.6 and 72.8 years for males and females, respectively.

3. In 1990, the leading causes of mortality were heart disease, cancer, diabetes mellitus, cerebrovascular disease and injury. It is noteworthy that during the decade, diabetes moved from rank five to three and cancer from three to two. The Infant Mortality Rate, according to official reports, had declined from 34.4 in 1970 to 9.5 in 1989. However, there are indications of underreporting of deaths in the perinatal period, where 2 independent surveys report an IMR of approximately 27. The death rate for conditions originating in the perinatal period (ICD9 760-799) for 1987 was 716.56 per 100,000 live births and has remained fairly constant despite the decrease in the IMR. The age specific mortality rate for the 0-4 year old age group has shown over the period 1977-1987 a downward trend from 5.7 to 2.7 per 100,000.

4. In 1989, among 0-4 year old, injuries constituted the leading cause of mortality but the infectious diseases, pneumonia and diarrhoeal illnesses, continue to contribute to mortality and significantly to morbidity.

5. Among young adults, suicides make up a large proportion of the deaths from injury. It is recognized that there is a growing problem of substance abuse among this group of the population. Among males, 5-44 year old, injury was the leading cause of death, with AIDS ranking among the five leading causes for the 15-44 year age group. Among females, 5-44 year old; injury, cancer and infectious diseases were the leading causes of death. Among females 15-44 year old; cancer of the breast, cancer of the cervix uteri and AIDS were of particular concern. Maternal mortality in 1989 was 80/100,000. For both males and females 45-64, the leading causes of death are lifestyle related and include in descending order: the cardiovascular diseases, diabetes mellitus, cancer and injury.

6. Gastroenteritis, scabies and gonorrhea were the leading reportable communicable diseases in 1990. Of concern, the incidence of HIV , tuberculosis and viral hepatitis continue to rise. EPI coverage has increased to an average of 90% of the relevant population, against those diseases targeted by the program.

### Factors affecting health status

7. Ninety eight percent (98%) of the population are served with potable water and 100% with sanitary waste disposal. However, there are concerns about the intermittence of water supply and functional efficiency of sewage treatment plants. Except in unplanned developments, collection of solid waste is generally adequate. Attention is required to the potential health and environmental impacts associated with disposal sites and the lack of adequate controls for the disposal of hazardous wastes.

8. Data are insufficient to quantify the magnitude or extent of air, water and soil pollution in a scientific manner. Nonetheless, widespread environmental pollution is certain on the basis of several rapid assessments and the heavy industrial, manufacturing and agricultural infrastructure that exists with little real control of pollutant discharges.

9. Dengue and yellow fever remain threats, although there have been no human cases of the latter since 1979. The cholera epidemic in the Americas reached Guyana in December 1992, therefore increasing the likelihood of cholera reaching Trinidad and Tobago in the biennium.

10. During the period 1982-1989, the economy contracted sharply due to the reduced domestic oil production and the decline in the price of oil in the early 1980s. Nominal Gross Domestic Product per capita fell by more than one half, and the unemployment rate more than doubled to 20.2% by the first half of 1992.

11. Beginning in the early 1980s, Government initiated a number of reform measures to address the imbalances in the economy. Much progress has been made in implementing the adjustment program. In 1990, for the first time in seven years, real GDP increased by 1.7%, and by an estimated 3.1% in 1991. However, this growth was largely attributable to expansion in the petroleum sector associated with the substantial rise in oil prices in the latter half of 1990 and early 1991. For 1992, the real GDP growth has been revised downwards to 0.2% due to 1992 budgetary measures, which included liberalization of the exchange control and trade regimes, and some deterioration in the collection of non-oil tax receipts. Estimates for 1993-1995 reflect a return to 3.0% in 1995.

12. The percentage allocation of Government expenditure to the social sector remained quite stable during the period 1980-1990, with health ranking second after education. In the health sector, total expenditure decreased, and while there was some reduction to recurrent expenditure, development expenditures practically declined to nil. This has had a severe impact on investment projects and the level of maintenance generally, and reveals itself in the inadequacy of plant and deteriorating physical conditions in a number of health facilities. In

an effort to address this situation, the Government implemented, in early 1992, a TT$69 million project aimed at improving the structure of selected health facilities, at both community and institutional levels.

13. A major problem in the health services remains the scarcity of human resources. The past few years have seen a migration of nursing and medical personnel to the United States and the United Kingdom. While it has been possible to replace medical doctors with an expatriate work force, the critical nurse shortage worldwide has made the nursing situation particularly difficult. National training programs in basic and psychiatric nursing were resumed in 1990, with the first graduating class, since 1987, scheduled for May 1993.

Plans and priorities for national health development

14. The Ministry of Health is the centralized Agency that manages the health sector. Linkages exist with other ministries in the social sector including: Education, Social and Family Services, Youth Affairs.

15. In the Government's publication of November 1992: Medium Term Policy Framework (MTPF): From Stabilization to Growth 1993-1995, three strategic initiatives are outlined: (a) enhanced fiscal discipline, (b) reliance on the private sector for incremental investment, and (c) exports as the major source of growth and employment. Moreover, the Government recognizes that in a period of rapid adjustment, the social safety net becomes even more important than normally. Accordingly, it acknowledges the need for improved programs in education, health, housing, unemployment insurance and retirement benefits. Policies aimed at addressing these issues will be designed and implemented in the period 1993-1995, with emphasis on improved targeting of beneficiaries, adequate funding, and sustainability of social programs to ensure consistency with the objectives of growth and equity. The strategy is to seek to empower the socially disadvantaged and vulnerable groups. Close collaboration with the NGOs will be pursued.

16. The Government is actively committed to restoring the quality of health care services in the country. Emphasis will be given to primary health care and the promotion of healthy lifestyles in order to reduce the incidence of certain illnesses and contain the burden on secondary health care facilities.

17. Over the period 1993-1995, the Government proposes to spend approximately TT$4.1 billion on investment activity, of which $TT1.09 billion is projected for the strengthening of the social infrastructure. In fiscal year 1993, major allocations will go to Health - TT$87 million; Housing - TT$104 million; Education - TT$45.7 million; and Social and Community Services - TT$51 million.

18. Of the TT$87 million for capital expenditure in health, TT$32 million and TT$54 million are allocated for construction of the Arima Health Facility and major improvements to the San Fernando General Hospital respectively. In addition, a further TT$38 million, funded from local sources, will be spent in 1993 to continue a program of rehabilitation works at major health institutions throughout the country.

19. As a further step, the Government is committed to the introduction of a National Health Insurance System (NHIS). The implementation of the NHIS will provide a safety net for the poor and unemployed, while requiring those who can to contribute to the financing of an improved health care service to the nation.

20. As a means of addressing the institutional and administrative constraints that are hindering the public sector from the effective and efficient delivery of high quality service, the Government has initiated a program of public service reform. In the initial phase, the reform program will seek to match staff skills to institutional objectives and to restructure agencies along program lines. Critical to the reform process is the development of the human resource capability. The Ministry of Health is one of the four ministries chosen for priority attention.

21. In keeping with the initiative to improve the delivery of quality service, the Ministry of Health distributed a major policy document in mid 1992 on "The Decentralization of the Ministry of Health". This paper proposes the decentralization of the Ministry of Health based on the establishment of regional administrative health boards; to be functionally integrated using the primary health care approach and community participation.

22. The overall objectives of the health sector is identified in the paper as follows: to make quality health care available to the population at affordable costs and to eliminate unnecessary financial burdens arising from inefficiency and waste; to achieve greater equity in the allocation and use of health resources so that there is adequate coverage for the population with respect to basic health services both curative and preventive; to promote healthy lifestyles and habits, and to cultivate from an early age positive attitudes to personal health and community responsibility;to promote and maintain an adequate program of preventive health care; to promote higher levels of intersectoral coordination in the provision of health care; to reduce the incidence of environmental health problems and to encourage the population to act in a manner that will ensure the protection of the environment; and to promote a high standard of industrial health and safety.

23. The role of the Ministry of Health will be transformed from program execution to that of policy analysis, formulation and monitoring of the decentralized system. The Ministry will be responsible for providing central services which are essential to cost containment, and will ensure equity and quality in the delivery of health care services through the coordination of the activities of the various boards.

24. The regional administrative health boards will be responsible for the daily management of the hospitals and health centers within well defined geographical areas. They will have flexibility and autonomy in decision-making

to ensure an improved health delivery service. The primary health care approach will be used to effect the functional integration of all the health facilities within the region, and then between regions and with the Ministry of Health. It is acknowledged that there must be available a pool of trained managerial manpower in order to ensure that decision-making can be safely delegated in the organization.

25. The promotion of healthy lifestyles will remain the major thrust of the campaign against the leading causes of mortality and morbidity, which includes chronic non-communicable diseases, HIV infection and injuries.

26. The MTPF states as one of the major policies for 1993 - 1995, the conservation and safeguarding of the environment. The Government's strategy will be underpinned by the principle that an anticipatory and preventive approach is preferable to correcting environmental problems after they occur. In this context, the Government's efforts will focus on the promotion of the efficient and optimum use and development of the country's natural and man-made resources; conservation; promotion of environmental education, information, training and public awareness; strengthening of environmental monitoring and enforcement through the development of standards and enactment of legislation; and the intensification of environmental research and development.

27. A major challenge for environmental health in the biennium will be the control of cholera. Emphasis will continue on improving the sewerage treatment facilities and the intermittence of water supply.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

28. The Government of Trinidad and Tobago will seek external assistance in the areas listed below, based on the priorities identified in 1992 and an analysis of its own resources: 1) the decentralization process with particular attention to development of policy and procedures and implementation and management of local health systems and services; 2) health manpower training; 3) strengthen the management systems at hospitals; 4) the development of the dental health system based on preventive community oriented practices; 5) identification and mobilization of government and nongovernmental resources; 6) health promotion through health education and community participation aimed at modification in lifestyles and early detection of the diseases; 7) develop rehabilitative medicine, mental and physical, with the major emphasis on a community based approach; 8) extending water and sanitation services to vulnerable groups; 9) institutional development of environmental units in the Ministry of Health and intersectoral partners; 10) develop the capacity of Ministry of Health, with particular emphasis on veterinary public health, in food borne disease prevention and control and food protection; 11) analysis of the gender issues in health, and the implications for the health status of the country and strengthening of health programs as they relate to women's health; 12) the implementation of the second Medium Term Plan for HIV Prevention and Control; 13) identification of infants at high risk for perinatal morbidity and mortality, and promotion of good child care practice; and 14) strengthening the capacity for epidemiological analysis.

29. External funding has been obtained to develop a curriculum for the training of dental nurses, and this is scheduled for implementation starting in September 1993 and continuing in the biennium 1994-1995.

30. The health sector reform program is funded by a non-reimbursable technical cooperation loan from the Inter-American Development Bank (IDB) for an amount of US$5.2 million and a Government of Trinidad and Tobago contribution of US$1.7 million. The program (IDB/GOTT) has three major components: policy reform and rationalization studies; commissioning of the Eric Williams Medical Sciences Complex; and the national health insurance system.

### National priorities for technical cooperation from PAHO/WHO

31. As the major provider of technical cooperation for health in Trinidad and Tobago, PAHO/WHO is being asked to provide support in most of the major priority areas identified for the biennium. Therefore in keeping with the priorities of the Organization as expressed in the SOPP, the areas identified include: supporting the reorganization of the health sector in activities complementary to the IDB/GOTT Project; promoting healthy lifestyles and the development of community based rehabilitation programs; improving the water and sanitation services; supporting the development of environmental units geared to monitoring and control of environmental pollution; developing the managerial and surveillance capacity of veterinary public health in food borne disease prevention and control; developing women's health programs as distinct from maternal health programs; continuing support of the HIV and STD control program; and improving epidemiological analysis and development of health information systems.

32. In addition to the projects supported by regular funds, PAHO/WHO manages projects supported by funds from outside the Organization. Included among these projects are: CEH where activities are carried out to preserve the national environment; training for cholera preparedness under the IDB Cholera Project; MCH where activities in child health are supported by UNICEF; strengthening of MCH health services and insect vector control under the Italian Project; training of

dental nurses under the IDB-funded project; and HIV where activities are directed toward the reduction of the impact of AIDS on the general population. In addition to the GPA funds, EEC funding is expected during the biennium.

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Control of Environmental Health Hazards (CEH)

33. The purpose of the project is to assess priority environmental health risks and to develop the institutional framework for the control of environmental health hazards. To accomplish this objective, research will be employed to assess priority environmental health risks. Counterparts will be trained to participate in risk assessment studies. Plans and policies will be developed on national environmental legislation, regulations and standards, and the environmental health services.

Community Water Supply and Sanitation (CWS)

34. The purpose of the project is to reduce the risk of transmission of water-related diseases and reduce breeding of insect vectors. To accomplish this purpose, training will be provided to improve water and sanitation services, and plans will be developed to promote the expansion of services to vulnerable groups. Information will be disseminated to address problems associated with intermittent water supplies, specifically household storage of water. Training will be conducted to promote integrated, community-based approaches to vector control and this will be further supported through resource mobilization for related demonstration projects and information dissemination.

Health Services Development (DHS)

35. The purpose of this project is to strengthen the capacity of administrative and technical personnel in the management and mobilization of resources in a decentralized health service.Given that a significant amount of the technical cooperation to be provided by IDB/GOTT Project in 1993/1994 will be in policy development, PAHO/WHO will focus on the implementation strategy based on the recommendations of the IDB/GOTT Project. This includes, at central and local levels: development of procedures; training of the administrative and technical personnel for their new roles; information dissemination, to the professional groups and the community at large, to gain support for the proposed changes; direct technical assistance with the development of legislation regarding decentralization; mobilization of resources aimed at strengthening NGOs, facilitating participation of the University and NIHERST in the making of critical changes in the formation and use of health personnel.

Food Safety (FOS)

36. The purpose of this project is to reduce the risk of food-borne illnesses. This will entail: advisement on the development of national policy; development of a plan to rationalize veterinary public health and food safety services, which are presently fragmented over several Units; and preparation of a legal brief for the updating of relevant legislation. Training will be employed to develop the skills of technical officers in certain key areas.

Health Situation and Trend Assessment (HST)

37. The purpose of the project is to improve the capacity of the health sector for epidemiological analysis and the management of information. Training for epidemiological analysis will be concentrated at the local levels to improve the information needed for program planning and public education. Resources, financial and human, will be mobilized to expand the computerized systems for surveillance and health information. Information will be disseminated on communicable diseases with emphasis on cholera, measles, neonatal tetanus and polio. Direct technical assistance with the development of procedures for collecting and disseminating health information will be provided.

Managerial Support for National Health Development (MPN)

38. The purpose of the project is to continue the provision of managerial, technical and administrative support for the delivery of the technical cooperation program as defined by the instruments of the AMPES and in accordance with organizational policies, procedures and goals. To achieve this purpose, managerial support for national health development will be provided to work with the institutions comprising the health sector in resource mobilization and development of policies, plans and norms. Other activities will include promoting and institutionalizing the Caribbean Cooperation in Health (CCH) Goals and Targets; continued strengthening of the infrastructure of the Representation; development of the administrative and technical capabilities of staff; and promoting health in development.

Health Promotion and Prevention and Control of Noncommunicable Diseases (NCD)

39. The purpose of this project is to improve the capacity of the health services in the promotion of healthy lifestyles. Epidemiological research will be conducted on the mental health situation in order to determine needs for training and provide the basis for development of policy and procedures. Direct technical assistance will be provided in the production of supporting material for health promotion aimed at mobilizing community sources and participation. Personnel at central and local levels will be trained to market healthy lifestyles. Particular attention will be paid to youth and other groups considered at high risk for non communicable diseases and disabling conditions.

Technical Cooperation among Countries (TCC)

40. The purpose of the project is to improve water supply services in Trinidad and Tobago and Jamaica and to improve the capacity of Trinidad and Tobago's health sector to mobilize resources in support of the process of administrative decentralization. The possibility of developing a TCC project will be explored with the PWR - Jamaica, which would entail the establishment of training standards and the preparation of a plan for the development of a training unit in the Jamaica National Water Commission. Training in instructional technology would be necessary to develop the skills of trainers. Resources would have to be mobilized to provide the training center with the necessary human and material resources. Trinidad and Tobago could benefit from Jamaica's experience with financing house connections in low-income neighborhoods and with metering and rate setting. Both countries could benefit by exchanging information on their institutional strengthening programs, including privatization and decentralization. Information would be shared through exchange visits and attachments, joint meetings and workshops and other similar activities.

Women, Health and Development (WHD)

41. The purpose of this project is to strengthen the capacity of the Ministry of Health, and other related agencies to recognize and analyze gender issues in health in order to develop health programs for women. Gender sensitization training will be conducted for health personnel, and other related agencies at central and local levels, in order to develop policy for WHD. Information on health issues as they relate to women and development will be regularly disseminated among women's groups and policy makers. Specific health programs to be strengthened will be those aimed a the reduction of Cancer cervix uteri and breast. Research on the nature of injuries in women will be conducted in order to develop and implement appropriate support programs.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 1,551,800 | 80.5 | 1,666,400 | 80.1 | 1,826,300 | 80.2 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 680,600 | 35.3 | 753,300 | 36.3 | 844,400 | 37.1 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 680,600 | 35.3 | 753,300 | 36.3 | 844,400 | 37.1 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 59,400 | 3.1 | 67,400 | 3.2 | 76,400 | 3.4 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 59,400 | 3.1 | 67,400 | 3.2 | 76,400 | 3.4 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 46,300 | 2.4 | 50,100 | 2.4 | 53,300 | 2.3 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 46,300 | 2.4 | 50,100 | 2.4 | 53,300 | 2.3 |
| HEALTH POLICY DEVELOPMENT | | 245,400 | 12.7 | 48,800 | 2.3 | 54,200 | 2.4 |
| HEALTH POLICY ANALYSIS AND DEVELOPMENT | HDP | 245,400 | 12.7 | 0 | - | 0 | - |
| WOMEN, HEALTH AND DEVELOPMENT | WHD | 0 | - | 48,800 | 2.3 | 54,200 | 2.4 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 485,900 | 25.2 | 746,800 | 35.9 | 798,000 | 35.0 |
| HEALTH SERVICES DEVELOPMENT | DHS | 485,900 | 25.2 | 746,800 | 35.9 | 798,000 | 35.0 |
| HUMAN RESOURCES DEVELOPMENT | | 34,200 | 1.8 | 0 | - | 0 | - |
| HUMAN RESOURCES EDUCATION | HRE | 34,200 | 1.8 | 0 | - | 0 | - |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 375,500 | 19.5 | 414,000 | 19.9 | 453,000 | 19.8 |
| ENVIRONMENTAL HEALTH | | 319,200 | 16.6 | 314,000 | 15.1 | 342,900 | 15.0 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 267,400 | 13.9 | 255,900 | 12.3 | 278,100 | 12.2 |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 51,800 | 2.7 | 58,100 | 2.8 | 64,800 | 2.8 |
| MATERNAL AND CHILD HEALTH | | 56,300 | 2.9 | 0 | - | 0 | - |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 56,300 | 2.9 | 0 | - | 0 | - |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| HEALTH PROMOTION | | 0 | - | 73,000 | 3.5 | 81,700 | 3.6 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 0 | - | 73,000 | 3.5 | 81,700 | 3.6 |
| VETERINARY PUBLIC HEALTH | | 0 | - | 27,000 | 1.3 | 28,400 | 1.2 |
| FOOD SAFETY | FOS | 0 | - | 27,000 | 1.3 | 28,400 | 1.2 |
| GRAND TOTAL | | 1,927,300 | 100.0 | 2,080,400 | 100.0 | 2,279,300 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 65,300 | 13.2 | 0 | - | 0 | |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 2,200 | .4 | 0 | - | 0 | |
| HEALTH SERVICES DEVELOPMENT | DHS | 2,200 | .4 | 0 | - | 0 | |
| HUMAN RESOURCES DEVELOPMENT | | 63,100 | 12.8 | 0 | - | 0 | - |
| HUMAN RESOURCES EDUCATION | HRE | 63,100 | 12.8 | 0 | - | 0 | - |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 426,100 | 86.8 | 360,000 | 100.0 | 0 | - |
| ENVIRONMENTAL HEALTH | | 37,400 | 7.6 | 0 | - | 0 | - |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 17,400 | 3.5 | 0 | - | 0 | - |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 20,000 | 4.1 | 0 | - | 0 | - |
| MATERNAL AND CHILD HEALTH | | 3,200 | .7 | 0 | - | 0 | - |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 3,200 | .7 | 0 | - | 0 | - |
| COMMUNICABLE DISEASES | | 385,500 | 78.5 | 360,000 | 100.0 | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 385,500 | 78.5 | 360,000 | 100.0 | 0 | - |
| GRAND TOTAL | | 491,400 | 100.0 | 360,000 | 100.0 | 0 | |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 673,000 | 2 | 0 | 110 | 447,200 | 21,500 | 14 | 28,000 | 34,900 | 11,100 | 0 | 130,300 |
| WHO - WR | 1,254,300 | 2 | 5 | 235 | 690,900 | 11,000 | 88 | 176,000 | 74,300 | 61,800 | 0 | 240,300 |
| TOTAL | 1,927,300 | 4 | 5 | 345 | 1,138,100 | 32,500 | 102 | 204,000 | 109,200 | 72,900 | 0 | 370,600 |
| % OF TOTAL | 100.0 | | | | 59.0 | 1.7 | | 10.6 | 5.7 | 3.8 | .0 | 19.2 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 547,000 | 1 | 0 | 120 | 275,700 | 32,900 | 0 | 0 | 51,300 | 40,500 | 0 | 146,600 |
| WHO - WR | 1,533,400 | 3 | 5 | 245 | 932,300 | 13,100 | 88 | 176,000 | 85,900 | 70,700 | 0 | 255,400 |
| TOTAL | 2,080,400 | 4 | 5 | 365 | 1,208,000 | 46,000 | 88 | 176,000 | 137,200 | 111,200 | 0 | 402,000 |
| % OF TOTAL | 100.0 | | | | 58.1 | 2.2 | | 8.5 | 6.6 | 5.3 | .0 | 19.3 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 602,200 | 1 | 0 | 120 | 294,500 | 37,300 | 0 | 0 | 58,200 | 46,000 | 0 | 166,200 |
| WHO - WR | 1,677,100 | 3 | 5 | 245 | 1,019,100 | 14,800 | 88 | 176,000 | 97,500 | 80,100 | 0 | 289,600 |
| TOTAL | 2,279,300 | 4 | 5 | 365 | 1,313,600 | 52,100 | 88 | 176,000 | 155,700 | 126,100 | 0 | 455,800 |
| % OF TOTAL | 100.0 | | | | 57.7 | 2.3 | | 7.7 | 6.8 | 5.5 | .0 | 20.0 |

TURKS AND CAICOS ISLANDS

## HEALTH SITUATION ANALYSIS

### Demography

1. According to the statistical yearbook 1991, the population of the Turks and Caicos Islands number 12,350. The population is comprised of persons from the Turks and Caicos, nationals from Haiti, the Dominican Republic, Jamaica, Eastern Caribbean States, the United Kingdom, and the United States of America. The age distribution of the population has been assessed as follows: under 5 years 17.7%; 5 to 16 years 31.2%; and 15 years and over 56.1%. The population increase between 1980-1987 was estimated at 7.5% per year, there having been a considerable influx of workers from Haiti, and the Dominican Republic.

### Health status indicators

2. The crude birth rate for 1986 was 23.1 per 1000 population and the crude death rate was 6.1. The infant mortality rate for 1991 was 11.69 per 1000 live births. Maternal Mortality has been zero since 1984. The leading causes of death are cerebrovascular disease, accidents, cardiovascular disease and malignant neoplasms. The leading causes of morbidity are cardiovascular disorders, hypertension and Diabetes Mellitus. Since 1986, there has been a decline in the rate of sexually transmitted diseases, specifically gonorrhoea and syphilis. However, as of June 1992, 30 cases of AIDS have been notified, of these 27 have died. During the period 562 seropositive persons have been identified.

### Factors affecting health status

3. The Turks and Caicos Islands comprises a large number of uninhabited cays and eight islands of which six are inhabited. Turks and Caicos is the largest British Dependent territory in the Caribbean. It has a land mass of 193 square miles spread over an area of approximately 200 square miles, consequently the coverage of services to a population scattered among several islands is a challenge to the Public Health system. The mainstay of the economy is tourism. The majority of persons are employed by that industry, government services, fishing and a small but growing financial sector. The growing tourism sector has created a corresponding demand on the supply of water and waste water services. Additionally, the complementary pressure for development in the coastal zone has emerged as the most critical constant in Environmental Health in the Turks and Caicos.

4. Due to the economic and political problems in Haiti there has been a considerable flow of nationals from Haiti to the Turks and Caicos Islands which in turn creates an added burden for the Health services.

### Plans and priorities for national health development

5. The Government, through the Ministry of Health, has allotted considerable national resources to continued improvement of physical facilities, manpower development and health services administration. The Ministry of Health's budget has consistently been approximately US$ 3 million. In 1991, government expenditure on health care amounted to US$ 166 per capita.

6. The health services function under the office of the Permanent Secretary for Health who is responsible to the Minister of Health and Education. The seminars are composed of Medical, Dental, and Environmental Health. The Chief Medical Officer who is responsible to the Permanent Secretary, is responsible for the Medical Department, the nucleus of which is the Hospital (36 beds) which is also the administrative base situated on Grand Turk. There are 10 Clinics throughout the Islands staffed by a trained nurse, nurse/midwife and a public health nurse. These are visited regularly by a physician, except for Providenciales and South Caicos where there are resident medical officers in addition to the nursing staff. The chief Dental Officer who is based in Grand Turk is responsible for the Dental Department. In addition to the Chief Dental Officer, there are three dental nurses who are all based in Grand Turk, however, they travel to the outer islands on a frequent basis to provide their services at Island clinics. The Chief Environmental Health Officer who is based in Grand Turk is responsible for the Environmental Health Department and is responsible to the Chief Medical Officer. In addition, there are three Environmental Health Officers along with other Environmental Health Personnel based in the outer islands.

7. The Government of the Turks and Caicos Islands fully agrees to the principles laid down in the Declaration of Alma Ata of 1978, adopting the Primary Health Care approach. According to the national health plan, the major areas of emphasis are improvement of the health information system, availability and training of human resources, improved maintenance of facilities and equipment, improvement of Health clinics, provision of more health facilities in Providenciales, and continued upgrading of Grand Turks Hospital.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

8. According to the National Health Plan, the following are the areas of priority for the Government: control of AIDS and sexually transmitted diseases; enhancement of the quality of environmental health as it relates to improvement of water quality, solid matter and management and food sanitation; improved care for prevention and control of chronic diseases (heart disease, hypertension, and Diabetes Mellitus); Improved care for mentally and physically handicapped persons; improvement in oral health; monitoring and improvement of nutritional status; prevention of traffic accidents; control of tuberculosis and Hansen's disease; strengthening of health systems; maternal and child health; and human resources development.

### National priorities for technical cooperation from PAHO/WHO

9. PAHO has been asked to provide technical cooperation in the following priority areas identified by the Government: improved managerial capacity for a reformed health sector; health manpower development; assistance with HIV/AIDS in collaboration with the United Kingdom Overseas Development Agency (ODA); strengthening of epidemiological surveillance; and strengthening of environmental

health in the Turks and Caicos Islands. These priority areas are consistent with the priorities of the organization as expressed in Strategic Orientations and Program Priorities (SOPP) and the CCH.

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Community water supply and sanitation (CWS)

10. The purpose of the project is to improve the level of environmental management and coastal zone development. To achieve this purpose it will be necessary to develop national policies which focus on the need for environmentalcontrol, improved water resources, national conservation and the protection of the marine and coastal zones; and develop solid waste, food protection, and conservation plans.

Health services development (DHS)

11. The purpose of this project is to strengthen the health care delivery services of the Turks and Caicos Islands. To achieve this purpose it will be necessary to focus on Health Sector reform, improved managerial capacity, computerization of health data, and enhancement of disease surveillance and control, and training of health services personnel with particular emphasis on administration of health care facilities.

Acquired immunodeficiency syndrome (HIV)

12. The purpose of this project is the prevention and control of HIV/STD in the population. To achieve this purpose it will be necessary to develop national policy to strengthen public health and increase the level of sensitivity in health personnel to enhance patient care.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 58,300 | 100.0 | 47,000 | 74.5 | 50,000 | 74.1 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 58,300 | 100.0 | 47,000 | 74.5 | 50,000 | 74.1 |
| HEALTH SERVICES DEVELOPMENT | DHS | 58,300 | 100.0 | 47,000 | 74.5 | 50,000 | 74.1 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 0 | - | 16,100 | 25.5 | 17,500 | 25.9 |
| ENVIRONMENTAL HEALTH | | 0 | - | 16,100 | 25.5 | 17,500 | 25.9 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 0 | - | 16,100 | 25.5 | 17,500 | 25.9 |
| GRAND TOTAL | | 58,300 | 100.0 | 63,100 | 100.0 | 67,500 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| III. HEALTH SCIENCE AND TECHNOLOGY | | 178,700 | 100.0 | 0 | | 0 | |
| COMMUNICABLE DISEASES | | 178,700 | 100.0 | 0 | | 0 | |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 178,700 | 100.0 | 0 | | 0 | |
| GRAND TOTAL | | 178,700 | 100.0 | 0 | | 0 | |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 58,300 | 0 | 0 | 45 | 12,000 | 0 | 6 | 12,000 | 11,600 | 4,700 | 0 | 18,000 |
| TOTAL | 58,300 | 0 | 0 | 45 | 12,000 | 0 | 6 | 12,000 | 11,600 | 4,700 | 0 | 18,000 |
| % OF TOTAL | 100.0 | | | | 20.6 | .0 | | 20.6 | 19.9 | 8.1 | .0 | 30.8 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 63,100 | 0 | 0 | 65 | 18,100 | 0 | 6 | 12,000 | 19,300 | 8,000 | 0 | 5,700 |
| TOTAL | 63,100 | 0 | 0 | 65 | 18,100 | 0 | 6 | 12,000 | 19,300 | 8,000 | 0 | 5,700 |
| % OF TOTAL | 100.0 | | | | 28.7 | .0 | | 19.0 | 30.6 | 12.7 | .0 | 9.0 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 67,500 | 0 | 0 | 65 | 18,100 | 0 | 6 | 12,000 | 21,900 | 9,000 | 0 | 6,500 |
| TOTAL | 67,500 | 0 | 0 | 65 | 18,100 | 0 | 6 | 12,000 | 21,900 | 9,000 | 0 | 6,500 |
| % OF TOTAL | 100.0 | | | | 26.8 | .0 | | 17.8 | 32.5 | 13.3 | .0 | 9.6 |

UNITED STATES OF AMERICA

## HEALTH SITUATION ANALYSIS

### Demography

1. The population of the United States of America is estimated at 252,916,000 for 1992. The percentage of population 15 years and under is 21.4, while those 65 and over constitute 12.8. Women age 15-49 constitute 26.7% of the population.

### Health status indicators

2. Between 1988 and 1989 overall life expectancy at birth increased from 74.9 to 75.3 years. In 1989 the infant mortality rate was 9.8 deaths per 1,000 live births. Between 1988 and 1989 infant mortality decreased by 4% for white infants to 8.1 deaths per 1,000 live births, and remained about the same for black infants at 18.6 deaths per 1,000 live births. Provisional data show that overall infant mortality declined by 6% to 9.1 deaths per 1,000 live births in 1990.

3. Between 1970-1989 the age-adjusted death rate for heart disease, the leading cause of death for both men and women, declined by 39%; in 1989 heart disease mortality was almost twice as great for white males as for white females and almost 60% greater for black males than for black females. During this same period the age-adjusted death rate for stroke, the third leading cause of death, declined by 58%.

4. Between 1980 and 1989 the age-adjusted death rate for lung cancer increased by 42% for black women. During this period lung cancer mortality remained fairly stable for men of both races.

5. Between 1980 and 1989 the age-adjusted death rate for breast cancer increased by 12% for black women while remaining stable for white women.

6. About one million citizens and residents of the United States are infected with HIV. Since the onset of the epidemic in 1981 through September 1992, approximately a quarter million U.S. citizens have been diagnosed with AIDS, and more than 66% of them have died. By the end of 1994, the cumulative number of reported AIDS cases in the United States may reach 380,000. In that year alone, it is projected that 42,000 to 93,000 new cases could be diagnosed, and there could be as many as 45,000 to 76,000 AIDS-related deaths.

7. In the 25 to 44-year old age group, AIDS is the leading killer of men and the fifth leading killer of women. In some cities, AIDS is the leading cause of death for men and minority women in this age group. AIDS has a disproportionate effect on minority populations. Of all AIDS cases reported, 85% of the people live in large metropolitan areas, 53% are White, 29% are Black, and 17% are Hispanic. 88% of reported cases are male and 12% are female. Almost three-fourths of the AIDS cases reported in females are in women who are racial or ethnic minorities.

### Factors affecting health status

8. The HIV virus is spreading rapidly among teenagers. Since the average length of time between HIV infection and the development of AIDS is 10 years, many of the nearly 9,000 people who had been 20 to 29 years of age when diagnosed with AIDS were infected during their teenage years.

9. In general, the highest rates of HIV infection are among persons engaging in high-risk sexual and drug use behaviors. The majority of AIDS cases are still occurring in men. Increasingly, however, AIDS is affecting women and children, racial and ethnic minority populations, heterosexuals, and people living in smaller cities and rural areas.

10. Violent behavior in the United States is at an all time high. Every year, over 20,000 people die from homicide and two million persons are injured. Homicide disproportionately affects minority communities. It is the second leading cause of death for young people ages 14-34 and is the leading cause of death for both young black men and women in that age group.

11. Although adolescents are relatively healthy when compared to the general population, their tendency toward risk taking behaviors presents problems that threaten their overall health and well-being. About 70% of all deaths to youth aged 10-19 are attributable to four major causes: motor vehicle accidents (half of which involve alcohol) (38%); suicides (10%); other violent acts or injury (10%); and homicides (9%). Large numbers of adolescents have experimented with drugs, and many engage in early or unprotected sexual activity or have multiple sexual partners.

12. A 1991 report by Office of Technology Assessment (OTA) on the state of adolescent health, suggests that one out of five of the 31 million adolescents of the United States have at least one serious health problem, and that adolescents face formidable barriers in obtaining health care, as evidenced by the fact that one out of seven adolescents lack health insurance. OTA offered several policy options to improve (1) the Federal role in adolescent health, (2) adolescents' access to services, and (3) adolescents' health environments.

13. In 1990 national health care expenditures in the United States totaled $666,000 million, an average of $2,566 per person. Health expenditures comprised 12.2% of the gross national product in 1990, a record high. Federal Government health expenditures rose from 3.1% of total Federal Government expenditures in 1960 to 15.3% in 1990. National health expenditures increased by 10.5% in 1990, compared with a 5.1% increase in the GNP.

14. In 1990 health spending in United States accounted for a larger share of gross domestic product (GDP) than in other industrialized countries and the gap continued to widen. The United States devoted 12.4% of GDP to health in 1990, up from 9.3% in 1980. Canada, the country with the second highest health share of GDP, devoted 9.0% of GDP to health in 1990. Rising prices continued as the largest portion (63%) of growth in personal health care expenditures. Ten percent of the growth was due to population increase and 27% to changes in the use of kinds of services and supplies. Furthermore, the rate of increase in the medical care components of the Consumer Price Index (CPI) was 9.0% compared with an overall inflation rate of 5.4%.

15. From 1965 to 1980 the share of health care expenditures paid by households declined from 61 to 38%, while the shares paid by private business and government increased. In 1990 the major sources of funds for hospital care were the government (55%) and private health insurance (35%). Medicare provided almost half of government funds for hospital care. Nursing home care was financed almost equally by Medicaid and out-of-pocket payments (45% each). Physician services were primarily funded by private health insurance (46%) and the government (35%) with Medicare providing nearly 70% of government funds.

16. The Federal Government is spending more money and developing more human resources to combat the AIDS epidemic than it has for any other infectious disease. Federal expenditures for HIV-related activities increased from $8 million in 1982 to almost $3 billion in 1990. By the end of 1993, the Federal Government will have devoted nearly $17 billion to the efforts. For Fiscal Year 1993, the Federal budget allotted $4.9 billion for AIDS research, prevention, treatment, income support, and education programs.

17. In 1989 total public health expenditures by State and territorial health agencies increased by 13%, compared with 5% in 1988. Supplemental food program for women, infants, and children (WIC) expenditures increased by 17% in 1989.

18. The proportion persons age 85 years and over enrolled in Medicare increased from 6.7% in 1967 to 10.5% in 1989. In 1989, payments per person enrolled in this system averaged $3,809 for those 85 years and over, compared with $1,737 for those 65-66 years of age.

Plans and priorities for national health development

19. By the late 1970s, lifestyle and environmental factors had gained national recognition for their role in the promotion of health and the prevention of disease. Despite advances in mortality rates for stroke and coronary heart disease as well as for overall life expectancy, more than half of U.S. citizens die prematurely. In the United States, these deaths carry a heavy toll in economic as well as human terms. More than twelve million years of potential life are lost to U.S. citizens every year as a result of deaths before the age of sixty-five. The cost of medical care and lost productivity for some of the country's leading health problems run as high as an estimated $135,000 million for heart disease and $158,000 million for injuries. The aggregate cost of morbidity for U.S. citizens is staggering, yet many of these illnesses are preventable.

20. This recognition was translated into a major initiative focused on health promotion and disease prevention. Five broad national goals were set, one for each of the five major stages of life; premature mortality and morbidity were highlighted. A course of action for the nation was produced in 1980 which targeted efforts by a wide range of public and private groups, and individuals.

21. In September 1990, a second national prevention initiative was unveiled in the publication "Healthy People 2000: National Health Promotion and Disease Prevention Objectives."

22. The Year 2000 initiative builds on not only the lessons learned from progress made toward the 1990 objectives, but also the decade's scientific research on health promotion and disease prevention. Healthy People 2000 aims to improve significantly the Nation's health over the decade of the 1990s through a comprehensive approach to three broad goals: to increase the span of healthy life of U.S. citizens, to reduce health disparities among U.S. citizens, and to achieve access to preventive services for all U.S. citizens. Healthy People 2000 sets forth 300 measurable objectives which, when accomplished by the year 2000, should lead to the achievement of these goals.

23. During the 3 years of its formulation, more than 10,000 people commented on Healthy People 2000, including national, state and local agencies and communities, private and voluntary groups, consumers, and other individuals.

24. Implicit throughout the Healthy People 2000 initiative is the principle that long life without good health is not enough. The prevention of disability, as well as the prevention of further impairment or morbidity for those people with disabilities, is an important aim. The Healthy People 2000 initiative emphasizes the full range of functional capacity from infancy through old age, including measures of health outcomes.

25. Substantial health improvements are needed for populations who have been disadvantaged economically and educationally. This new initiative includes special targets for reducing the disparities in death, disease, and disability rates of these groups as compared to the majority population. The specific groups targeted are racial and ethnic minority populations, people with low income, and people with disabilities.

26. There has been an appropriate increasing interest in promoting the health of U.S. women. The recognition that women have unique medical problems and have been under-represented in clinical trials even on common conditions, has catalyzed efforts to improve research and to enhance health services delivery and access. Efforts have also focused upon increasing the number of women researchers and health professionals as well as improving educational outreach programs, especially for minority, elderly and economically disadvantaged women. Long-standing assumptions about the prevalence of diseases of public health significance, such as heart disease, lung cancer and AIDS, among women are being challenged.

27. In defining the scope of the problem, the following statistics stand out:

28. Heart disease is the leading killer of women, accounting for 375,000 deaths each year. 49% of women, compared to 39% of men, die within one year following diagnosis.

29. The incidence of breast cancer has increased by more than 1% every year since the early 1970s; current estimates indicate that 1 woman in 19 will develop breast cancer in her lifetime.

30. Lung cancer is now the leading cause of cancer deaths in women, up 400% in 30 years; approximately 26% of American women smoke.

31. Reported cases of women with AIDS nearly doubled between 1984 and 1991, from 6%-11% of the total number of AIDS cases.

32. To more accurately measure the number and incidence of people with severe HIV-related immunosuppression and disease, the AIDS surveillance case definition was expanded on 1 January 1993. For the first time it includes a laboratory marker of severe immunosuppression as well as three additional diseases (invasive cervical cancer, pulmonary tuberculosis, and recurrent bacterial pneumonia).

33. The development of a safe and effective vaccine(s) is a major research priority. Currently, the Public Health Service (PHS) is evaluating six vaccines, and an additional 11 vaccines are being tested worldwide by various manufacturers. More than one vaccine, perhaps many, will be required. Vaccine efficacy studies will require significant infrastructure support and development in international and domestic sites with populations at high risk of HIV infection.

34. Healthy People 2000 initiative also recognizes that many U.S. citizens lack access to an ongoing source of primary care and therefore to essential clinical preventive services. The initiative addresses the many barriers to access to health care. These barriers include inadequate health insurance, low numbers of primary care providers, geographic barriers (for example, distance in rural areas), language and cultural barriers, restrictive hours of service availability, inadequate child care options, and lack of transportation. Even when people have access to primary care, they may not be offered clinical preventive services at recommended intervals; thus, many individuals do not receive all of the services that would benefit them. This initiative emphasizes the need for access to preventive services as an important factor in achieving many of the objectives of Healthy people 2000.

35. All of the 300 objectives for the year 2000 are designed to have quantifiable and realistic targets. The objectives are organized into 22 separate priority areas. The first 21 focus on health promotion activities related to individual lifestyle, health protection strategies related to environmental or regulatory measures, and preventive services such as counseling, screening, and immunization. Priority area 22, "Surveillance and Data Systems," addresses the critical need for data to monitor progress toward the objectives at the national, state and local levels, as well as to enhance the public health data systems.

36. A key issue for the early 1990 is health care reform. Health care reform will expand financial access to vulnerable populations served by Government programs. The new Administration has outlined broad plans and is preparing new approaches to pay for health care which will profoundly affect the organization of the delivery system.

37. An often overlooked element of health care reform is the supply and mix of providers available. The provider mix cannot be changed quickly, but the substantial Federal funding for medical and health professionals training programs could be better targeted to increase the number of primary care providers, including physicians, nurse practitioners and physician assistants.

38. Another key element is changing the behavior of providers and consumers. Efforts to contain costs can also be helped by providing information on the relative effectiveness of alternative treatments, identifying cost-effective practices, and giving consumers information about the most efficient and effective providers. The PHS, through the Medical Effectiveness Treatment Program of the Agency for Health Care Policy and Research (AHCPR), is developing and disseminating a wide variety of outcomes and effectiveness information which will be critical to this educational effort. In addition, PHS is launching a "Put Prevention Into Practice Campaign" to educate and motivate providers and consumers.

39. Health care reform will require accurate data on health care utilization and expenditures which can be provided by the National Medical Expenditure Survey (NMES) and other Federal data bases.

40. In addition, for each of the leading causes of death and disability, epidemiologic and biomedical research have identified risks that can be reduced to improve health prospects. Measures such as early detection, intervention, and changes in individual behavior could eliminate an estimated 45% of cardiovascular disease deaths, 23% of cancer deaths, and more than 50% of the disabling complications of diabetes. Attention to even a few risk factors such as poor diet, infrequent exercise, the use of tobacco and drugs, and the abuse of alcohol, could prevent between 40 and 70% of all premature deaths, and one-third of all cases of acute disability. In contrast, technologically oriented medical treatment currently promises to reduce morbidity and mortality by no more than perhaps 10%-15%.

41. Although each individual will eventually die, proven preventive measures can decrease suffering, decrease disability, and improve the quality of life by thwarting problems before they occur or become irreversible. More than 95% of the over $666 billion spent in 1990 for medical care in the United States went to treat rather than prevent disease. Many of the interventions purchased with this sizable investment were for conditions that could have been avoided.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

42. The global strategy for technical cooperation with the United States of America focuses on three themes. The first is the provision of fellowships for United States health professionals to receive advanced training and experience in settings outside the country. The second is the use of funds of the Organization to supplement the considerable investment being made by the United States to address health problems along the United States - Mexico border by stimulating binational cooperation in a variety of sister city projects, the third is to use the considerable expertise available in the United States to support health development in other countries of the Americas, with particular attention to disease prevention and health promotion. Efforts will be concentrated on communicable disease control, chronic disease control, food safety, drug abuse control, environmental health and equipment maintenance. Likewise, experts from the Americas as well as other Regions will participate with national health authorities in consultations regarding achievement of the national health agenda.

## PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

### Health services development (DHS)

43. The purpose of this project is, in general, to provide technical cooperation between the United States and other countries of the Region in disease control and infrastructure development, and to support United States - Mexico binational sister-city projects addressing disease prevention, health promotion and health infrastructure development in particular. Consultants to and from the United States will be provided to promote international exchange of information. Approximately five sister-city projects in health and environment will be supported along the United States - Mexico border.

### Human resources education (HRE)

44. The purpose of this project is to provide fellowships to U.S. citizens for international training in developed and developing countries. At least 20 U.S. fellows will be provided specialized training in health issues of relevance to the United States.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 373,700 | 100.0 | 396,400 | 100.0 | 416,400 | 100.0 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 255,700 | 68.4 | 278,400 | 70.2 | 298,400 | 71.7 |
| HEALTH SERVICES DEVELOPMENT | DHS | 255,700 | 68.4 | 278,400 | 70.2 | 298,400 | 71.7 |
| HUMAN RESOURCES DEVELOPMENT | | 118,000 | 31.6 | 118,000 | 29.8 | 118,000 | 28.3 |
| HUMAN RESOURCES EDUCATION | HRE | 118,000 | 31.6 | 118,000 | 29.8 | 118,000 | 28.3 |
| GRAND TOTAL | | 373,700 | 100.0 | 396,400 | 100.0 | 416,400 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 2,100 | 100.0 | 0 | | 0 | |
| HEALTH INFORMATION SUPPORT | | 2,100 | 100.0 | 0 | | 0 | |
| LANGUAGE SERVICES | HBL | 2,100 | 100.0 | 0 | | 0 | |
| GRAND TOTAL | | 2,100 | 100.0 | 0 | | 0 | |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 160,900 | 0 | 0 | 405 | 108,100 | 0 | 0 | 0 | 0 | 52,800 | 0 | 0 |
| WHO - WR | 212,800 | 0 | 0 | 255 | 68,100 | 0 | 59 | 118,000 | 26,700 | 0 | 0 | 0 |
| TOTAL | 373,700 | 0 | 0 | 660 | 176,200 | 0 | 59 | 118,000 | 26,700 | 52,800 | 0 | 0 |
| % OF TOTAL | 100.0 | | | | 47.2 | .0 | | 31.6 | 7.1 | 14.1 | .0 | .0 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 175,000 | 0 | 0 | 210 | 58,400 | 0 | 0 | 0 | 0 | 59,900 | 56,700 | 0 |
| WHO - WR | 221,400 | 0 | 0 | 255 | 70,900 | 0 | 59 | 118,000 | 32,500 | 0 | 0 | 0 |
| TOTAL | 396,400 | 0 | 0 | 465 | 129,300 | 0 | 59 | 118,000 | 32,500 | 59,900 | 56,700 | 0 |
| % OF TOTAL | 100.0 | | | | 32.6 | .0 | | 29.8 | 8.2 | 15.1 | 14.3 | .0 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 190,600 | 0 | 0 | 210 | 58,400 | 0 | 0 | 0 | 0 | 67,900 | 64,300 | 0 |
| WHO - WR | 225,800 | 0 | 0 | 255 | 70,900 | 0 | 59 | 118,000 | 36,900 | 0 | 0 | 0 |
| TOTAL | 416,400 | 0 | 0 | 465 | 129,300 | 0 | 59 | 118,000 | 36,900 | 67,900 | 64,300 | 0 |
| % OF TOTAL | 100.0 | | | | 31.1 | .0 | | 28.3 | 8.9 | 16.3 | 15.4 | .0 |

URUGUAY

## HEALTH SITUATION ANALYSIS

### Demography

1. Uruguay is the first Latin American country to achieve a post-transitional demographic and epidemiological situation. The current population (approximately 3,100,000 inhabitants) is growing by 0.7% annually, and its age structure will vary less than during the transition. Thus, if between 1950 and 1990 the percentage of children under 15 years of age went from 32% to 22%, and adults over 65 from 8% to 12%, it is estimated that by the year 2000 the former group will have reached 24% and the latter 13%.

### Indicators of Health Status

2. Life expectancy is 72 years, and little change is expected in this indicator (it is predicted to be 73 by the year 2000). Infant mortality fluctuated at around 21% from 1988 to 1991, with a neonatal component of around 12%, total mortality is steady at approximately 10%, and the birth rate has declined slightly (from 18.2 in 1983 to 17.6 in 1991), causing a reduction in the actual number of births. Maternal mortality rose in 1991 (it was about 16 per 100,000 in 1990) to 38 per 100,000 as a result of new record-keeping procedures. The structure of mortality shows that two thirds of all deaths are caused by cardiovascular diseases and cancer. Noteworthy among the causes of morbidity is the growing impact of lifestyle choices, while there is a decrease in the importance of factors found in the natural environment. In the current situation, eating habits that favor red meat--which is widely available in the country--become risk factors, as does the persistence of unhygienic practices in the disposal of viscera in cattle slaughterhouses.

3. Some communicable diseases have disappeared from the morbidity table (rabies for example), while for others, such as Chagas' disease, there are indications that human transmission has been interrupted.

### Factors affecting health status

4. Rising awareness of the epidemiological situation has led the government to decide upon a reorientation of health policy for 1990-1995 toward the promotion of healthy lifestyles and behavior modification, on the one hand, and toward the restructuring of the system of services and environmental control, on the other. In the first area, priority programs have been formulated, and their coordination/integration is just beginning. With regard to the second area, various social actors have brought about serious conflicts with regard to working conditions in the services, which are sidetracking and hindering actions geared toward adapting these services to the current and future epidemiological situation. With regard to environmental health and food protection and control, the delineation of the areas of authority of the various agencies and levels of government as poses an initial difficulty that will have to be resolved.

### Plans and Priorities for National Health Development

5. The Ministry of Public Health has decided to change its central focus, which had been the administration of its own services, which cover the population with the lowest incomes, (around 25% of the total). The new focus is health promotion and coordination and monitoring of all private and public services (including monitoring of the quality of care). The Ministry's own services constitute the sphere of operations of the Government Health Services Administration (ASSE), a ministerial agency within which attempts are being made to conduct an effective decentralization process, as well as to make managerial changes aimed at participatory administration of the services.

6. Around two thirds of the population obtains services from the collective medical care institutions, which comprise both mutual and cooperative health care providers. Around 10% of the population is covered by government services under other ministries (military and police health services, for example).

7. The complementary system of public and private services generated under the framework of decentralizations is currently hindered by a highly discordant climate, which has prevailed for the past two years. The explicit desire to restructure services in order to ensure greater continuity of care was originally realized through the implementation of a family physicians programs (in the public subsector only). This program has been expanded in recent years, but its coordination with the traditional establishments is insufficient.

8. The restructuring of services entails modifying the quantity and quality of the uneven supply of human resources, which is why these resources have become a crucial issue in health policy, both in terms of their number and structure and in terms of systems of work and payments. The priority health problems have been identified--including those that have emerged as part of the new epidemiological situation--so that they can become favored courses of action for social communication and for the public and private health services.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

9. The government has expressed its intention to improve Uruguay's economy, within a framework of social justice, through: government reforms and open markets. To that end, it has concentrated external cooperation on three basic areas; (a) the promotion of investments and retrofitting of the manufacturing sector; (b) the reform of the government and the modernization of its management and (c) the formulation and implementation of social policies. In all of these fields, efforts to establish new external ties are to take place initially in the context of MERCOSUR.

10. For government reforms and the formulation and implementation of social policies, funds are available from agencies of the United Nations system--the OAS, IDB, and the World Bank--as well as through bilateral loans (Spain and Italy, for example).

National priorities for technical cooperation from PAHO/WHO

11. In accordance with the strategic guidelines, technical cooperation is basically aimed at accompanying and facilitating the reorganization of the sector and the consolidation of intersectoral coordination, both of which have been undertaken as a result of awareness of the country's epidemiological situation--awareness which arose when the current government came to power. The decision to be part of a process of subregional integration (MERCOSUR) has reinforced both actions. The program priorities of the Organization coincide with the courses of action chosen by the authorities in the form of national priority programs. In the area of environmental health, a recent restructuring has elevated the environmental health unit of the Ministry of Public Health to the category of a Bureau, under the auspices of the General Bureau of Health, and has assigned it the explicit duty of coordinating its actions with the Ministry of Housing, Territorial Planning, and Environment and with the departmental governments. In the formulation of programs, special consideration has been given to health promotion, the utilization of social communication, and the mobilization of resources, as well as to focusing actions on high-risk groups. With regard to health services, decentralization, the development of local health systems, and coordination/integration with Social Security remain in force as governmental objectives which require continued technical cooperation. The status of human resources for health has become a prime focus of the University and the Ministry of Public Health. During the biennium, efforts will be made to take the final steps to free the country of rabies and leprosy and to interrupt transmission of Chagas' disease, as well to intensify the activities of coordination among sectors, with a view to the reduction/elimination of hydatid disease.

12. HIV project activities supported by WHO funds will endeavor to design and coordinate actions to reduce the impact of the AIDS epidemic on society.

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Control of environmental health hazards (CEH)

13. The purpose of this project is to enhance environmental control, especially with regard to risks caused by human activity. The activities necessary for achieving this objective include support for agencies of the MPH, MVOTyMA, the Ministry of Labor and Social Security (MTSS), State Sanitation Works (OSE), and for the municipal governments, with a view to the design and establishment of systems for water quality control, the transport of toxic substances, and risk management in the workplace.

Health services development (DHS)

14. The purpose of this project is to promote modernization of the health services and their adaptation to the epidemiological profile. In order to achieve this objective, the following will be necessary: support for the consolidation of ministerial restructuring at the central level and for gradual decentralization, through the establishment of local health systems; more extensive cooperation among the public and private subsectors; and closer monitoring of the quality of care.

Foot-and-mouth disease (FMD)

15. The purpose of this project is the eradication of foot-and-mouth disease. In order to achieve this objective, it will be necessary to strengthen epidemiological surveillance and broaden vaccination coverage.

Scientific and technical information dissemination (HBD)

16. The purpose of this project is to facilitate access to information and to modernize techniques for its management. In order to achieve this objective, it will be necessary to continue development of the Documentation and Information Center and to furnish advisory services on scientific and technical information management.

Human resources education (HRE)

17. The purpose of this project is to enhance the training of human resources for health. In order to achieve this objective, it will be necessary to support the effective establishment of greater coordination between MPH and the University in the formulation and implementation of policies on human resources education for health.

Growth, development and human reproduction (MCH)

18. The purpose of this project is to improve the health of mothers, children, and adolescents. In order to achieve this objective, it will be necessary to consolidate the actions geared toward enhancing prenatal and perinatal care, as well as toward the health education of the adolescent, and to strengthen prevention and control of domestic violence and child abuse.

Managerial support for national health development (MPN)

19. The purpose of this project is to expand the area of cooperation to the institutions that share responsibility for the health of the population, to promote the greatest possible degree of coordination among them, and to accentuate the technical aspects of cooperation, as well as its role in the PAHO Strategic Orientations and Program Priorities. The changes begun in 1990 should be intensified and consolidated during the 94-95 biennium.

Health promotion and prevention and control of noncommunicable diseases (NCD)

20. The purpose of this project is to promote the control of pathologies relevant to the national epidemiological profile. In order to achieve this objective, it will be necessary to maintain ongoing development of health promotion through the mass media and to support the consolidation and growth of the coverage of programs for the prevention and control of chronic degenerative diseases, tumors, and accidents.

URUGUAY (Cont.)

Technical cooperation among countries (TCC)

21. The purpose of this project will be to pave the way for effective relations among countries for the improvement of health. In order to achieve this objective, it will be necessary to participate in regional and subregional events and in border meetings and to support actions to make intercountry coordination a reality (especially at the subregional level).

Zoonoses (ZNS)

22. The purpose of this project is to promote the greatest possible efficacy in the control of zoonoses through interinstitutional coordination. In order to achieve this objective, it will be necessary to consolidate national programs and enhance the coordination among MPH, MGAP, and local governments.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 861,900 | 67.2 | 978,100 | 67.1 | 1,087,800 | 67.6 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 463,800 | 36.2 | 623,000 | 42.8 | 693,000 | 43.0 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 463,800 | 36.2 | 623,000 | 42.8 | 693,000 | 43.0 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 43,700 | 3.4 | 49,600 | 3.4 | 56,200 | 3.5 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 43,700 | 3.4 | 49,600 | 3.4 | 56,200 | 3.5 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 212,900 | 16.6 | 129,500 | 8.9 | 141,400 | 8.8 |
| HEALTH SERVICES DEVELOPMENT | DHS | 212,900 | 16.6 | 129,500 | 8.9 | 141,400 | 8.8 |
| HUMAN RESOURCES DEVELOPMENT | | 83,500 | 6.5 | 70,400 | 4.8 | 76,500 | 4.8 |
| HUMAN RESOURCES EDUCATION | HRE | 83,500 | 6.5 | 70,400 | 4.8 | 76,500 | 4.8 |
| HEALTH INFORMATION SUPPORT | | 58,000 | 4.5 | 105,600 | 7.2 | 120,700 | 7.5 |
| SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION | HBD | 58,000 | 4.5 | 105,600 | 7.2 | 120,700 | 7.5 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 419,800 | 32.8 | 479,900 | 32.9 | 521,700 | 32.4 |
| ENVIRONMENTAL HEALTH | | 60,000 | 4.7 | 30,500 | 2.1 | 32,900 | 2.0 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 60,000 | 4.7 | 0 | - | 0 | - |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 0 | - | 30,500 | 2.1 | 32,900 | 2.0 |
| MATERNAL AND CHILD HEALTH | | 0 | - | 52,100 | 3.6 | 57,900 | 3.6 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 0 | - | 52,100 | 3.6 | 57,900 | 3.6 |
| HEALTH PROMOTION | | 359,800 | 28.1 | 397,300 | 27.2 | 430,900 | 26.8 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 359,800 | 28.1 | 397,300 | 27.2 | 430,900 | 26.8 |
| GRAND TOTAL | | 1,281,700 | 100.0 | 1,458,000 | 100.0 | 1,609,500 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| III. HEALTH SCIENCE AND TECHNOLOGY | | 475,900 | 100.0 | 904,400 | 100.0 | 0 | |
| MATERNAL AND CHILD HEALTH | | 37,500 | 7.9 | 0 | - | 0 | |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 37,500 | 7.9 | 0 | - | 0 | |
| COMMUNICABLE DISEASES | | 438,400 | 92.1 | 904,400 | 100.0 | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 438,400 | 92.1 | 904,400 | 100.0 | 0 | - |
| GRAND TOTAL | | 475,900 | 100.0 | 904,400 | 100.0 | 0 | |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 1,151,500 | 2 | 2 | 490 | 648,400 | 11,600 | 31 | 62,000 | 94,400 | 41,300 | 0 | 293,800 |
| WHO - WR | 130,200 | 0 | 0 | 210 | 56,000 | 2,700 | 9 | 18,000 | 6,500 | 5,200 | 0 | 41,800 |
| TOTAL | 1,281,700 | 2 | 2 | 700 | 704,400 | 14,300 | 40 | 80,000 | 100,900 | 46,500 | 0 | 335,600 |
| % OF TOTAL | 100.0 | | | | 55.0 | 1.1 | | 6.2 | 7.9 | 3.6 | .0 | 26.2 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 1,346,200 | 2 | 3 | 120 | 677,800 | 13,200 | 18 | 36,000 | 111,200 | 55,600 | 0 | 452,400 |
| WHO - WR | 111,800 | 0 | 0 | 180 | 50,100 | 0 | 8 | 16,000 | 11,400 | 7,900 | 0 | 26,400 |
| TOTAL | 1,458,000 | 2 | 3 | 300 | 727,900 | 13,200 | 26 | 52,000 | 122,600 | 63,500 | 0 | 478,800 |
| % OF TOTAL | 100.0 | | | | 49.9 | .9 | | 3.6 | 8.4 | 4.4 | .0 | 32.8 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 1,491,600 | 2 | 3 | 120 | 738,400 | 15,000 | 18 | 36,000 | 126,100 | 63,100 | 0 | 513,000 |
| WHO - WR | 117,900 | 0 | 0 | 180 | 50,100 | 0 | 8 | 16,000 | 12,900 | 9,000 | 0 | 29,900 |
| TOTAL | 1,609,500 | 2 | 3 | 300 | 788,500 | 15,000 | 26 | 52,000 | 139,000 | 72,100 | 0 | 542,900 |
| % OF TOTAL | 100.0 | | | | 49.1 | .9 | | 3.2 | 8.6 | 4.5 | .0 | 33.7 |

## HEALTH SITUATION ANALYSIS

### Demography

1. In accordance with the census Venezuela had a population of 19,352,222 inhabitants as of 30 June 1990. The official projections are that the country had 20,200,000 inhabitants on 30 June 1992 and will have 21,644,000 by 30 June 1995, with a gross rate of growth of 2.7% a year. The population groups over age 65 are increasing gradually, but Venezuela is still a young country, as 37% of the population is 0-14 years of age, with 47% between 0 and 24. The process of aging of the population should accelerate in the 1990s.

### Health status indicators

2. Life expectancy at birth is very close to 70 years, which represents a major increase over the 59.5 years in 1960. Life expectancy at birth was 67 years for males and 73.3 for females in 1990.

3. The leading causes of death are heart disease, cancer, and accidents. Only 2 of the 10 leading causes are infectious diseases, pneumonia, enteritis, and diarrhea.

4. The study of the health situation according to living conditions has demonstrated that there is a correlation between the percentage of unmet basic needs and the birth rate, general mortality, and infant mortality due to diarrhea, tuberculosis, obstetric causes, communicable diseases, diseases preventable by vaccination, including neonatal tetanus, and death from unknown causes, which means that the vulnerable populations in Venezuela are the rural communities and the marginalized urban populations.

5. The infant mortality rate is four times higher among the groups with worse living conditions than among those who live in better conditions. The social survey of 1992 revealed low coverage in prenatal care, as only 7.1% of pregnant women have four or more prenatal visits. In rural areas high percentages of deliveries continue to be handled by untrained personnel. Nationwide, the figure is approximately 10%, but among marginalized rural and indigenous groups it is much higher. Reported maternal mortality has remained at around 60 per 100,000 live births.

### Factors affecting health status

6. The policy applied by the Government has included among its most important measures the decontrol of prices, an open door to trade, the decontrol of interest rates, a floating dollar, promotion of foreign investment, the law promoting and protecting competition, the elimination of major pockets of corruption, the elimination of indirect subsidies, and the privatization of some national companies. This economic program has been quite successful, having increased international reserves, which are estimated at $12.8 billion. Inflation, which in 1989 was 84%, has come down gradually and was estimated in 1992 at 32%, one point higher than at the close of 1991. The nominal devaluation of the bolívar vis-a-vis the dollar was only 28.5% in 1992. However, non-oil exports, which were expected to be around $4,000 million in 1992, reached only $2,800 million. The World Bank indicates that 81% of Venezuelan families have incomes below US$ 250 a month, and of this percentage half survive on less than US$ 110. Illiteracy in the work force stood at 9%, and only 40% had finished primary school. The 1990 food intake, in caloric values, was 2,160 kcal/day, which is below the traditional availability of 2,500 kcal/day in the country.

7. The sharp differences in living conditions among distinct population groups, especially those in rural and marginalized urban areas, are causes of major health problems. The expansion of the exploration frontier in the regions bordering Brazil and Guyana will continue to be a major factor in the increasing incidence of malaria.

8. The budget of the Ministry of Health and Social Welfare (MSAS) for 1993 is 87,700 million bolívares (7.9% of the national budget). In 1992, investment in the MSAS, the Venezuelan Institute of Social Security, and other health-care providers was estimated at some 150 billion bolívares (around US$ 2,000 million); however, this budget is geared mainly toward curative care to the detriment of preventive medicine, which has a greater impact on the population's health status.

9. With regard to the environmental situation, in 1988, 89% of the population was covered with drinking water service, 70% of the rural population and 89% in the urban area. In 1990 the urban area declined to 87%, and the rural rose to 73%. In 1988 the coverage of sewage service was 92.39% of the population, 96.9% for the urban area and 70.09% for the rural area.

10. The restructuring of services that is being promoted as part of the process of decentralization should have a major impact on the quality of care, especially in the more highly developed states.

### Plans and priorities for national health development

11. The health sector encompasses more than 70 institutions. The Ministry of Health and Social Welfare is the only agency in the sector that engages in comprehensive activities for the entire population (promotion, prevention, recovery, and rehabilitation). It is estimated that the private sector covers approximately 10% of the population. In the public sector there are five institutions with a large population to serve; they are the Ministry of Health and Social Welfare, the Venezuelan Institute of Social Security (with 34% coverage), the Government of the Federal District, the Institute of Social Welfare of the Ministry of Education (IPASME), and the military health services.

12. The Document of Health Policies in Venezuela, prepared by the Ministry of Health, contains the following general policy lines for the sector: administrative decentralization with centralization of policy making; integration of all health subsectors into a single entity; development of programs of primary health care; reorganization of the health care sector; and emphasis on programs for promoting health and preventing problems.

13. The priorities established for action, which are based on the criteria of magnitude, risk, importance, and vulnerability, are: accidents; cancer; cardiovascular diseases; maternal and child health; diseases preventable by vaccination; basic sanitation, with emphasis on rural areas; food safety; control of diarrheal diseases; workers' health; monitoring of the quality of life; mental health; health of adolescents; promoting and restoring health in the elderly; and nutrition. All of these programs should be supported and complemented by programs of research, technological development, and human resources training.

14. The instrument for carrying out the health policy and plans of the State is the national health system, which has three levels: a central level, with political, policy-making, and supervisory functions; a regional level, with managerial, supervisory, coordinating, and control functions; and the district or local level, with programming, execution, evaluation, and control functions. As of 1989 a process of accrediting the health districts as local health systems was begun. The primary health care strategy through activities and programs is pursued in them.

15. The preparation of the health project has been another priority of the sector. It calls for investments of 246,000 million bolívares over the next five years (US$ 3,000 million approximately), to improve environmental sanitation, strengthen and modernize the health system, and implement a program to control endemic diseases.

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

### National priority areas for technical cooperation

16. Based on the document "Health Policies in Venezuela," and the Agreement between the Ministry of Agriculture and Livestock and PAHO, as well as an analysis of its resources, the Government has requested technical cooperation in the following priority fields: support for the process of decentralization and transfer of responsibilities to the municipalities and for the process of integration into the national health system through the accreditation of the health districts as local health systems and the horizontal integration of programs; the development of excellent primary care that includes family medicine and medical-hospital treatment; health promotion as regards: cancer, cardiovascular diseases, other chronic diseases and accidents, and promotion and restoration of health in the elderly, with a view to bringing about changes in the environment, lifestyles, and behavior patterns, with full community participation (concentrating on the involvement of women), through mass education, the mass media, and the training of community volunteers in prevention, health promotion and restoration, and rehabilitation. In addition, support will be given to programs in maternal mortality, growth and development, family planning, children's health, diarrheal diseases, and adolescent health, with the focus on projects within the local health systems in the maternal and child area, prioritizing their execution on the basis of unmet basic needs. There will also be support for activities that help to increase the capacity to gauge and evaluate environmental health hazards, with an emphasis on drinking water and basic sanitation, in localities and municipalities that report unmet basic needs, as well as the development of health programs for workers in highly industrialized areas. In the area of food safety, support will be provided for integrated programs of food protection and the epidemiological surveillance of food-borne diseases, while promoting community participation at the local level, as will support for educating the population about consumption and food supplementation among vulnerable groups, through the development of the nutritional food surveillance system. Technical cooperation will also be channeled toward the establishment of a policy and strategy for human resources in health and promotion of teaching-service integration into development and the strengthening of the health districts; technological research and development through characterization at the local levels of institutions, organizations, experts, problems, and projects, for the purpose of initiating a process of technical cooperation between health districts and a process of convergence in the search for financing and/or technical cooperation; and the identification and control of local endemic problems by strengthening and utilizing the systems of epidemiological surveillance, with emphasis on the diseases preventable by vaccination addressed under the Expanded Program on Immunization (EPI), diarrheal diseases, acute respiratory infections, cholera, dengue, malaria, yellow fever, sexually transmitted diseases, AIDS, leprosy, leishmaniasis, cholera, the use of tobacco, drug abuse, oral health, and zoonoses, in an effort to promote the primary health care strategy for solving these problems at the local level. Finally, support will be provided to promote the establishment and operation of the system for monitoring health status according to living conditions at the national level and in certain states, with a view to guiding the development of the major lines of health policy in the country and the states, within the framework of the decentralization process; for the program on essential drugs to promote their rational use; for the program for the eradication of foot-and-mouth disease and bovine tuberculosis and for the intersectoral control of other zoonoses; and for technical cooperation among countries, with emphasis on bordering countries and with a view towards integration among Andean countries and with the Caribbean.

17. The Government has additional, external resources to achieve the established goals. The Inter-American Development Bank (IDB) has several projects that in some way impact on health: a $32.1 million project with the Ministry of the Environment to protect and conserve water sources, with a component of potable water quality; another $84 million project with the Social Investment Fund for technical support to municipalities for local water systems; and another with the Ministry of the Environment for the clean-up of Lake Valencia. A very large $600 million agricultural project ($300 million from the IDB and $300 million from the World Bank) has a large animal-health component ($13.6 million). The World Bank also approved a $100 million project for children's health through the Ministries of the Family, Health, and Education.

18. The Ministry of the Environment has scheduled the execution of the project to clean up the Central Coast, which has US$ 51.4 million in financing from the Inter-American Development Bank. Among its components is the provision of sewage and piping systems for the collection and natural treatment of wastewater from the population.

19. As for projects directly related to the health sector, the Ministry of Health and Social Welfare has proposed the implementation of these projects: endemic disease control, modernization and strengthening of the health sector, and modernization of hospitals. The first will have US$ 94 million in financing from the World Bank. Among its components are activities of epidemiological and entomological surveillance, vector-borne disease prevention, health education, and water treatment, as well as institutional strengthening through personnel training, development of information systems, and construction of new bases of operations. The project to modernize and strengthen the health sector will have US$ 150 million in financing from the Inter-American Development Bank. This project has a component for institutional strengthening through the improvement of physical infrastructure, equipment, and the capacity of the services network in the district and local systems of the country, in addition to the institutional strengthening of the Ministry of Health and Social Welfare. Finally, the project for hospital modernization, financed by the World Bank in the amount of US$ 80 million, calls for the institutional strengthening of the sector in the areas of management, organization, and finances and is also designed to rehabilitate physical plant and to supply high priority equipment.

20. During the next biennium (1994-1995), the PAHO/WHO Representative Office will manage extrabudgetary resources for the Projects VEN/FMD/011 "Control of Foot-and-mouth Disease and Paralytic Rabies," which is being financed with funds from the Ministry of Agriculture and Livestock of Venezuela.

21. In addition, continued financing is expected for the VEN/HIV Projects to Prevent and Control AIDS, which have been successfully carried out in the country, and the donors have pledged to continue supporting the Program to Combat AIDS of Venezuela's Ministry of Health and Social Welfare.

22. Moreover, extrabudgetary funds will continue to be raised to support the national cholera and EPI programs, which have had the backing of the IDB and the Government of the Netherlands.

National priorities for technical cooperation from PAHO/WHO

23. The process of decentralization and municipalization in health care and the process of integration into the national health system will be the principal objective of PAHO/WHO technical cooperation, through the operational tactic of the local health systems and the utilization of the primary health care strategy. The strengthening of the local health systems (at the municipal level) through their accreditation and the establishment within them of integrated systems of information that will permit decision-making at the local level and the execution of programs in an integrated manner.

24. Support for the preparation of policies, plans, and standards for the purpose of identifying avoidable inequities, such as sex discrimination, hazards to workers' health, etc. Utilization of alternate technologies and unmet basic needs as planning tools at the local level, the participation of the primary schools and the community, the rational use of essential drugs, as well as intersectoral cooperation, and the coordination thereof in the execution of programs.

25. Mobilization of resources, primarily national experts, identified through the resolution of problems so that such solutions can shared by other local health systems; enlightment of support for a project of convergence in health and social development, the latter through basic sanitation projects, interventions geared toward food production, and other forms of microbusiness.

26. The training of human resources for decision-making, through the preparation of projects in health and social development, and in the management of local health systems, as well as health education and mass communication directed towards community participation in the solution of local problems.

27. A research strategy, in order to correlate living conditions with the high risks faced by groups in connection with the different local problems; the development of new proposals to enhance response capacity, the integrated utilization of the different sources of epidemiological information to define high-risk groups, factors of intervention, and the use of essential drugs; the relationship between the distribution of diseases and their vectors, with a view towards gauging the effectiveness of interventions.

28. The dissemination of information in health promotion, in the development of outpatient care and family medicine, in the rational use of essential drugs, and in legislation concerning health.

29. Technical cooperation among countries directed toward the establishment of common health policies, the mobilization of resources toward the solution of common problems; coordination of training between countries for the purpose of sharing experiences, research for the development and establishment of these common policies, at the level of Andean Cooperation in Health (ACH), with bordering countries, and with the countries of the Caribbean region.

30. In addition to providing regular resources, PAHO/WHO will participate actively in the World Bank project for the control of endemic diseases and will continue to manage funding that arrives from other sources for AIDS control, the EPI, and foot-and-mouth disease.

## PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Control of environmental health hazards (CEH)

31. The purpose of this project is to improve the quality of life, as well as to pursue activities that will help to enhance the ability to gauge and evaluate environmental health hazards. To this end, support will be provided to promote the development of policies, plans, and standards that will make it possible to improve the drinking water supply and basic sanitation both quantitatively and

qualitatively and to promote the inclusion of appropriate, low-cost technology into national design standards so as to deliver services to scattered rural areas and to marginalized urban areas. The computer system of the autonomous rural housing service (housing, water supply systems, and sewerage) will be strengthened for the purpose of implementing programs aimed at the communities reported in the study on unmet basic needs. Direct technical cooperation will be provided to the public and private organizations that require it to enhance the health of the population, with a major emphasis on communities, in which the local health systems operate.

Health services development (DHS)

32. The purpose is to develop methodologies that will make possible a decentralized model that will provide timely, high-quality, and compassionate health care. The intention is to develop policies, plans, and standards under the project "Operations Research," which has three facets (extension, expansion, and consolidation) and consists of five lines (knowledge, supply, maintenance, strengthening, and management, and operational methodologies) and four phases (motivation, implementation, monitoring, and evaluation). The project is expected to promote the development of excellent outpatient care by disseminating information on family medicine and hospital treatment, as well as hospital accreditation. Efforts will be made to promote the mobilization of resources within the ACH, particularly in the area of infrastructure, through the development of an appropriate methodology.

Essential drugs and vaccines (EDV)

33. The purpose of this project is to disseminate the concept of essential drugs by promoting the rational use of high-quality, effective, and safe drugs that are accessible to the entire population by prescription, are dispensed correctly, and are in adequate supply. To this end, it will be necessary to provide more of an incentive at decision-making levels in government to define effective policies, plans, and standards concerning drugs; to promote the concept and the rational use of essential drugs, both on the part of prescribers and dispensers and of users, through different systems of information dissemination; and to improve the supply systems at the institutional level and within local health systems, through curriculum reforms in the various schools of pharmacy.

Health policy analysis and development (HDP)

34. The purpose of the project is to contribute to the process of decentralization and transfer of responsibilities in health and social development to state governments and municipalities and to the consolidation of the national health system. The lines of action focus on the development of standards, plans, and policies for the decentralization of health care toward state governments and municipalities and the consolidation of the national health system, as well as the dissemination of information for the preparation of health legislation and regulations in the Ministry of Health, the congress of the republic, legislative assemblies, and municipal councils.

Human resources education (HRE)

35. The aim is to disseminate information in order to improve what is done at the local level and to incorporate new methods into these activities. The intention is to establish policies and strategies for human resources training in the area of health education, in the health sector, in the education sector at the level of primary schools, and in communities; to train primary-school teachers, health workers, and community volunteers in health education and community participation; to promote the development of grass-roots health projects; to participate in the formulation and execution of policies and strategies for human resources development in the area of the communication and health; to educate, train, and guide communities in health care and the use of instruments that will enable them in turn to promote and create forms and strategies for their own advancement; to establish policies and strategies for the development of human resources for health; to train middle managers in administrative aspects of local health systems; to mobilize resources in teaching-service integration, particularly in those aspects that will develop and strengthen the health district; and to disseminate information in order to promote the exchange and generation of new knowledge, particularly with regard to methodology.

Health situation and trend assessment (HST)

36. The purpose of this project is to support the entire process of epidemiology development at the national, regional, and local levels. To this end, the intention is to carry out integrated activities of technical cooperation, encompassing all operational approaches, developing new policies, establishing standards, training personnel at the central, regional, and local levels, pursuing research, disseminating information, mobilizing resources, and providing direct technical cooperation; to step up the development of both long- and short-term training programs, and to hold motivation events with chiefs of districts, regional directors, and decision-making personnel of the Ministry of Health and Social Welfare in order to ensure that it truly serves as the regulatory agency of the sector as provided in the organic law of the national health system; to train personnel and to promote and lend direct technical cooperation in the process of boosting and improving the level of epidemiological research, especially in the services.

Growth, development and human reproduction (MCH)

37. The purpose is to support the pursuit of actions in maternal and child care on the basis of an approach that is integrated into the process of human growth and development. Efforts will be made to provide: technical cooperation and training for the establishment and utilization of the perinatal information system in the local health systems; support for the preparation of standards,

policies, and plans relating to the health of schoolchildren and adolescents for the purpose of decentralizing the programs and integrating them into the local health systems; training in the programs to control diarrheal and acute respiratory diseases with the participation of the communities and with a full presence at all levels of care within the local health systems.

Managerial support for national health development (MPN)

38. This project is aimed at providing managerial, technical and administrative support for the delivery of technical cooperation in Venezuela, the Netherlands Antilles, and Aruba. To this end, the intention is to formulate standards, plans, and policies in conjunction with the national authorities concerning the process and impact of technical cooperation on the expected outcomes; to mobilize national and international resources in support of technical cooperation in the country and among countries, with emphasis on the Andean Region and on the plan for investment in the environment and health; to develop the PAHO/WHO Representative Office, through an ongoing, prioritized program of training based on the results of the ongoing evaluation of personnel and of the impact of technical cooperation, with a view to achieving technical excellence; and to strengthen the Documentation Center of the PAHO/WHO Representative Office.

Health promotion and prevention and control of noncommunicable diseases (NCD)

39. The purpose of this project is to protect the health of adults and the elderly by inducing changes in the environment, in lifestyles, and in patterns of behavior that will promote optimum levels of health, while involving more and more social sectors in decision-making. In order to achieve this goal, the intention is to mobilize resources from different governmental and nongovernmental sectors, for the purpose of uniting efforts and coordinating action, this being one of the most specific lines of action under this project; to train personnel by strengthening not only academic programs but also the training of personnel within the services at the local levels; to disseminate information through the preparation and dissemination of educational material aimed at changes in behavior that are necessary to prevent disease; to cooperate in the design, execution, and evaluation of the programs, support for the promotion and development of policies and other specific aspects of the implementation of the projects; to develop policies, plans, and programs that will allow for the adoption of measures and strategies aimed at health promotion and the prevention of noncommunicable diseases.

Nutrition (NUT)

40. The intention is to support the development of the Food and Nutrition Surveillance System (FNSS), with emphasis on the regional and local level. In order to achieve the stated goal, there will be support for the development of policies, plans, and standards to promote the use of the FNSS as a tool for characterizing the nutritional situation and managing nutritional intervention measures at the central, regional, and local levels; the training of personnel in the analysis and use of information from the FNSS at the local level and in the incorporation of the nutrition component in local health systems, giving priority to those that have unmet basic needs; the promotion of epidemiological research on malnutrition in high-risk states and groups and cooperation in establishing and evaluating a control program; and cooperation in order to incorporate a project for education in food and nutrition into the mass health education program in schools.

General communicable disease prevention and control activities (OCD)

41. The stated purpose of this project is to train human resources and to support research projects that can contribute to the design, planning, execution, and evaluation of communicable disease control activities. An attempt will be made to mobilize human and financial resources for the training of personnel at the technical and upper level in epidemiology and entomology, in support of the programs of control. Special attention will be paid to the evaluation of the programs to control malaria, Chagas' disease, schistosomiasis, leprosy, and leishmaniasis and the program to control Aedes aegypti, in connection with the evaluation of coverage, the strategies adopted, impact, and alternative procedures for prevention, diagnosis, treatment, and control. Support will be offered to research groups in the ongoing process of human resources training, the study of the distribution of diseases and vectors, the evaluation of the efficiency of the programs at the population level, as well as the development of alternative methods of intervention. Emphasis will be placed on the process of automating control programs and on the integrated control of vectors, with a view to optimizing the gathering and analysis of available information. Managerial training will be promoted at the various levels, and support for research on health systems will be emphasized in connection with the development of the national plans to eliminate leprosy as a public health problem.

Oral health (ORH)

42. The purpose is to attune the scientific, technical, and social response of dentistry to the socioepidemiological needs of the population. In order to achieve this goal, there will be support for research and technology to generate and apply knowledge in order to help strengthen the capacity of dentistry to resolve the prevalent oral problems of the population; the strengthening and development of the health districts by incorporating the oral-health component in accordance with the theoretical-methodological and technical-administrative guidelines; and intersectoral action for the mobilization of national resources, both of dentistry and of the health sector and other sectors, in order to bring the scientific, technical and social response of dentistry into accord with the needs of the population.

Technical cooperation among countries (TCC)

43. The purpose of the project is to promote TCC for the exchange of experiences and to help improve the health conditions of the population. There will be support for the promotion of research and the development of standards,

policies, and plans with a view to establishing common health policies in the border regions, the mobilization of resources aimed at the solution of common problems between countries, and the staging of shared training events between countries.

Women, health and development (WHD)

44. The purpose of the project is to foster a strategy of multisectoral development that will permit the implementation of actions geared to the development and advancement of women at local levels. In order to implement this project, the intention is to develop policies, plans, and standards that will further the situation of women within the community, by eliminating forms of sex discrimination, through training and the dissemination of information in this area, and by supporting research that will make it possible to identify and deliver more effective responses to the needs of women.

Zoonoses (ZNS)

45. The intention is to support the consolidated elimination of urban rabies, the control of other zoonoses, and the development of integrated food-protection programs. The project will devote its resources to the development of policies, plans, and standards to promote greater participation by governmental and nongovernmental sectors at the national, regional, and local levels in order to obtain political support and achieve the consolidation of the elimination of urban rabies and implement integrated food protection programs; direct technical cooperation in order to implement a system of epidemiological surveillance of the major zoonoses utilizing the system of cartographic quadrants; promotion of training courses on Principles of Epidemiology and Hazard Analysis Critical Control Point Evaluations (HACCP); and the promotion of information dissemination in the area of zoonoses and food protection.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 2,811,100 | 80.6 | 2,882,900 | 73.2 | 3,210,300 | 73.2 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 796,900 | 22.9 | 1,022,500 | 26.1 | 1,151,600 | 26.3 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 796,900 | 22.9 | 1,022,500 | 26.1 | 1,151,600 | 26.3 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 97,300 | 2.8 | 122,300 | 3.1 | 138,700 | 3.2 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 97,300 | 2.8 | 122,300 | 3.1 | 138,700 | 3.2 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 442,000 | 12.7 | 417,600 | 10.6 | 459,900 | 10.5 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 442,000 | 12.7 | 417,600 | 10.6 | 459,900 | 10.5 |
| HEALTH POLICY DEVELOPMENT | | 0 | - | 89,800 | 2.3 | 101,800 | 2.3 |
| HEALTH POLICY ANALYSIS AND DEVELOPMENT | HDP | 0 | - | 54,300 | 1.4 | 61,600 | 1.4 |
| WOMEN, HEALTH AND DEVELOPMENT | WHD | 0 | - | 35,500 | .9 | 40,200 | .9 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 915,200 | 26.1 | 713,500 | 18.0 | 790,800 | 18.0 |
| HEALTH SERVICES DEVELOPMENT | DHS | 841,500 | 24.0 | 541,200 | 13.7 | 597,700 | 13.6 |
| ESSENTIAL DRUGS AND VACCINES | EDV | 0 | - | 96,200 | 2.4 | 108,700 | 2.5 |
| ORAL HEALTH | ORH | 73,700 | 2.1 | 76,100 | 1.9 | 84,400 | 1.9 |
| HUMAN RESOURCES DEVELOPMENT | | 479,900 | 13.8 | 517,200 | 13.1 | 567,500 | 12.9 |
| HUMAN RESOURCES EDUCATION | HRE | 479,900 | 13.8 | 517,200 | 13.1 | 567,500 | 12.9 |
| RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT | | 79,800 | 2.3 | 0 | - | 0 | - |
| RESEARCH PROMOTION AND DEVELOPMENT | RPD | 79,800 | 2.3 | 0 | - | 0 | - |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| III. HEALTH SCIENCE AND TECHNOLOGY | | 675,000 | 19.4 | 1,061,200 | 26.8 | 1,182,200 | 26.8 |
| FOOD AND NUTRITION | | 69,400 | 2.0 | 91,700 | 2.3 | 104,000 | 2.4 |
| NUTRITION | NUT | 69,400 | 2.0 | 91,700 | 2.3 | 104,000 | 2.4 |
| ENVIRONMENTAL HEALTH | | 157,800 | 4.5 | 170,400 | 4.3 | 189,500 | 4.3 |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 157,800 | 4.5 | 170,400 | 4.3 | 189,500 | 4.3 |
| MATERNAL AND CHILD HEALTH | | 169,100 | 4.9 | 179,200 | 4.5 | 198,300 | 4.5 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 169,100 | 4.9 | 179,200 | 4.5 | 198,300 | 4.5 |
| COMMUNICABLE DISEASES | | 0 | - | 202,200 | 5.1 | 229,300 | 5.2 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 0 | - | 202,200 | 5.1 | 229,300 | 5.2 |
| HEALTH PROMOTION | | 0 | - | 123,500 | 3.1 | 138,300 | 3.1 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 0 | - | 123,500 | 3.1 | 138,300 | 3.1 |
| VETERINARY PUBLIC HEALTH | | 278,700 | 8.0 | 294,200 | 7.5 | 322,800 | 7.3 |
| ZOONOSES | ZNS | 278,700 | 8.0 | 294,200 | 7.5 | 322,800 | 7.3 |
| GRAND TOTAL | | 3,486,100 | 100.0 | 3,944,100 | 100.0 | 4,392,500 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 111,400 | 16.5 | 0 | - | 0 | |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 111,400 | 16.5 | 0 | - | 0 | |
| ESSENTIAL DRUGS AND VACCINES | EDV | 111,400 | 16.5 | 0 | - | 0 | |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 561,800 | 83.5 | 449,900 | 100.0 | 0 | - |
| MATERNAL AND CHILD HEALTH | | 67,800 | 10.1 | 0 | - | 0 | - |
| DIARRHEAL DISEASES | CDD | 67,800 | 10.1 | 0 | - | 0 | - |
| COMMUNICABLE DISEASES | | 254,900 | 37.9 | 449,900 | 100.0 | 0 | - |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 254,900 | 37.9 | 449,900 | 100.0 | 0 | - |
| VETERINARY PUBLIC HEALTH | | 239,100 | 35.5 | 0 | - | 0 | - |
| FOOT-AND-MOUTH DISEASE | FMD | 239,100 | 35.5 | 0 | - | 0 | - |
| GRAND TOTAL | | 673,200 | 100.0 | 449,900 | 100.0 | 0 | |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 2,308,800 | 2 | 7 | 330 | 833,100 | 89,600 | 68 | 136,000 | 377,700 | 133,100 | 15,800 | 723,500 |
| WHO - WR | 1,177,300 | 3 | 3 | 340 | 758,800 | 42,700 | 42 | 84,000 | 122,500 | 77,900 | 0 | 91,400 |
| TOTAL | 3,486,100 | 5 | 10 | 670 | 1,591,900 | 132,300 | 110 | 220,000 | 500,200 | 211,000 | 15,800 | 814,900 |
| % OF TOTAL | 100.0 | | | | 45.6 | 3.8 | | 6.3 | 14.3 | 6.1 | .5 | 23.4 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 2,685,700 | 2 | 9 | 270 | 1,015,300 | 129,300 | 49 | 98,000 | 371,700 | 200,700 | 15,400 | 855,300 |
| WHO - WR | 1,258,400 | 3 | 3 | 85 | 772,000 | 33,800 | 23 | 46,000 | 137,800 | 91,700 | 0 | 177,100 |
| TOTAL | 3,944,100 | 5 | 12 | 355 | 1,787,300 | 163,100 | 72 | 144,000 | 509,500 | 292,400 | 15,400 | 1,032,400 |
| % OF TOTAL | 100.0 | | | | 45.3 | 4.1 | | 3.7 | 12.9 | 7.4 | .4 | 26.2 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 3,005,300 | 2 | 9 | 270 | 1,124,300 | 146,600 | 49 | 98,000 | 421,400 | 227,700 | 17,500 | 969,800 |
| WHO - WR | 1,387,200 | 3 | 3 | 85 | 841,800 | 38,300 | 23 | 46,000 | 156,400 | 103,900 | 0 | 200,800 |
| TOTAL | 4,392,500 | 5 | 12 | 355 | 1,966,100 | 184,900 | 72 | 144,000 | 577,800 | 331,600 | 17,500 | 1,170,600 |
| % OF TOTAL | 100.0 | | | | 44.8 | 4.2 | | 3.3 | 13.2 | 7.5 | .4 | 26.6 |

CARIBBEAN PROGRAM
COORDINATION (CPC)

CARIBBEAN PROGRAM
COORDINATION (CPC)

## GLOBAL STRATEGY FOR TECHNICAL COOPERATION

1. The technical cooperation strategy will emphasize the further development of the Office of Caribbean Program Coordination to enable it to carry out its functions of coordination of the use of PAHO/WHO resources assigned to the Caribbean and to provide direct support to the technical cooperation activities carried out in Barbados, the Eastern Caribbean, and the French Departments. Continued efforts will be undertaken to continue to promote efficiency and increase productivity.

2. Linkages with the CARICOM Secretariat and subregional institutions will continue to be strengthened, so as to facilitate the smooth functioning of the Caribbean Cooperation in Health (CCH) Initiative, as well as fostering technical cooperation activities among the Caribbean countries. Management of knowledge will continue to be emphasized. Appropriate research will be actively promoted. Databases on health and health conditions in the Caribbean will be established in the documentation center, which will be linked electronically to international databases.

3. PAHO/WHO will also continue to seek to create or optimize windows of opportunity through its cooperation with sectors other than health to ensure health and development issues are fully considered in the development process of the Caribbean. The formulation and adoption of healthy policies will be vigorously promoted, and the capacity for the consideration of gender issues as an integral part of development planning strengthened.

4. Staff development will be actively pursued and PAHO/WHO staff will be trained in project development and management so that more effective and efficient participation in resource mobilization and execution of projects is realized.

## PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Health policy analysis and development (HDP)

5. The purpose of the project is to improve the efficiency of the functioning of the Joint Secretariat of the CCH Initiative. The project will provide support to the CARICOM Secretariat for specific projects to enable the Secretariat to efficiently discharge its responsibilities as part of the Joint Secretariat of the CCH Initiative. PAHO/WHO will support and collaborate with CARICOM in the preparation and execution of the subregional plan for investment in health and the environment.

Managerial support for national health development (MPN)

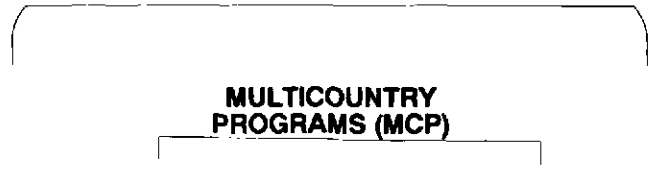
6. The purpose of the project is to provide managerial, technical and administrative support for the delivery of the technical cooperation as defined in the instruments of the AMPES; and coordinate the delivery of the subregional programs and programs of technical cooperation in the Eastern Caribbean and the French Departments. The Office of the Caribbean Program Coordinator will work closely with Caribbean institutions and political bodies in promoting health and developmental issues, including women in health and development. Close linkages will be established with the subregional mass media to be utilized for information dissemination on health issues and implementing the PAHO/WHO media award program. Training activities in related sectors will be implemented. There will be continued focus on the management of knowledge and the databases on health and health conditions in the Caribbean will be fully established. Development of the CPC Office will continue, with a particular focus upon development of automated management systems and staff development. The logical framework approach will be used as a way of thinking through projects and problems and appropriate software introduced for project management.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 1,755,700 | 100.0 | 1,974,000 | 100.0 | 2,206,900 | 100.0 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 1,707,900 | 97.3 | 1,919,800 | 97.3 | 2,145,400 | 97.2 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 1,707,900 | 97.3 | 1,919,800 | 97.3 | 2,145,400 | 97.2 |
| HEALTH POLICY DEVELOPMENT | | 47,800 | 2.7 | 54,200 | 2.7 | 61,500 | 2.8 |
| HEALTH POLICY ANALYSIS AND DEVELOPMENT | HDP | 47,800 | 2.7 | 54,200 | 2.7 | 61,500 | 2.8 |
| GRAND TOTAL | | 1,755,700 | 100.0 | 1,974,000 | 100.0 | 2,206,900 | 100.0 |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 901,400 | 2 | 6 | 0 | 772,700 | 34,800 | 0 | 0 | 3,900 | 34,800 | 47,800 | 7,400 |
| WHO - WR | 854,300 | 1 | 3 | 0 | 392,500 | 23,200 | 0 | 0 | 0 | 0 | 0 | 438,600 |
| TOTAL | 1,755,700 | 3 | 9 | 0 | 1,165,200 | 58,000 | 0 | 0 | 3,900 | 34,800 | 47,800 | 446,000 |
| % OF TOTAL | 100.0 | | | | 66.4 | 3.3 | | .0 | .2 | 2.0 | 2.7 | 25.4 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 938,100 | 2 | 5 | 0 | 792,300 | 39,500 | 0 | 0 | 4,400 | 39,500 | 54,200 | 8,200 |
| WHO - WR | 1,035,900 | 1 | 3 | 0 | 512,000 | 26,300 | 0 | 0 | 0 | 0 | 0 | 497,600 |
| TOTAL | 1,974,000 | 3 | 8 | 0 | 1,304,300 | 65,800 | 0 | 0 | 4,400 | 39,500 | 54,200 | 505,800 |
| % OF TOTAL | 100.0 | | | | 66.2 | 3.3 | | .0 | .2 | 2.0 | 2.7 | 25.6 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 1,039,300 | 2 | 5 | 0 | 873,900 | 44,800 | 0 | 0 | 5,000 | 44,800 | 61,500 | 9,300 |
| WHO - WR | 1,167,600 | 1 | 3 | 0 | 573,500 | 29,800 | 0 | 0 | 0 | 0 | 0 | 564,300 |
| TOTAL | 2,206,900 | 3 | 8 | 0 | 1,447,400 | 74,600 | 0 | 0 | 5,000 | 44,800 | 61,500 | 573,600 |
| % OF TOTAL | 100.0 | | | | 65.6 | 3.4 | | .0 | .2 | 2.0 | 2.8 | 26.0 |


MULTICOUNTRY
PROGRAMS (MCP)

MULTICOUNTRY
PROGRAMS (MCP)

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| I. DIRECTION, COORDINATION AND MANAGEMENT | | 1,501,600 | 5.6 | 1,493,600 | 5.0 | 1,611,700 | 5.0 |
| GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT | | 1,501,600 | 5.6 | 1,493,600 | 5.0 | 1,611,700 | 5.0 |
| GENERAL PROGRAM DEVELOPMENT | GPD | 1,306,000 | 4.9 | 1,284,300 | 4.3 | 1,389,600 | 4.3 |
| EXTERNAL COORD. FOR HEALTH AND SOCIAL DEVELOPMENT | COR | 195,600 | .7 | 209,300 | .7 | 222,100 | .7 |
| II. HEALTH SYSTEM INFRASTRUCTURE | | 14,000,900 | 52.5 | 16,642,800 | 55.4 | 17,813,900 | 55.3 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 227,500 | .9 | 1,449,300 | 4.8 | 1,526,700 | 4.8 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 0 | - | 1,212,400 | 4.0 | 1,273,900 | 4.0 |
| ADMINISTRATIVE ANALYSIS | AAN | 227,500 | .9 | 236,900 | .8 | 252,800 | .8 |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 273,900 | 1.0 | 296,400 | 1.0 | 320,800 | 1.0 |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 273,900 | 1.0 | 296,400 | 1.0 | 320,800 | 1.0 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 1,232,000 | 4.6 | 1,370,900 | 4.6 | 1,466,000 | 4.6 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 1,232,000 | 4.6 | 1,370,900 | 4.6 | 1,466,000 | 4.6 |
| HEALTH POLICY DEVELOPMENT | | 2,233,400 | 8.4 | 2,987,300 | 9.9 | 3,208,700 | 10.0 |
| HEALTH POLICY ANALYSIS AND DEVELOPMENT | HDP | 1,349,500 | 5.1 | 516,100 | 1.7 | 552,100 | 1.7 |
| HEALTH ECONOMICS AND FINANCING | HDE | 496,900 | 1.9 | 957,400 | 3.2 | 1,030,400 | 3.2 |
| HEALTH LEGISLATION | HLE | 193,300 | .7 | 545,300 | 1.8 | 580,100 | 1.8 |
| WOMEN, HEALTH AND DEVELOPMENT | WHD | 193,700 | .7 | 208,500 | .7 | 223,800 | .7 |
| PROMOTION OF BIOETHICS | HBE | 0 | - | 760,000 | 2.5 | 822,300 | 2.6 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 3,809,500 | 14.3 | 3,889,400 | 13.0 | 4,169,600 | 12.9 |
| HEALTH SERVICES DEVELOPMENT | DHS | 2,416,800 | 9.1 | 2,428,500 | 8.1 | 2,608,700 | 8.1 |
| ESSENTIAL DRUGS AND VACCINES | EDV | 197,600 | .7 | 203,800 | .7 | 216,100 | .7 |
| ORAL HEALTH | ORH | 296,500 | 1.1 | 317,400 | 1.1 | 342,000 | 1.1 |
| DISASTER PREPAREDNESS | DPP | 233,100 | .9 | 250,900 | .8 | 269,500 | .8 |
| CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY | CLR | 335,900 | 1.3 | 347,600 | 1.2 | 369,800 | 1.1 |
| HEALTH EDUCATION AND COMMUNITY PARTICIPATION | HED | 215,800 | .8 | 223,500 | .7 | 238,000 | .7 |
| REHABILITATION | RHB | 113,800 | .4 | 117,700 | .4 | 125,500 | .4 |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| HUMAN RESOURCES DEVELOPMENT | | 3,654,500 | 13.7 | 4,016,500 | 13.3 | 4,299,900 | 13.2 |
| HUMAN RESOURCES TRAINING | HRC | 2,240,300 | 8.4 | 2,504,900 | 8.2 | 2,677,800 | 8.1 |
| HUMAN RESOURCES PLANNING AND POLICY | HRP | 534,500 | 2.0 | 566,400 | 1.9 | 607,000 | 1.9 |
| HUMAN RESOURCES EDUCATION | HRE | 879,700 | 3.3 | 945,200 | 3.2 | 1,015,100 | 3.2 |
| RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT | | 2,570,100 | 9.6 | 2,633,000 | 8.8 | 2,822,200 | 8.8 |
| RESEARCH PROMOTION AND DEVELOPMENT | RPD | 2,143,300 | 8.0 | 2,174,900 | 7.3 | 2,334,100 | 7.3 |
| HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT | HDT | 264,000 | 1.0 | 283,200 | .9 | 301,500 | .9 |
| RESEARCH AND DEVELOPMENT IN THE FIELD OF VACCINES | RDV | 162,800 | .6 | 174,900 | .6 | 186,600 | .6 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 11,123,900 | 41.9 | 11,859,400 | 39.6 | 12,737,700 | 39.7 |
| FOOD AND NUTRITION | | 703,700 | 2.7 | 762,300 | 2.5 | 823,400 | 2.5 |
| FOOD | FOD | 121,000 | .5 | 127,300 | .4 | 136,700 | .4 |
| NUTRITION | NUT | 582,700 | 2.2 | 635,000 | 2.1 | 686,700 | 2.1 |
| ENVIRONMENTAL HEALTH | | 877,100 | 3.3 | 996,400 | 3.3 | 1,063,600 | 3.3 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 314,700 | 1.2 | 317,900 | 1.1 | 338,000 | 1.1 |
| SOLID WASTES AND HOUSING HYGIENE | RUD | 81,200 | .3 | 87,500 | .3 | 92,100 | .3 |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 282,600 | 1.1 | 373,400 | 1.2 | 401,000 | 1.2 |
| WORKERS' HEALTH | OCH | 198,600 | .7 | 217,600 | .7 | 232,500 | .7 |
| MATERNAL AND CHILD HEALTH | | 2,198,100 | 8.2 | 2,548,100 | 8.5 | 2,728,300 | 8.6 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 431,400 | 1.6 | 671,400 | 2.2 | 724,300 | 2.3 |
| ADOLESCENT HEALTH | ADH | 63,700 | .2 | 67,700 | .2 | 70,500 | .2 |
| ACUTE RESPIRATORY INFECTIONS | ARI | 184,600 | .7 | 198,100 | .7 | 211,300 | .7 |
| IMMUNIZATION | EPI | 797,600 | 3.0 | 837,200 | 2.8 | 897,800 | 2.8 |
| DIARRHEAL DISEASES | CDD | 720,800 | 2.7 | 773,700 | 2.6 | 824,400 | 2.6 |
| COMMUNICABLE DISEASES | | 4,216,900 | 16.0 | 4,687,900 | 15.6 | 5,036,200 | 15.6 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 174,700 | .7 | 181,000 | .6 | 193,500 | .6 |
| TROPICAL DISEASE RESEARCH | TDR | 44,400 | .2 | 255,000 | .9 | 274,200 | .9 |
| TUBERCULOSIS | TUB | 157,700 | .6 | 372,000 | 1.2 | 399,100 | 1.2 |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 271,300 | 1.0 | 282,600 | .9 | 299,900 | .9 |
| VECTOR-BORNE DISEASES | VBC | 2,540,900 | 9.7 | 2,281,000 | 7.6 | 2,457,400 | 7.6 |
| MALARIA | MAL | 615,100 | 2.3 | 886,000 | 3.0 | 951,900 | 3.0 |
| PARASITIC DISEASES | PDP | 90,300 | .3 | 96,700 | .3 | 102,500 | .3 |
| LEPROSY | LEP | 274,600 | 1.0 | 282,900 | .9 | 305,100 | .9 |
| SEXUALLY TRANSMITTED DISEASES | VDT | 47,900 | .2 | 50,700 | .2 | 52,600 | .2 |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| HEALTH PROMOTION | | 1,167,400 | 4.3 | 1,202,500 | 4.1 | 1,277,800 | 4.1 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 561,500 | 2.1 | 633,700 | 2.1 | 674,800 | 2.1 |
| TOBACCO OR HEALTH | TOH | 57,700 | .2 | 62,000 | .2 | 66,000 | .2 |
| PREV/TREAT. OF MENTAL AND NEUROLOGICAL DISORDERS | MND | 152,400 | .6 | 137,800 | .5 | 145,700 | .5 |
| ACCIDENT PREVENTION | APR | 50,300 | .2 | 53,800 | .2 | 56,900 | .2 |
| HEALTH OF THE ELDERLY | HEE | 164,500 | .6 | 149,800 | .5 | 158,500 | .5 |
| PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE | ADA | 117,300 | .4 | 107,500 | .4 | 114,500 | .4 |
| OCULAR HEALTH | PBD | 63,700 | .2 | 57,900 | .2 | 61,400 | .2 |
| VETERINARY PUBLIC HEALTH | | 1,960,700 | 7.4 | 1,662,200 | 5.6 | 1,808,400 | 5.6 |
| FOOD SAFETY | FOS | 161,100 | .6 | 165,400 | .6 | 173,700 | .5 |
| FOOT-AND-MOUTH DISEASE | FMD | 471,200 | 1.8 | 501,000 | 1.7 | 540,100 | 1.7 |
| ZOONOSES | ZNS | 1,328,400 | 5.0 | 995,800 | 3.3 | 1,094,600 | 3.4 |
| GRAND TOTAL | | 26,626,400 | 100.0 | 29,995,800 | 100.0 | 32,163,300 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| I. DIRECTION, COORDINATION AND MANAGEMENT | | 280,900 | .5 | 254,000 | .9 | 0 | - |
| GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT | | 280,900 | .5 | 254,000 | .9 | 0 | - |
| EXTERNAL COORD. FOR HEALTH AND SOCIAL DEVELOPMENT | COR | 280,900 | .5 | 254,000 | .9 | 0 | - |
| II. HEALTH SYSTEM INFRASTRUCTURE | | 16,770,100 | 32.5 | 6,244,200 | 22.4 | 260,000 | 6.0 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 399,800 | .8 | 0 | - | 0 | - |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 256,200 | .5 | 0 | - | 0 | - |
| ADMINISTRATIVE ANALYSIS | AAN | 143,600 | .3 | 0 | - | 0 | - |
| TECHNICAL COOPERATION AMONG COUNTRIES | | 1,563,100 | 3.0 | 113,000 | .4 | 0 | - |
| TECHNICAL COOPERATION AMONG COUNTRIES | TCC | 1,563,100 | 3.0 | 113,000 | .4 | 0 | - |
| HEALTH SITUATION AND TREND ASSESSMENT | | 5,000 | .* | 0 | - | 0 | - |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 5,000 | .* | 0 | - | 0 | - |
| HEALTH POLICY DEVELOPMENT | | 697,100 | 1.4 | 1,300,000 | 4.7 | 0 | - |
| HEALTH ECONOMICS AND FINANCING | HDE | 30,000 | .1 | 0 | - | 0 | - |
| WOMEN, HEALTH AND DEVELOPMENT | WHD | 667,100 | 1.3 | 1,300,000 | 4.7 | 0 | - |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 9,479,900 | 18.3 | 2,167,800 | 7.8 | 0 | - |
| HEALTH SERVICES DEVELOPMENT | DHS | 2,438,400 | 4.7 | 1,893,800 | 6.8 | 0 | - |
| ESSENTIAL DRUGS AND VACCINES | EDV | 730,300 | 1.4 | 0 | - | 0 | - |
| DISASTER PREPAREDNESS | DPP | 6,205,400 | 12.0 | 274,000 | 1.0 | 0 | - |
| CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY | CLR | 105,800 | .2 | 0 | - | 0 | - |
| HUMAN RESOURCES DEVELOPMENT | | 1,532,700 | 3.0 | 2,663,400 | 9.5 | 260,000 | 6.0 |
| HUMAN RESOURCES TRAINING | HRC | 415,700 | .8 | 403,400 | 1.4 | 260,000 | 6.0 |
| HUMAN RESOURCES PLANNING AND POLICY | HRP | 1,117,000 | 2.2 | 2,260,000 | 8.1 | 0 | - |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)

| | PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|---|
| | HEALTH INFORMATION SUPPORT | | 415,100 | .8 | 0 | - | 0 | - |
| | OFFICIAL AND TECHNICAL PUBLICATIONS | HBP | 50,000 | .1 | 0 | - | 0 | - |
| | PUBLIC INFORMATION | HBF | 365,100 | .7 | 0 | - | 0 | - |
| | RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT | | 2,677,400 | 5.2 | 0 | - | 0 | - |
| | RESEARCH AND DEVELOPMENT IN THE FIELD OF VACCINES | RDV | 2,677,400 | 5.2 | 0 | - | 0 | - |
| III. | HEALTH SCIENCE AND TECHNOLOGY | | 34,712,300 | 67.0 | 21,329,900 | 76.7 | 4,104,100 | 94.0 |
| | FOOD AND NUTRITION | | 165,600 | .3 | 0 | - | 0 | - |
| | NUTRITION | NUT | 165,600 | .3 | 0 | - | 0 | - |
| | ENVIRONMENTAL HEALTH | | 1,815,800 | 3.5 | 3,261,700 | 11.8 | 0 | - |
| | COMMUNITY WATER SUPPLY AND SANITATION | CWS | 1,283,500 | 2.5 | 97,700 | .4 | 0 | - |
| | CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 274,500 | .5 | 3,164,000 | 11.4 | 0 | - |
| | WORKERS' HEALTH | OCH | 257,800 | .5 | 0 | - | 0 | - |
| | MATERNAL AND CHILD HEALTH | | 25,337,400 | 49.2 | 16,233,400 | 58.3 | 4,104,100 | 94.0 |
| | GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 2,808,400 | 5.4 | 2,994,100 | 10.8 | 1,382,100 | 31.7 |
| | ADOLESCENT HEALTH | ADH | 225,700 | .4 | 247,000 | .9 | 271,500 | 6.2 |
| | ACUTE RESPIRATORY INFECTIONS | ARI | 1,121,800 | 2.2 | 1,250,600 | 4.5 | 108,500 | 2.5 |
| | IMMUNIZATION | EPI | 14,384,700 | 28.1 | 8,596,500 | 30.8 | 2,342,000 | 53.6 |
| | DIARRHEAL DISEASES | CDD | 6,796,800 | 13.1 | 3,145,200 | 11.3 | 0 | - |
| | COMMUNICABLE DISEASES | | 4,294,000 | 8.1 | 1,284,800 | 4.6 | 0 | - |
| | GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 22,600 | .* | 0 | - | 0 | - |
| | ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 3,328,800 | 6.4 | 1,171,800 | 4.2 | 0 | - |
| | VECTOR-BORNE DISEASES | VBC | 3,600 | .* | 0 | - | 0 | - |
| | MALARIA | MAL | 641,000 | 1.2 | 113,000 | .4 | 0 | - |
| | PARASITIC DISEASES | PDP | 10,000 | .* | 0 | - | 0 | - |
| | LEPROSY | LEP | 265,700 | .5 | 0 | - | 0 | - |
| | SEXUALLY TRANSMITTED DISEASES | VDT | 22,300 | .* | 0 | - | 0 | - |
| | HEALTH PROMOTION | | 701,300 | 1.3 | 0 | - | 0 | - |
| | HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 254,100 | .5 | 0 | - | 0 | - |
| | TOBACCO OR HEALTH | TOH | 42,300 | .1 | 0 | - | 0 | - |
| | PREV/TREAT. OF MENTAL AND NEUROLOGICAL DISORDERS | MND | 30,400 | .1 | 0 | - | 0 | - |
| | CANCER | CAN | 102,700 | .2 | 0 | - | 0 | - |
| | HEALTH OF THE ELDERLY | HEE | 123,800 | .2 | 0 | - | 0 | - |
| | PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE | ADA | 24,600 | .* | 0 | - | 0 | - |
| | OCULAR HEALTH | PBD | 123,400 | .2 | 0 | - | 0 | - |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| VETERINARY PUBLIC HEALTH | | 2,398,200 | 4.6 | 550,000 | 2.0 | 0 | - |
| FOOD SAFETY | FOS | 3,200 | .* | 0 | - | 0 | - |
| FOOT-AND-MOUTH DISEASE | FMD | 1,242,400 | 2.4 | 0 | - | 0 | - |
| ZOONOSES | ZNS | 1,152,600 | 2.2 | 550,000 | 2.0 | 0 | - |
| GRAND TOTAL | | 51,763,300 | 100.0 | 27,828,100 | 100.0 | 4,364,100 | 100.0 |

* LESS THAN .05 PER CENT

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| **1992-1993** | | | | | | | | | | | | |
| PAHO - PR | 18,363,500 | 8 | 0 | 8770 | 4,566,800 | 3,009,200 | 0 | 0 | 4,105,300 | 1,115,600 | 1,879,200 | 3,687,400 |
| WHO - WR | 8,262,900 | 22 | 3 | 2535 | 5,318,600 | 983,600 | 0 | 0 | 1,090,900 | 300,000 | 45,700 | 524,100 |
| TOTAL | 26,626,400 | 30 | 3 | 11305 | 9,885,400 | 3,992,800 | 0 | 0 | 5,196,200 | 1,415,600 | 1,924,900 | 4,211,500 |
| % OF TOTAL | 100.0 | | | | 37.2 | 15.0 | | .0 | 19.5 | 5.3 | 7.2 | 15.8 |
| **1994-1995** | | | | | | | | | | | | |
| PAHO - PR | 20,951,400 | 8 | 1 | 8830 | 5,076,400 | 2,931,500 | 75 | 150,000 | 4,775,300 | 1,441,300 | 1,959,000 | 4,617,900 |
| WHO - WR | 9,044,400 | 23 | 3 | 2972 | 5,959,500 | 1,210,200 | 0 | 0 | 1,016,400 | 378,300 | 27,100 | 452,900 |
| TOTAL | 29,995,800 | 31 | 4 | 11802 | 11,035,900 | 4,141,700 | 75 | 150,000 | 5,791,700 | 1,819,600 | 1,986,100 | 5,070,800 |
| % OF TOTAL | 100.0 | | | | 36.8 | 13.8 | | .5 | 19.3 | 6.1 | 6.6 | 16.9 |
| **1996-1997** | | | | | | | | | | | | |
| PAHO - PR | 22,456,200 | 8 | 1 | 8830 | 5,309,300 | 3,171,900 | 75 | 150,000 | 5,167,100 | 1,559,500 | 2,119,100 | 4,979,300 |
| WHO - WR | 9,707,100 | 23 | 3 | 2972 | 6,369,300 | 1,309,600 | 0 | 0 | 1,099,200 | 409,400 | 29,300 | 490,300 |
| TOTAL | 32,163,300 | 31 | 4 | 11802 | 11,678,600 | 4,481,500 | 75 | 150,000 | 6,266,300 | 1,968,900 | 2,148,400 | 5,469,600 |
| % OF TOTAL | 100.0 | | | | 36.3 | 13.9 | | .5 | 19.5 | 6.1 | 6.7 | 17.0 |

## HEALTH SITUATION ANALYSIS

### Demography

1. The border between Mexico and the United States is not just a geographical line it is a region integrated by two nations. The ten border states (four on the U.S. side and six in Mexico) had a total population of 65.1 million in 1990. That border population has risen by one quarter since 1980, and is still growing fast. The population trend of the U.S. is growing at an annual rate of 1%. The Hispanic population is increasing at three times that rate. Various social, economic, and political factors have accounted for this mass migration during the past decades. One of the most identifiable reasons has been the job opportunities made available by the Maquiladora plants located along the Mexican northern border states.

2. The highest population density is observed in California in the U.S. side with 73.2 persons by km² and in Nuevo Leon, Mexico with 47.8.

3. In 1980, about 19% of the population of the U.S. lived within the four border states, and one-fifth of them were of Hispanic origin. Furthermore, over one-third of the combined border-county population of these States was of Hispanic origin or descent.

### Indicators of health status

4. In 1980 the life expectancy at birth was 70 years for males and 78.1 for females in the U.S. side and 64.1 for males and 70.5 for females in Mexico, but by 1990 this had increased to 72 for males and 79 for females in U.S. and 66 for males and 72 for females in Mexico.

5. The leading causes of overall mortality in 1988 the U.S. states were cardiovascular diseases, malignant tumors, accidents and pulmonary diseases; in the border Mexican states, in the same period the leading causes of death were heart disease, accidents, malignant tumors, intestinal infectious diseases and diabetes. The causes of mortality in U.S. are all chronic and in Mexico infectious diseases are still appearing. Among infants in the U.S. side states, perinatal causes were in first place followed by congenital anomalies, sudden death syndrome, accidents, and pneumonia and influenza; in the border states of Mexico infant mortality leading causes were those originated in the perinatal period, followed by intestinal infectious diseases, pneumonia and influenza, congenital anomalies and nutritional deficiencies.

6. In the 1-4 year old group, in the U.S. border states the three principal causes of death were accidents, congenital anomalies and malignant tumors. In the Mexican side, the principal causes of death were intestinal infectious diseases, pneumonia and influenza, and accidents.

7. In the youth group (15-24 years old group) accidents are the principal cause of death in both sides of the border. The leading causes of death in the 25-44 old group are similar in both countries, accidents, malignant tumors and heart diseases are the most common. In the 65 years old and over group the three leading causes in the Mexican side are heart diseases, malignant tumors and diabetes mellitus, in the U.S. heart diseases, malignant tumors and cerebrovascular diseases are the leading causes.

### Factors affecting health status

8. The continuous migration to the border area has started problems like the inability of cities, towns and "municipios" to provide basic public services, such as potable water, disposal of wastes and health services.

9. The growing migration to the border areas, especially in south Texas and New Mexico in the U.S. side and in the northern part of Mexico, has visible signs of this in the growing of shanty-towns known as "colonias". These areas sometimes little more than legalized squatter's camps. Most homes have simple outhouses with pit latrines. Slops from the house are simply run out on the grass. Some families have built septic tanks; most plots are 50 feet by 100 feet; and residents draw their water from shallow aquifers that are easily polluted.

10. Human waste is a preoccupation along the border. San Diego has, in effect, to absorb the entire Tijuana river and put it through the city's waste-water system before it reaches the Pacific. Nuevo Laredo, Tamaulipas, throws raw sewage each day into the Rio Grande, the river from which communities downstream draw all their drinking water.

11. Mexico is emerging from a decade of crisis, characterized by a decrease on the economic and social indicators, as well as mortality and morbidity indicators. In this time, the population saw the purchasing power of their salary decrease as well as the elimination of some food subsidies. The inflation in the Mexican economy showed positive results during the last part of the previous decade.

12. In the U.S. the most difficult challenges for environmental health come from uncertainties about toxic and ecological effects of the use of fossil fuel and synthetic chemicals in modern society. An estimated 82% of major industrial chemicals have not been tested for their toxic properties and links to specific diseases, and only a small proportion of chemicals have been adequately tested for their ability to cause or promote cancer.

13. Nearly one of every eight Americans lives in a family with an income below the Federal poverty level. Nearly a quarter of children younger than 6 area members of such families. At the border, the proportion of poor among Hispanic families was 27% compared with 7% for non-Hispanics.

14. In the U.S., Hispanic unemployment in 1980 was consistently higher than for non-Hispanics; for instance, 9.8% of Hispanic males at the border were unemployed, compared with 6.3% of non-Hispanic males the rate was higher in the border-county area than in the non-border area.

15. In the U.S. borderland area, non-Hispanic family income in 1979 was noticeably higher than for Hispanic families; for instance, median income of non-Hispanic families was $20,300, compared with $12,400 for Hispanic families.

National and binational health plans

16. Health is an important element in the development of a country, considering not only the absence of disease, but physical, mental and social well being. Within this frame of reference, the Mexican Ministry of Health developed its 1990-1994 Health Priorities. The major priorities established in for this four year period are: increase health education; equality of access and quality in health services; prevention and control of diseases and accidents; environmental protection and basic sanitation; regulation of the demographic growth; and support social services. The major strategies for the achievement of the priorities are: coordination of the national health system; strengthen the local health services; decentralization of health services; intersectorial coordination; and community participation.

17. In the United states there are three national goals: increase the span of healthy life for the population; reduce health disparities among various groups; and achieve access to preventive services for the whole population. Twenty two priority areas had been identified and are grouped into three broad categories: health promotion, health protection and preventive services. Health promotion strategies are those related to individual lifestyle (personal choices made in a social context) that can have powerful influence over one's health prospects. Health protection strategies are those related to environmental or regulatory measures that provide protection on large population groups. Preventive services include counseling, screening, immunization, or chemoprophylactic interventions for individuals in clinical settings. The strategies to reach the established goals and objectives are based on the shared responsibilities: personal responsibility, the family, community, health professionals, media and government.

18. The Binational health needs perceived by health personnel at state an local level on the U.S./Mexico border were similar to those presented by the federal level in both countries. The identified priorities for action on the border area are: environmental health, occupational health, maternal and child health, primary health care, health promotion and disease prevention, and substance abuse.

GLOBAL STRATEGY FOR TECHNICAL COOPERATION

Binational priority areas for technical cooperation

19. Based on the priorities identified by both nations and an analysis of their own resources, the Federal Governments will seek external assistance in the following areas: support the decentralization process in the areas of data gathering and analysis of information and management of local health systems and services; support the process of coordination and collaboration of the different institutions at federal, state and local level on both countries; promote simultaneous activities of institutions and agencies working with disease prevention and health education in the border area; strengthening the capacity for epidemiological analysis, aiming at identifying causes, and establishing reliable surveillance systems along the border area; and establishment of norms and standards for solid waste disposal in marginal urban and selected areas.

20. Currently, several governmental and non governmental institutions are working on health programs on the border. In Mexico, the governmental institutions that are working are the "Secretaría de Salud (SSA), the "Instituto Mexicano del Seguro Social" (IMSS), the "Instituto de Seguridad y Servicios Sociales para los Trabajadores del Estado" (ISSSTE). Each one of these institutions is working with the Mexico's priority programs such as immunizations, adequate management of acute respiratory and diarrheic diseases and health education/disease prevention programs. In United States, the county health departments and projects with special funding from state and federal levels are in charge of educational and early detection of chronic diseases programs. Among non governmental projects are the "Federación Mexicana de Asociaciones de Planificación Familiar" (FEMAP). This program develops activities on health promotion directed towards working women and high risk adolescents, family planning and community participation among others. The "Secretaría de Desarrollo Social" (SEDESOL) in Mexico, and the Environmental Protection Agency (EPA) in U.S., are working to solve and prevent environmental problems. The "Colegio de la Frontera Norte" and several U.S. universities are involved very active in research.

Binational priorities for technical cooperation from PAHO/WHO

21. On the five major priority areas in which technical cooperation is requested in order to improve the health picture on the border area and to achieve binational health objectives during the biennium, EPFO will provide technical cooperation on the following: improving the efficiency of the solid waste disposal services; supporting the decentralization process in the areas of data gathering and analysis and managing local health systems and services; developing policies and plans related to manpower production and utilization; institutionalizing efficient surveillance methods at the local level and improving information processing for binational health policies and decision; and developing ways to increase women's and children's health conditions along the border. These priority areas area fully consistent with PAHO/WHO priorities as expressed in the Strategic Orientations and Program Priorities. After discussions with the representatives from both governments, it was agreed that EPFO resources should be devoted to those priorities which deal mainly with primary health care.

22. As a way to initiate activities aimed to solved the health problems identified in the border area, representatives from the governments of Mexico and the United States invited each set of sister cities along the border to present project proposals that address the priority areas for action. In February 1991, a total of twelve proposals were presented to a trilateral group composed for representatives from Mexico, the United States and PAHO/WHO for its review and recommendations. Nine proposals were accepted and received funding for their implementation. The projects that were financed are: Tijuana/San Diego (Health Promotion/Disease Prevention); Mexicali/Calexico (Health Promotion/Disease Prevention); San Luis Rio Colorado/Yuma (Health Promotion/Disease Prevention); Nogales/Nogales (Environmental Health/Basic Sanitation); Juarez/El Paso/Las Cruces (Maternal and Child Health); Laredo/Nuevo Laredo (Health Promotion/Disease Prevention); Acuña/Eagle Pass (Health Promotion/Disease Prevention); Piedras Negras/Del Rio (Environmental Health/Basic Sanitation); and Matamoros/Brownsville (Health Promotion/Disease Prevention).

23. For the 1994-1995 biennium The Field Office will continue working with projects with PAHO/WHO extra budgetary funds and projects funded through the U.S./Mexico Border Health Association (USMBHA). The projects with extra-budgetary funds are the Maternal and Child Health and the Publications projects. Among the projects that have been funded through the USMBHA during 1993 which are expected to continue during the next biennium are the Tuberculosis Control Project funded by the Centers for Disease Control; the Compañeros project, focussed in the prevention of AIDS, with funds from Prototypes of California. For the biennium 1994-1995 we will submit a proposal to National Institute for Drug Abuse for funding a project on the use of drugs on the work place.

PROJECTS SUPPORTED WITH PAHO/WHO REGULAR FUNDS

Community water supply and sanitation (CWS)

24. The purpose of this project is to promote collaboration and cooperation between health and environmental health sectors of Mexico and the United States and generate concrete results for jointly prepared projects. To achieve this end it will be necessary to disseminate information through seminars and the use of mass media to create public awareness of environmental health issues. Political and professional leaders will be informed on activities to gain their support for development of norms, plans and policies, and mobilization of resources.

Health services development (DHS)

25. The purpose of this project is to coordinate the execution and evaluation of the Sister City Projects and increase data collection, data analysis, as well as the sharing and dissemination of information among border sister cities. To achieve this purpose it will be necessary to focus on the collection and analysis of data from border sister cities. Field Office publications will be used to inform health personnel of disease trends in the border area.

Health situation and trend assessment (HST)

26. The purpose of this project is to increase the capabilities of the health authorities in the analysis and evaluation of the health situation in the border area between Mexico and the United States. To achieve this end personnel at state, jurisdictional and local level will be trained on surveillance methods to aid planning and programming. Standard practices will be developed for gathering, processing and disseminating health information. Resource mobilization efforts will be aimed at bringing in financial and human resources to develop and install surveillance systems.

Management support for national health development (MPN)

27. The purpose of this project is to provide managerial, technical and administrative support for the delivery of technical cooperation for binational health programs. Providing the necessary managerial support for technical cooperation will require the Field Office Chief to work with both Government Officials in resource mobilization. Other activities will focus on administrative management of resources, information dissemination through conferences, seminars, and publications and monitoring the delivery of technical cooperation.

General communicable disease prevention and control activities (OCD)

28. The purpose of this project is to coordinate and promote activities on: prevention and treatment of tuberculosis; prevention of substance abuse; and prevention of the spread of zoonosis and food-borne diseases in the border population. In order to increase awareness of tuberculosis and drug abuse, information will be disseminated through the distribution of educational materials, seminars, conferences, and the participation in the RADAR Network. Resources will be enhanced through the mobilization of funds, goods, and personnel between U.S. and Mexico border. Resource mobilization and training will be used as tools to prevent food-borne disease along the border. Health education and disease prevention will be reinforced in schools of veterinary medicine.

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 1,164,300 | 89.2 | 1,233,300 | 87.5 | 1,338,600 | 87.5 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 1,019,500 | 78.1 | 904,100 | 64.2 | 980,400 | 64.1 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 1,019,500 | 78.1 | 904,100 | 64.2 | 980,400 | 64.1 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 121,600 | 9.3 | 285,100 | 20.2 | 310,500 | 20.3 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 121,600 | 9.3 | 285,100 | 20.2 | 310,500 | 20.3 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 0 | - | 44,100 | 3.1 | 47,700 | 3.1 |
| HEALTH SERVICES DEVELOPMENT | DHS | 0 | - | 44,100 | 3.1 | 47,700 | 3.1 |
| HUMAN RESOURCES DEVELOPMENT | | 23,200 | 1.8 | 0 | - | 0 | - |
| HUMAN RESOURCES EDUCATION | HRE | 23,200 | 1.8 | 0 | - | 0 | - |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 141,300 | 10.8 | 176,900 | 12.5 | 191,500 | 12.5 |
| ENVIRONMENTAL HEALTH | | 0 | - | 45,200 | 3.2 | 48,900 | 3.2 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 0 | - | 45,200 | 3.2 | 48,900 | 3.2 |
| MATERNAL AND CHILD HEALTH | | 0 | - | 61,200 | 4.3 | 66,300 | 4.3 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 0 | - | 61,200 | 4.3 | 66,300 | 4.3 |
| COMMUNICABLE DISEASES | | 141,300 | 10.8 | 70,500 | 5.0 | 76,300 | 5.0 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 141,300 | 10.8 | 70,500 | 5.0 | 76,300 | 5.0 |
| GRAND TOTAL | | 1,305,600 | 100.0 | 1,410,200 | 100.0 | 1,530,100 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 17,200 | 9.3 | 0 | | 0 | |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 17,200 | 9.3 | 0 | | 0 | |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 17,200 | 9.3 | 0 | | 0 | |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 167,900 | 90.7 | 0 | | 0 | |
| MATERNAL AND CHILD HEALTH | | 167,900 | 90.7 | 0 | | 0 | |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 167,900 | 90.7 | 0 | | 0 | |
| GRAND TOTAL | | 185,100 | 100.0 | 0 | | 0 | |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 1,038,400 | 1 | 3 | 0 | 394,300 | 65,000 | 0 | 0 | 66,500 | 32,900 | 127,600 | 352,100 |
| WHO - WR | 267,200 | 1 | 1 | 0 | 200,800 | 0 | 0 | 0 | 10,700 | 0 | 0 | 55,700 |
| TOTAL | 1,305,600 | 2 | 4 | 0 | 595,100 | 65,000 | 0 | 0 | 77,200 | 32,900 | 127,600 | 407,800 |
| % OF TOTAL | 100.0 | | | | 45.6 | 5.0 | | .0 | 5.9 | 2.5 | 9.8 | 31.2 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 1,027,100 | 1 | 3 | 0 | 425,700 | 28,700 | 0 | 0 | 83,900 | 60,500 | 132,000 | 296,300 |
| WHO - WR | 383,100 | 1 | 1 | 0 | 215,700 | 0 | 0 | 0 | 42,200 | 0 | 0 | 125,200 |
| TOTAL | 1,410,200 | 2 | 4 | 0 | 641,400 | 28,700 | 0 | 0 | 126,100 | 60,500 | 132,000 | 421,500 |
| % OF TOTAL | 100.0 | | | | 45.5 | 2.0 | | .0 | 8.9 | 4.3 | 9.4 | 29.9 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 1,114,100 | 1 | 3 | 0 | 463,400 | 31,000 | 0 | 0 | 90,800 | 65,500 | 142,800 | 320,600 |
| WHO - WR | 416,000 | 1 | 1 | 0 | 234,900 | 0 | 0 | 0 | 45,600 | 0 | 0 | 135,500 |
| TOTAL | 1,530,100 | 2 | 4 | 0 | 698,300 | 31,000 | 0 | 0 | 136,400 | 65,500 | 142,800 | 456,100 |
| % OF TOTAL | 100.0 | | | | 45.7 | 2.0 | | .0 | 8.9 | 4.3 | 9.3 | 29.8 |

REGIONAL DIRECTOR'S
DEVELOPMENT PROGRAM

## PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| I. DIRECTION, COORDINATION AND MANAGEMENT | | 2,945,200 | 100.0 | 2,686,300 | 100.0 | 2,906,500 | 100.0 |
| GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT | | 2,945,200 | 100.0 | 2,686,300 | 100.0 | 2,906,500 | 100.0 |
| REGIONAL DIRECTOR'S DEVELOPMENT PROGRAM | DGP | 2,945,200 | 100.0 | 2,686,300 | 100.0 | 2,906,500 | 100.0 |
| GRAND TOTAL | | 2,945,200 | 100.0 | 2,686,300 | 100.0 | 2,906,500 | 100.0 |

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL: PROF. POSTS | PERSONNEL: LOCAL POSTS | PERSONNEL: CONS. DAYS | PERSONNEL: AMOUNT | DUTY TRAVEL AMOUNT | FELLOWSHIPS: MONTHS | FELLOWSHIPS: AMOUNT | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 2,789,200 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,789,200 |
| WHO - WR | 156,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 156,000 |
| TOTAL | 2,945,200 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,945,200 |
| % OF TOTAL | 100.0 | | | | .0 | .0 | | .0 | .0 | .0 | .0 | 100.0 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 2,566,300 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,566,300 |
| WHO - WR | 120,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 120,000 |
| TOTAL | 2,686,300 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,686,300 |
| % OF TOTAL | 100.0 | | | | .0 | .0 | | .0 | .0 | .0 | .0 | 100.0 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 2,776,700 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,776,700 |
| WHO - WR | 129,800 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 129,800 |
| TOTAL | 2,906,500 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,906,500 |
| % OF TOTAL | 100.0 | | | | .0 | .0 | | .0 | .0 | .0 | .0 | 100.0 |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 3,650,000 | 100.0 | 3,949,300 | 100.0 | 4,273,100 | 100.0 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 3,650,000 | 100.0 | 3,949,300 | 100.0 | 4,273,100 | 100.0 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 3,650,000 | 100.0 | 3,949,300 | 100.0 | 4,273,100 | 100.0 |
| GRAND TOTAL | | 3,650,000 | 100.0 | 3,949,300 | 100.0 | 4,273,100 | 100.0 |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL PROF. POSTS | PERSONNEL LOCAL POSTS | PERSONNEL CONS. DAYS | PERSONNEL AMOUNT | DUTY TRAVEL AMOUNT | FELLOWSHIPS MONTHS | FELLOWSHIPS AMOUNT | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 2,433,500 | 0 | 0 | 0 | 2,433,500 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| WHO - WR | 1,216,500 | 0 | 0 | 0 | 1,216,500 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL | 3,650,000 | 0 | 0 | 0 | 3,650,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| % OF TOTAL | 100.0 | | | | 100.0 | .0 | | .0 | .0 | .0 | .0 | .0 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 2,649,300 | 0 | 0 | 0 | 2,649,300 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| WHO - WR | 1,300,000 | 0 | 0 | 0 | 1,300,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL | 3,949,300 | 0 | 0 | 0 | 3,949,300 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| % OF TOTAL | 100.0 | | | | 100.0 | .0 | | .0 | .0 | .0 | .0 | .0 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 2,866,500 | 0 | 0 | 0 | 2,866,500 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| WHO - WR | 1,406,600 | 0 | 0 | 0 | 1,406,600 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL | 4,273,100 | 0 | 0 | 0 | 4,273,100 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| % OF TOTAL | 100.0 | | | | 100.0 | .0 | | .0 | .0 | .0 | .0 | .0 |

## PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| I. DIRECTION, COORDINATION AND MANAGEMENT | | 5,861,600 | 14.4 | 4,965,800 | 10.8 | 5,386,800 | 10.9 |
| GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT | | 5,861,600 | 14.4 | 4,965,800 | 10.8 | 5,386,800 | 10.9 |
| INFORMATICS MANAGEMENT | ISS | 5,861,600 | 14.4 | 4,965,800 | 10.8 | 5,386,800 | 10.9 |
| II. HEALTH SYSTEM INFRASTRUCTURE | | 25,049,100 | 59.5 | 28,117,600 | 62.0 | 30,569,200 | 62.1 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 576,600 | 1.4 | 1,781,700 | 4.0 | 1,934,200 | 4.0 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 0 | - | 1,123,200 | 2.5 | 1,218,400 | 2.5 |
| ADMINISTRATIVE ANALYSIS | AAN | 576,600 | 1.4 | 658,500 | 1.5 | 715,800 | 1.5 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 2,889,500 | 6.9 | 2,767,500 | 6.1 | 3,002,800 | 6.1 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 2,889,500 | 6.9 | 2,767,500 | 6.1 | 3,002,800 | 6.1 |
| HEALTH POLICY DEVELOPMENT | | 2,591,300 | 6.1 | 3,089,500 | 6.8 | 3,361,100 | 6.8 |
| HEALTH POLICY ANALYSIS AND DEVELOPMENT | HDP | 1,428,900 | 3.4 | 1,046,300 | 2.3 | 1,141,300 | 2.3 |
| HEALTH ECONOMICS AND FINANCING | HDE | 495,700 | 1.2 | 971,700 | 2.1 | 1,055,500 | 2.1 |
| HEALTH LEGISLATION | HLE | 270,900 | .6 | 589,800 | 1.3 | 641,200 | 1.3 |
| WOMEN, HEALTH AND DEVELOPMENT | WHD | 395,800 | .9 | 481,700 | 1.1 | 523,100 | 1.1 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 4,560,700 | 10.8 | 5,174,600 | 11.3 | 5,619,200 | 11.5 |
| HEALTH SERVICES DEVELOPMENT | DHS | 2,449,800 | 5.9 | 2,839,000 | 6.3 | 3,082,500 | 6.3 |
| ESSENTIAL DRUGS AND VACCINES | EDV | 472,700 | 1.1 | 518,600 | 1.1 | 562,700 | 1.1 |
| ORAL HEALTH | ORH | 270,900 | .6 | 294,900 | .6 | 320,600 | .7 |
| DISASTER PREPAREDNESS | DPP | 334,300 | .8 | 373,400 | .8 | 406,000 | .8 |
| CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY | CLR | 537,300 | 1.3 | 639,900 | 1.4 | 695,300 | 1.4 |
| HEALTH EDUCATION AND COMMUNITY PARTICIPATION | HED | 270,900 | .6 | 294,900 | .6 | 320,600 | .7 |
| REHABILITATION | RHB | 224,800 | .5 | 213,900 | .5 | 231,500 | .5 |
| HUMAN RESOURCES DEVELOPMENT | | 3,947,600 | 9.4 | 3,921,400 | 8.7 | 4,276,400 | 8.7 |
| HUMAN RESOURCES TRAINING | HRC | 2,355,500 | 5.6 | 2,536,100 | 5.6 | 2,769,000 | 5.6 |
| HUMAN RESOURCES PLANNING AND POLICY | HRP | 614,600 | 1.5 | 526,400 | 1.2 | 571,200 | 1.2 |
| HUMAN RESOURCES EDUCATION | HRE | 977,500 | 2.3 | 858,900 | 1.9 | 936,200 | 1.9 |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| HEALTH INFORMATION SUPPORT | | 9,016,000 | 21.5 | 9,678,700 | 21.3 | 10,525,800 | 21.3 |
| OFFICIAL AND TECHNICAL PUBLICATIONS | HBP | 4,692,000 | 11.2 | 4,965,200 | 10.9 | 5,396,700 | 10.9 |
| PUBLIC INFORMATION | HBF | 1,763,300 | 4.2 | 1,891,400 | 4.2 | 2,059,800 | 4.2 |
| LANGUAGE SERVICES | HBL | 1,606,000 | 3.8 | 1,733,900 | 3.8 | 1,883,600 | 3.8 |
| SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION | HBD | 954,700 | 2.3 | 1,088,200 | 2.4 | 1,185,700 | 2.4 |
| RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT | | 1,467,400 | 3.4 | 1,704,200 | 3.8 | 1,849,700 | 3.7 |
| RESEARCH PROMOTION AND DEVELOPMENT | RPD | 1,017,800 | 2.4 | 988,700 | 2.2 | 1,076,000 | 2.2 |
| HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT | HDT | 224,800 | .5 | 464,700 | 1.0 | 502,600 | 1.0 |
| RESEARCH AND DEVELOPMENT IN THE FIELD OF VACCINES | RDV | 224,800 | .5 | 250,800 | .6 | 271,100 | .5 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 10,952,800 | 26.1 | 12,303,800 | 27.2 | 13,358,800 | 27.0 |
| FOOD AND NUTRITION | | 808,200 | 2.0 | 853,800 | 1.9 | 926,800 | 1.9 |
| FOOD | FOD | 196,200 | .5 | 213,900 | .5 | 231,500 | .5 |
| NUTRITION | NUT | 612,000 | 1.5 | 639,900 | 1.4 | 695,300 | 1.4 |
| ENVIRONMENTAL HEALTH | | 2,501,800 | 6.0 | 2,662,800 | 5.9 | 2,888,600 | 5.8 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 1,257,000 | 3.0 | 964,100 | 2.1 | 1,046,900 | 2.1 |
| SOLID WASTES AND HOUSING HYGIENE | RUD | 196,200 | .5 | 250,800 | .6 | 271,100 | .5 |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 749,100 | 1.8 | 1,116,100 | 2.5 | 1,210,400 | 2.5 |
| WORKERS' HEALTH | OCH | 299,500 | .7 | 331,800 | .7 | 360,200 | .7 |
| MATERNAL AND CHILD HEALTH | | 2,415,900 | 5.7 | 2,537,100 | 5.6 | 2,753,000 | 5.5 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 1,084,900 | 2.6 | 1,079,100 | 2.4 | 1,168,900 | 2.4 |
| ACUTE RESPIRATORY INFECTIONS | ARI | 224,800 | .5 | 250,800 | .6 | 271,100 | .5 |
| IMMUNIZATION | EPI | 719,000 | 1.7 | 781,200 | 1.7 | 849,200 | 1.7 |
| DIARRHEAL DISEASES | CDD | 387,200 | .9 | 426,000 | .9 | 463,800 | .9 |
| COMMUNICABLE DISEASES | | 2,011,600 | 4.8 | 2,371,800 | 5.2 | 2,581,100 | 5.2 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 299,500 | .7 | 1,247,200 | 2.7 | 1,353,600 | 2.7 |
| TROPICAL DISEASE RESEARCH | TDR | 74,700 | .2 | 94,200 | .2 | 103,600 | .2 |
| TUBERCULOSIS | TUB | 270,900 | .6 | 81,000 | .2 | 89,100 | .2 |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 87,700 | .2 | 94,200 | .2 | 103,600 | .2 |
| MALARIA | MAL | 917,700 | 2.2 | 454,400 | 1.0 | 495,100 | 1.0 |
| PARASITIC DISEASES | PDP | 286,400 | .7 | 319,800 | .7 | 347,000 | .7 |
| LEPROSY | LEP | 74,700 | .2 | 81,000 | .2 | 89,100 | .2 |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| HEALTH PROMOTION | | 2,136,200 | 5.0 | 2,692,700 | 6.0 | 2,922,300 | 5.9 |
| HEALTH PROMOTION, PREV/CONTROL OF NONCOMMUNIC.DIS. | NCD | 1,224,700 | 2.9 | 1,765,100 | 3.9 | 1,916,300 | 3.9 |
| PREV/TREAT. OF MENTAL AND NEUROLOGICAL DISORDERS | MND | 312,500 | .7 | 345,000 | .8 | 374,700 | .8 |
| HEALTH OF THE ELDERLY | HEE | 299,500 | .7 | 331,800 | .7 | 360,200 | .7 |
| PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE | ADA | 299,500 | .7 | 250,800 | .6 | 271,100 | .5 |
| VETERINARY PUBLIC HEALTH | | 1,079,100 | 2.6 | 1,185,600 | 2.6 | 1,287,000 | 2.7 |
| FOOD SAFETY | FOS | 299,500 | .7 | 294,900 | .6 | 320,600 | .7 |
| ZOONOSES | ZNS | 779,600 | 1.9 | 890,700 | 2.0 | 966,400 | 2.0 |
| GRAND TOTAL | | 41,863,500 | 100.0 | 45,387,200 | 100.0 | 49,314,800 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

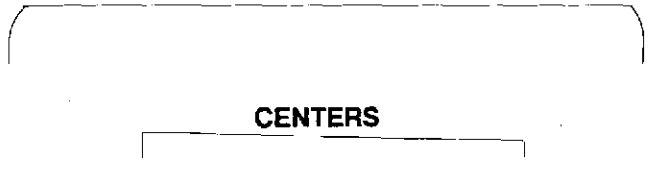
| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| I. DIRECTION, COORDINATION AND MANAGEMENT | | 183,200 | 2.5 | 213,000 | 3.4 | 231,500 | 7.0 |
| GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT | | 183,200 | 2.5 | 213,000 | 3.4 | 231,500 | 7.0 |
| INFORMATICS MANAGEMENT | ISS | 183,200 | 2.5 | 213,000 | 3.4 | 231,500 | 7.0 |
| II. HEALTH SYSTEM INFRASTRUCTURE | | 1,694,200 | 22.8 | 837,200 | 13.4 | 903,600 | 27.2 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 370,800 | 5.0 | 502,500 | 8.0 | 543,100 | 16.4 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 36,000 | .5 | 70,000 | 1.1 | 77,000 | 2.3 |
| ADMINISTRATIVE ANALYSIS | AAN | 334,800 | 4.5 | 432,500 | 6.9 | 466,100 | 14.1 |
| HEALTH SERVICES BASED ON PRIMARY HEALTH CARE | | 811,700 | 10.9 | 126,000 | 2.0 | 137,000 | 4.1 |
| HEALTH SERVICES DEVELOPMENT | DHS | 128,700 | 1.7 | 126,000 | 2.0 | 137,000 | 4.1 |
| DISASTER PREPAREDNESS | DPP | 683,000 | 9.2 | 0 | - | 0 | - |
| HEALTH INFORMATION SUPPORT | | 455,700 | 6.1 | 148,700 | 2.4 | 159,000 | 4.8 |
| OFFICIAL AND TECHNICAL PUBLICATIONS | HBP | 337,100 | 4.5 | 63,700 | 1.0 | 68,000 | 2.1 |
| PUBLIC INFORMATION | HBF | 99,800 | 1.3 | 85,000 | 1.4 | 91,000 | 2.7 |
| LANGUAGE SERVICES | HBL | 18,800 | .3 | 0 | - | 0 | - |
| RESEARCH PROMOTION AND TECHNOLOGY DEVELOPMENT | | 56,000 | .8 | 60,000 | 1.0 | 64,500 | 1.9 |
| HEALTH TECHNOLOGY POLICIES AND DEVELOPMENT | HDT | 56,000 | .8 | 60,000 | 1.0 | 64,500 | 1.9 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 5,559,200 | 74.7 | 5,241,200 | 83.2 | 2,179,200 | 65.8 |
| FOOD AND NUTRITION | | 55,200 | .7 | 70,500 | 1.1 | 77,400 | 2.3 |
| FOOD | FOD | 55,200 | .7 | 70,500 | 1.1 | 77,400 | 2.3 |
| ENVIRONMENTAL HEALTH | | 184,000 | 2.5 | 167,500 | 2.7 | 181,400 | 5.5 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 184,000 | 2.5 | 167,500 | 2.7 | 181,400 | 5.5 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| MATERNAL AND CHILD HEALTH | | 2,480,900 | 33.3 | 2,356,900 | 37.4 | 1,666,800 | 50.3 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 1,164,000 | 15.7 | 975,200 | 15.5 | 1,048,500 | 31.7 |
| ACUTE RESPIRATORY INFECTIONS | ARI | 85,000 | 1.1 | 91,000 | 1.4 | 97,400 | 2.9 |
| IMMUNIZATION | EPI | 894,900 | 12.0 | 1,048,900 | 16.7 | 520,900 | 15.7 |
| DIARRHEAL DISEASES | CDD | 337,000 | 4.5 | 241,800 | 3.8 | 0 | - |
| COMMUNICABLE DISEASES | | 2,505,800 | 33.8 | 2,486,700 | 39.5 | 82,900 | 2.5 |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 2,505,800 | 33.8 | 2,486,700 | 39.5 | 82,900 | 2.5 |
| HEALTH PROMOTION | | 182,700 | 2.4 | 0 | - | 0 | - |
| HEALTH OF THE ELDERLY | HEE | 17,200 | .2 | 0 | - | 0 | - |
| OCULAR HEALTH | PBD | 165,500 | 2.2 | 0 | - | 0 | - |
| VETERINARY PUBLIC HEALTH | | 150,600 | 2.0 | 159,600 | 2.5 | 170,700 | 5.2 |
| ZOONOSES | ZNS | 150,600 | 2.0 | 159,600 | 2.5 | 170,700 | 5.2 |
| GRAND TOTAL | | 7,436,600 | 100.0 | 6,291,400 | 100.0 | 3,314,300 | 100.0 |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 27,221,400 | 89 | 84 | 0 | 24,066,300 | 243,700 | 0 | 0 | 85,200 | 1,883,400 | 0 | 942,800 |
| WHO - WR | 14,642,100 | 50 | 46 | 30 | 13,655,700 | 2,200 | 0 | 0 | 16,000 | 228,200 | 0 | 740,000 |
| TOTAL | 41,863,500 | 139 | 130 | 30 | 37,722,000 | 245,900 | 0 | 0 | 101,200 | 2,111,600 | 0 | 1,682,800 |
| % OF TOTAL | 100.0 | | | | 90.2 | .6 | | .0 | .2 | 5.0 | .0 | 4.0 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 29,101,600 | 87 | 85 | 0 | 26,649,800 | 249,900 | 0 | 0 | 0 | 1,560,000 | 0 | 641,900 |
| WHO - WR | 16,285,600 | 49 | 47 | 34 | 14,920,400 | 16,500 | 0 | 0 | 18,300 | 249,300 | 0 | 1,081,100 |
| TOTAL | 45,387,200 | 136 | 132 | 34 | 41,570,200 | 266,400 | 0 | 0 | 18,300 | 1,809,300 | 0 | 1,723,000 |
| % OF TOTAL | 100.0 | | | | 91.6 | .6 | | .0 | .0 | 4.0 | .0 | 3.8 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 31,622,100 | 87 | 85 | 0 | 28,969,300 | 270,300 | 0 | 0 | 0 | 1,688,000 | 0 | 694,500 |
| WHO - WR | 17,692,700 | 49 | 47 | 34 | 16,215,700 | 17,900 | 0 | 0 | 19,700 | 269,600 | 0 | 1,169,800 |
| TOTAL | 49,314,800 | 136 | 132 | 34 | 45,185,000 | 288,200 | 0 | 0 | 19,700 | 1,957,600 | 0 | 1,864,300 |
| % OF TOTAL | 100.0 | | | | 91.6 | .6 | | .0 | .0 | 4.0 | .0 | 3.8 |


CENTERS


CENTERS

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 2,248,300 | 9.0 | 1,430,200 | 5.3 | 1,575,000 | 5.3 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 1,219,200 | 4.9 | 0 | - | 0 | - |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 1,219,200 | 4.9 | 0 | - | 0 | - |
| HEALTH INFORMATION SUPPORT | | 1,029,100 | 4.1 | 1,430,200 | 5.3 | 1,575,000 | 5.3 |
| SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION | HBD | 1,029,100 | 4.1 | 1,430,200 | 5.3 | 1,575,000 | 5.3 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 22,832,400 | 91.0 | 25,487,800 | 94.7 | 28,334,200 | 94.7 |
| FOOD AND NUTRITION | | 5,148,300 | 20.5 | 5,354,200 | 19.9 | 5,953,400 | 19.9 |
| FOOD | FOD | 948,600 | 3.8 | 903,100 | 3.4 | 1,014,600 | 3.4 |
| NUTRITION | NUT | 4,199,700 | 16.7 | 4,451,100 | 16.5 | 4,938,800 | 16.5 |
| ENVIRONMENTAL HEALTH | | 4,433,800 | 17.6 | 5,458,900 | 20.3 | 6,042,200 | 20.2 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 1,655,100 | 6.6 | 2,360,100 | 8.8 | 2,654,000 | 8.9 |
| SOLID WASTES AND HOUSING HYGIENE | RUD | 259,800 | 1.0 | 243,500 | .9 | 263,700 | .9 |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 2,518,900 | 10.0 | 2,855,300 | 10.6 | 3,124,500 | 10.4 |
| MATERNAL AND CHILD HEALTH | | 1,526,000 | 6.1 | 1,714,100 | 6.4 | 1,899,000 | 6.3 |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 1,526,000 | 6.1 | 1,714,100 | 6.4 | 1,899,000 | 6.3 |
| COMMUNICABLE DISEASES | | 0 | - | 1,294,800 | 4.8 | 1,407,800 | 4.7 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 0 | - | 1,294,800 | 4.8 | 1,407,800 | 4.7 |
| VETERINARY PUBLIC HEALTH | | 11,724,300 | 46.8 | 11,665,800 | 43.3 | 13,031,800 | 43.6 |
| FOOD SAFETY | FOS | 714,700 | 2.8 | 1,430,100 | 5.3 | 1,567,400 | 5.2 |
| FOOT-AND-MOUTH DISEASE | FMD | 8,114,900 | 32.5 | 7,840,700 | 29.1 | 8,843,400 | 29.6 |
| ZOONOSES | ZNS | 2,894,700 | 11.5 | 2,395,000 | 8.9 | 2,621,000 | 8.8 |
| GRAND TOTAL | | 25,080,700 | 100.0 | 26,918,000 | 100.0 | 29,909,200 | 100.0 |

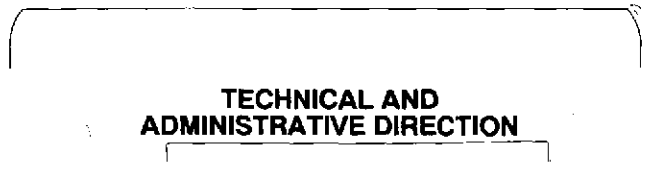
PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| II. HEALTH SYSTEM INFRASTRUCTURE | | 6,944,000 | 17.6 | 900,000 | 3.0 | 900,000 | 3.0 |
| HEALTH SITUATION AND TREND ASSESSMENT | | 5,645,100 | 14.3 | 0 | - | 0 | - |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 5,645,100 | 14.3 | 0 | - | 0 | - |
| HEALTH INFORMATION SUPPORT | | 1,298,900 | 3.3 | 900,000 | 3.0 | 900,000 | 3.0 |
| SCIENTIFIC AND TECHNICAL INFORMATION DISSEMINATION | HBD | 1,298,900 | 3.3 | 900,000 | 3.0 | 900,000 | 3.0 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 32,579,100 | 82.4 | 29,592,600 | 97.0 | 28,759,700 | 97.0 |
| FOOD AND NUTRITION | | 15,250,800 | 38.6 | 14,809,000 | 48.6 | 14,795,000 | 50.0 |
| NUTRITION | NUT | 15,250,800 | 38.6 | 14,809,000 | 48.6 | 14,795,000 | 50.0 |
| ENVIRONMENTAL HEALTH | | 2,142,100 | 5.4 | 1,306,200 | 4.3 | 1,230,700 | 4.1 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 718,600 | 1.8 | 490,000 | 1.6 | 428,000 | 1.4 |
| SOLID WASTES AND HOUSING HYGIENE | RUD | 400 | .* | 0 | - | 0 | - |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 1,423,100 | 3.6 | 816,200 | 2.7 | 802,700 | 2.7 |
| MATERNAL AND CHILD HEALTH | | 2,641,100 | 6.7 | 0 | - | 0 | - |
| GROWTH, DEVELOPMENT AND HUMAN REPRODUCTION | MCH | 2,637,200 | 6.7 | 0 | - | 0 | - |
| IMMUNIZATION | EPI | 3,900 | .* | 0 | - | 0 | - |
| COMMUNICABLE DISEASES | | 3,929,200 | 9.9 | 4,922,700 | 16.1 | 3,714,000 | 12.5 |
| GENERAL COMMUNICABLE DISEASE PREVENTION & CONTROL | OCD | 400,000 | 1.0 | 4,372,800 | 14.3 | 3,714,000 | 12.5 |
| ACQUIRED IMMUNODEFICIENCY SYNDROME | HIV | 3,474,300 | 8.8 | 549,900 | 1.8 | 0 | - |
| LEPROSY | LEP | 54,900 | .1 | 0 | - | 0 | - |
| HEALTH PROMOTION | | 12,700 | .* | 0 | - | 0 | - |
| CANCER | CAN | 12,700 | .* | 0 | - | 0 | - |
| VETERINARY PUBLIC HEALTH | | 8,603,200 | 21.8 | 8,554,700 | 28.0 | 9,020,000 | 30.4 |
| FOOD SAFETY | FOS | 2,049,000 | 5.2 | 2,421,000 | 7.9 | 2,700,000 | 9.1 |
| FOOT-AND-MOUTH DISEASE | FMD | 5,238,500 | 13.3 | 4,520,000 | 14.8 | 4,520,000 | 15.2 |
| ZOONOSES | ZNS | 1,315,700 | 3.3 | 1,613,700 | 5.3 | 1,800,000 | 6.1 |
| GRAND TOTAL | | 39,523,100 | 100.0 | 30,492,600 | 100.0 | 29,659,700 | 100.0 |

* LESS THAN .05 PER CENT

## ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 21,761,800 | 51 | 71 | 620 | 16,515,400 | 895,100 | 112 | 224,000 | 329,100 | 823,400 | 0 | 2,974,800 |
| WHO - WR | 3,318,900 | 9 | 6 | 285 | 2,336,300 | 136,300 | 0 | 0 | 55,300 | 121,000 | 0 | 670,000 |
| TOTAL | 25,080,700 | 60 | 77 | 905 | 18,851,700 | 1,031,400 | 112 | 224,000 | 384,400 | 944,400 | 0 | 3,644,800 |
| % OF TOTAL | 100.0 | | | | 75.2 | 4.1 | | .9 | 1.5 | 3.8 | .0 | 14.5 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 23,045,600 | 51 | 66 | 1169 | 17,764,000 | 1,013,400 | 110 | 220,000 | 855,000 | 892,000 | 0 | 2,301,200 |
| WHO - WR | 3,872,400 | 9 | 6 | 321 | 2,728,600 | 149,500 | 0 | 0 | 5,700 | 125,900 | 0 | 862,700 |
| TOTAL | 26,918,000 | 60 | 72 | 1490 | 20,492,600 | 1,162,900 | 110 | 220,000 | 860,700 | 1,017,900 | 0 | 3,163,900 |
| % OF TOTAL | 100.0 | | | | 76.1 | 4.3 | | .8 | 3.2 | 3.8 | .0 | 11.8 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 25,616,900 | 51 | 66 | 1169 | 19,657,000 | 1,149,100 | 110 | 220,000 | 969,700 | 1,011,500 | 0 | 2,609,600 |
| WHO - WR | 4,292,300 | 9 | 6 | 321 | 2,995,200 | 169,500 | 0 | 0 | 6,500 | 142,800 | 0 | 978,300 |
| TOTAL | 29,909,200 | 60 | 72 | 1490 | 22,652,200 | 1,318,600 | 110 | 220,000 | 976,200 | 1,154,300 | 0 | 3,587,900 |
| % OF TOTAL | 100.0 | | | | 75.7 | 4.4 | | .7 | 3.3 | 3.9 | .0 | 12.0 |


TECHNICAL AND
ADMINISTRATIVE DIRECTION

TECHNICAL AND
ADMINISTRATIVE DIRECTION

## PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| I. DIRECTION, COORDINATION AND MANAGEMENT | | 7,755,800 | 22.2 | 7,109,900 | 19.9 | 7,684,900 | 19.7 |
| GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT | | 7,755,800 | 22.2 | 7,109,900 | 19.9 | 7,684,900 | 19.7 |
| EXECUTIVE MANAGEMENT | EXM | 3,241,600 | 9.3 | 3,667,100 | 10.3 | 3,964,000 | 10.2 |
| GENERAL PROGRAM DEVELOPMENT | GPD | 3,467,400 | 9.9 | 2,533,500 | 7.1 | 2,734,000 | 7.0 |
| EXTERNAL COORD. FOR HEALTH AND SOCIAL DEVELOPMENT | COR | 1,046,800 | 3.0 | 909,300 | 2.5 | 986,900 | 2.5 |
| II. HEALTH SYSTEM INFRASTRUCTURE | | 2,225,200 | 6.3 | 1,894,100 | 5.3 | 2,053,000 | 5.3 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 2,225,200 | 6.3 | 1,894,100 | 5.3 | 2,053,000 | 5.3 |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 1,829,400 | 5.2 | 1,894,100 | 5.3 | 2,053,000 | 5.3 |
| ADMINISTRATIVE ANALYSIS | AAN | 395,800 | 1.1 | 0 | - | 0 | - |
| IV. PROGRAM SUPPORT | | 24,905,300 | 71.5 | 26,765,100 | 74.8 | 29,129,700 | 75.0 |
| ADMINISTRATION | | 24,905,300 | 71.5 | 26,765,100 | 74.8 | 29,129,700 | 75.0 |
| BUDGET AND FINANCE | BFI | 7,649,400 | 21.9 | 7,978,600 | 22.3 | 8,715,300 | 22.4 |
| GENERAL SERVICES & HEADQUARTERS OPERATING EXPENSES | PGS | 12,208,900 | 35.1 | 13,106,700 | 36.6 | 14,226,700 | 36.7 |
| PERSONNEL | PER | 3,513,400 | 10.1 | 4,025,300 | 11.3 | 4,390,600 | 11.3 |
| PROCUREMENT | SUP | 1,533,600 | 4.4 | 1,654,500 | 4.6 | 1,797,100 | 4.6 |
| GRAND TOTAL | | 34,886,300 | 100.0 | 35,769,100 | 100.0 | 38,867,600 | 100.0 |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| I. DIRECTION, COORDINATION AND MANAGEMENT | | 328,900 | 4.5 | 485,700 | 9.6 | 614,100 | 11.0 |
| GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT | | 328,900 | 4.5 | 485,700 | 9.6 | 614,100 | 11.0 |
| GENERAL PROGRAM DEVELOPMENT | GPD | 149,100 | 2.0 | 267,800 | 5.3 | 291,800 | 5.2 |
| EXTERNAL COORD. FOR HEALTH AND SOCIAL DEVELOPMENT | COR | 179,800 | 2.5 | 217,900 | 4.3 | 322,300 | 5.8 |
| II. HEALTH SYSTEM INFRASTRUCTURE | | 97,600 | 1.3 | 0 | - | 0 | - |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | | 97,600 | 1.3 | 0 | - | 0 | - |
| MANAGERIAL SUPPORT FOR NATIONAL HEALTH DEVELOPMENT | MPN | 97,600 | 1.3 | 0 | - | 0 | - |
| IV. PROGRAM SUPPORT | | 6,882,300 | 94.2 | 4,607,600 | 90.4 | 4,957,100 | 89.0 |
| ADMINISTRATION | | 6,882,300 | 94.2 | 4,607,600 | 90.4 | 4,957,100 | 89.0 |
| BUDGET AND FINANCE | BFI | 2,005,900 | 27.4 | 1,887,000 | 37.0 | 2,037,900 | 36.6 |
| GENERAL SERVICES & HEADQUARTERS OPERATING EXPENSES | PGS | 3,651,500 | 50.0 | 1,542,000 | 30.3 | 1,653,600 | 29.7 |
| PERSONNEL | PER | 355,100 | 4.9 | 271,600 | 5.3 | 289,800 | 5.2 |
| PROCUREMENT | SUP | 869,800 | 11.9 | 907,000 | 17.8 | 975,800 | 17.5 |
| GRAND TOTAL | | 7,308,800 | 100.0 | 5,093,300 | 100.0 | 5,571,200 | 100.0 |

ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 26,599,600 | 59 | 105 | 1410 | 20,006,200 | 575,500 | 0 | 0 | 15,000 | 61,100 | 0 | 5,941,800 |
| WHO - WR | 8,286,700 | 14 | 25 | 0 | 4,755,000 | 177,000 | 0 | 0 | 0 | 39,500 | 0 | 3,315,200 |
| TOTAL | 34,886,300 | 73 | 130 | 1410 | 24,761,200 | 752,500 | 0 | 0 | 15,000 | 100,600 | 0 | 9,257,000 |
| % OF TOTAL | 100.0 | | | | 71.0 | 2.2 | | .0 | .0 | .3 | .0 | 26.5 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 27,927,500 | 54 | 101 | 1143 | 20,367,600 | 539,500 | 0 | 0 | 21,000 | 87,500 | 0 | 6,911,900 |
| WHO - WR | 7,841,600 | 10 | 26 | 0 | 4,718,900 | 188,200 | 0 | 0 | 0 | 78,500 | 0 | 2,856,000 |
| TOTAL | 35,769,100 | 64 | 127 | 1143 | 25,086,500 | 727,700 | 0 | 0 | 21,000 | 166,000 | 0 | 9,767,900 |
| % OF TOTAL | 100.0 | | | | 70.1 | 2.0 | | .0 | .1 | .5 | .0 | 27.3 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 30,343,900 | 54 | 101 | 1143 | 22,164,100 | 583,800 | 0 | 0 | 22,700 | 94,600 | 0 | 7,478,700 |
| WHO - WR | 8,523,700 | 10 | 26 | 0 | 5,144,800 | 203,700 | 0 | 0 | 0 | 85,000 | 0 | 3,090,200 |
| TOTAL | 38,867,600 | 64 | 127 | 1143 | 27,308,900 | 787,500 | 0 | 0 | 22,700 | 179,600 | 0 | 10,568,900 |
| % OF TOTAL | 100.0 | | | | 70.2 | 2.0 | | .0 | .1 | .5 | .0 | 27.2 |

## PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| I. DIRECTION, COORDINATION AND MANAGEMENT | | 2,536,500 | 100.0 | 2,645,700 | 100.0 | 2,870,200 | 100.0 |
| GOVERNING BODIES | | 2,536,500 | 100.0 | 2,645,700 | 100.0 | 2,870,200 | 100.0 |
| GOVERNING BODIES | GOB | 2,536,500 | 100.0 | 2,645,700 | 100.0 | 2,870,200 | 100.0 |
| GRAND TOTAL | | 2,536,500 | 100.0 | 2,645,700 | 100.0 | 2,870,200 | 100.0 |

## PROGRAM BUDGET - EXTRABUDGETARY FUNDS

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| I. DIRECTION, COORDINATION AND MANAGEMENT | | 19,000 | 100.0 | 0 | | 0 | |
| GOVERNING BODIES | | 19,000 | 100.0 | 0 | | 0 | |
| GOVERNING BODIES | GOB | 19,000 | 100.0 | 0 | | 0 | |
| GRAND TOTAL | | 19,000 | 100.0 | 0 | | 0 | |

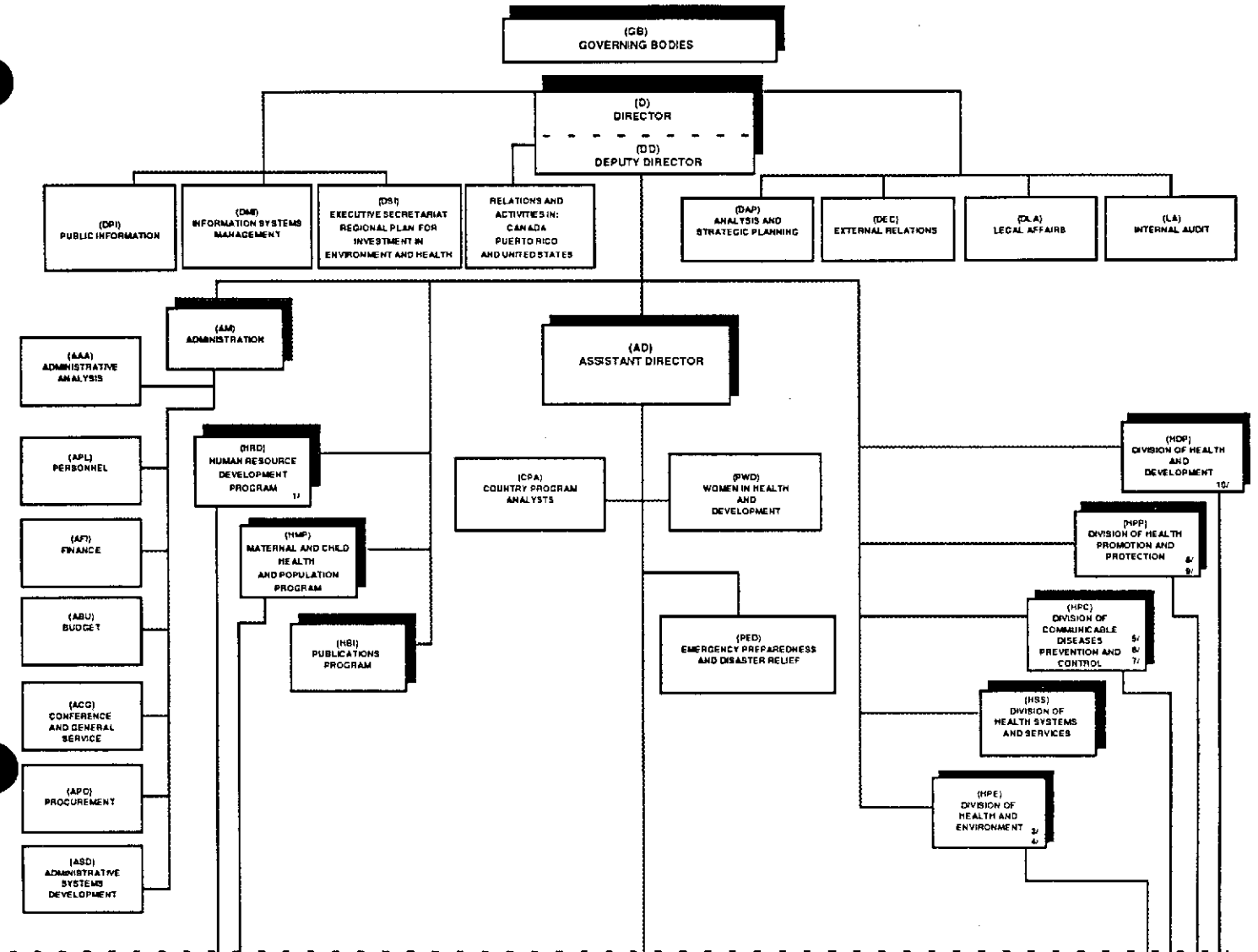
ALLOCATION BY OBJECT OF EXPENDITURE - PAHO AND WHO REGULAR FUNDS

| SOURCE OF FUNDS | TOTAL AMOUNT | PERSONNEL | | | | DUTY TRAVEL | FELLOWSHIPS | | SEMINARS AND COURSES | SUPPLIES AND EQUIPMENT | GRANTS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PROF. POSTS | LOCAL POSTS | CONS. DAYS | AMOUNT | AMOUNT | MONTHS | AMOUNT | | | | |
| | $ | | | | $ | $ | | $ | $ | $ | $ | $ |
| 1992-1993 | | | | | | | | | | | | |
| PAHO - PR | 2,176,100 | 3 | 4 | 0 | 874,600 | 0 | 0 | 0 | 0 | 0 | 0 | 1,301,500 |
| WHO - WR | 360,400 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 360,400 |
| TOTAL | 2,536,500 | 3 | 4 | 0 | 874,600 | 0 | 0 | 0 | 0 | 0 | 0 | 1,661,900 |
| % OF TOTAL | 100.0 | | | | 34.5 | .0 | | .0 | .0 | .0 | .0 | 65.5 |
| 1994-1995 | | | | | | | | | | | | |
| PAHO - PR | 2,262,600 | 3 | 4 | 0 | 847,600 | 0 | 0 | 0 | 0 | 0 | 0 | 1,415,000 |
| WHO - WR | 383,100 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 383,100 |
| TOTAL | 2,645,700 | 3 | 4 | 0 | 847,600 | 0 | 0 | 0 | 0 | 0 | 0 | 1,798,100 |
| % OF TOTAL | 100.0 | | | | 32.0 | .0 | | .0 | .0 | .0 | .0 | 68.0 |
| 1996-1997 | | | | | | | | | | | | |
| PAHO - PR | 2,455,700 | 3 | 4 | 0 | 924,700 | 0 | 0 | 0 | 0 | 0 | 0 | 1,531,000 |
| WHO - WR | 414,500 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 414,500 |
| TOTAL | 2,870,200 | 3 | 4 | 0 | 924,700 | 0 | 0 | 0 | 0 | 0 | 0 | 1,945,500 |
| % OF TOTAL | 100.0 | | | | 32.2 | .0 | | .0 | .0 | .0 | .0 | 67.8 |

## IV. PAHO ORGANIZATIONAL STRUCTURE

## IV. PAHO ORGANIZATIONAL STRUCTURE

# PAHO ORGANIZATIONAL CHART




1/ PASCAP PROGRAM FOR HEALTH TRAINING FOR CENTRAL AMERICA AND PANAMA

2/CLAP LATIN AMERICAN CENTER FOR PERINATOLOGY AND HUMAN DEVELOPMENT

PAHO/WHO REPRESENTATIVE (PWR) OFFICES:

| | |
|---|---|
| ARGENTINA | GUYANA |
| BAHAMAS 2/ | HAITI |
| BELIZE | HONDURAS |
| BOLIVIA | JAMAICA 1/ |
| BRAZIL | MEXICO |
| CHILE | NICARAGUA |
| COLOMBIA | PANAMA |
| COSTA RICA | PARAGUAY |
| CUBA | PERU |
| DOMINICAN REPUBLIC | SURINAME |
| ECUADOR | TRINIDAD AND TOBAGO |
| EL SALVADOR | URUGUAY |
| GUATEMALA | VENEZUELA 3/ |

OFFICE RESPONSIBLE FOR ACTIVITIES IN::

1/NORTHERN CARIBBEAN:
BERMUDA, CAYMAN ISLANDS
2/ TURKS AND CAICOS ISLANDS
3/ NETHERLANDS ANTILLES

CARIBBEAN PROGRAM COORDINATION (CPC): BARBADOS

OFFICE RESPONSIBLE FOR ACTIVITIES IN:

| | |
|---|---|
| ANTIGUA AND BARBUDA | ST. KITTS & NEVIS |
| BARBADOS | SAINT LUCIA |
| DOMINICA | ST. VINCENT & THE GRENADINES |
| GRENADA | |

EASTERN CARIBBEAN:
ANGUILLA, IBRITISH VIRGIN ISLANDS, MONTSERRAT

FRENCH DEPARTMENTS IN THE AMERICAS:
FRENCH GUIANA, GUADELOUPE, MARTINIQUE, ST. MARTIN & ST. BARTHOLOMEW

FIELD OFFICE US/MEXICO BORDER: EL PASO, TEXAS

| | |
|---|---|
| 3/ CEPIS | PAN AMERICAN CENTER FOR SANITARY ENGINEERING AND ENVIRONMENTAL SCIENCES |
| 4/ ECO | PAN AMERICAN CENTER FOR HUMAN ECOLOGY AND HEALTH |
| 5/ CAREC | CARIBBEAN EPIDEMIOLOGY CENTER |
| 6/ PANAFTOSA | PAN AMERICAN FOOT-AND-MOUTH DISEASE CENTER |
| 7/ INPPAZ | PAN AMERICAN INSTITUTE FOR FOOD PROTECTION AND ZOONOSES |
| 8/ CFNI | CARIBBEAN FOOD AND NUTRITION INSTITUTE |
| 9/ INCAP | INSTITUTE OF NUTRITION OF CENTRAL AMERICA AND PANAMA |
| 10/ BIREME | LATIN AMERICAN AND CARIBBEAN CENTER FOR HEALTH SCIENCES INFORMATION |

1 February 1993

## INTRODUCTION

1. The organizational structure of the Pan American Health Organization Secretariat has been adjusted recently to better enable the Organization to meet its constitutional obligations to assist Member Countries in achieving health for the people of the Americas. The reorganization of PAHO Secretariat at PAHO headquarters (HQ) is described below. Although the field offices operations remain unchanged, reporting and management will conform to the new organizational structure.

2. These structural adjustments have been made to strengthen the Secretariat of the Organization in order to: (a) improve implementation of policies, strategic orientations, and priorities established by the Pan American Sanitary Conference and the preliminary proposal of the 9th General Program of Work of the World Health Organization; (b) facilitate and stimulate communication and coordination of HQ units to ensure consistency in supporting development of country programs and strategic approaches to subregional initiatives; (c) improve programming and evaluation processes at all levels; (d) improve response capability of HQ to changes in the general environment and in the health situation; and (e) facilitate and stimulate organizational development and the capacity to innovate and take new initiatives within the overall context of the objectives of the Organization.

## GOVERNING BODIES (GB)

3. Included in this section are the cost estimates for the meetings of the Pan American Sanitary Conference, the Directing Council, the Executive Committee and the WHO Regional Committee. The cost estimates assume that the meetings will be held in Washington, D.C. Estimated costs for the services of the External Auditor, who is engaged by and reports directly to the Governing Bodies, are also included in this section.

## OFFICE OF THE DIRECTOR/DEPUTY DIRECTOR (D/DD)

4. The Office of the Director which includes the Office of the Deputy Director, is responsible for management of the Secretariat, including the establishment of institutional policy, overall program formulation and implementation, and high-level administrative functions involving utilization of the Organization's resources. The Office of the Deputy Director is also directly responsible for relations and activities in Canada, the United States of America and Puerto Rico. The following units are under D/DD:

### Analysis and Strategic Planning (DAP)

5. DAP is responsible for analyzing, developing and implementing established policies of the Organization and for monitoring changes in political, economic, and social conditions in the Region to adapt PAHO's policies on technical cooperation to these changing conditions. DAP serves as the Secretariat for the Subcommittee on Planning and Programming of the Executive Committee. As such, it coordinates follow-up activities on policies approved by the Governing Bodies and institutional adjustments made by the Office of the Director. DAP also serves as the Secretariat of the General Advisory Committee to the Director (DAC).

6. With regard to program management, DAP is responsible for the development of a planning and programming methodology (AMPES) and for coordinating its application to monitor the short, medium and long-term planning and evaluation processes. DAP is also responsible for coordinating the Special Initiative of Central America and for supporting other special initiatives of the Organization.

### External Relations (DEC)

7. External Relations serves as a focal point for coordinating activities between PAHO and other international agencies and with bilateral or multilateral official organizations. It is also responsible for maintaining relations with international and regional development banks and with non-governmental organizations in order to mobilize technical and financial resources required in health programs. DEC also provides support to PAHO offices in the field in order to facilitate procedural approaches to external financing of health projects. It also serves as focal point for the project review process.

### Legal Affairs (DLA)

8. Legal Affairs is responsible for providing legal advice and counsel to the Director and other PAHO officials and to PAHO Governing Bodies regarding application of international law and national laws in respect to PAHO's programs and activities, as well as on questions involving PAHO constitutional, procedural and administrative provisions. DLA represents the Organization in disputes and negotiations involving legal issues, including contractual, personnel, extrabudgetary and legislative matters. The Office also prepares or assists in the preparation of contracts, treaties, agreements, resolutions and other documents which have legal implications for the Organization.

ORGANIZATIONAL STRUCTURE - DESCRIPTION (Cont.)

Central Management Information Systems (DMI)

9. Central Management Information Systems is responsible for: (a) developing institutional policies on management of information systems and data processing; (b) providing computational services for HQ administrative and technical programs; (c) conducting and/or managing external feasibility studies, systems analysis, and in-house program development and maintenance; (d) providing advisory services on the selection of hardware and software to the Organization; and (e) developing computer technology to improve the productivity of technical and administrative activities; and (f) coordinating the administration of the electronic communications suystem in the Organization .

Public Information (DPI)

10. DPI is responsible for PAHO's communications activities with the mass media and the general public as well as projects related to video production, photography, exhibits and graphic arts. It handles special activities such as television programs, teleconferences, and other social communications efforts and provides training for journalists and personnel from PAHO and other organizations.

11. DPI issues information on PAHO and country programs and activities and produces non-technical publications, video documentaries and spots, visual and graphic arts and the PAHO Today newsletter. It coordinates field video production and handles regional and international projects related to social communications in cooperation with the technical divisions within and outside the Americas. It serves as a reference center for all communications materials and methods, and coordinates research in mass media aspects of social communications. DPI also handles outreach programs to the private sector in communications.

Executive Secretariat of the Regional Plan for Investment in the Environment and Health (DSI)

12. The basic functions of the Executive Secretariat and the Coordinating Group for the Regional Plan for Investment in the Environment and Health is to design, promote, and coordinate actions for the implementation of the Regional Plan for Investment in the Environment and Health. This involves coordinating the implementation of strategies established for the execution of the Regional Plan for Investment in the Environment and Health, both through the Secretariat's own actions and through actions carried out by the various units in the field and at Headquarters; making provision for the establishment of the Fund for Development of Preinvestment Activities, assuming responsibility for its technical and administrative management, and fostering ties with multilateral lending institutions with a view to arriving at a strategic alliance to promote implementation of the Regional Plan for Investment in Environment and Health.

Internal Audit (IA)

13. Audit ensures that internal financial controls are maintained in the Organization and provides current examination and/or review of all PAHO and WHO financial transactions to ensure regularity of the receipt, custody and disbursement of all funds and other PAHO/WHO resources. It reviews financial operations to ensure conformity of commitments or obligations and expenditures with the appropriations or other financial provisions or with the purposes, rules and provisions relating to the fund concerned. Internal Audit also ensures the economical use of PAHO/WHO resources.

OFFICE OF THE ASSISTANT DIRECTOR

14. Operational Coordination of Country Programs, under the responsibility of the Assistant Director with the support of Country Program Analysts, provides overall technical and administrative supervision and coordination of activities at PWRs, CPC and FO/USMB, as well as coordination of activities between HQ units and the field offices. The Assistant Director is also directly responsible for technical cooperation activities among countries (TCC), as well as for the Emergency Preparedness and Disaster Relief Program and the Women in Health and Development Program. The following units are under the AD:

Country Program Analysts (CPA)

15. The Country Program Analysts as part of the office of the Assistant Director, participate in planning, programming and evaluation processes by providing support to PWRs in the preparation of the Biennial and Annual Program Budgets; participating in the development of PAHO's planning, programming budgeting and evaluation systems; serving as focal point for the organization and follow-up of PAHO/WHO-Government Joint Evaluation Process in collaboration with other units; monitoring the implementation of country programs and assisting in reprogramming and adjustments as needed; and maintaining relevant information with regard to the analysis of the overall country situation and the implementation of the country programs of technical cooperation. They also assist and provide support to the Assistant Director and the other focal points for subregional initiatives.

Emergency Preparedness and Disaster Relief (PED)

16. The objective of the Office of Emergency Preparedness and Disaster Relief is to improve the countries' ability to prepare for emergencies and to strengthen the participation of the health sector in disaster cases. To this end, it promotes the establishment of programs that serve as focal points in national

health services, carries out manpower training activities, prepares guidelines, manuals and teaching materials, supports operations and epidemiological research in emergency situations and compiles, selects and distributes technical material. It cooperates with various international agencies and institutions that provide assistance to the health sector to countries facing emergencies.

Women in Health and Development (PWD)

17. The Office of Women in Health and Development promotes, supports and monitors fulfillment of mandates of PAHO/WHO Governing Bodies and is responsible for the Regional Five-Year Plan of Action on Women in Health and Development. It serves as a focal point for all information and initiatives that the countries and the Organization undertake with regard to this Plan, and coordinates activities with other interested agencies in this field.

OFFICE OF ADMINISTRATION (AM)

18. Administrative Support, under the responsibility of the Chief of Administration, is provided through HQ Units that are entrusted with the overall supervision and execution of administrative policy and the application of regulations, rules and standard procedures in the fields of personnel, finance, budget, general services, administrative systems development and procurement. Units under AM are defined as follows:

Administrative Analysis (AAA) (*)

19. Administrative Analysis is responsible for the development of administrative systems for HQ and field offices. It is also responsible for conducting administrative surveys and for providing in-house management advisory services and assistance. AAA is in charge of the system of directives and general information bulletins. It is also responsible for processing delegations of authority as required by PAHO's internal organizational development and serves as Secretariat of the General Committee on Communications (GCC).

(*) Effective 1 January 1994 this Unit will be disbanded and the functions will be reassigned to other offices.

Budget (ABU)

20. Budget is responsible for formulating and maintaining budgetary policies and procedures required for the implementation of PAHO program activities in accordance with mandates of Governing Bodies and instructions issued by the Director. The Office supports planning, development, and preparation of the biennial program budget and annual operating program budget documents. It controls and analyzes financing of the biennial program budget and annual operating program budget by monitoring inflow of funding and utilization of these resources.

Conference and General Services (ACG)

21. Conference and General Services is responsible for conference arrangements and records, language services, building management, administrative supplies and equipment, communications and mail, transportation, inventory records, and for in-house text processing and reproduction services.

Finance (AFI)

22. Finance is responsible for financial management and accounting policies, rules and procedures and for the control, disbursement and reporting of regular funds and funds from external sources. The Department is also responsible for the operation of the health insurance program, banking and investments, the field office financial administration, and for processes involved in pension and income tax reimbursement.

Personnel (APL)

23. Personnel is responsible for recruitment and assignment, post classification and salary systems, performance appraisal system, staff entitlements, staff rules and personnel policies/procedures, as well as for personnel records and files. It is also responsible for the implementation of staff development and training policies, and for the development and consolidation of training needs of the various units in the Organization into an operating overall program.

Procurement (APO)

24. Procurement is responsible for the procurement and shipment of supplies and equipment for PAHO operating programs and for purchases on behalf of Member Countries and WHO offices.

Administrative Systems Development (ASD)

25. Administrative Systems Development provides systems support to all AM units and PAHO field offices, including feasibility studies and development of computer-supported administrative systems, as well as enhancement and maintenance of installed systems, especially FFMS and FMS (FAMIS). When called upon, ASD provides assistance to the Member Governments and country-level institutions in the area of computerized administrative systems.

ORGANIZATIONAL STRUCTURE - DESCRIPTION (Cont.)

TECHNICAL PROGRAM SUPPORT

Special Programs:

Publications (HBI)

26. Promotes, coordinates and supports PAHO's production and distribution of publications and provides bibliographic information and references to HQ users. Major areas of responsibility are: Editing documents and production of PAHO's official publications as well as technical and scientific publications; coordinating and providing editorial support to publications originated in other units of the Organization; distribution and sale of in-house publications; provision of bibliographic information to HQ staff and to the field, when requested;and collecting and indexing bibliographic material and other PAHO/WHO documents, in collaboration with BIREME.

Maternal and Child Health and Population (HMP)

27. Promotes, coordinates and supports PAHO's programs to improve health conditions in children, adolescents and women. Major areas of responsibility are: perinatal health care; child health care; adolescent health care; women's health care; family planning and other population activities as part of the comprehensive and reproductive health of the family; expanded program on immunization; and control of diarrheal diseases and acute respiratory infections.

Human Resource Development (HRD)

28. Promotes, coordinates and supports PAHO's program activities with respect to training and utilization of human resources in health. The major areas of responsibility are: basic training of health personnel including all categories, levels and professional groups; continuing education of health services personnel; analysis of the conditions of employment and of the labor market to improve the utilization of health personnel and management practices; review of the theory and practice of public health and promotion of training and leadership in that field; in-house international health residency program; administration of the Program of Textbooks and Instructional Materials (PALTEX); and overall administration of the fellowship program.

Technical Support Divisions:

Division of Health and Development (HDP)

29. Promotes, coordinates and supports PAHO's program activities towards the improvement of the participation of the health sector in the national development process. The major areas of responsibility are: development of programs for improvement of the capability for analysis of the health situation and trend assessment at the national level as well as development of general surveillance systems and the regional contribution to the International Classification of Diseases; improvement of the research capability at the national level as related to national needs and the requirements of PAHO's cooperation; support to technology development according to established priorities; support in the development of the capability of the health sector to participate in the political and decision-making processes related to the socioeconomic development, as well as in planning and enactment of appropriate legislation for the Health Sector and for inter-sectoral coordination; analysis and formulation of health policies, especially in regard to health economics including financing of the health sector; improvement of relations between national health services and social security systems, and promotion of activities related to the workers' health; and distribution of scientific and technical information through the Latin American and Caribbean network under the responsibility of BIREME.

Division of Communicable Diseases Prevention and Control (HPC)

30. Promotes, coordinates and supports PAHO's program activities to prevent and control communicable diseases. The major areas of responsibility are: Communicable diseases, including those commonly known as tropical diseases, other viral diseases, and cholera; AIDS, human immunodeficiency virus infections (HIV), and sexually transmitted diseases; monitoring of diseases that require mandatory notification; activities in the field of veterinary public health, including the prevention and control of zoonosis and foot-and-mouth disease; and food protection and surveillance, and control of food-borne diseases.

Division of Health and Environment (HPE)

31. Promotes, coordinates and supports PAHO's program activities with respect to the prevention and control of environmental conditions adverse to human health. The major areas of responsibility are: Water supply and water quality; Basic and general sanitation; management of solid waste, urban and housing sanitation; safety of chemical substances and evaluation and control of environmental risks to health; assessment of the environment with respect to health conditions and promotion of improvements including the protection of water sources and control of land and air pollution; support to basic research and to the development of technology required in the solution of environmental problems related to health.

Division of Health Systems and Services (HSS)

32. Promotes, coordinates and supports PAHO's programs to improve organization and management, as well as effectiveness and efficiency of health systems and services. Major areas of responsibility are: organization and management of health systems and services; decentralization of national health systems and development of SILOS; planning and administration of medical care services; community participation especially at the local level; health care technology and quality; diagnosis and treatment technology; the economics and financing of health services; information support systems in medical care; essential drugs and other medical supplies; oral health; maintenance of health facilities and equipment; training and development of health personnel at the services level, in coordination with HRD; research on health systems and services; and uses and risks of ionizing radiations.

Division of Health Promotion and Protection (HPP)

33. Promotes, coordinates and supports PAHO's program activities in respect to health promotion and control of non-communicable diseases. The major areas of responsibility are: promotion of healthy communities; promotion of individual healthy lifestyles; control of risks related to chronic non-communicable diseases; health actions to combat the abuse of drugs; health of the elderly and prevention of injuries caused by accidents and violence; utilization of social communication for the promotion of health and healthy behaviors; mental health; and human food and nutrition.

PROGRAM BUDGET BY ORGANIZATIONAL STRUCTURE - PAHO AND WHO REGULAR FUNDS

| | | 1992-1993 | | 1994-1995 | | 1996-1997 | |
|---|---|---|---|---|---|---|---|
| | | AMOUNT | % | AMOUNT | % | AMOUNT | % |
| | GOVERNING BODIES | 2,536,500 | 1.1 | 2,645,700 | 1.1 | 2,870,200 | 1.1 |
| | DIRECTOR/DEPUTY DIRECTOR | 15,475,800 | 7.0 | 16,306,100 | 6.7 | 17,616,300 | 6.6 |
| D/DD | OFFICE OF THE DIRECTOR/DEPUTY DIRECTOR | 2,068,400 | .9 | 2,194,100 | .9 | 2,364,800 | .9 |
| DAP | ANALYSIS AND STRATEGIC PLANNING | 2,161,000 | 1.0 | 2,225,000 | .9 | 2,398,500 | .9 |
| DEC | EXTERNAL RELATIONS | 1,242,400 | .6 | 1,118,600 | .5 | 1,209,000 | .5 |
| DLA | LEGAL AFFAIRS | 795,500 | .4 | 1,054,000 | .4 | 1,139,200 | .4 |
| DMI | INFORMATION SYSTEMS MANAGEMENT | 5,861,600 | 2.6 | 4,965,800 | 2.0 | 5,386,800 | 2.0 |
| DPI | PUBLIC INFORMATION | 1,763,300 | .8 | 1,891,400 | .8 | 2,059,800 | .8 |
| DSI | SECRETARIAT, REGIONAL PLAN FOR INVESTMENT IN ENVIRONMENT/HEALTH | - | | 2,335,600 | 1.0 | 2,492,300 | .9 |
| IA | INTERNAL AUDIT | 472,800 | .2 | 521,600 | .2 | 565,900 | .2 |
| HPD | HEALTH PROGRAMS DEVELOPMENT | 516,700 | .2 | - | | - | |
| HSI | HEALTH SERVICES INFRASTRUCTURE | 594,100 | .3 | - | | - | |
| | ASSISTANT DIRECTOR | 4,401,700 | 2.0 | 4,737,600 | 1.9 | 5,134,100 | 1.9 |
| AD | OFFICE OF THE ASSISTANT DIRECTOR | 1,939,200 | .8 | 2,012,900 | .8 | 2,181,600 | .8 |
| PED | EMERGENCY PREPAREDNESS AND DISASTER RELIEF | 567,400 | .3 | 624,300 | .2 | 675,500 | .2 |
| PWD | WOMEN IN HEALTH AND DEVELOPMENT | 589,500 | .3 | 690,200 | .3 | 746,900 | .3 |
| FEP | FIELD OFFICE: USA/MEXICO BORDER | 1,305,600 | .6 | 1,410,200 | .6 | 1,530,100 | .6 |
| | ADMINISTRATION | 29,881,800 | 13.3 | 31,706,000 | 13.0 | 34,478,600 | 12.9 |
| AM | OFFICE OF ADMINISTRATION | 517,100 | .2 | 553,400 | .2 | 592,600 | .2 |
| AAA | ADMINISTRATIVE ANALYSIS | 452,700 | .2 | - | | - | |
| ABU | BUDGET | 1,246,200 | .5 | 1,091,300 | .4 | 1,186,600 | .4 |
| ACG | CONFERENCE AND GENERAL SERVICES | 13,802,700 | 6.2 | 14,828,400 | 6.1 | 16,097,100 | 6.0 |
| AFI | FINANCE | 6,403,200 | 2.9 | 6,887,300 | 2.8 | 7,528,700 | 2.8 |
| APL | PERSONNEL | 5,179,100 | 2.3 | 5,795,700 | 2.4 | 6,307,900 | 2.4 |
| APO | PROCUREMENT | 1,533,600 | .7 | 1,654,500 | .7 | 1,797,100 | .7 |
| ASD | ADMINISTRATIVE SYSTEMS DEVELOPMENT | 747,200 | .3 | 895,400 | .4 | 968,600 | .4 |

PROGRAM BUDGET BY ORGANIZATIONAL STRUCTURE - PAHO AND WHO REGULAR FUNDS (CONT.)

| | | 1992-1993 | | 1994-1995 | | 1996-1997 | |
|---|---|---|---|---|---|---|---|
| | | AMOUNT | % | AMOUNT | % | AMOUNT | % |
| | TECHNICAL PROGRAM SUPPORT | 18,788,800 | 8.4 | 20,146,800 | 8.2 | 21,853,700 | 8.2 |
| HBI | PUBLICATIONS | 5,646,700 | 2.5 | 6,053,400 | 2.5 | 6,582,400 | 2.5 |
| HMP | MATERNAL AND CHILD HEALTH AND POPULATION | 5,540,000 | 2.5 | 6,155,500 | 2.5 | 6,695,000 | 2.5 |
| HRD | HUMAN RESOURCE DEVELOPMENT | 7,602,100 | 3.4 | 7,937,900 | 3.2 | 8,576,300 | 3.2 |
| | TECHNICAL SUPPORT DIVISION | 61,214,400 | 27.3 | 66,583,800 | 27.3 | 72,702,300 | 27.2 |
| HDP | HEALTH AND DEVELOPMENT | 13,921,400 | 6.2 | 15,841,800 | 6.5 | 17,131,300 | 6.4 |
| HPC | COMMUNICABLE DISEASES PREVENTION AND CONTROL | 22,211,800 | 9.9 | 22,868,100 | 9.4 | 25,152,300 | 9.4 |
| HPE | HEALTH AND ENVIRONMENT | 7,314,600 | 3.3 | 8,568,700 | 3.5 | 9,401,700 | 3.5 |
| HPP | HEALTH PROMOTION AND PROTECTION | 9,963,800 | 4.4 | 10,865,500 | 4.4 | 11,903,700 | 4.5 |
| HSS | HEALTH SYSTEMS AND SERVICES | 7,802,800 | 3.5 | 8,439,700 | 3.5 | 9,113,300 | 3.4 |
| | COUNTRIES | 83,417,100 | 37.2 | 93,524,400 | 38.3 | 103,410,300 | 38.6 |
| | CARIBBEAN PROGRAM COORDINATION | 1,755,700 | .8 | 1,974,000 | .8 | 2,206,900 | .8 |
| | REGIONAL DIRECTOR'S DEVELOPMENT PROGRAM | 2,945,200 | 1.3 | 2,686,300 | 1.1 | 2,906,500 | 1.1 |
| | CONTRIBUTION TO RETIREES' HEALTH INSURANCE | 3,650,000 | 1.6 | 3,949,300 | 1.6 | 4,273,100 | 1.6 |
| | TOTAL | 224,067,000 | 100.0 | 244,260,000 | 100.0 | 267,452,000 | 100.0 |

PROGRAM BUDGET BY ORGANIZATIONAL STRUCTURE - EXTRABUDGETARY FUNDS

| | | 1992-1993 | | 1994-1995 | | 1996-1997 | |
|---|---|---|---|---|---|---|---|
| | | AMOUNT | % | AMOUNT | % | AMOUNT | % |
| | GOVERNING BODIES | 19,000 | * | - | - | - | - |
| | DIRECTOR/DEPUTY DIRECTOR | 4,730,600 | 2.6 | 1,322,300 | 1.3 | 1,013,600 | 2.3 |
| DAP | ANALYSIS AND STRATEGIC PLANNING | 614,700 | .3 | 380,800 | .4 | 291,800 | .7 |
| DEC | EXTERNAL RELATIONS | 1,320,700 | .7 | 573,500 | .5 | 322,300 | .7 |
| DMI | INFORMATION SYSTEMS MANAGEMENT | 183,200 | .1 | 213,000 | .2 | 231,500 | .5 |
| DPI | PUBLIC INFORMATION | 2,321,300 | 1.3 | 85,000 | .1 | 91,000 | .2 |
| DSI | SECRETARIAT, REGIONAL PLAN FOR INVESTMENT IN ENVIRONMENT/HEALTH | 290,700 | .2 | 70,000 | .1 | 77,000 | .2 |
| | ASSISTANT DIRECTOR | 8,166,600 | 4.6 | 1,574,000 | 1.6 | - | - |
| AD | OFFICE OF THE ASSISTANT DIRECTOR | 426,000 | .2 | - | - | - | - |
| PED | EMERGENCY PREPAREDNESS AND DISASTER RELIEF | 6,888,400 | 3.9 | 274,000 | .3 | - | - |
| PWD | WOMEN IN HEALTH AND DEVELOPMENT | 667,100 | .4 | 1,300,000 | 1.3 | - | - |
| FEP | FIELD OFFICE: USA/MEXICO BORDER | 185,100 | .1 | - | - | - | - |
| | ADMINISTRATION | 7,472,200 | 4.2 | 5,040,100 | 5.0 | 5,423,200 | 12.4 |
| AM | OFFICE OF ADMINISTRATION | 162,600 | .1 | 76,000 | .1 | 83,000 | .2 |
| ABU | BUDGET | 366,600 | .2 | 351,700 | .3 | 377,100 | .9 |
| ACG | CONFERENCE AND GENERAL SERVICES | 3,600,400 | 2.0 | 1,466,000 | 1.5 | 1,570,600 | 3.6 |
| AFI | FINANCE | 1,639,300 | .9 | 1,535,300 | 1.5 | 1,660,800 | 3.8 |
| APL | PERSONNEL | 355,100 | .2 | 271,600 | .3 | 289,800 | .7 |
| APO | PROCUREMENT | 869,800 | .5 | 907,000 | .9 | 975,800 | 2.2 |
| ASD | ADMINISTRATIVE SYSTEMS DEVELOPMENT | 478,400 | .3 | 432,500 | .4 | 466,100 | 1.0 |

PROGRAM BUDGET BY ORGANIZATIONAL STRUCTURE - EXTRABUDGETARY FUNDS (CONT.)

| | | 1992-1993 | | 1994-1995 | | 1996-1997 | |
|---|---|---|---|---|---|---|---|
| | | AMOUNT | % | AMOUNT | % | AMOUNT | % |
| | TECHNICAL SUPPORT PROGRAMS | 27,564,900 | 15.4 | 20,428,400 | 20.3 | 6,098,900 | 13.9 |
| HBI | PUBLICATIONS | 387,100 | .2 | 63,700 | .1 | 68,000 | .1 |
| HMP | MATERNAL AND CHILD HEALTH AND POPULATION | 25,645,100 | 14.3 | 17,701,300 | 17.6 | 5,770,900 | 13.2 |
| HRD | HUMAN RESOURCE DEVELOPMENT | 1,532,700 | .9 | 2,663,400 | 2.6 | 260,000 | .6 |
| | TECHNICAL SUPPORT DIVISION | 58,282,600 | 32.5 | 41,340,600 | 41.0 | 30,373,600 | 69.4 |
| HDP | HEALTH AND DEVELOPMENT | 4,326,600 | 2.4 | 960,000 | .9 | 964,500 | 2.2 |
| HPC | COMMUNICABLE DISEASES PREVENTION AND CONTROL | 30,407,400 | 16.9 | 18,745,900 | 18.6 | 12,987,600 | 29.7 |
| HPE | HEALTH AND ENVIRONMENT | 3,884,100 | 2.2 | 4,735,400 | 4.7 | 1,412,100 | 3.2 |
| HPP | HEALTH PROMOTION AND PROTECTION | 16,262,900 | 9.1 | 14,879,500 | 14.8 | 14,872,400 | 34.0 |
| HSS | HEALTH SYSTEMS AND SERVICES | 3,401,600 | 1.9 | 2,019,800 | 2.0 | 137,000 | .3 |
| | COUNTRIES | 72,952,100 | 40.7 | 31,028,600 | 30.8 | 885,700 | 2.0 |
| | TOTAL | 179,188,000 | 100.0 | 100,734,000 | 100.0 | 43,795,000 | 100.0 |

* LESS THAN .05 PER CENT

**ANNEX**

**ANNEX**

PROGRAM BUDGET - PAHO REGULAR FUNDS
(WHO CLASSIFIED LIST OF PROGRAMS)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| I. DIRECTION, COORDINATION AND MANAGEMENT | | 17,697,600 | 11.5 | 16,481,600 | 10.1 | 17,841,100 | 10.0 |
| GOVERNING BODIES | | 2,176,100 | 1.4 | 2,262,600 | 1.4 | 2,455,700 | 1.4 |
| REGIONAL COMMITTEES | RCO | 2,176,100 | 1.4 | 2,262,600 | 1.4 | 2,455,700 | 1.4 |
| WHO'S GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT | | 15,521,500 | 10.1 | 14,219,000 | 8.7 | 15,385,400 | 8.6 |
| EXECUTIVE MANAGEMENT | EXM | 2,902,600 | 1.9 | 3,295,600 | 2.0 | 3,566,500 | 2.0 |
| DIR.-GENERAL'S/REG. DIRECTORS' DEVELOPMENT PROGRAM | DGP | 2,789,200 | 1.8 | 2,566,300 | 1.6 | 2,776,700 | 1.5 |
| GENERAL PROGRAM DEVELOPMENT | GPD | 2,201,900 | 1.4 | 1,502,600 | .9 | 1,625,700 | .9 |
| EXTERNAL COORDINATION FOR HEALTH & SOCIAL DEVELOP. | COR | 1,242,400 | .8 | 1,118,600 | .7 | 1,209,000 | .7 |
| HEALTH-FOR-ALL STRATEGY COORDINATION | HSC | 1,244,900 | .8 | 1,263,000 | .8 | 1,354,100 | .8 |
| INFORMATICS MANAGEMENT | ISS | 5,140,500 | 3.4 | 4,472,900 | 2.7 | 4,853,400 | 2.7 |
| II. HEALTH SYSTEM INFRASTRUCTURE | | 60,861,300 | 40.1 | 65,092,200 | 39.8 | 71,679,200 | 39.8 |
| HEALTH SYSTEM DEVELOPMENT | | 36,861,700 | 24.3 | 42,207,300 | 25.9 | 46,756,300 | 26.0 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 4,381,700 | 2.9 | 3,058,000 | 1.9 | 3,333,800 | 1.8 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | MPN | 32,015,800 | 21.1 | 38,014,200 | 23.3 | 42,201,200 | 23.5 |
| HEALTH LEGISLATION | HLE | 464,200 | .3 | 1,135,100 | .7 | 1,221,300 | .7 |
| ORG.OF HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE | | 13,364,000 | 8.8 | 12,501,500 | 7.6 | 13,597,100 | 7.5 |
| ORG.OF HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE | PHC | 13,364,000 | 8.8 | 12,501,500 | 7.6 | 13,597,100 | 7.5 |
| DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH | | 8,997,200 | 5.9 | 8,435,200 | 5.1 | 9,192,900 | 5.1 |
| DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH | HRH | 8,997,200 | 5.9 | 8,435,200 | 5.1 | 9,192,900 | 5.1 |
| PUBLIC INFORMATION AND EDUCATION FOR HEALTH | | 1,638,400 | 1.1 | 1,948,200 | 1.2 | 2,132,900 | 1.2 |
| PUBLIC INFORMATION AND EDUCATION FOR HEALTH | IEH | 1,638,400 | 1.1 | 1,948,200 | 1.2 | 2,132,900 | 1.2 |

PROGRAM BUDGET - PAHO REGULAR FUNDS (CONT.)
(WHO CLASSIFIED LIST OF PROGRAMS)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| III. HEALTH SCIENCE AND TECHNOLOGY | | 27,680,500 | 18.1 | 32,551,300 | 19.6 | 35,633,100 | 19.6 |
| RESEARCH PROMOTION AND DEVELOPMENT | | 3,528,700 | 2.3 | 3,785,400 | 2.3 | 4,081,100 | 2.3 |
| RESEARCH PROMOTION AND DEVELOPMENT | RPD | 3,528,700 | 2.3 | 3,785,400 | 2.3 | 4,081,100 | 2.3 |
| GENERAL HEALTH PROTECTION AND PROMOTION | | 6,000,900 | 3.9 | 6,115,000 | 3.6 | 6,750,600 | 3.6 |
| NUTRITION | NUT | 5,462,200 | 3.6 | 5,610,200 | 3.4 | 6,205,400 | 3.4 |
| ORAL HEALTH | ORH | 430,700 | .3 | 389,000 | .2 | 422,300 | .2 |
| ACCIDENT PREVENTION | APR | 50,300 | .* | 53,800 | .* | 56,900 | .* |
| TOBACCO OR HEALTH | TOH | 57,700 | .* | 62,000 | .* | 66,000 | .* |
| HEALTH OF SPECIFIC POPULATION GROUPS | | 5,922,400 | 3.8 | 7,456,500 | 4.5 | 8,195,800 | 4.5 |
| MATERNAL AND CHILD HEALTH | MCH | 5,331,800 | 3.5 | 6,806,800 | 4.1 | 7,495,700 | 4.2 |
| ADOLESCENT HEALTH | ADH | 63,700 | .* | 67,700 | .* | 70,500 | .* |
| WORKERS' HEALTH | OCH | 526,900 | .3 | 582,000 | .4 | 629,600 | .3 |
| PROTECTION AND PROMOTION OF MENTAL HEALTH | | 117,300 | .1 | 107,500 | .1 | 114,500 | .1 |
| PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE | ADA | 117,300 | .1 | 107,500 | .1 | 114,500 | .1 |
| PROMOTION OF ENVIRONMENTAL HEALTH | | 10,660,600 | 7.0 | 13,278,700 | 8.0 | 14,531,600 | 8.0 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 5,985,800 | 3.9 | 6,975,600 | 4.2 | 7,660,400 | 4.2 |
| ENVIRONMENTAL HEALTH IN RURAL & URBAN DEVELOPMENT | RUD | 277,400 | .2 | 338,300 | .2 | 363,200 | .2 |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 3,189,300 | 2.1 | 4,086,500 | 2.5 | 4,453,000 | 2.5 |
| FOOD SAFETY | FOS | 1,208,100 | .8 | 1,878,300 | 1.1 | 2,055,000 | 1.1 |
| DIAGNOSTIC, THERAPEUTIC, REHABILITATIVE TECHNOLOGY | | 1,450,600 | 1.0 | 1,808,200 | 1.1 | 1,959,500 | 1.1 |
| CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY | CLR | 560,700 | .4 | 642,500 | .4 | 690,400 | .4 |
| ESSENTIAL DRUGS AND VACCINES | EDV | 445,500 | .3 | 758,300 | .5 | 831,500 | .5 |
| REHABILITATION | RHB | 444,400 | .3 | 407,400 | .2 | 437,600 | .2 |

PROGRAM BUDGET - PAHO REGULAR FUNDS (CONT.)
(WHO CLASSIFIED LIST OF PROGRAMS)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| IV. DISEASE PREVENTION AND CONTROL | | 22,879,300 | 14.9 | 24,071,400 | 14.7 | 26,563,500 | 14.8 |
| DISEASE PREVENTION AND CONTROL | | 22,879,300 | 14.9 | 24,071,400 | 14.7 | 26,563,500 | 14.8 |
| IMMUNIZATION | EPI | 156,800 | .1 | 284,900 | .2 | 323,100 | .2 |
| DISEASE VECTOR CONTROL | VBC | 331,100 | .2 | 308,100 | .2 | 333,300 | .2 |
| MALARIA | MAL | 880,400 | .6 | 302,000 | .2 | 334,200 | .2 |
| PARASITIC DISEASES | PDP | 90,300 | .1 | 96,700 | .1 | 102,500 | .1 |
| DIARRHEAL DISEASES | CDD | 674,700 | .4 | 724,800 | .4 | 774,400 | .4 |
| ACUTE RESPIRATORY INFECTIONS | ARI | 184,600 | .1 | 198,100 | .1 | 211,300 | .1 |
| TUBERCULOSIS | TUB | 196,200 | .1 | 209,600 | .1 | 226,900 | .1 |
| ZOONOSES | VPH | 12,968,800 | 8.5 | 11,932,800 | 7.3 | 13,333,400 | 7.4 |
| RESEARCH AND DEVELOPMENT IN THE FIELD OF VACCINES | RDV | 387,600 | .3 | 425,700 | .3 | 457,700 | .3 |
| AIDS | GPA | 359,000 | .2 | 376,800 | .2 | 403,500 | .2 |
| OTHER COMMUNICABLE DISEASE PREVENTION AND CONTROL | OCD | 2,930,800 | 1.9 | 4,697,700 | 2.9 | 5,142,600 | 2.9 |
| CANCER | CAN | 57,000 | * | 0 | - | 0 | - |
| OTHER NONCOMMUNIC. DISEASE PREVENTION AND CONTROL | NCD | 3,662,000 | 2.4 | 4,514,200 | 2.7 | 4,920,600 | 2.7 |
| V. PROGRAM SUPPORT | | 23,457,300 | 15.4 | 26,269,500 | 15.8 | 28,640,100 | 15.8 |
| HEALTH INFORMATION SUPPORT | | 5,449,600 | 3.6 | 5,922,300 | 3.6 | 6,492,800 | 3.6 |
| HEALTH INFORMATION SUPPORT | HBI | 5,449,600 | 3.6 | 5,922,300 | 3.6 | 6,492,800 | 3.6 |
| SUPPORT SERVICES | | 18,007,700 | 11.8 | 20,347,200 | 12.2 | 22,147,300 | 12.2 |
| PERSONNEL | PER | 2,260,000 | 1.5 | 2,704,300 | 1.6 | 2,954,300 | 1.6 |
| GENERAL ADMINISTRATION AND SERVICES | GAD | 8,636,700 | 5.7 | 9,934,400 | 6.0 | 10,783,900 | 6.0 |
| BUDGET AND FINANCE | BFI | 5,976,500 | 3.9 | 6,490,700 | 3.9 | 7,085,000 | 3.9 |
| EQUIPMENT AND SUPPLIES FOR MEMBER STATES | SUP | 1,134,500 | .7 | 1,217,800 | .7 | 1,324,100 | .7 |
| GRAND TOTAL | | 152,576,000 | 100.0 | 164,466,000 | 100.0 | 180,357,000 | 100.0 |

* LESS THAN .05 PER CENT

PROGRAM BUDGET - WHO REGULAR FUNDS
(WHO CLASSIFIED LIST OF PROGRAMS)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| I. DIRECTION, COORDINATION AND MANAGEMENT | | 2,903,100 | 4.1 | 2,419,700 | 3.1 | 2,619,000 | 3.0 |
| GOVERNING BODIES | | 360,400 | .5 | 383,100 | .5 | 414,500 | .5 |
| REGIONAL COMMITTEES | RCO | 360,400 | .5 | 383,100 | .5 | 414,500 | .5 |
| WHO'S GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT | | 2,542,700 | 3.6 | 2,036,600 | 2.6 | 2,204,500 | 2.5 |
| EXECUTIVE MANAGEMENT | EXM | 339,000 | .5 | 371,500 | .5 | 397,500 | .5 |
| DIR.-GENERAL'S/REG. DIRECTORS' DEVELOPMENT PROGRAM | DGP | 156,000 | .2 | 120,000 | .2 | 129,800 | .1 |
| GENERAL PROGRAM DEVELOPMENT | GPD | 574,600 | .8 | 267,800 | .3 | 291,600 | .3 |
| HEALTH-FOR-ALL STRATEGY COORDINATION | HSC | 752,000 | 1.1 | 784,400 | 1.0 | 852,200 | 1.0 |
| INFORMATICS MANAGEMENT | ISS | 721,100 | 1.0 | 492,900 | .6 | 533,400 | .5 |
| II. HEALTH SYSTEM INFRASTRUCTURE | | 30,588,000 | 42.9 | 35,647,200 | 44.6 | 39,027,400 | 44.7 |
| HEALTH SYSTEM DEVELOPMENT | | 12,307,100 | 17.2 | 13,917,500 | 17.4 | 15,369,000 | 17.7 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 6,200,200 | 8.7 | 6,951,700 | 8.7 | 7,572,900 | 8.7 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | MPN | 6,106,900 | 8.5 | 6,965,800 | 8.7 | 7,796,100 | 9.0 |
| ORG.OF HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE | | 13,232,100 | 18.7 | 15,702,200 | 19.6 | 17,141,100 | 19.5 |
| ORG.OF HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE | PHC | 13,232,100 | 18.7 | 15,702,200 | 19.6 | 17,141,100 | 19.5 |
| DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH | | 4,311,200 | 6.0 | 5,330,600 | 6.7 | 5,766,400 | 6.6 |
| DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH | HRH | 4,311,200 | 6.0 | 5,330,600 | 6.7 | 5,766,400 | 6.6 |
| PUBLIC INFORMATION AND EDUCATION FOR HEALTH | | 737,600 | 1.0 | 696,900 | .9 | 750,900 | .9 |
| PUBLIC INFORMATION AND EDUCATION FOR HEALTH | IEH | 737,600 | 1.0 | 696,900 | .9 | 750,900 | .9 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 14,978,600 | 20.9 | 16,205,000 | 20.2 | 17,702,000 | 20.3 |
| RESEARCH PROMOTION AND DEVELOPMENT | | 541,100 | .8 | 456,200 | .6 | 499,200 | .6 |
| RESEARCH PROMOTION AND DEVELOPMENT | RPD | 541,100 | .8 | 456,200 | .6 | 499,200 | .6 |

PROGRAM BUDGET - WHO REGULAR FUNDS (CONT.)
(WHO CLASSIFIED LIST OF PROGRAMS)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| GENERAL HEALTH PROTECTION AND PROMOTION | | 2,183,400 | 3.1 | 2,312,200 | 2.9 | 2,546,800 | 3.0 |
| NUTRITION | NUT | 1,903,400 | 2.7 | 2,012,800 | 2.5 | 2,222,100 | 2.6 |
| ORAL HEALTH | ORH | 280,000 | .4 | 299,400 | .4 | 324,700 | .4 |
| HEALTH OF SPECIFIC POPULATION GROUPS | | 2,589,200 | 3.5 | 3,100,500 | 3.8 | 3,364,400 | 3.8 |
| MATERNAL AND CHILD HEALTH | MCH | 2,090,600 | 2.9 | 2,584,800 | 3.2 | 2,808,100 | 3.2 |
| WORKERS' HEALTH | OCH | 34,600 | .* | 34,100 | .* | 37,600 | .* |
| HEALTH OF THE ELDERLY | HEE | 464,000 | .6 | 481,600 | .6 | 518,700 | .6 |
| PROTECTION AND PROMOTION OF MENTAL HEALTH | | 764,400 | 1.1 | 733,600 | .9 | 791,500 | .9 |
| PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE | ADA | 299,500 | .4 | 250,800 | .3 | 271,100 | .3 |
| PREV./TREAT. OF MENTAL AND NEUROLOGICAL DISORDERS | MND | 464,900 | .7 | 482,800 | .6 | 520,400 | .6 |
| PROMOTION OF ENVIRONMENTAL HEALTH | | 7,729,300 | 10.8 | 8,438,300 | 10.6 | 9,231,800 | 10.6 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 4,662,600 | 6.5 | 5,109,000 | 6.4 | 5,593,100 | 6.4 |
| ENVIRONMENTAL HEALTH IN RURAL & URBAN DEVELOPMENT | RUD | 259,800 | .4 | 243,500 | .3 | 263,700 | .3 |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 1,882,700 | 2.6 | 2,157,100 | 2.7 | 2,367,800 | 2.7 |
| FOOD SAFETY | FOS | 924,200 | 1.3 | 928,700 | 1.2 | 1,007,200 | 1.2 |
| DIAGNOSTIC, THERAPEUTIC, REHABILITATIVE TECHNOLOGY | | 1,171,200 | 1.6 | 1,164,200 | 1.4 | 1,268,300 | 1.4 |
| CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY | CLR | 312,500 | .4 | 345,000 | .4 | 374,700 | .4 |
| ESSENTIAL DRUGS AND VACCINES | EDV | 858,700 | 1.2 | 819,200 | 1.0 | 893,600 | 1.0 |
| IV. DISEASE PREVENTION AND CONTROL | | 12,895,100 | 17.9 | 15,128,000 | 19.0 | 16,448,600 | 19.0 |
| DISEASE PREVENTION AND CONTROL | | 12,895,100 | 17.9 | 15,128,000 | 19.0 | 16,448,600 | 19.0 |
| IMMUNIZATION | EPI | 1,516,600 | 2.1 | 1,618,400 | 2.0 | 1,747,000 | 2.0 |
| DISEASE VECTOR CONTROL | VBC | 2,668,200 | 3.7 | 2,302,100 | 2.9 | 2,483,300 | 2.9 |
| MALARIA | MAL | 952,100 | 1.3 | 1,340,400 | 1.7 | 1,447,000 | 1.7 |
| PARASITIC DISEASES | POP | 286,400 | .4 | 319,800 | .4 | 347,000 | .4 |
| DIARRHEAL DISEASES | CDD | 433,300 | .6 | 592,500 | .7 | 647,200 | .7 |
| ACUTE RESPIRATORY INFECTIONS | ARI | 224,800 | .3 | 250,800 | .3 | 271,100 | .3 |
| TUBERCULOSIS | TUB | 232,400 | .3 | 243,400 | .3 | 261,300 | .3 |
| LEPROSY | LEP | 349,300 | .5 | 363,900 | .5 | 394,200 | .5 |
| ZOONOSES | VPH | 1,881,000 | 2.6 | 2,305,200 | 2.9 | 2,502,200 | 2.9 |
| SEXUALLY TRANSMITTED DISEASES | VDT | 47,900 | .1 | 50,700 | .1 | 52,600 | .1 |
| RESEARCH AND DEVELOPMENT IN THE FIELD OF VACCINES | RDV | 0 | - | 239,300 | .3 | 259,700 | .3 |
| AIDS | GPA | 15,700 | .* | 241,700 | .3 | 269,600 | .3 |
| OTHER COMMUNICABLE DISEASE PREVENTION AND CONTROL | OCD | 3,011,000 | 4.2 | 3,807,600 | 4.8 | 4,186,800 | 4.8 |
| BLINDNESS AND DEAFNESS | PBD | 63,700 | .1 | 57,900 | .1 | 61,400 | .1 |
| OTHER NONCOMMUNIC. DISEASE PREVENTION AND CONTROL | NCD | 1,212,700 | 1.7 | 1,394,300 | 1.7 | 1,518,200 | 1.7 |

PROGRAM BUDGET - WHO REGULAR FUNDS (CONT.)
(WHO CLASSIFIED LIST OF PROGRAMS)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| V. PROGRAM SUPPORT | | 10,126,200 | 14.2 | 10,394,100 | 13.1 | 11,298,000 | 13.0 |
| HEALTH INFORMATION SUPPORT | | 3,228,600 | 4.5 | 3,976,200 | 5.0 | 4,315,600 | 5.0 |
| HEALTH INFORMATION SUPPORT | HBI | 3,228,600 | 4.5 | 3,976,200 | 5.0 | 4,315,600 | 5.0 |
| SUPPORT SERVICES | | 6,897,600 | 9.7 | 6,417,900 | 8.1 | 6,982,400 | 8.0 |
| PERSONNEL | PER | 1,253,400 | 1.8 | 1,321,000 | 1.7 | 1,436,300 | 1.6 |
| GENERAL ADMINISTRATION AND SERVICES | GAD | 3,572,200 | 5.0 | 3,172,300 | 4.0 | 3,442,800 | 4.0 |
| BUDGET AND FINANCE | BFI | 1,672,900 | 2.3 | 1,487,900 | 1.9 | 1,630,300 | 1.9 |
| EQUIPMENT AND SUPPLIES FOR MEMBER STATES | SUP | 399,100 | .6 | 436,700 | .5 | 473,000 | .5 |
| GRAND TOTAL | | 71,491,000 | 100.0 | 79,794,000 | 100.0 | 87,095,000 | 100.0 |

* LESS THAN .05 PER CENT

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS
(WHO CLASSIFIED LIST OF PROGRAMS)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| I. DIRECTION, COORDINATION AND MANAGEMENT | | 20,600,700 | 9.1 | 18,901,300 | 7.7 | 20,460,100 | 7.7 |
| GOVERNING BODIES | | 2,536,500 | 1.1 | 2,645,700 | 1.1 | 2,870,200 | 1.1 |
| REGIONAL COMMITTEES | RCO | 2,536,500 | 1.1 | 2,645,700 | 1.1 | 2,870,200 | 1.1 |
| WHO'S GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT | | 18,064,200 | 8.0 | 16,255,600 | 6.6 | 17,589,900 | 6.6 |
| EXECUTIVE MANAGEMENT | EXM | 3,241,600 | 1.4 | 3,667,100 | 1.5 | 3,964,000 | 1.5 |
| DIR.-GENERAL'S/REG. DIRECTORS' DEVELOPMENT PROGRAM | DGP | 2,945,200 | 1.3 | 2,686,300 | 1.1 | 2,906,500 | 1.1 |
| GENERAL PROGRAM DEVELOPMENT | GPD | 2,776,500 | 1.2 | 1,770,400 | .7 | 1,917,300 | .7 |
| EXTERNAL COORDINATION FOR HEALTH & SOCIAL DEVELOP. | COR | 1,242,400 | .6 | 1,118,600 | .5 | 1,209,000 | .5 |
| HEALTH-FOR-ALL STRATEGY COORDINATION | HSC | 1,996,900 | .9 | 2,047,400 | .8 | 2,206,300 | .8 |
| INFORMATICS MANAGEMENT | ISS | 5,861,600 | 2.6 | 4,965,800 | 2.0 | 5,386,800 | 2.0 |
| II. HEALTH SYSTEM INFRASTRUCTURE | | 91,449,300 | 40.8 | 100,739,400 | 41.4 | 110,706,600 | 41.3 |
| HEALTH SYSTEM DEVELOPMENT | | 49,168,800 | 21.9 | 56,124,800 | 23.2 | 62,125,300 | 23.1 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 10,581,900 | 4.7 | 10,009,700 | 4.1 | 10,906,700 | 4.1 |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | MPN | 38,122,700 | 17.0 | 44,980,000 | 18.6 | 49,997,300 | 18.5 |
| HEALTH LEGISLATION | HLE | 464,200 | .2 | 1,135,100 | .5 | 1,221,300 | .5 |
| ORG.OF HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE | | 26,596,100 | 11.9 | 28,203,700 | 11.5 | 30,738,200 | 11.5 |
| ORG.OF HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE | PHC | 26,596,100 | 11.9 | 28,203,700 | 11.5 | 30,738,200 | 11.5 |
| DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH | | 13,308,400 | 5.9 | 13,765,800 | 5.6 | 14,959,300 | 5.6 |
| DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH | HRH | 13,308,400 | 5.9 | 13,765,800 | 5.6 | 14,959,300 | 5.6 |
| PUBLIC INFORMATION AND EDUCATION FOR HEALTH | | 2,376,000 | 1.1 | 2,645,100 | 1.1 | 2,883,800 | 1.1 |
| PUBLIC INFORMATION AND EDUCATION FOR HEALTH | IEH | 2,376,000 | 1.1 | 2,645,100 | 1.1 | 2,883,800 | 1.1 |

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)
(WHO CLASSIFIED LIST OF PROGRAMS)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| III. HEALTH SCIENCE AND TECHNOLOGY | | 42,659,100 | 19.1 | 48,756,300 | 19.7 | 53,335,100 | 19.9 |
| RESEARCH PROMOTION AND DEVELOPMENT | | 4,069,800 | 1.8 | 4,241,600 | 1.7 | 4,580,300 | 1.7 |
| RESEARCH PROMOTION AND DEVELOPMENT | RPD | 4,069,800 | 1.8 | 4,241,600 | 1.7 | 4,580,300 | 1.7 |
| GENERAL HEALTH PROTECTION AND PROMOTION | | 8,184,300 | 3.6 | 8,427,200 | 3.4 | 9,297,400 | 3.5 |
| NUTRITION | NUT | 7,365,600 | 3.3 | 7,623,000 | 3.1 | 8,427,500 | 3.2 |
| ORAL HEALTH | ORH | 710,700 | .3 | 688,400 | .3 | 747,000 | .3 |
| ACCIDENT PREVENTION | APR | 50,300 | .* | 53,800 | .* | 56,900 | .* |
| TOBACCO OR HEALTH | TOH | 57,700 | .* | 62,000 | .* | 66,000 | .* |
| HEALTH OF SPECIFIC POPULATION GROUPS | | 8,511,600 | 3.8 | 10,557,000 | 4.3 | 11,560,200 | 4.3 |
| MATERNAL AND CHILD HEALTH | MCH | 7,422,400 | 3.3 | 9,391,600 | 3.8 | 10,303,800 | 3.9 |
| ADOLESCENT HEALTH | ADH | 63,700 | .* | 67,700 | .* | 70,500 | .* |
| WORKERS' HEALTH | OCH | 561,500 | .3 | 616,100 | .3 | 667,200 | .2 |
| HEALTH OF THE ELDERLY | HEE | 464,000 | .2 | 481,600 | .2 | 518,700 | .2 |
| PROTECTION AND PROMOTION OF MENTAL HEALTH | | 881,700 | .4 | 841,100 | .3 | 906,000 | .3 |
| PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE | ADA | 416,800 | .2 | 358,300 | .1 | 385,600 | .1 |
| PREV./TREAT. OF MENTAL AND NEUROLOGICAL DISORDERS | MND | 464,900 | .2 | 482,800 | .2 | 520,400 | .2 |
| PROMOTION OF ENVIRONMENTAL HEALTH | | 18,389,900 | 8.3 | 21,717,000 | 8.8 | 23,763,400 | 8.9 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 10,648,400 | 4.8 | 12,084,600 | 4.9 | 13,253,500 | 5.0 |
| ENVIRONMENTAL HEALTH IN RURAL & URBAN DEVELOPMENT | RUD | 537,200 | .2 | 581,800 | .2 | 626,900 | .2 |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 5,072,000 | 2.3 | 6,243,600 | 2.6 | 6,820,800 | 2.6 |
| FOOD SAFETY | FOS | 2,132,300 | 1.0 | 2,807,000 | 1.1 | 3,062,200 | 1.1 |
| DIAGNOSTIC, THERAPEUTIC, REHABILITATIVE TECHNOLOGY | | 2,621,800 | 1.2 | 2,972,400 | 1.2 | 3,227,800 | 1.2 |
| CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY | CLR | 873,200 | .4 | 987,500 | .4 | 1,065,100 | .4 |
| ESSENTIAL DRUGS AND VACCINES | EDV | 1,304,200 | .6 | 1,577,500 | .6 | 1,725,100 | .6 |
| REHABILITATION | RHB | 444,400 | .2 | 407,400 | .2 | 437,600 | .2 |

## PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)
## (WHO CLASSIFIED LIST OF PROGRAMS)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| IV. DISEASE PREVENTION AND CONTROL | | 35,774,400 | 16.0 | 39,199,400 | 16.1 | 43,012,100 | 16.2 |
| DISEASE PREVENTION AND CONTROL | | 35,774,400 | 16.0 | 39,199,400 | 16.1 | 43,012,100 | 16.2 |
| IMMUNIZATION | EPI | 1,673,400 | .7 | 1,903,300 | .8 | 2,070,100 | .8 |
| DISEASE VECTOR CONTROL | VBC | 2,999,300 | 1.3 | 2,610,200 | 1.1 | 2,816,600 | 1.1 |
| MALARIA | MAL | 1,832,500 | .8 | 1,642,400 | .7 | 1,781,200 | .7 |
| PARASITIC DISEASES | PDP | 376,700 | .2 | 416,500 | .2 | 449,500 | .2 |
| DIARRHEAL DISEASES | CDD | 1,108,000 | .5 | 1,317,300 | .5 | 1,421,600 | .5 |
| ACUTE RESPIRATORY INFECTIONS | ARI | 409,400 | .2 | 448,900 | .2 | 482,400 | .2 |
| TUBERCULOSIS | TUB | 428,600 | .2 | 453,000 | .2 | 488,200 | .2 |
| LEPROSY | LEP | 349,300 | .2 | 363,900 | .1 | 394,200 | .1 |
| ZOONOSES | VPH | 14,849,800 | 6.6 | 14,238,000 | 5.8 | 15,835,600 | 5.9 |
| SEXUALLY TRANSMITTED DISEASES | VDT | 47,900 | * | 50,700 | * | 52,600 | * |
| RESEARCH AND DEVELOPMENT IN THE FIELD OF VACCINES | RDV | 387,600 | .2 | 665,000 | .3 | 717,400 | .3 |
| AIDS | GPA | 374,700 | .2 | 618,500 | .3 | 673,100 | .3 |
| OTHER COMMUNICABLE DISEASE PREVENTION AND CONTROL | OCD | 5,941,800 | 2.7 | 8,505,300 | 3.5 | 9,329,400 | 3.5 |
| BLINDNESS AND DEAFNESS | PBD | 63,700 | * | 57,900 | * | 61,400 | * |
| CANCER | CAN | 57,000 | * | 0 | - | 0 | - |
| OTHER NONCOMMUNIC. DISEASE PREVENTION AND CONTROL | NCD | 4,874,700 | 2.2 | 5,908,500 | 2.4 | 6,438,800 | 2.4 |
| V. PROGRAM SUPPORT | | 33,583,500 | 15.0 | 36,663,600 | 15.1 | 39,938,100 | 14.9 |
| HEALTH INFORMATION SUPPORT | | 8,678,200 | 3.9 | 9,898,500 | 4.1 | 10,808,400 | 4.0 |
| HEALTH INFORMATION SUPPORT | HBI | 8,678,200 | 3.9 | 9,898,500 | 4.1 | 10,808,400 | 4.0 |
| SUPPORT SERVICES | | 24,905,300 | 11.1 | 26,765,100 | 11.0 | 29,129,700 | 10.9 |
| PERSONNEL | PER | 3,513,400 | 1.6 | 4,025,300 | 1.6 | 4,390,600 | 1.6 |
| GENERAL ADMINISTRATION AND SERVICES | GAD | 12,208,900 | 5.4 | 13,106,700 | 5.4 | 14,226,700 | 5.3 |
| BUDGET AND FINANCE | BFI | 7,649,400 | 3.4 | 7,978,600 | 3.3 | 8,715,300 | 3.3 |
| EQUIPMENT AND SUPPLIES FOR MEMBER STATES | SUP | 1,533,600 | .7 | 1,654,500 | .7 | 1,797,100 | .7 |
| GRAND TOTAL | | 224,067,000 | 100.0 | 244,260,000 | 100.0 | 267,452,000 | 100.0 |

* LESS THAN .05 PER CENT

PROGRAM BUDGET - EXTRABUDGETARY FUNDS
(WHO CLASSIFIED LIST OF PROGRAMS)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| I. DIRECTION, COORDINATION AND MANAGEMENT | | 812,000 | .5 | 952,700 | 1.0 | 845,600 | 1.9 |
| GOVERNING BODIES | | 19,000 | .* | 0 | - | 0 | - |
| REGIONAL COMMITTEES | RCO | 19,000 | .* | 0 | - | 0 | - |
| WHO'S GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT | | 793,000 | .5 | 952,700 | 1.0 | 845,600 | 1.9 |
| GENERAL PROGRAM DEVELOPMENT | GPD | 1,100 | .* | 0 | - | 0 | - |
| EXTERNAL COORDINATION FOR HEALTH & SOCIAL DEVELOP. | COR | 460,700 | .3 | 471,900 | .5 | 322,300 | .7 |
| HEALTH-FOR-ALL STRATEGY COORDINATION | HSC | 148,000 | .1 | 267,800 | .3 | 291,800 | .7 |
| INFORMATICS MANAGEMENT | ISS | 183,200 | .1 | 213,000 | .2 | 231,500 | .5 |
| II. HEALTH SYSTEM INFRASTRUCTURE | | 47,731,600 | 26.7 | 12,678,800 | 12.6 | 1,444,100 | 3.3 |
| HEALTH SYSTEM DEVELOPMENT | | 9,622,800 | 5.4 | 1,006,500 | 1.0 | 956,100 | 2.2 |
| HEALTH SITUATION AND TREND ASSESSMENT | HST | 5,650,100 | 3.2 | 0 | - | 0 | - |
| MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT | MPN | 3,972,700 | 2.2 | 1,006,500 | 1.0 | 956,100 | 2.2 |
| ORG.OF HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE | | 35,887,900 | 20.1 | 8,923,900 | 8.9 | 137,000 | .3 |
| ORG.OF HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE | PHC | 35,887,900 | 20.1 | 8,923,900 | 8.9 | 137,000 | .3 |
| DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH | | 1,700,300 | .9 | 2,663,400 | 2.6 | 260,000 | .6 |
| DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH | HRH | 1,700,300 | .9 | 2,663,400 | 2.6 | 260,000 | .6 |
| PUBLIC INFORMATION AND EDUCATION FOR HEALTH | | 520,600 | .3 | 85,000 | .1 | 91,000 | .2 |
| PUBLIC INFORMATION AND EDUCATION FOR HEALTH | IEH | 520,600 | .3 | 85,000 | .1 | 91,000 | .2 |
| III. HEALTH SCIENCE AND TECHNOLOGY | | 48,033,000 | 26.7 | 31,889,400 | 31.6 | 22,223,800 | 50.7 |
| RESEARCH PROMOTION AND DEVELOPMENT | | 56,000 | .* | 60,000 | .1 | 64,500 | .1 |
| RESEARCH PROMOTION AND DEVELOPMENT | RPD | 56,000 | .* | 60,000 | .1 | 64,500 | .1 |

## PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)
## (WHO CLASSIFIED LIST OF PROGRAMS)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| GENERAL HEALTH PROTECTION AND PROMOTION | | 15,921,000 | 8.8 | 14,879,500 | 14.8 | 14,872,400 | 34.0 |
| NUTRITION | NUT | 15,807,400 | 8.8 | 14,879,500 | 14.8 | 14,872,400 | 34.0 |
| ORAL HEALTH | ORH | 51,300 | .* | 0 | - | 0 | - |
| TOBACCO OR HEALTH | TOH | 62,300 | .* | 0 | - | 0 | - |
| HEALTH OF SPECIFIC POPULATION GROUPS | | 17,676,800 | 9.9 | 8,247,000 | 8.1 | 3,116,100 | 7.1 |
| MATERNAL AND CHILD HEALTH | MCH | 16,649,700 | 9.3 | 7,984,000 | 7.9 | 2,844,600 | 6.5 |
| ADOLESCENT HEALTH | ADH | 511,500 | .3 | 247,000 | .2 | 271,500 | .6 |
| WORKERS' HEALTH | OCH | 374,600 | .2 | 16,000 | .* | 0 | - |
| HEALTH OF THE ELDERLY | HEE | 141,000 | .1 | 0 | - | 0 | - |
| PROTECTION AND PROMOTION OF MENTAL HEALTH | | 118,800 | .* | 0 | - | 0 | - |
| PREVENTION AND CONTROL OF ALCOHOL AND DRUG ABUSE | ADA | 62,900 | .* | 0 | - | 0 | - |
| PREV./TREAT. OF MENTAL AND NEUROLOGICAL DISORDERS | MND | 55,900 | .* | 0 | - | 0 | - |
| PROMOTION OF ENVIRONMENTAL HEALTH | | 8,015,300 | 4.4 | 7,572,900 | 7.5 | 4,170,800 | 9.5 |
| COMMUNITY WATER SUPPLY AND SANITATION | CWS | 3,480,400 | 1.9 | 810,100 | .8 | 668,100 | 1.5 |
| ENVIRONMENTAL HEALTH IN RURAL & URBAN DEVELOPMENT | RUD | 400 | .* | 0 | - | 0 | - |
| CONTROL OF ENVIRONMENTAL HEALTH HAZARDS | CEH | 2,482,300 | 1.4 | 4,341,800 | 4.3 | 802,700 | 1.8 |
| FOOD SAFETY | FOS | 2,052,200 | 1.1 | 2,421,000 | 2.4 | 2,700,000 | 6.2 |
| DIAGNOSTIC, THERAPEUTIC, REHABILITATIVE TECHNOLOGY | | 6,245,100 | 3.6 | 1,130,000 | 1.1 | 0 | - |
| CLINICAL, LABORATORY AND RADIOLOGICAL TECHNOLOGY | CLR | 105,800 | .1 | 0 | - | 0 | - |
| ESSENTIAL DRUGS AND VACCINES | EDV | 4,768,300 | 2.7 | 0 | - | 0 | - |
| DRUG AND VACCINE QUALITY, SAFETY AND EFFICACY | DSE | 135,600 | .1 | 0 | - | 0 | - |
| REHABILITATION | RHB | 1,235,400 | .7 | 1,130,000 | 1.1 | 0 | - |
| IV. DISEASE PREVENTION AND CONTROL | | 74,022,200 | 41.3 | 49,641,800 | 49.2 | 13,356,400 | 30.5 |
| DISEASE PREVENTION AND CONTROL | | 74,022,200 | 41.3 | 49,641,800 | 49.2 | 13,356,400 | 30.5 |
| IMMUNIZATION | EPI | 16,934,400 | 9.5 | 9,645,400 | 9.6 | 2,862,900 | 6.5 |
| DISEASE VECTOR CONTROL | VBC | 799,800 | .4 | 0 | - | 0 | - |
| MALARIA | MAL | 5,669,100 | 3.2 | 4,179,400 | 4.1 | 0 | - |
| PARASITIC DISEASES | PDP | 632,500 | .4 | 0 | - | 0 | - |
| DIARRHEAL DISEASES | CDD | 9,722,000 | 5.4 | 3,387,000 | 3.4 | 0 | - |
| ACUTE RESPIRATORY INFECTIONS | ARI | 1,541,100 | .9 | 1,341,600 | 1.3 | 205,900 | .5 |
| TUBERCULOSIS | TUB | 3,700 | .* | 0 | - | 0 | - |
| LEPROSY | LEP | 392,900 | .2 | 0 | - | 0 | - |
| ZOONOSES | VPH | 9,493,200 | 5.3 | 6,843,300 | 6.8 | 6,490,700 | 14.8 |
| SEXUALLY TRANSMITTED DISEASES | VDT | 189,900 | .1 | 6,200 | .* | 0 | - |
| RESEARCH AND DEVELOPMENT IN THE FIELD OF VACCINES | RDV | 2,677,400 | 1.5 | 0 | - | 0 | - |
| AIDS | GPA | 21,869,500 | 12.2 | 19,811,400 | 19.6 | 82,900 | .2 |
| OTHER COMMUNICABLE DISEASE PREVENTION AND CONTROL | OCD | 3,038,300 | 1.7 | 4,427,500 | 4.4 | 3,714,000 | 8.5 |
| BLINDNESS AND DEAFNESS | PBD | 379,000 | .2 | 0 | - | 0 | - |
| CANCER | CAN | 414,800 | .2 | 0 | - | 0 | - |
| OTHER NONCOMMUNIC. DISEASE PREVENTION AND CONTROL | NCD | 264,600 | .1 | 0 | - | 0 | - |

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)
(WHO CLASSIFIED LIST OF PROGRAMS)

| PROGRAM CLASSIFICATION | | 1992-1993 AMOUNT | 1992-1993 % OF TOTAL | 1994-1995 AMOUNT | 1994-1995 % OF TOTAL | 1996-1997 AMOUNT | 1996-1997 % OF TOTAL |
|---|---|---|---|---|---|---|---|
| V. PROGRAM SUPPORT | | 8,589,200 | 4.8 | 5,571,300 | 5.6 | 5,925,100 | 13.6 |
| HEALTH INFORMATION SUPPORT | | 1,706,900 | 1.0 | 963,700 | 1.0 | 968,000 | 2.2 |
| HEALTH INFORMATION SUPPORT | HBI | 1,706,900 | 1.0 | 963,700 | 1.0 | 968,000 | 2.2 |
| SUPPORT SERVICES | | 6,882,300 | 3.8 | 4,607,600 | 4.6 | 4,957,100 | 11.4 |
| PERSONNEL | PER | 355,100 | .2 | 271,600 | .3 | 289,800 | .7 |
| GENERAL ADMINISTRATION AND SERVICES | GAD | 3,651,500 | 2.0 | 1,542,000 | 1.5 | 1,653,600 | 3.8 |
| BUDGET AND FINANCE | BFI | 2,005,900 | 1.1 | 1,887,000 | 1.9 | 2,037,900 | 4.7 |
| EQUIPMENT AND SUPPLIES FOR MEMBER STATES | SUP | 869,800 | .5 | 907,000 | .9 | 975,800 | 2.2 |
| GRAND TOTAL | | 179,188,000 | 100.0 | 100,734,000 | 100.0 | 43,795,000 | 100.0 |

* LESS THAN .05 PER CENT