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# **PROGRAM BUDGET**

**PAN AMERICAN HEALTH ORGANIZATION, PROPOSAL 2000-2001  
WORLD HEALTH ORGANIZATION, REGION OF THE AMERICAS, 2000-2001**



**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 2000-2001**
- 2. The proposed program budget of the World Health Organization for the Region of the Americas for the financial period 2000-2001**

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## I. INTRODUCTION







# INTRODUCTION

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1. I am pleased to present the Proposed Program Budget of the Pan American Health Organization (PAHO) for the biennium 2000-2001. This Program Budget is based on the Strategic and Programmatic Orientations (SPO) for the Pan American Sanitary Bureau (PASB), approved by the 25th Pan American Sanitary Conference. These SPO consider inequity the main challenge facing the health sector during the present quadrennium, which began in 1999.

2. In its commitment to the Member States to reduce and eliminate inequities, the Secretariat has included the documentation, study, and analysis of equity gaps among its work priorities. To complement this effort, it will be necessary to strengthen the capacity of the Bureau to collaborate with the countries in the development of health information systems, improving their capacity to analyze the data, its impact, and its expression in policies and proposals for action to improve the health conditions of the population.

3. As a general frame of reference, I am presenting below a summary of the political, economic, and social conditions of the Region and their impact on the work of the countries and the Secretariat, together with a brief description of the health conditions and the PAHO response as expressed in the Proposed Program Budget.

## *Context Analysis*

4. The current international climate is marked by an easing of the Asian economic crisis, a return to stability in globalization, and continued progress in economic harmonization. Perseverance in the efforts to construct regional, political, and economic blocs is evident in the consolidation of the European Union, the adoption of the Euro as the single currency for trade, and the lifting of all trade and immigration barriers. In the field of health, the World Health Organization has entered a new phase. In addition to bringing new impetus to WHO, the new Director has instituted structural and operational reforms, seeking unified action in all the regions. Operational initiatives have been launched to mobilize the countries in joint efforts--among them, I might add,

the effort to control smoking, which is reflected in our regional budget priorities.

5. The Region of the Americas is still recovering from the devastation wrought by the natural disasters of recent years and is proceeding with the work of reconstruction. This has served as an incentive for the vigorous pursuit of the paradigm of Pan Americanism, which will come together in a common Pan American health agenda in our sector--an effort in which the Organization continues to make headway. I have already observed clear indications of results in the mobilization of resources for cooperation among countries to respond to the hurricanes and earthquakes that have mercilessly battered some of our national territories. It is this show of solidarity that must characterize our common concerted effort.

6. Throughout the Western Hemisphere there has been a marked and steady movement toward democracy. Regional stability has not been threatened recently by any phenomena but those beyond the control of the authorities, such as Hurricanes Mitch and Georges in Central America and the Caribbean and the earthquake that struck Colombia's coffee region with particular intensity in the city of Armenia. All other political or economic situations that have arisen in the Region in recent years have been resolved either through civic action within the countries or joint Pan American action to address them in a show of solidarity. This is certain, and I point out with particular pride that it has occurred not only in natural disasters, but at times of economic or political crisis, some countries mobilizing to provide assistance and cooperation to others; some peoples sharing the concerns and solutions of others. This is the true Pan American spirit, which we advocate and desire not only in health but in all areas of human development.

7. As pointed out in the publications of the Economic Commission for Latin America and the Caribbean (ECLAC), the economy of the Region is continuing to consolidate its structural adjustment efforts aimed at creating the necessary conditions to increase the competitiveness of the national

economies. This is reflected in the continuing efforts to privatize public enterprises and relieve the national budgets of an onerous burden, and in the reduction of tariffs, thus facilitating the exchange of goods and services. The outlook for the economic performance of the countries of the Region is favorable, especially for the United States of America and Canada. However, there has still been no rise in the social indicators of employment and income, which, in the final analysis, will be what most clearly reflects the success of the measures adopted several years ago and pursued to date. In the end it will be the reduction of the unfair disparities in the living conditions of one-quarter of the Region's inhabitants that will be the measure and ultimate proof that the long-awaited human development has been achieved.

8. In the field of policy, since the Region adopted the path of Pan American consensus-building, it has maintained that path through the Summits of Presidents and Heads of State. These summits are increasingly defining the course and the social goals of the countries of the Region. Health retains its dominant place on the Pan American social agenda, and PAHO, our Organization, continues to work side by side with the countries in this area.

9. As noted in the report *Health in the Americas*, published in 1998, the countries of the Region can be proud of the great strides they have made in the struggle against disease. Poliomyelitis has been eradicated since 1991, major progress has been made in the eradication of measles and neonatal tetanus, and there has been a clear drop in the number of episodes of acute diarrheal disease, together with a significant reduction in mortality from intestinal infectious diseases and acute respiratory infections. To highlight the advances in measles control, suffice it to say that the number of confirmed cases fell from 6,489 in 1995 to 1,464 in 1996 to less than 500 so far in 1999. Progress continues in the elimination of leprosy and human rabies. At the same time, the countries of the Southern Cone have made great strides in reducing household infestations of *T. cruzi*, the vector for Chagas' disease; extensive areas of the Southern Cone are already free of foot-and-mouth disease, a zoonosis with enormous economic implications; and these gains have only been possible because the countries have agreed to collaborate in this spirit of Pan Americanism.

10. As we stated in the publication cited above, health conditions, as measured by trends in mortality and life expectancy, continue to improve in the Region as a whole. However, gaps between countries and population groups defined by geographical location, sex, income, education, or ethnic group not only persist but are widening. These health conditions in the Americas are the manifestation of social inequity, which has not diminished.

11. Nearly all the countries have fully or partially implemented health sector reforms characterized by measures to decentralize the public health services, foster greater private sector participation in health service delivery, and change their health financing models. The object of a significant number of these reforms is to reduce inequities in access, promote universal coverage, and improve sectoral efficiency. Progress has been slow, and the expected results spelled out in the sectoral reform objectives are not yet visible. In fact, infrastructure utilization rates remain low, and the resources available to expand the infrastructure have not increased sufficiently, even though the availability of physicians, nurses, and dentists has increased in all the countries, albeit more slowly than population growth.

12. At the same time, a rising trend can be observed in the proportion of the gross domestic product (GDP) allocated to health in the countries. In reality, this growth represents an increase in out-of-pocket expenditures by the population, since public spending has decreased proportionally. This phenomenon is leading to an increase in the number of private health service providers. The regulation, management, and control of the systems are reserved to the State, which, in most cases, retains the responsibility for providing coverage for the low-income population. As a result of these changes, new forms of insurance, financing, and service delivery are being developed.

13. Nevertheless, marked differences persist among the countries, associated primarily with their income levels. In higher-income countries, national health expenditure is greater, up to 45 times greater than that of the lower-income countries. Furthermore, the accessibility, coverage, and availability of medical care are lower in countries with lower per capita GDP. These countries also have higher infant mortality rates. Thus, a newborn in a high-income country is roughly 10 times more likely to survive the first year of life than one born in a low-income

country, and this profile of inequality is mirrored within each country.

14. In short, nearly 105 million people in the Region lack regular access to health care, more than 2 million women per year give birth without professional assistance, and in eight countries 40% of the population has no access to basic health services. Health gaps related to the geographic location of the population can also be observed. In virtually all the health indicators, rural dwellers fare more poorly than urban dwellers.

15. The Region is currently in a phase of demographic transition, characterized by changing morbidity profiles that will have an impact on the demand for health services. Thus, there is a need to train primary health care personnel to meet these new challenges, a situation that is likely to persist for some time to come. Thus, while infectious and reemerging diseases are still an important problem, chronic and noncommunicable diseases are on the rise. This puts the efforts to train the responsible sectoral entities not only in patient care but disease prevention and health promotion among PAHO's priorities. The degree to which national institutions develop their capacity will determine how successful they are in responding to new circumstances.

### *The Response of PASB*

16. For the countries to achieve the highest attainable level of health for their populations, the PASB provides technical cooperation, promotes cooperation among them, and facilitates international coordination in health.

17. The fundamental purposes of the Pan American Health Organization are to promote and coordinate the efforts of the countries of the Americas, combat disease, lengthen life, and promote the physical and mental health of the people. It must be acknowledged that enjoyment of the highest attainable level of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief, or economic or social condition. Guided by these premises, the Bureau will focus intensely on attaining the highest degree of well-being for all the inhabitants of the Region, thus contributing to a reduction in the existing health inequities.

18. In this regard, its technical cooperation activities with the countries of the Region will be marked by the search for greater ongoing application of ethics to health policies, research, and service delivery; the adoption of policies geared toward equity and of strategies that emphasize solidarity; and incorporation of the gender perspective into health policies and strategies. In particular, the Bureau will intensify cooperation activities that will enable the countries to move forward in the control of smoking and matters linked to the mental health of the population. To this end, the Program Budget that I am presenting provides for a specific increase in the resources allocated to these areas.

19. The adoption of the Strategic and Programmatic Orientations for 1999-2002 ratified the commitment of the Member Governments to the goal of health for all, an expression of which is the decision to advance in the elimination of inequities in health. This will be a priority in technical cooperation over the next two years at the regional and country level.

20. It will be critical to work with the countries toward achieving the regional goals established in the SPO for the quadrennium, in terms of health outcomes, intersectoral activities targeting health determinants, and health policies and health systems. Efforts will center on monitoring the respective indicators, generating the corresponding data, and creating conditions that will make it possible to show national progress in terms of the goals set.

21. The Strategic and Programmatic Orientations for the quadrennium retain the strategic orientations of Health in Human Development, Health Promotion and Protection, Environmental Protection and Development, Health Systems and Services Development, and Disease Prevention and Control. For each of them, I will describe the most salient aspects of the technical cooperation that the Secretariat will provide in the next two years. We will continue to develop and strengthen the national and regional capacity for analyzing and monitoring the health situation and the reciprocal relationship between health, economic growth, and equity in the context of globalization. This, coupled with the dialogue among the authorities of the social, health, and economic sectors will make it possible to observe the link between economic growth, health, and human development, thus reducing the negative impact of

economic policies on the living conditions of the population and, hence, the health situation.

22. To contribute to sustainable human development and encourage the principal social and political actors of this and other sectors of the State and civil society to assign greater value to health in local, subnational, national, subregional, and regional policy agendas, technical cooperation will emphasize the production, dissemination, and utilization of information on health promotion, health care, and health recovery. The development of a series of disciplines related to public health, coupled with relevant research and dissemination of the information generated, is also proposed, so that responses can be articulated that are adequate to the health needs of the population, especially those of the most neglected and excluded groups.

23. PAHO will work with the countries to create a new culture of health promotion and protection, in which health is a social value. This implies preparing people, communities, and public, nongovernmental, and private institutions to accept and both, individually and collectively, exercise responsibility for the preservation and ongoing improvement of their health and well-being. We will make a special effort to promote human development and disease prevention throughout the entire life cycle through strategies and programs for health promotion and protection, since they are indispensable tools that should be part of all health activities. In this regard, technical cooperation to prevent and decrease tobacco use, especially among young people, will be especially important.

24. Using all the technical means available, we will assist the countries in meeting the objectives and goals adopted in Agenda 21 and the Plans of Action of the Summits of Presidents and Heads of State of the Hemisphere, as well as the orientations spelled out in the Plan of Action of the Pan American Conference on Health and Environment in Sustainable Human Development.

25. In addition, priority will be given to technical cooperation activities that move the countries to take action on physical, biological, chemical, psychosocial, and organizational risk factors, as well

as those harmful to health of workers in both the informal and formal sector.

26. In water supply and sanitation, we will emphasize the expansion of service coverage, improvement of the bacteriological quality of drinking water, and the intensification of activities to improve water supply and sanitary excreta disposal in rural areas inhabited by indigenous populations. We will make an equal effort to improve municipal solid waste management, taking the rapid decentralization and privatization processes into account.

27. The technical cooperation of the Secretariat will continue to support the sectoral reform processes of the countries of the Region. Here, special attention will be paid to strengthening sectoral steering capacity, health systems and services development, and the financing of sector activities. To this end, the basic strategies will be the systematic and periodic sharing of national experiences, as well as the development and dissemination of methodologies and instruments that support the institutional capacity for analysis, the formulation of policies, the implementation and evaluation of sectoral reform, and the development of a regional system for monitoring the dynamic, content, and impact of the reforms.

28. In order to cope with the regional challenges and reduce and control disease, health services programs should include components on disease prevention and health promotion. For positive outcomes to be achieved, community participation and behavioral changes will be necessary. These changes must be guided by sound, scientifically validated policies and procedures. Here, we will concentrate our efforts on strengthening the national capacity to control, reduce, or eradicate particular diseases. With regard to communicable and vaccine-preventable diseases, we will continue down the road of the progress that has already been achieved to date. Furthermore, tremendous strides can be made in the control of noncommunicable diseases if there is commitment and scientifically validated policies and programs are adopted by communities, individuals, and clinicians. It is important for health organizations to allocate human and financial resources in order to benefit from these possibilities. In addition, veterinary public health will continue to be a very important field for the countries' progress in food

security and food safety; as a result, technical cooperation in this area will have the necessary intensity.

29. We have introduced improvements in the format of this document to highlight the achievements that we anticipate during the biennium. In this regard, we have included a new typology of Expected Results for the technical cooperation of the Bureau; these are therefore grouped into the new categories. Also attached is the revised structure of the Pan American Sanitary Bureau, which reflects operational changes in the Secretariat.

30. I hope that this Program Budget will be acceptable to the Member States and that it will constitute a mechanism to support the work of the countries in their search for better health now and in the future.

### *The Program Budget as Part of the Response*

31. The Program Budget represents the mechanism whereby the Organization can respond to the needs of the countries. This Program Budget is presented in a format that reflects the development of the American Region Planning, Programming, Monitoring, and Evaluation System (AMPES) over many years. It has an internal logic that derives from our recent developments and practice with regard to the Logical Approach to Project

Management in PAHO. It should be possible to understand the results that are expected and the resources to be applied to achieve those results.

32. The Regular Budget proposal of \$256,245,000 includes \$79,109,000 in WHO regular funds and \$177,136,000 in PAHO regular funds, of which \$163,036,000 come from quota contributions and \$14,100,000 from projected miscellaneous income. This Program Budget tries to emphasize health outcomes and is consistent with our belief that there should be such resources at the country level as to permit a positive impact on the health of people. We present this budget with the realization that it represents a small fraction of resources dedicated to health in the Americas. But we do so with the belief that our Program and its Budget has been in the past and will be in the future a significant force in stimulating and advocating action in areas critical for health in this Hemisphere.



George A. O. Alleyne  
Director



# ANALYSIS AND STRUCTURE OF THE PROGRAM BUDGET

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1. The original provisional draft of the 2000-2001 PAHO/WHO Regular combined program budget was previously projected in Official Document No. 281 of May 1997. The projected increase at that time was estimated to be 6.6% over the 1998-1999 budget. The current proposal for 2000-2001, amounting to \$256,245,000, represents an increase of only 2.0% (an annual increase of 1.0%) over 1998-1999, or a reduction of \$11,481,000 from the original provisional draft.
2. The PAHO Regular portion of the 2000-2001 proposal, amounting to \$177,136,000, reflects an increase of 5.1% (an annual increase of approximately 2.55%). The proposal was discussed by the Subcommittee on Planning and Programming in March 1999 and subsequently reviewed by the Executive Committee in June 1999. It is proposed to fund the 2000-2001 PAHO Regular budget through Member State contributions of \$163,036,000 and estimated Miscellaneous Income of \$14,100,000.
3. The WHO Regular portion of the 2000-2001 proposal amounts to \$79,109,000. This amount is made up of \$77,725,000 approved as core funding plus an additional \$1,384,000 allocated to AMRO as its share of the \$15 million of casual income approved by the World Health Assembly in May 1999 to be implemented in high priority areas. The reduction in core funding to \$77,725,000, or 6% less than 1998-1999, is a result of the revised regional allocation methodology approved by the World Health Assembly in May of 1998. The total amount of \$79,109,000 represents a net reduction of \$3,577,000, or 4.3% less than the approved level for 1998-1999.
4. The details of the proposal, and how it was estimated and distributed, are included in the explanations of the various tables in the following paragraphs. Draft appropriations and assessments resolutions are included on pages II-1 through II-5.
5. Table A on page II-7 summarizes the PAHO and WHO Regular budget history since the 1970-1971 biennium. The PAHO Regular portion of the total 2000-2001 proposal is 69.1%, while the WHO Regular portion is 30.9% of the total.
6. Table B on page II-9 is divided between posts funded by PAHO/WHO Regular funds and those funded by extrabudgetary funds. The budget location of the posts is also indicated. Note that there is an overall reduction of 15 posts funded by PAHO/WHO Regular funds compared to 1998-1999. In fact, since the 1980-1981 biennium, 374 posts have been eliminated, amounting to a reduction of over 30% of the regular workforce. The decline in posts funded by extrabudgetary funds is caused by the inability to predict commitments into future years.
7. Table C on page II-11 provides an analysis of the PAHO/WHO Regular budget by budget location category. It shows the level of program increases and decreases as well as calculated cost increases. In general, program increases relate to those new items in the budget location categories that were not included in the 1998-1999 biennium. Program decreases pertain to those items that were included in the 1998-1999 program but were reduced or eliminated in the 2000-2001 proposal. Table C shows that the overall net program decrease for 2000-2001 is \$6,249,200. Several items should be noted. First, the only program increase occurs in country programs, and the overall increase in country programs accounts for over two-thirds of the total proposed budget increase. Second, the portion of the budget devoted to Direct Cooperation with Countries increased from 84.8% to 85.1%. Third, the portion of the budget for Technical and Administrative Direction continues to decline (from 14.2% to 13.9%).

8. The cost increase factors used in the proposal were developed by location. All post costs are based upon the average of actual post costs by grade and location of the post. After the reduction of 15 posts, the overall net increase for posts is approximately 6.9%, or 3.45% annually. For the non-post elements of the budget, the cost increase factor related to inflation was originally calculated at 5.5% for Washington-based expenditure (based primarily upon the current consumer price index for the United States), and 2.0% for field-based expenditure. The cost factor used for field-based expenditure is conservative given that the latest econometric data provided by the United Nations Economic Commission for Latin America and the Caribbean (ECLAC) shows that the region as a whole is expected to experience annual inflationary costs of approximately 10.0%. However, based upon decisions made during the Director's Cabinet's consideration of this proposal, it was decided not to include these costs and to propose a budget reflecting less than zero real growth. Thus, PAHO is absorbing approximately \$3.7 million in real terms in the 2000-2001 biennium, representing a program reduction as compared with 1998-1999.

9. Graphs I and II on pages II-12 and II-13 illustrate the information provided in Table C. Graph II shows the steady increase in Country Programs over the past several years.

10. Table D on page II-15 is a summary of the various funds committed to the Organization for 1998-1999 at this time. The 1998-1999 amounts for extrabudgetary funds, \$139,993,100 from PAHO sources and \$16,858,900 from WHO sources, are the most accurate estimate of these funds at this time. The projection for 2000-2001 is significantly lower than the current level of extrabudgetary funds given that future commitments from external sources cannot be predicted. The estimates for 2000-2001 are based primarily on current commitments that extend into that period.

11. Table E-1 starting on page II-17 through II-19 presents the PAHO/WHO Regular proposal in the 3-digit program classification structure. This table illustrates the percentage of the total budget for each of the programs for the 1998-1999 and 2000-2001 biennia.

12. Graph III on page II-20 shows the distribution of PAHO/WHO Regular budget funds at the highest level (appropriation) of the program classification.

13. Table E-2 on pages II-21 through II-23 contains the distribution of extrabudgetary funds in the 3-digit program classification structure.

14. Table F on page II-25 shows the distribution of the proposed budget by major budget element, showing the increases and decreases between the two biennia.

15. Section III (yellow tab) of this document contains a description of the classified list of programs. Each of the seven parts of the program budget has a narrative description together with a presentation of the sources of funds devoted to the parts and by budget location.

16. Section IV (orange tab) of the document contains narratives for each country with a summary presentation of the proposed budget allocation at the appropriation level.

17. The green tabs contain the detailed budget proposals for each country (section V) and for regional and intercountry (section VI) in the PAHO program classification structure.

18. Section VII (pink tab) provides the proposed budget by the organizational structure of the Secretariat.

**II. SUMMARY TABLES**

**II. SUMMARY TABLES**

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PROPOSED APPROPRIATION RESOLUTION FOR THE  
PAN AMERICAN HEALTH ORGANIZATION FOR 2000-2001

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THE 41<sup>st</sup> MEETING OF THE DIRECTING COUNCIL,

RESOLVES:

1. To appropriate for the financial period 2000-2001 an amount of \$195,145,178 as follows:

Part I	GOVERNING BODIES	2,151,600
Part II	HEALTH IN HUMAN DEVELOPMENT	77,897,400
Part III	HEALTH SYSTEMS AND SERVICES DEVELOPMENT	22,120,800
Part IV	HEALTH PROMOTION AND PROTECTION	18,992,400
Part V	ENVIRONMENTAL PROTECTION AND DEVELOPMENT	13,041,100
Part VI	DISEASE PREVENTION AND CONTROL	21,963,100
Part VII	ADMINISTRATIVE SERVICES	<u>20,969,600</u>
	<u>Effective Working Budget for 2000-2001 (Parts I-VII)</u>	<u>177,136,000</u>
Part VIII	STAFF ASSESSMENT (Transfer to Tax Equalization Fund)	18,009,178
	<u>TOTAL - ALL PARTS</u>	<u>195,145,178</u>

2. That the appropriation shall be financed from:

(a) Assessments in respect to:

Member Governments, Participating Governments and Associate Members assessed under the scale adopted by the Organization of American States in accordance with Article 60 of the Pan American Sanitary Code or in accordance with Directing Council and Pan American Sanitary Conference resolutions

181,045,178

(b) Miscellaneous Income

14,100,000

TOTAL

195,145,178

In establishing the contributions of Member Governments, Participating Governments and Associate Members, their assessments shall be reduced further by the amount standing to their credit in the Tax Equalization Fund, except that credits of those which levy taxes on the emoluments received from the Pan American Sanitary Bureau (PASB) by their nationals and residents shall be reduced by the amounts of such tax reimbursements by PASB.

3. That, in accordance with the Financial Regulations of PAHO, amounts not exceeding the appropriations noted under paragraph 1 shall be available for the payment of obligations incurred during the period 1 January 2000 to 31 December 2001, inclusive. Notwithstanding the provision of this paragraph, obligations during the financial period 2000-2001 shall be limited to the effective working budget, i.e., Parts I-VII.

4. That the Director shall be authorized to transfer credits between parts of the effective working budget, provided that such transfer of credits between parts as are made do not exceed 10% of the part from which the credit is transferred, exclusive of the provision made for transfers from the Director's Development Program in Part II. Except for the provision made for the Director's Development Program in Part II, transfers of credits between parts of the budget in excess of 10% of the part from which the credit is transferred may be made with the concurrence of the Executive Committee. The Director is authorized to apply amounts not exceeding the provision for the Director's Development Program to those parts of the effective working budget under which the program obligation will be incurred. All transfers of budget credits shall be reported to the Directing Council or the Pan American Sanitary Conference.

ASSESSMENTS OF THE MEMBER GOVERNMENTS, PARTICIPATING GOVERNMENTS AND  
ASSOCIATE MEMBERS OF THE PAN AMERICAN HEALTH ORGANIZATION FOR 2000-2001

PROPOSED RESOLUTION

Whereas, Member Governments appearing in the scale adopted by the Organization of American States (OAS) are assessed according to the percentages shown in that scale, adjusted to PAHO Membership, in compliance with Article 60 of the Pan American Sanitary Code; and

Whereas, adjustments were made taking into account the assessments of Cuba, the Participating Governments and Associate Members; now, therefore,

THE 41st MEETING OF THE DIRECTING COUNCIL,

RESOLVES:

To establish the assessments of the Member Governments, Participating Countries and Associate Members of the Pan American Health Organization for the financial period 2000-2001 in accordance with the scale of quotas shown below and in the corresponding amounts.

(1) Membership	(2) Scale Adjusted to PAHO Membership		(3) Gross Assessment		(4) Credit from Tax Equalization Fund		(5) Adjustment for Taxes Imposed by Member Governments on Emoluments of PASB Staff		(6) Net Assessment	
	2000	2001	2000	2001	2000	2001	2000	2001	2000	2001
	%	%	US\$	US\$	US\$	US\$	US\$	US\$	US\$	US\$
<b>Member Governments:</b>										
Antigua and Barbuda	0.019993	0.019993	18,098	18,098	1,800	1,800			16,298	16,298
Argentina	4.897907	4.897907	4,433,713	4,433,713	441,037	441,037			3,992,676	3,992,676
Bahamas	0.069971	0.069971	63,340	63,340	6,301	6,301			57,039	57,039
Barbados	0.079965	0.079965	72,387	72,387	7,201	7,201			65,186	65,186
Belize	0.029987	0.029987	27,145	27,145	2,700	2,700			24,445	24,445
Bolivia	0.069971	0.069971	63,340	63,340	6,301	6,301			57,039	57,039
Brazil	8.546348	8.546348	7,736,376	7,736,376	769,564	769,564			6,966,812	6,966,812
Canada	12.354723	12.354723	11,183,815	11,183,815	1,112,492	1,112,492	75,000	75,000	10,146,323	10,146,323
Chile	0.539769	0.539769	488,613	488,613	48,604	48,604			440,009	440,009
Colombia	0.939599	0.939599	850,549	850,549	84,607	84,607			765,942	765,942
Costa Rica	0.129945	0.129945	117,630	117,630	11,701	11,701			105,929	105,929
Cuba	0.730372	0.730372	661,152	661,152	65,767	65,767			595,385	595,385
Dominica	0.019993	0.019993	18,098	18,098	1,800	1,800			16,298	16,298
Dominican Republic	0.179924	0.179924	162,871	162,871	16,201	16,201			146,670	146,670
Ecuador	0.179924	0.179924	162,871	162,871	16,201	16,201			146,670	146,670

ASSESSMENTS OF THE MEMBER GOVERNMENTS, PARTICIPATING GOVERNMENTS AND  
ASSOCIATE MEMBERS OF THE PAN AMERICAN HEALTH ORGANIZATION FOR 2000-2001

(1) Membership	(2) Scale Adjusted to PAHO Membership		(3) Gross Assessment		(4) Credit from Tax Equalization Fund		(5) Adjustment for Taxes Imposed by Member Governments on Emoluments of PASB Staff		(6) Net Assessment	
	2000	2001	2000	2001	2000	2001	2000	2001	2000	2001
	%	%	US\$	US\$	US\$	US\$	US\$	US\$	US\$	US\$
<b>Member Governments:</b>										
El Salvador	0.069971	0.069971	63,340	63,340	6,301	6,301			57,039	57,039
Grenada	0.029987	0.029987	27,145	27,145	2,700	2,700			24,445	24,445
Guatemala	0.129945	0.129945	117,630	117,630	11,701	11,701			105,929	105,929
Guyana	0.019993	0.019993	18,098	18,098	1,800	1,800			16,298	16,298
Haiti	0.069971	0.069971	63,340	63,340	6,301	6,301			57,039	57,039
Honduras	0.069971	0.069971	63,340	63,340	6,301	6,301			57,039	57,039
Jamaica	0.179924	0.179924	162,871	162,871	16,201	16,201			146,670	146,670
Mexico	6.077403	6.077403	5,501,422	5,501,422	547,245	547,245			4,954,177	4,954,177
Nicaragua	0.069971	0.069971	63,340	63,340	6,301	6,301			57,039	57,039
Panama	0.129945	0.129945	117,630	117,630	11,701	11,701			105,929	105,929
Paraguay	0.179924	0.179924	162,871	162,871	16,201	16,201			146,670	146,670
Peru	0.409825	0.409825	370,984	370,984	36,903	36,903			334,081	334,081
Saint Kitts and Nevis	0.019993	0.019993	18,098	18,098	1,800	1,800			16,298	16,298
Saint Lucia	0.029987	0.029987	27,145	27,145	2,700	2,700			24,445	24,445
Saint Vincent and the Grenadines	0.019993	0.019993	18,098	18,098	1,800	1,800			16,298	16,298
Suriname	0.069971	0.069971	63,340	63,340	6,301	6,301			57,039	57,039
Trinidad and Tobago	0.179924	0.179924	162,871	162,871	16,201	16,201			146,670	146,670
United States of America	59.444615	59.444615	53,810,805	53,810,805	5,352,743	5,352,743	3,800,000	3,800,000	52,258,062	52,258,062
Uruguay	0.259889	0.259889	235,258	235,258	23,402	23,402			211,856	211,856
Venezuela	<u>3.198634</u>	<u>3.198634</u>	<u>2,895,486</u>	<u>2,895,486</u>	<u>288,024</u>	<u>288,024</u>	<u>5,000</u>	<u>5,000</u>	<u>2,612,462</u>	<u>2,612,462</u>
Subtotal	<u>99.448227</u>	<u>99.448227</u>	<u>90,023,110</u>	<u>90,023,110</u>	<u>8,954,904</u>	<u>8,954,904</u>	<u>3,880,000</u>	<u>3,880,000</u>	<u>84,948,206</u>	<u>84,948,206</u>

ASSESSMENTS OF THE MEMBER GOVERNMENTS, PARTICIPATING GOVERNMENTS AND  
ASSOCIATE MEMBERS OF THE PAN AMERICAN HEALTH ORGANIZATION FOR 2000-2001

(1) Membership	(2) Scale Adjusted to PAHO Membership		(3) Gross Assessment		(4) Credit from Tax Equalization Fund		(5) Adjustment for Taxes Imposed by Member Governments on Emoluments of PASB Staff		(6) Net Assessment	
	2000	2001	2000	2001	2000	2001	2000	2001	2000	2001
	%	%	US\$	US\$	US\$	US\$	US\$	US\$	US\$	US\$
<b>Participating Governments:</b>										
France	0.289876	0.289876	262,403	262,403	26,102	26,102			236,301	236,301
Kingdom of the Netherlands	0.089961	0.089961	81,435	81,435	8,101	8,101			73,334	73,334
United Kingdom	0.059974	0.059974	54,290	54,290	5,400	5,400			48,890	48,890
Subtotal	<u>0.439811</u>	<u>0.439811</u>	<u>398,128</u>	<u>398,128</u>	<u>39,603</u>	<u>39,603</u>			<u>358,525</u>	<u>358,525</u>
<b>Associate Member:</b>										
Puerto Rico	0.111962	0.111962	101,351	101,351	10,082	10,082			91,269	91,269
Subtotal	<u>0.111962</u>	<u>0.111962</u>	<u>101,351</u>	<u>101,351</u>	<u>10,082</u>	<u>10,082</u>			<u>91,269</u>	<u>91,269</u>
<b>TOTAL</b>	<u>100.000000</u>	<u>100.000000</u>	<u>90,522,589</u>	<u>90,522,589</u>	<u>9,004,589</u>	<u>9,004,589</u>	<u>3,880,000</u>	<u>3,880,000</u>	<u>85,398,000</u>	<u>85,398,000</u>

(5) This column includes estimated amounts to be received by the respective Member Governments in 2000-2001 in respect of taxes levied by them on staff members' emoluments received from PASB, adjusted for the difference between the estimated and the actual for prior years.



TABLE A

REGULAR BUDGET HISTORY FOR THE REGION OF THE AMERICAS								
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	5.5	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
1996-97	168,578,000	67.9	2.5	79,794,000	32.1	0.0	248,372,000	1.7
1998-99	168,578,000	67.1	0.0	82,686,000	32.9	3.6	251,264,000	1.2
2000-01 *	177,136,000	69.1	5.1	79,109,000	30.9	-4.3	256,245,000	2.0

\* THE PAHO REGULAR AMOUNT FOR 2000-2001 IS PROPOSED. THE WHO REGULAR AMOUNT FOR 2000-2001 INCLUDES \$1,384,000 ALLOCATED TO THE REGION OF THE AMERICAS FROM WHO CASUAL INCOME AS APPROVED BY THE MAY 1999 WORLD HEALTH ASSEMBLY.



TABLE B

POST ANALYSIS - PAHO AND WHO REGULAR FUNDS						
LOCATION	1998-1999			2000-2001		
	PROFESSIONAL	LOCAL	TOTAL	PROFESSIONAL	LOCAL	TOTAL
<b>A. COOPERATION WITH COUNTRIES</b>						
A.1 COUNTRY PROGRAMS	136	167	303	144	162	306
A.2 INTERCOUNTRY PROGRAMS	153	121	274	159	127	286
A.3 CENTERS	57	53	110	57	41	98
SUBTOTAL: COOPERATION WITH COUNTRIES	346	341	687	360	330	690
<b>B. TECHNICAL AND ADMINISTRATIVE DIRECTION</b>	58	112	170	47	105	152
<b>C. GOVERNING BODIES</b>	3	3	6	3	3	6
=====	=====	=====	=====	=====	=====	=====
GRAND TOTAL	407	456	863	410	438	848
=====	=====	=====	=====	=====	=====	=====

POST ANALYSIS - EXTRABUDGETARY FUNDS						
LOCATION	1998-1999			2000-2001		
	PROFESSIONAL	LOCAL	TOTAL	PROFESSIONAL	LOCAL	TOTAL
<b>A. COOPERATION WITH COUNTRIES</b>						
A.1 COUNTRY PROGRAMS	20	9	29	2	7	9
A.2 INTERCOUNTRY PROGRAMS	77	47	124	41	27	68
A.3 CENTERS	1	15	16	0	15	15
SUBTOTAL: COOPERATION WITH COUNTRIES	98	71	169	43	49	92
<b>B. TECHNICAL AND ADMINISTRATIVE DIRECTION</b>	12	29	41	14	27	41
<b>C. GOVERNING BODIES</b>	0	1	1	0	1	1
=====	=====	=====	=====	=====	=====	=====
GRAND TOTAL	110	101	211	57	77	134
=====	=====	=====	=====	=====	=====	=====

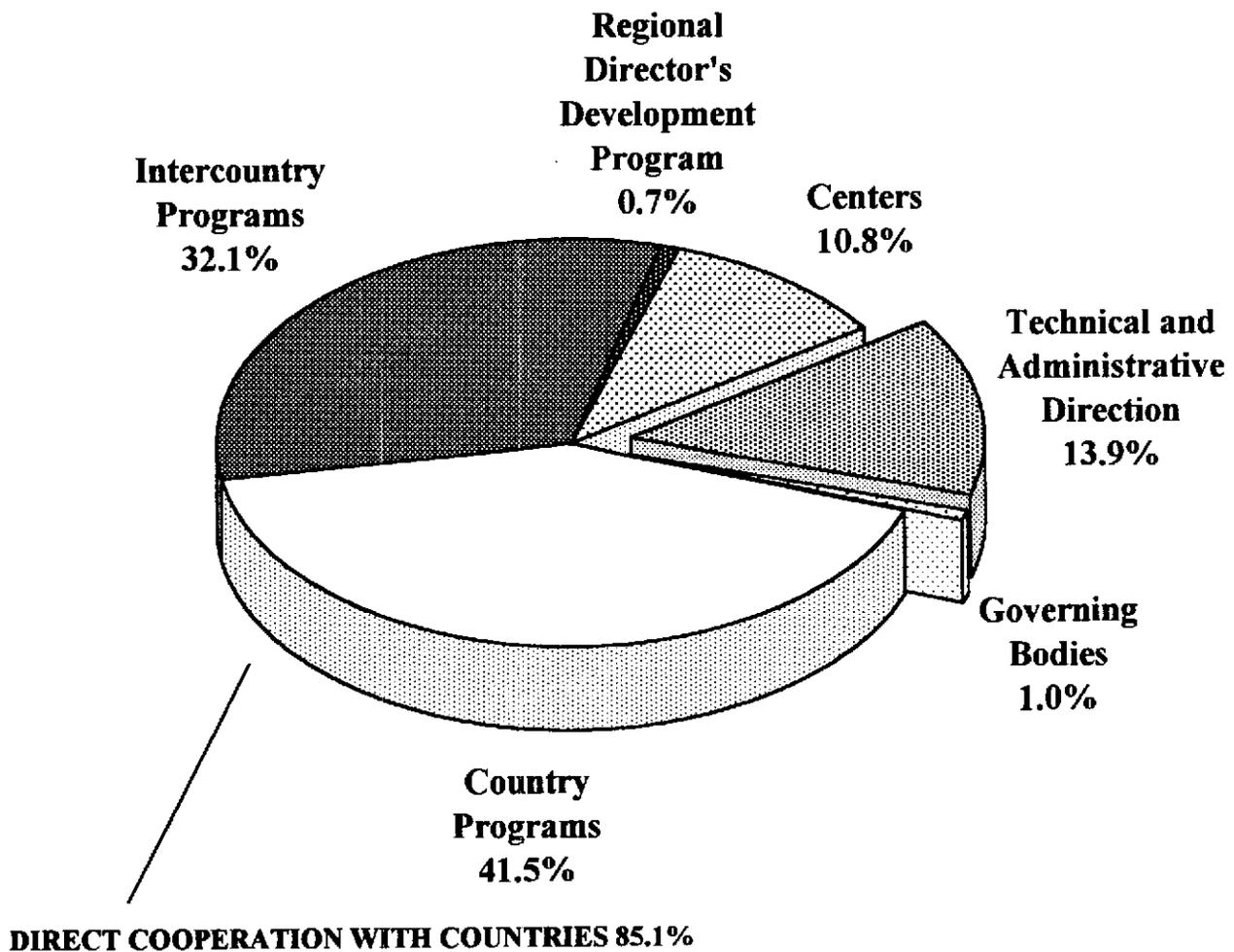


TABLE C

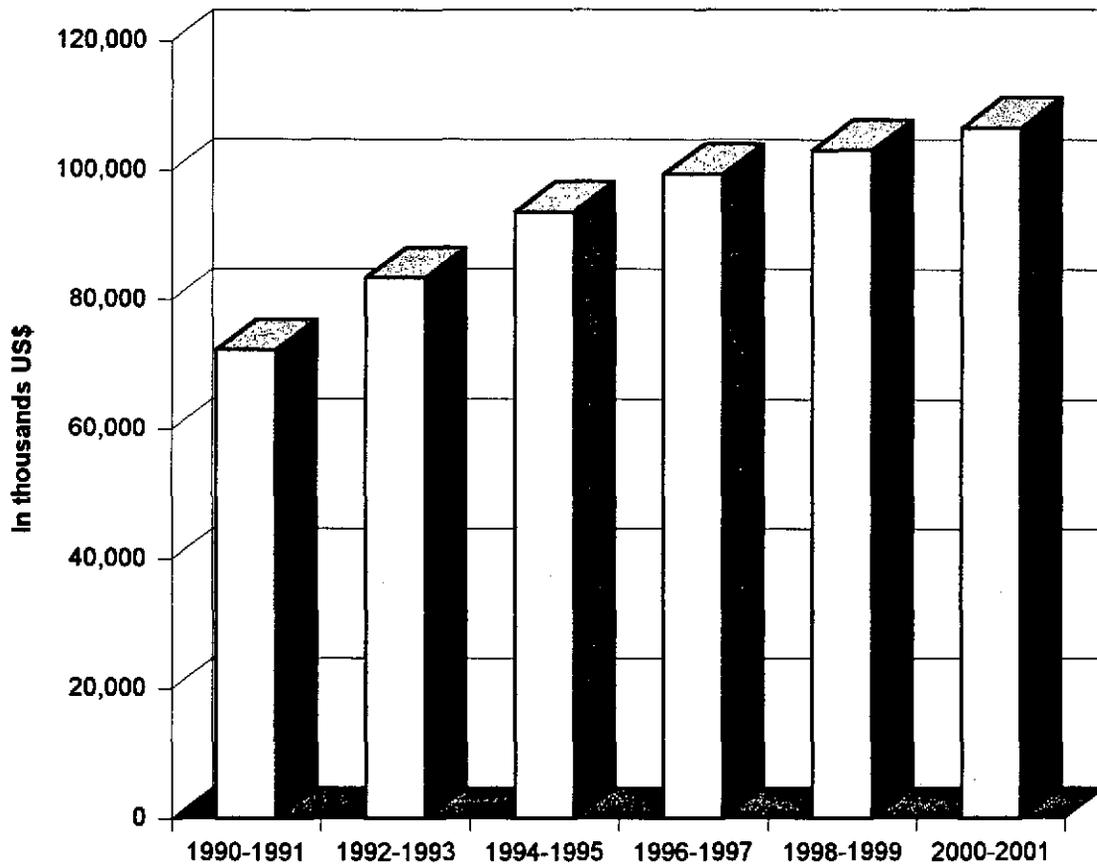
PAHO/WHO REGULAR BUDGET ANALYSIS OF PROGRAM AND COST  
INCREASES/(DECREASES) BY LOCATION

LOCATION	1998-1999 APPROPRIATION		PROGRAM INCREASE (DECREASE)	COST INCREASE (DECREASE)	TOTAL INCREASE (DECREASE)	2000-2001 PROPOSAL	
	AMOUNT	% OF TOTAL				AMOUNT	% OF TOTAL
A.1 COUNTRY PROGRAMS	103,068,000	41.0	1,504,700 1.5%	1,890,400 1.8%	3,395,100 3.3%	106,463,100	41.5
A.2 INTERCOUNTRY PROGRAMS	78,979,400	31.4	(1,833,200) (2.3%)	5,168,200 6.5%	3,335,000 4.2%	82,314,400	32.1
A.3 REGIONAL DIRECTOR'S DEVELOPMENT PROGRAM	2,204,400	0.9	(427,400) (19.4%)	- 0.0%	(427,400) (19.4%)	1,777,000	0.7
A.4 CENTERS	28,925,300	11.5	(1,946,400) (6.7%)	594,100 2.1%	(1,352,300) (4.7%)	27,573,000	10.8
A. SUBTOTAL, COOPERATION WITH COUNTRIES	213,177,100	84.8	(2,702,300) (1.3%)	7,652,700 3.6%	4,950,400 2.3%	218,127,500	85.1
B. TECHNICAL AND ADMINISTRATIVE DIRECTION	35,606,800	14.2	(3,413,400) (9.6%)	3,469,600 9.7%	56,200 0.2%	35,663,000	13.9
C. GOVERNING BODIES	2,480,100	1.0	(133,500) (5.4%)	107,900 4.4%	(25,600) (1.0%)	2,454,500	1.0
TOTAL	<u>251,264,000</u>	<u>100.0</u>	<u>(6,249,200)</u> (2.5%)	<u>11,230,200</u> 4.5%	<u>4,981,000</u> 2.0%	<u>256,245,000</u>	<u>100.0</u>

**GRAPH I**  
**2000-2001 PAHO/WHO**  
**REGULAR PROGRAM BUDGET BY LOCATION**  
**(Percent of Total)**



## GRAPH II COUNTRY PROGRAM BUDGET, 1990-1991 TO 2000-2001



Country Programs	72,289	83,417	93,524	99,374	103,068	106,463
% of Total	37.1	37.2	38.3	40.0	41.0	41.5
Total Budget	195,050	224,067	244,260	248,372	251,264	256,245



TABLE D

TOTAL BUDGET BY SOURCE OF FUNDS					
	1998-1999 BIENNIUM APPROVED		INCREASE (DECREASE) 2000-2001 OVER 1998 - 1999	2000-2001 BIENNIUM PROPOSED	
	AMOUNT \$	% OF TOTAL		AMOUNT \$	% OF TOTAL
<b>REGULAR BUDGET:</b>	251,264,000	61.4	2.0	256,245,000	78.9
PR PAHO REGULAR BUDGET	168,578,000	41.1	5.1	177,136,000	54.5
WR WHO REGULAR BUDGET	82,686,000	20.3	(4.3)	79,109,000	24.3
<b>EXTRABUDGETARY FUNDS:</b>	156,852,000	38.6	(56.2)	68,661,000	21.1
PAN AMERICAN HEALTH ORGANIZATION	139,993,100	34.4	(53.8)	64,651,300	19.9
HC CFNI Membership and Miscellaneous Funds	648,700	0.2	2.9	667,200	0.2
PB Building Fund	1,810,400	0.4	(17.1)	1,500,000	0.5
PD Natural Disaster Relief Voluntary Fund	9,277,500	2.3	(88.2)	1,091,000	0.3
PG Grants and Contractual Agreements	107,615,900	26.4	(56.4)	46,875,200	14.4
PI Income from Services	5,607,100	1.4	(18.8)	4,552,500	1.4
PV Special Fund for Measles	338,800	0.1	(100.0)	0	0.0
PW Special Fund for Capital Equipment	301,400	0.1	(100.0)	0	0.0
PX Program Support Costs	14,393,300	3.5	(30.8)	9,965,400	3.1
WORLD HEALTH ORGANIZATION	16,858,900	4.2	(76.2)	4,009,700	1.2
AS Special Account for Servicing Costs	3,716,000	0.9	(72.4)	1,027,000	0.3
DD UN System Support for Policy and Program	30,100	0.0	(100.0)	0	0.0
DL Standard Letter of Agreement between Executing Agencies	44,000	0.0	(100.0)	0	0.0
DP United Nations Development Program	388,600	0.1	(61.4)	150,000	*
FB Associate Professional Officers	1,128,900	0.3	(95.7)	48,400	*
FP United Nations Population Fund	2,079,800	0.5	(100.0)	600	*
RF WHO Renewal Fund	103,100	0.0	(100.0)	0	0.0
ST Sasakawa Health Fund	742,600	0.2	(87.8)	90,400	*
VC Special Account for Diarrheal Diseases including Cholera	1,838,300	0.5	32.7	2,439,000	0.8
VD Special Account for Miscellaneous Designated Contributions	3,909,900	1.0	(100.0)	0	0.0
VI Special Account for Expanded Program on Immunization	842,100	0.2	(69.8)	254,300	0.1
VN Special Account for Disasters and Natural Catastrophes	1,411,200	0.4	(100.0)	0	0.0
VP Special Account for Mental Health Program	55,000	0.0	(100.0)	0	0.0
VT Special Account for Tuberculosis	553,900	0.1	(100.0)	0	0.0
VY Special Account for Yaws Program	15,400	0.0	(100.0)	0	0.0
<b>TOTAL BUDGET</b>	<b>408,116,000</b>	<b>100.0</b>	<b>(20.4)</b>	<b>324,906,000</b>	<b>100.0</b>

\* INDICATES LESS THAN .05 PERCENT



TABLE E-1

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS					
PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
<u>1. GOVERNING BODIES</u>	<u>2,480,100</u>	<u>1.0</u>	<u>2,454,500</u>	<u>1.0</u>	
GOVERNING BODIES	GOB	2,480,100	1.0	2,454,500	1.0
<u>2. HEALTH IN HUMAN DEVELOPMENT</u>	<u>93,176,000</u>	<u>37.1</u>	<u>98,024,300</u>	<u>38.3</u>	
GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT		19,533,800	7.8	20,220,400	7.9
EXECUTIVE MANAGEMENT	EXM	4,236,100	1.7	4,599,300	1.8
PROGRAM DEVELOPMENT AND MANAGEMENT	GPD	7,405,200	2.9	7,881,300	3.1
STAFF DEVELOPMENT	SDP	1,675,200	0.7	1,608,100	0.6
REGIONAL DIRECTOR'S DEVELOPMENT PROGRAM	DGP	2,204,400	0.9	1,777,000	0.7
EXTERNAL COORDINATION	ECO	1,460,900	0.6	1,567,000	0.6
PUBLIC INFORMATION	INF	2,552,000	1.0	2,787,700	1.1
PUBLIC POLICY AND HEALTH		11,411,100	4.5	11,710,200	4.6
HEALTH IN SOCIOECONOMIC DEVELOPMENT	HSD	4,983,800	2.0	5,566,400	2.2
HEALTH LEGISLATION, HUMAN RIGHTS AND ETHICS	HLE	1,673,800	0.7	1,588,400	0.6
RESEARCH POLICY AND STRATEGY DEVELOPMENT	RPS	3,251,600	1.3	3,090,900	1.2
WOMEN, HEALTH AND DEVELOPMENT	WHD	1,501,900	0.6	1,464,500	0.6
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.		38,784,800	15.4	42,114,000	16.4
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS	37,565,500	15.0	40,848,900	15.9
HEALTH PLANNING	HPL	270,000	0.1	333,800	0.1
EMERGENCY AND HUMANITARIAN ACTION	EHA	949,300	0.4	931,300	0.4
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS		19,445,200	7.7	20,299,100	7.9
HEALTH SITUATION AND TREND ASSESSMENT	HST	9,098,300	3.6	9,758,700	3.8
HEALTH AND BIOMEDICAL INFORMATION	HBI	10,346,900	4.1	10,540,400	4.1
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	4,001,100	1.6	3,680,600	1.4
<u>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</u>		<u>42,384,400</u>	<u>16.9</u>	<u>41,286,800</u>	<u>16.1</u>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC		29,279,200	11.7	27,930,100	10.9
UNIVERSAL ACCESS TO HEALTH CARE	UAH	28,423,300	11.3	26,861,900	10.5
HEALTH SYSTEMS RESEARCH	HSR	15,000	-	134,200	0.1
TRADITIONAL MEDICINE AND INDIGENOUS HEALTH	TRM	20,000	-	53,400	*
DISABILITY PREVENTION AND RENABILITATION	DPR	355,600	0.1	371,800	0.1
ORAL HEALTH	ORH	465,300	0.2	508,800	0.2

TABLE E-1

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

PAHO PROGRAM CLASSIFICATION		1998-1999		2000-2001	
		AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
HUMAN RESOURCES FOR HEALTH	HRH	9,939,400	4.0	9,714,200	3.8
ESSENTIAL DRUGS	EDV	1,649,900	0.7	1,731,300	0.7
QUALITY OF CARE AND HEALTH TECHNOLOGY		1,515,900	0.6	1,911,200	0.7
QUALITY OF CARE AND HEALTH TECHNOLOGY ASSESSMENT	QAC	129,400	0.1	312,600	0.1
CLINICAL, LABORATORY AND IMAGING TECHNOLOGY	CLT	1,386,500	0.6	1,549,000	0.6
QUALITY, SAFETY & EFFICACY OF DRUGS & BIOLOGICALS	DSE	0	-	49,600	.*
4. HEALTH PROMOTION AND PROTECTION		27,392,300	10.9	27,957,600	10.9
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES		9,223,300	3.7	9,085,300	3.5
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH	8,041,400	3.2	7,827,900	3.1
ADOLESCENT HEALTH	ADH	820,000	0.3	912,000	0.4
HEALTH OF THE ELDERLY	HEE	361,900	0.1	345,400	0.1
HEALTHY LIFESTYLES AND MENTAL HEALTH		7,180,500	2.9	7,622,000	3.0
HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED	2,985,900	1.2	3,262,000	1.3
PREVENTION AND CONTROL OF SUBSTANCE ABUSE	ADT	431,000	0.2	862,000	0.3
MENTAL HEALTH	MNH	962,300	0.4	948,400	0.4
SETTINGS FOR HEALTH PROMOTION	STP	2,801,300	1.1	2,547,600	1.0
PROTECTION FROM VIOLENCE	PRV	0	-	2,000	-
NUTRITION, FOOD SECURITY AND SAFETY		10,988,500	4.4	11,250,300	4.4
FOOD AND NUTRITION	NUT	7,765,200	3.1	7,688,100	3.0
FOOD SAFETY	FOS	3,223,300	1.3	3,562,200	1.4
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT		20,537,400	8.2	20,797,600	8.1
ENVIRONMENTAL HEALTH		20,537,400	8.2	20,797,600	8.1
WATER SUPPLY AND SANITATION	CWS	13,433,900	5.3	13,621,600	5.3
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA	5,689,200	2.3	5,543,200	2.2
MANAGEMENT OF SOLID WASTE AND HOUSING HYGIENE	MWH	750,800	0.3	941,300	0.4
CHEMICAL SAFETY	PCS	60,100	.*	95,700	.*
WORKERS' HEALTH	OCH	603,400	0.2	595,800	0.2

TABLE E-1

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)					
OPS PROGRAM CLASSIFICATION		1998-1999		2000-2001	
		AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
6. DISEASE PREVENTION AND CONTROL		39,334,600	15.7	38,601,000	15.1
CONTROL OF COMMUNICABLE DISEASE		21,450,600	8.5	22,009,400	8.6
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID	4,275,400	1.7	4,442,000	1.7
ACUTE RESPIRATORY INFECTIONS	ARI	670,000	0.3	668,900	0.3
DIARRHEAL DISEASES	CDD	628,300	0.3	567,900	0.2
AIDS	GPA	1,174,200	0.5	1,319,000	0.5
SEXUALLY TRANSMITTED DISEASES	STD	216,500	0.1	183,100	0.1
TUBERCULOSIS	TUB	546,200	0.2	614,900	0.2
MALARIA AND OTHER TROPICAL DISEASES	CTD	3,859,100	1.5	3,964,200	1.5
RESEARCH IN TROPICAL DISEASES	TDR	378,100	0.2	411,900	0.2
OTHER COMMUNICABLE DISEASES	OCD	9,329,000	3.7	9,479,200	3.7
LEPROSY	LEP	373,800	0.1	358,300	0.1
CONTROL OF NONCOMMUNICABLE DISEASES		3,883,200	1.5	4,122,200	1.6
CANCER	CAN	24,000	-	13,600	-
CARDIOVASCULAR DISEASES	CVD	15,000	-	9,900	-
OTHER NONCOMMUNICABLE DISEASES	NCD	3,844,200	1.5	4,098,700	1.6
VETERINARY PUBLIC HEALTH		14,000,800	5.6	12,469,400	4.9
FOOT-AND-MOUTH DISEASE	FMD	9,319,700	3.7	8,209,600	3.2
ZOOZOSIS	ZNS	4,681,100	1.9	4,259,800	1.7
7. ADMINISTRATIVE SERVICES		25,959,200	10.3	27,123,200	10.6
PERSONNEL	PER	3,951,100	1.6	4,652,700	1.8
GENERAL ADMINISTRATION	GAD	12,160,200	4.8	11,669,400	4.6
BUDGET AND FINANCE	BFI	8,046,500	3.2	9,135,200	3.6
LOGISTICAL SUPPORT TO COUNTRY PROGRAMS	SUP	1,801,400	0.7	1,665,900	0.7
GRAND TOTAL		251,264,000	100.0	256,245,000	100.0

\* INDICATES LESS THAN .05 PERCENT

**GRAPH III**  
**2000-2001 PAHO/WHO REGULAR**  
**PROGRAM BUDGET**  
**APPROPRIATION SECTION**  
**(Percent of Total)**

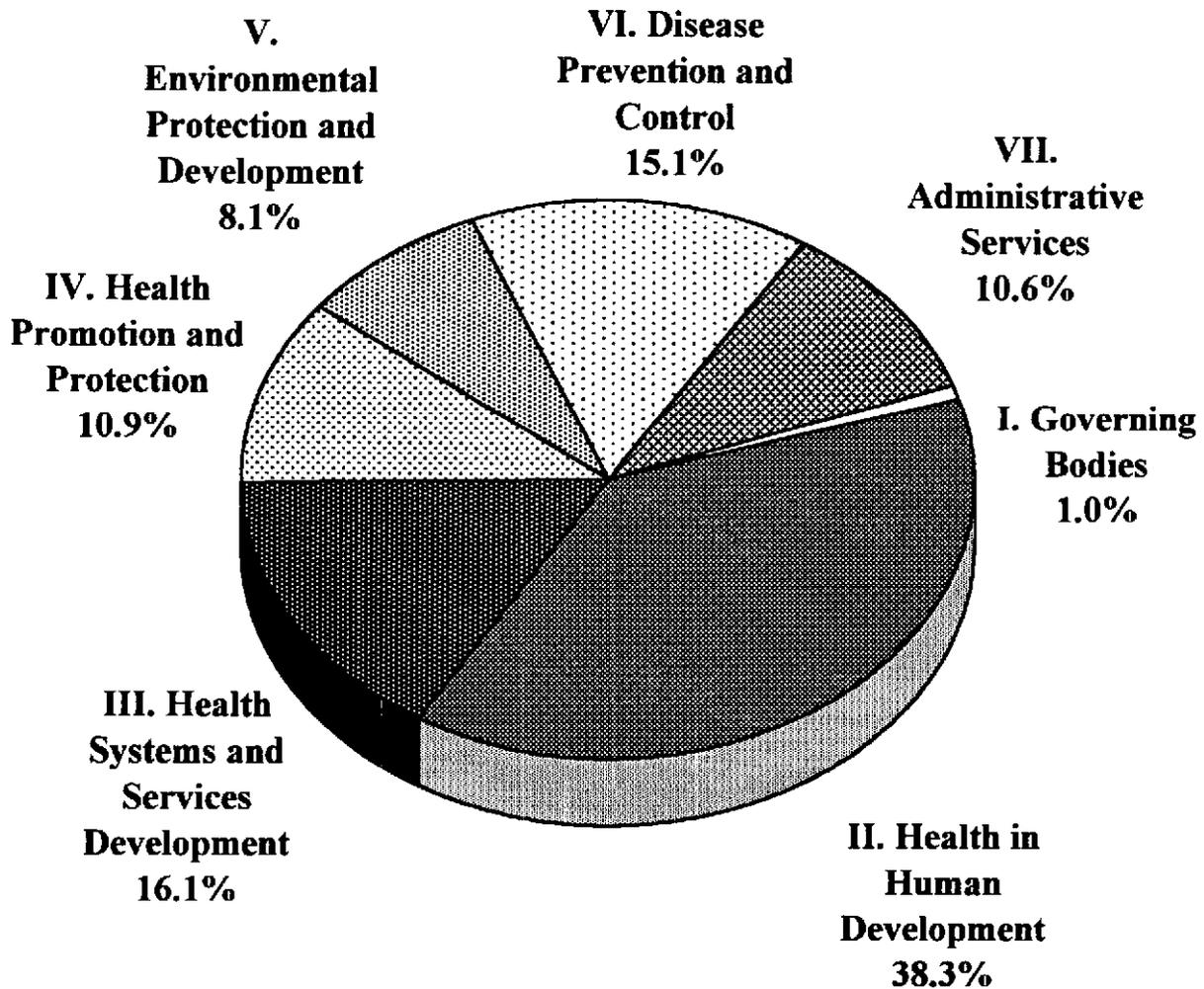


TABLE E-2

PROGRAM BUDGET - EXTRABUDGETARY FUNDS					
PAHO PROGRAM CLASSIFICATION		1998-1999		2000-2001	
		AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>1. GOVERNING BODIES</b>		<b>110,300</b>	<b>0.1</b>	<b>90,000</b>	<b>0.1</b>
=====		=====	=====	=====	=====
GOVERNING BODIES	GOB	110,300	0.1	90,000	0.1
-----		-----	-----	-----	-----
<b>2. HEALTH IN HUMAN DEVELOPMENT</b>		<b>32,737,800</b>	<b>20.9</b>	<b>10,545,800</b>	<b>15.4</b>
=====		=====	=====	=====	=====
GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT		4,156,000	2.6	2,122,400	3.1
-----		-----	-----	-----	-----
EXECUTIVE MANAGEMENT	EXM	312,000	0.2	300,000	0.4
PROGRAM DEVELOPMENT AND MANAGEMENT	GPD	2,150,000	1.4	692,000	1.0
STAFF DEVELOPMENT	SDP	350,000	0.2	0	-
EXTERNAL COORDINATION	ECO	887,300	0.6	868,400	1.3
PUBLIC INFORMATION	INF	456,700	0.3	262,000	0.4
PUBLIC POLICY AND HEALTH		3,368,300	2.1	698,000	1.0
-----		-----	-----	-----	-----
HEALTH IN SOCIOECONOMIC DEVELOPMENT	HSD	202,300	0.1	57,000	0.1
HEALTH LEGISLATION, HUMAN RIGHTS AND ETHICS	HLE	198,100	0.1	180,000	0.3
RESEARCH POLICY AND STRATEGY DEVELOPMENT	RPS	390,100	0.2	108,000	0.2
WOMEN, HEALTH AND DEVELOPMENT	WHD	2,577,800	1.6	353,000	0.5
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.		20,194,900	12.9	4,401,000	6.4
-----		-----	-----	-----	-----
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS	1,962,500	1.3	997,700	1.5
HEALTH PLANNING	HPL	286,000	0.2	0	-
EMERGENCY AND HUMANITARIAN ACTION	EHA	17,946,400	11.4	3,403,300	5.0
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS		4,744,300	3.0	3,324,400	4.8
-----		-----	-----	-----	-----
HEALTH SITUATION AND TREND ASSESSMENT	HST	90,900	0.1	106,400	0.2
HEALTH AND BIOMEDICAL INFORMATION	HBI	4,653,400	3.0	3,218,000	4.7
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	274,300	0.2	0	-
-----		-----	-----	-----	-----
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b>		<b>46,951,800</b>	<b>29.9</b>	<b>14,887,600</b>	<b>21.7</b>
=====		=====	=====	=====	=====
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC		32,472,800	20.7	9,312,400	13.6
-----		-----	-----	-----	-----
UNIVERSAL ACCESS TO HEALTH CARE	UAH	31,766,700	20.3	9,287,400	13.5
HEALTH SYSTEMS RESEARCH	HSR	25,000	.*	0	-
DISABILITY PREVENTION AND REHABILITATION	DPR	65,200	.*	0	-
ORAL HEALTH	ORH	615,900	0.4	25,000	.*

TABLE E-2

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)

PAHD PROGRAM CLASSIFICATION		1998-1999		2000-2001	
		AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
HUMAN RESOURCES FOR HEALTH	HRH	4,215,100	2.7	305,000	0.4
ESSENTIAL DRUGS	EDV	9,240,500	5.9	5,029,200	7.3
QUALITY OF CARE AND HEALTH TECHNOLOGY		1,023,400	0.7	241,000	0.4
CLINICAL, LABORATORY AND IMAGING TECHNOLOGY	CLT	963,600	0.6	241,000	0.4
QUALITY, SAFETY & EFFICACY OF DRUGS & BIOLOGICALS	DSE	59,800	.*	0	-
<b>4. HEALTH PROMOTION AND PROTECTION</b>		<b>9,472,000</b>	<b>6.0</b>	<b>4,406,700</b>	<b>6.4</b>
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES		5,540,300	3.5	1,932,700	2.8
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH	5,226,300	3.3	1,932,700	2.8
ADOLESCENT HEALTH	ADH	117,000	0.1	0	-
HEALTH OF THE ELDERLY	HEE	197,000	0.1	0	-
HEALTHY LIFESTYLES AND MENTAL HEALTH		1,733,300	1.1	832,300	1.2
HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED	690,100	0.4	650,000	0.9
PREVENTION AND CONTROL OF SUBSTANCE ABUSE	ADT	728,600	0.5	182,300	0.3
MENTAL HEALTH	MNH	272,100	0.2	0	-
SETTINGS FOR HEALTH PROMOTION	STP	42,500	.*	0	-
NUTRITION, FOOD SECURITY AND SAFETY		2,198,400	1.4	1,641,700	2.4
FOOD AND NUTRITION	NUT	1,426,800	0.9	916,700	1.3
FOOD SAFETY	FOS	771,600	0.5	725,000	1.1
<b>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</b>		<b>20,281,400</b>	<b>12.9</b>	<b>10,523,100</b>	<b>15.3</b>
ENVIRONMENTAL HEALTH		20,281,400	12.9	10,523,100	15.3
WATER SUPPLY AND SANITATION	CWS	11,320,900	7.2	5,848,000	8.5
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA	8,381,600	5.3	4,325,100	6.3
MANAGEMENT OF SOLID WASTE AND HOUSING HYGIENE	MWH	427,500	0.3	350,000	0.5
CHEMICAL SAFETY	PCS	124,300	0.1	0	-
WORKERS' HEALTH	OCH	27,100	.*	0	-

TABLE E-2

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)					
PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
6. DISEASE PREVENTION AND CONTROL	38,428,900	24.5	20,951,800	30.5	
CONTROL OF COMMUNICABLE DISEASE	30,738,900	19.6	16,003,400	23.3	
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID	11,398,600	7.3	6,201,500	9.0
ACUTE RESPIRATORY INFECTIONS	ARI	1,222,000	0.8	1,030,600	1.5
DIARRHEAL DISEASES	CDD	3,605,200	2.3	2,575,300	3.8
AIDS	GPA	3,632,500	2.3	1,502,000	2.2
SEXUALLY TRANSMITTED DISEASES	STD	15,400	-	0	-
TUBERCULOSIS	TUB	577,800	0.4	0	-
MALARIA AND OTHER TROPICAL DISEASES	CTD	8,049,900	5.1	4,483,100	6.5
RESEARCH IN TROPICAL DISEASES	TDR	200,500	0.1	0	-
OTHER COMMUNICABLE DISEASES	OCD	1,283,300	0.8	110,000	0.2
LEPROSY	LEP	753,700	0.5	100,900	0.1
CONTROL OF NONCOMMUNICABLE DISEASES		876,700	0.6	188,800	0.3
CANCER	CAN	153,200	0.1	33,900	.*
CARDIOVASCULAR DISEASES	CVD	163,000	0.1	12,400	.*
OTHER NONCOMMUNICABLE DISEASES	MCD	560,500	0.4	142,500	0.2
VETERINARY PUBLIC HEALTH		6,813,300	4.3	4,759,600	6.9
FOOT-AND-MOUTH DISEASE	FMD	5,071,900	3.2	3,604,600	5.2
ZOOZOSIS	ZNS	1,741,400	1.1	1,155,000	1.7
7. ADMINISTRATIVE SERVICES		8,869,800	5.7	7,256,000	10.6
PERSONNEL	PER	710,400	0.5	1,001,500	1.5
GENERAL ADMINISTRATION	GAD	3,715,000	2.4	1,500,000	2.2
BUDGET AND FINANCE	BFI	3,305,000	2.1	3,308,000	4.8
LOGISTICAL SUPPORT TO COUNTRY PROGRAMS	SUP	1,139,400	0.7	1,446,500	2.1
GRAND TOTAL		156,852,000	100.0	68,661,000	100.0

\* INDICATES LESS THAN .05 PERCENT



TABLE F

ANALYSIS OF BUDGETARY ELEMENTS - PAHO AND WHO REGULAR FUNDS					
BUDGET ELEMENTS	1998-1999		PER CENT INCREASE/ (DECREASE)	2000-2001	
	AMOUNT	% OF TOTAL		AMOUNT	% OF TOTAL
PERSONNEL:					
POSTS	138,346,600	55.1	6.9	147,900,200	57.7
LOCAL CONDITIONS STAFF	886,200	.3	352.1	4,006,900	1.6
RETIREEES' HEALTH INSURANCE	3,949,300	1.6	14.0	4,501,000	1.8
TOTAL, PERSONNEL	143,182,100	57.0	9.2	156,408,100	61.1
SUPPLIES AND EQUIPMENT	8,276,800	3.3	3.0	8,526,900	3.3
GENERAL OPERATING EXPENSES	17,693,500	7.0	(1.2)	17,472,800	6.8
ALL OTHER ELEMENTS	82,111,600	32.7	(10.1)	73,837,200	28.8
<u>GRAND TOTAL</u>	<u>251,264,000</u>	<u>100.0</u>	<u>2.0</u>	<u>256,245,000</u>	<u>100.0</u>

ANALYSIS OF BUDGETARY ELEMENTS - EXTRABUDGETARY FUNDS					
BUDGET ELEMENTS	1998-1999		PER CENT INCREASE/ (DECREASE)	2000-2001	
	AMOUNT	% OF TOTAL		AMOUNT	% OF TOTAL
PERSONNEL:					
POSTS	18,521,100	11.8	(22.4)	14,378,700	20.9
LOCAL CONDITIONS STAFF	1,527,600	1.0	(17.5)	1,260,000	1.8
TOTAL, PERSONNEL	20,048,700	12.8	(22.0)	15,638,700	22.7
SUPPLIES AND EQUIPMENT	30,735,800	19.6	(96.0)	1,220,700	1.8
GENERAL OPERATING EXPENSES	7,400,000	4.7	(56.6)	3,210,700	4.7
ALL OTHER ELEMENTS	98,667,500	62.9	(50.8)	48,590,900	70.8
<u>GRAND TOTAL</u>	<u>156,852,000</u>	<u>100.0</u>	<u>(56.2)</u>	<u>68,661,000</u>	<u>100.0</u>



### III. PROGRAM STATEMENTS

### III. PROGRAM STATEMENTS

# PAHO CLASSIFIED LIST OF PROGRAMS 2000-2001

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1. GOV GOVERNING BODIES

1.1 GOB Governing Bodies

1.1.1 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. HHD HEALTH IN HUMAN DEVELOPMENT

2.1 PDM General Program Development and Management

2.1.1 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).

2.1.2 GPD *PAHO/WHO Program Development and Management*

Activities of Analysis and Strategic Planning Office (DAP); activities of information support services (software development) for PAHO's management by Management and Information Support Office (ACS).

2.1.3 SDP *PAHO/WHO Staff Development*

Activities of the Program of Staff Development and Training (APL/SD).

2.1.4 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.

2.1.5 ECO *External Coordination*

Activities of a unit under D/DD: External Relations (DEC), including collaboration with United Nations and inter-American systems in the Region, with other organizations, and with multilateral and bilateral programs.

2.1.6 INF *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.

**2.2 PPH Public Policy and Health**

**2.2.1 HSD *Health in Socioeconomic Development***

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; and participation of the health system in integrated programs to combat poverty. 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 adjustment policies on health and the relationships between health and economy.

**2.2.2 HLE *Health Legislation, Human Rights, and Ethics***

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; implementation of the Documentation System of Basic Health Legislation for 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. Contributions 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 and to cooperate with other countries in the establishment of rules and regulations for bioethics-related issues.

**2.2.3 RPS *Research Policy and Strategy Development***

Activities aimed at development of a conceptual framework and analytical, administrative, and evaluation tools applied to technological development in health. An essential part of PAHO's main strategy of management of knowledge, comprising overall coordination of biomedical and public health research, highlighting the functions of the regional Advisory Committee on Health 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 policies and development mechanisms.

**2.2.4 WHD *Women, Health, and Development***

Activities aimed at strengthening the capacity of the health sector to analyze epidemiological data from a gender perspective so as to develop programs and policies aimed at reducing gender inequities in health. Includes information dissemination on the health situation of women from a gender perspective and the formulation of training and research initiatives that enhance the grasp of gender differentials in the health-illness process.

**2.3 NHP National Health Policies and Program Development and Management**

**2.3.1 CPS *Support to the Development, Management and Coordination of Country Programs***

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 Field Office on the US-Mexico Border.

**2.3.2 HPL *Health Planning***

Analysis of the constitution, organization, resources, and operation of the health sector in order to give strategic orientation to health policies and sectoral development projects.

**2.3.3 EHA *Emergency and Humanitarian Action***

Activities related to disaster preparedness and emergency assistance, included in this program due to their close relationship to the support of country programs.

**2.4 BHT Biomedical and Health Information and Trends**

**2.4.1 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.

**2.4.2 HBI *Health and Biomedical Information***

Production of publications and documents of the Organization. Development and promotion of health bibliographic and documentation services, including libraries and regional document centers. Activities related to simultaneous interpretation during executive, technical, and administrative meetings; and to translation of books, documents, and other publications of the Organization.

**2.5 TCC Technical Cooperation among Countries**

**2.5.1 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.

**3. HSS HEALTH SYSTEMS AND SERVICES DEVELOPMENT**

**3.1 PHC Organization and Management of Health Systems Based on Primary Health Care**

**3.1.1 UAH *Universal Access to Health Care***

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 non-governmental 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. Activities of information support for national health services.

**3.1.2 HSR *Health Systems Research***

Research intended to identify mechanisms to make health services more effective and efficient, with special focus on primary health care, decentralization, and community participation.

**3.1.3 TRM *Traditional Medicine and Indigenous Health***

Activities including technical cooperation and resource mobilization directed at improving the health and well-being of indigenous peoples of the Region. Development, implementation, and evaluation of health development projects in areas with large indigenous populations; health promotion efforts and projects addressing priority populations (indigenous women) and health problems (safe water, nutrition). Special consideration is given to the area of traditional medicine, including but not limited to medicinal plants. In particular, work in this area is directed at enhancing the articulation between traditional and occidental health systems, principally at local level, taking full advantage of all resources including traditional practitioners and making health services more culturally acceptable to the population.

**3.1.4 DPR *Disability Prevention and 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.

**3.1.5 ORH *Oral Health***

Activities related to community prevention and control of oral diseases and to general promotion of oral health.

**3.2 HRH Human Resources for Health**

**3.2.1 HRH *Human Resources for Health***

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. Promotion of the institutional development for personnel management with emphasis in the analysis of the labor market, formulation of human resource policies, and advanced training in these fields. 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.

**3.3 EDV Essential Drugs**

**3.3.1 EDV *Essential Drugs***

Formulation and implementation of national drug policies to ensure quantification of needs, procurement, production, distribution, and management of essential drugs, 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.

**3.4 QCT Quality of Care and Health Technology**

**3.4.1 QAC *Quality of Care and Health Technology Assessment***

Promotion of health technology assessment and health care quality assurance activities to improve effectiveness and reduce costs through information dissemination, training, and a network of collaborating centers. Support of national programs and cooperation among countries to exchange information and develop common standards.

**3.4.2 CLT *Clinical, Laboratory, and Imaging Technology***

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.

**3.4.3 DSE *Quality, Safety, and Efficacy of Drugs and Biologicals***

Activities aimed at assuring the quality, safety, and efficacy of drugs and biologicals, including establishment of norms, standards, and regulations; quality control procedures; and sharing of resources among countries.

**4. HPP HEALTH PROMOTION AND PROTECTION**

**4.1 FCH Family/Community Health and Population Issues**

**4.1.1 WCH *Women and Child Health, and Family Planning***

Activities oriented towards strengthening technical, managerial and operative national capacity to design, implement, and evaluate programs and services for the

reproductive health of the population and the comprehensive health of women and children, using intersectoral approaches for health promotion and protection to individuals, the family, and communities.

**4.1.2 ADH     *Adolescent Health***

Activities intended to promote development of programs and human resources, to provide better care for adolescent populations. Emphasis will be on intersectoral approaches to adolescent health promotion and prevention of risk behaviors. Development of instruments to obtain data on adolescent care, family health, and evaluation of services.

**4.1.3 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.

**4.2 HYL     Healthy Lifestyles and Mental Health**

**4.2.1 HED     *Health Education and Social Communication***

Activities that will assist Member Governments in building and strengthening health sector capacity to implement and evaluate health education and social communications programs at all levels, particularly local health systems, schools, communities, and the work place. Involving people and all sectors of society in the analysis of knowledge, behaviors, and life styles that are associated with health and disease, developing skills and abilities to implement solutions to needs and problems. Of particular importance are social communications activities in the mobilization of society for the purpose of establishing healthy public policy. Also, the exchange of knowledge and experiences within and between countries in support of traditional healing practices among different indigenous cultures and ethnic groups.

**4.2.2 ADT     *Prevention and Control of Substance Abuse  
(Alcohol, Drugs, Tobacco)***

Promotional and technical advisory services on the formulation of national policies and programs for research on and prevention and treatment of problems resulting from substance abuse. Support to countries' actions aimed at reducing the incidence and prevalence of substance abuse. Efforts to educate societies and new generations to avoid substance abuse.

**4.2.3 MNH     *Mental Health***

Activities aimed at the development of policies, plans, programs, and standards for promoting and improving mental health and risk reduction. Prevention and care of mental and neurological disorders at the community level, with psychosocial determinants being taken into account.

**4.2.4 STP     *Settings for Health Promotion***

Activities aimed at strengthening health promotion in families, schools, community health systems and services, civil societies, cities, and municipalities. Mobilizing

resources to formulate and establish healthy public policies and to implement and evaluate health education and communication programs for health action. Priority will be given to schools as privileged settings to develop and strengthen health promotion and education programs and supportive environments for healthy behaviors and lifestyles.

**4.2.5 PRV      *Protection from Violence***

Activities intended to develop intersectoral public policies on health promotion and violence prevention at national and local levels, establishing networks of healthy and non-violent local action groups, establishing social communications programs at the community level in support of a culture of health and non-violence, and assisting in the implementation of interventions at the community level.

**4.3    NFS      Nutrition, Food Security, and Safety**

**4.3.1 NUT      *Food and Nutrition***

Activities related to the improvement of food supply and its availability and nutritional quality. Incorporation within the national and local development plans of interventions for the promotion of good nutrition and for reducing morbidity and mortality from malnutrition. Also included are activities to promote exclusive breast-feeding practices at least through the fourth month of life.

**4.3.2 FOS      *Food Safety***

Promoting activities for the development of national policies and programs to ensure quality and innocuity of food, harmonizing international and national norms and standards to facilitate access of food products to international markets, and developing inspection and integrated epidemiological surveillance systems to prevent and control food-borne diseases.

**5.    EPD      ENVIRONMENTAL PROTECTION AND DEVELOPMENT**

**5.1    PEH      Environmental Health**

**5.1.1 CWS      *Water Supply and Sanitation***

Activities aimed at the implementation of programs of urban, peri-urban, and rural water supply and sanitation, including aspects of quality, coverage, and reuse. Also includes aspects of planning, legislation, community participation, and institutional development.

**5.1.2 ERA      *Environmental Health Risk Assessment and Management***

Activities concerned with the development of national capabilities for the protection, surveillance, conservation, and use of natural resources, incorporating the health dimension into the processes of evaluation, monitoring, and control of environmental impacts.

**5.1.3 MWH    *Management of Solid Waste and Health in Housing***

Support of activities regarding the aspects of collection, transport and disposal of municipal solid waste, including institutional development; promotion of activities related to the health aspects of housing and its perimeter.

**5.1.4 PCS    *Chemical Safety***

Support for activities aiming at the development of national capacities for the evaluation of environmental risk to health and for measures aimed at the management of environmental quality as related to chemical substances, environmental contaminants, and natural and technological disasters.

**5.1.5 OCH    *Workers Health***

Support for activities aimed at the development of national capabilities for the improvement and protection of the health of workers and the quality of working environments.

**6.    DPC    DISEASE PREVENTION AND CONTROL**

**6.1    CCD    Control of Communicable Diseases**

**6.1.1 VID    *Vaccine-preventable Diseases and Immunization***

Activities aimed at stimulating and supporting research on new vaccines, the organization of vaccines trials with the Member Governments, and the evaluation of the results of introducing new vaccines. Activities related to the Expanded Program on Immunization.

**6.1.2 ARI    *Acute Respiratory Infections***

Activities related to prevention and control of acute respiratory infections and asthma and broncho-obstructive syndrome in children, and prevention and treatment of the "sick child."

**6.1.3 CDD    *Diarrheal Diseases***

Activities related to diarrheal disease prevention and control, including actions against cholera.

**6.1.4 GPA    *AIDS***

Prevention and control of acquired immunodeficiency syndrome and HIV infection.

**6.1.5 STD    *Sexually Transmitted Diseases***

Prevention and control of sexually transmitted diseases.

**6.1.6 TUB    *Tuberculosis***

Prevention and control of Tuberculosis.

**6.1.7 CTD      *Malaria and Other Tropical Diseases***

Activities oriented toward the promotion of the prevention and control of vector-borne diseases, including malaria, arboviral diseases, American trypanosomiasis, schistosomiasis, filariasis (including onchocerciasis), and the leishmaniases, including the integrated control of vectors. Activities related to the prevention and control of the intestinal parasite infections.

**6.1.8 TDR      *Research in Tropical Diseases***

Activities pertaining to and included in the special program only.

**6.1.9 OCD      *Other Communicable Diseases, Including Surveillance of Emerging Diseases and Antibiotic Resistance***

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, viral hemorrhagic fevers, hantavirus pulmonary syndrome, and viral hepatitis.

**6.1.10 LEP      *Leprosy***

Prevention and control of leprosy.

**6.2 NDI      *Control of Non-communicable Diseases***

**6.2.1 CAN      *Cancer***

Operational research and development support for activities in cancer prevention and control, with emphasis on programs for the prevention and early detection of cervical cancer and the development of cancer registries. Epidemiological support for the primary prevention of tobacco-related cancers, including dissemination of information and health promotion initiatives.

**6.2.2 CVD      *Cardiovascular Diseases***

Support to strengthen prevention activities, with emphasis on the role of primary care and local health systems, in order to reduce the prevalence of cardiovascular risk factors. Activities for the detection and control of arterial hypertension. Training and support for the conduct of risk factor surveys and the development of model intervention programs.

**6.2.3 NCD      *Other Non-communicable Diseases***

Operational research and development support for the improvement of diabetes case-finding and quality of care. Support for health promotion initiatives addressing the prevention and control of injuries, including demonstration projects and the dissemination of information on impact and cost-effectiveness of interventions. Support for non-communicable disease prevention and control in the context of local health systems, health promotion initiatives, and environmental health, via training, priority-setting, and consultation. Analysis of current and projected impacts of non-communicable diseases of public health importance, including economic burden and the projected impact of selected interventions.

**6.3 VPH Veterinary Public Health**

**6.3.1 FMD *Foot-and-Mouth disease***

Prevention and control of foot-and-mouth disease.

**6.3.2 ZNS *Zoonosis***

Prevention and control of the major zoonoses and related food-borne diseases.

**7. PAS ADMINISTRATIVE SERVICES**

**7.1 PER Personnel**

**7.1.1 PER *Personnel***

Personnel services.

**7.2 GAD General Administration**

**7.2.1 GAD *General Administration***

Conference, office, and building services.

**7.3 BFI Budget and Finance**

**7.3.1 BFI *Budget and Finance***

Budget, finance, and accounting services.

**7.4 SUP Procurement**

**7.4.1 SUP *Logistical Support to Country Programs***

Procurement services.

# GOVERNING BODIES

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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 Governing Bodies meet every year, as needed. The category "Governing Bodies" covers the cost of scheduled meetings and supporting staff, as well as the cost of the external audit. The staff also serves other seminars and conferences as time allows.

<b>GOVERNING BODIES PROGRAM BUDGET DISTRIBUTION BY LOCATION</b>				
<b>Location</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
<b>Governing Bodies</b>	2,480,100	2,454,500	110,300	90,000
<b>Total</b>	<b>2,480,100</b>	<b>2,454,500</b>	<b>110,300</b>	<b>90,000</b>



# HEALTH IN HUMAN DEVELOPMENT

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## *Regional Situation*

1. Aware of the dominant trends in the Americas and the world, and of the profound inequities which still persist in the Region, the Organization's leadership proposed, and the Member States adopted the Strategic and Programmatic Orientations (SPO) for the period 1999-2002.

2. The challenge for the biennium includes translating the general guidelines represented by the SPO into practical, operational, cooperative efforts undertaken by the Secretariat and the Member States. While the Organization enjoys solid political support, the evolving politico-economic and technological environment make it imperative for the Secretariat and the Governments to explore new ways to implement the SPO and carry out the Organization's mission, including the development of public-private partnerships. Financial instability across global markets threatens to destabilize decades of work and sacrifice by the Member States of PAHO. From reduction of infant mortality to overcoming the challenges posed by tobacco, the Organization will use this biennium to define and refine its work objectives to fulfill the specific SPO goals, compatible with its mission and mandates.

## *Analysis and Strategic Planning*

3. A new cycle and a new administration were established in PASB in 1999 that are consistent with the recently adoption of global policy frameworks (Declaration of HFA WHA A51/5): Strategic and Programmatic Orientations for the Pan American Sanitary Bureau 1999-2002 (CSP25/8). The Renewal of the Call for Health for All (HFA) was also adopted and disseminated in view of the resolve of the countries to renew this commitment.

4. These changes require a constant rethinking of technical cooperation, the principal functional result of the Bureau's activities--not only conceptually, but practically. Likewise, there is a need to adopt and incorporate techniques and methods that will make it possible to anticipate and take action to address environmental changes and implications as

appropriately as possible to ensure that the Organization is prepared and able to adapt to the future.

5. During this period it will be necessary to make progress toward greater effectiveness and efficiency in the management cycle of technical cooperation in all stages, with broad participation by the Organization's units in a reform-oriented environment in the international and national system.

## *Legal Affairs*

6. As an international organization in the health field, PAHO has certain special needs of a legal nature that must be satisfied. These needs are many and diverse and must be addressed in an efficient and effective manner if PAHO is to function and accomplish its stated objectives.

7. A large percentage of the technical cooperation services provided by PAHO is done with funding from extrabudgetary sources, be they private foundations, associations etc., or national agencies for international development. In order to assure that these funds are transferred and used responsibly and in accordance with the expectations of the donors and recipients, some type of formal relationship must be established between the Parties. This will almost always result in the signing of a legally binding instrument detailing the respective responsibilities.

8. As with any large organization, PAHO must deal on a daily basis with matters concerning its administration, personnel and its host countries. Many legal questions arise in the relationship between PAHO and its employees and in the interactions with the different levels of government of the countries that host its Representations. Additionally, PAHO's interests must be represented in matters that arise before local authorities to ensure that its personnel and property are granted the required privileges and immunities to enable the Organization to perform effectively.

9. Given PAHO's technical cooperation in health and medicine, it is necessary to seek appreciation of new areas of interest to the Organization providing

advice to technical divisions in specific matters which have a high level of legal content such as intellectual property rights, human rights, ethics, and, more generally, on how the law interacts with health and medicine.

10. To better serve its Member States, PAHO has a vast network of Representative Offices (PWR) and Specialized Centers throughout the Region. These Offices and Centers are faced with the same need for legal counsel as Headquarters. It will be necessary to guarantee that a certain uniformity is observed in the application of PAHO policies, rules, regulations, procedures, and practices. When the Representations and Centers interact with the local authorities in matters that could have legal repercussions, it is necessary to advise and support them, and when necessary, get actively involved and work closely with local counsel to protect the Organization's interests.

#### ***PAHO/WHO Staff Development***

11. The process of rethinking the Organization's mission and goals to meet the challenges posed by the social, economic, and political changes in the countries emphasizes the need for a workforce able to expand its technical knowledge of position health policies and issues into the national development plans of the countries. The skill to continuously scan the environment and to develop effective and timely responses to advance the interests of health is considered essential. This skill requires competency in strategic thinking and planning in the use of instruments and tools for political and economic analysis as well as for project design and management. It also requires innovative use of leadership, negotiation, managerial, and communication skills.

12. The increased use of networks, temporary partnerships, collaboration with diverse institutions, and actors concerned with health issues requires competencies which include political awareness, ability to mobilize resources, and ability to manage conflict and competing interests.

13. The support of the ongoing process of health reform demands continuous work both with central and local health systems while keeping in mind the

system as a whole. In this context, competencies in systems thinking, participatory program development, and the construction of technical cooperation with a process consultation approach are a must.

14. In advancing the issues of health, the Organization requires the generation of a corporate image which emphasizes its power to bring together diverse actors and resources from various sectors in the promotion of health in the Americas. Increased recognition of the Organization's role and expertise by other institutions, governments, and public is key to the success of such efforts. The competencies required are increased ability both at the institutional and individual levels to deal with the media and to seize opportunities where the Organization's expertise can be more visible, such as involvement in community programs in the developed member countries and the convening of strategic conferences with high level figures which can influence the implementation of health policies.

15. Therefore, it is important to continue to promote policies and organizational structures that advance institutional and human resource development. This requires articulation of the different systems of human resources management throughout the Organization as well as managerial behaviors which emphasize group work and staff development, increased participation of the PAHO community in the decision-making process, and use of conflict resolution and interpersonal skills. The inclusion of support as an important member of the work team must be the preferred way of working.

16. It is important to continue to support technical updating for the management of knowledge as well as technical updating for teams and individuals in critical program areas. Updating in new technologies as they are introduced into the Organization, such as computer training, is a constant, although it is considered that basic competency should be required on recruitment.

17. In the international environment in which the Organization operates, the use of English as the primary language of communication has become increasingly critical. Internally, Spanish is essential for English speakers. Given the high cost of this

training, it is advisable that new staff members have fluency in both languages when they are hired.

18. University assistance in fields of interest to the Organization will continue both to override new skills and advance career opportunities.

#### ***External Coordination***

19. PAHO's external world is comprised by the Inter-American System, the UN System, the International Lending Institutions, the Bilateral Agencies, the Private Sector and the NGO Community. This external environment is characterized by an accelerated process of globalization and interdependency along with a revolution in information.

20. The UN System is evolving towards a more comprehensive response to countries' needs thus requiring new modalities of cooperation, sharing analysis, programming, and facilities. Expectations from the international community are that agencies such as ours will be devoted to setting standards, norms, and building capacity at country level. Resources available in our Hemisphere will hopefully be maintained, but it is not expected that they will increase, due to relative country development and the increasing demands from other parts of the world.

21. Inter-American cooperation will continue its enhanced activities through the various presidential summits, the Summit of the Americas process, and the First Ladies Summits, the Iberoamerican and European-LAC Summits. The Summit of the Americas has assigned specific responsibilities to the Inter-American Agencies. PAHO has a significant role to play as the specialized health agency.

22. The International Lending Institutions will continue their upward trend in health lending, delivering not only capital loans, but also technical cooperation. It has become imperative that the technical and financial institutions establish effective mechanisms of coordination and collaboration. Private sector and civil society are becoming major partners in decision making in the LAC democracies, and as such will be important in PAHO's cooperation. Among these, the NGOs have significant importance.

23. Bilateral cooperation will continue complementing national resources for health, usually, but with some exceptions, in a downward trend. It will be crucial to continue attracting resources to sustain the countries and regional health priorities. PAHO will play a crucial role in this respect.

#### ***Public Information***

24. The demand for non-technical -as well as technical- health information continues to rise sharply throughout the Region, in part because of shifting concerns to health and healthy lifestyles, rapid increases in health advancements, and the ease of access brought on by rapid electronic technology. Diagnoses, prescriptions, explanations on any given disease are available in seconds on the Internet from any number of sources. While only a handful of newspapers and health institutions in the Region relied on the Internet as a source of information just a few years ago, as we move into the new millennium almost all use the Internet as a public relations vehicle and an avenue to reach the public. This has meant a dramatic change in the way health news is prepared, presented and delivered.

25. In general, there is more of an emphasis on packaging and an increased use of multi-media to get the health messages out to the general public. Television stations are seeking simple yet direct health news. Journalists demand jargon-free explanations on a myriad of subjects. People are seeking health news. And in the news business, the word is that health sells.

26. There has been a growing recognition within the Organization that PAHO needs to get its message out not only to the scientific community, but to a broad general audience. PAHO has assisted by offering media training. To adequately promote PAHO and its work, communications will be included in the planning, programming and implementation of projects. PAHO staff will be trained to create clear messages and attractive packages to "sell" those messages. PAHO's successes are well known among the health community; it is our obligation to see that the word does not stop there and to assure that our messages reach all our publics.

#### ***Support to the Development, Management and Coordination of Country Program***

27. The context in which the Country PAHO/WHO Offices are operating has become increasingly

complex. This trend can be pinpointed to the following factors: the UN Reform Process; the decentralization of resources of donor to their respective embassies; the presence of the International Financing Institutions (WB and IDB) and their carrying out large projects in the health sector; decentralization of our privileged/principal counterparts-MOH-; presence of important actors in the health arena; the progress of integration processes, with an important although not always recognized impact on health sector and health situation, and the WHO Reform Process. The Office of the AD needs to ensure that PWRs adequately take into account these factors in their respective programs of technical cooperation. Its primary challenge is to ensure technical, political and administrative responsiveness and coherence to PAHO policies at the field level of the organization. This is further complicated by the need to coordinate a wide range of programmatic and managerial issues in the context of expanding the delegation of authority of the field offices. One of PAHO's basic tenets is that the Country Offices are fundamental to the ultimate success of any program of technical cooperation. It is therefore critical to ensure that the Country Offices are efficiently organized, managed and supervised.

28. All countries can improve some aspect of the management of their health services and of their infrastructure by carefully managing their human, financial, organizational and material resources. The vast majority of these resources are national in origin although a significant part comes from external sources. A major effort is required to coordinate these various resources to ensure a comprehensive and cohesive program which addresses national health development priorities. The Pan American Health Organization provides technical cooperation to aid national health authorities in addressing these priorities.

29. The PAHO Governing Bodies have approved the promotion of joint actions between countries as one of the key strategies for improving the health of the populations in the Americas. Technical Cooperation Among Countries (TCC) is an expression of Panamericanism and promotes the development of national capabilities. PAHO will stimulate its use to satisfy the technical cooperation needs of the countries.

### *Emergency and Humanitarian Action*

30. As PAHO is approaching its 100th anniversary, the Emergency Preparedness and Disaster Relief Coordination Program is entering its third decade. In the last 20 years, the countries of Latin American and Caribbean countries have continued to face the same threats of disasters from a host of natural hazards including floods, earthquakes, hurricanes, droughts, volcanic eruptions and landslides, were reported in the Americas.

31. Significant strides in preparing for and mitigating the effects of disasters have been made in recent years. This has been coupled with new technologies that have enhanced disasters management -- particularly in terms of training, communications and the dissemination of information. Long distance education and courses have become more common and will continue to be encouraged. The growing availability and use of the Internet in many countries of the Americas has also had an impact, particularly as countries employ this tool to exchange information, stimulate coordination and seek solutions to common cross-border problems. The Internet has offered a particularly cost-effective solution to widespread access to and distribution of information.

32. With the close of the International Decade for Natural Disaster Reduction, it becomes even more critical to monitor, lobby for, promote and assess the continuing commitment of the countries of this Region to prevent the natural hazards that surround them from becoming natural disasters.

### *Health and Biomedical Information*

33. Positive social change depends in good measure on scientific progress. The objectives of publishing and information dissemination are to identify priorities among health problems; broadcast the results of research and recommend well-tried methods; provide guidance so that countries can solve their own health problems; develop new tools and fresh strategies; and advance basic understanding and the frontiers of knowledge.

34. Today, information that is validated, useful, and relevant to public health researchers, teachers, and service personnel takes the form of books, journal articles, documents, diskettes, CD-ROMs, and online texts. While traditional print publishing continues to serve most of the hemisphere's health sector,

evolving electronic technologies and networks are making it possible to distribute information more widely than ever, while reducing the costs of producing and distributing it.

35. From 1996 to 1998 worldwide access to the Internet tripled (from 9 million hosts in 1996 to 29 million 1998), and access in Latin America and the Caribbean grew sixfold (from 45,000 to 240,000 hosts). Although Brazil represents half of the Region's Internet presence and four countries--Brazil, Argentina, Mexico, and Chile--account for 85% of the Region's hosts, the growth in other countries--most notably Colombia, Uruguay, and Costa Rica--has also been explosive. In 1998, 8.5 million people in Latin America had online access, and the projection is 15 million for the year 2000. While the Internet is influencing every sector of society, its impact on publishing is particularly notable. It is spawning a networked knowledge industry, with electronic publications increasing the visibility and use of their printed counterparts. The access afforded by electronic publishing economically and effectively connects sources, publishers, librarians, and users; among many positive consequences of this increased scientific communication is a boost in citations. Organizations the world over are making the Web the dominant platform for their information activities. All of the Ministries of Health in the Americas are connected to the Internet and have their own Web sites. The challenge for the year 2000 and 2001 will be to take advantage of leading Web developments and to combine them with online multimedia to expand and enhance the production, dissemination, and communication of health information.

36. For PAHO, the critical issue in marketing is to provide access to information to whomever wants and needs it, assuring that the organization's primary clientele has free access and that others obtain publications at a fair price.

37. The "virtual library," capitalizing on electronic information sites and networks, will make it possible to provide access to and delivery from public and private information sources. Processes and services will become increasingly electronic, with online integrated library catalogs and digital collections. Because much of the international public health information of interest to the Americas is administered by PAHO, it behooves the Organization

to intensify efforts to capture, manage, and distribute that information.

#### *Public Policy and Health*

38. The advancing introduction of new communication technologies and data processing capabilities in the countries, along with the emergence of numerous national and international agencies, governmental and non-governmental, bilateral and multilateral, all involved in the collection, analysis and dissemination of health-related information, confer PAHO a perceived mandate to provide leadership for the coordination of these efforts and for the accreditation of the data and information on health in the Region. PAHO's leadership role in health in the Americas will be strengthened and reaffirmed in the collection and dissemination of health information, including vital statistics and data on morbidity and mortality and data on socio-economic factors for better targeting of health actions, the analysis of political determinants for more effective advocacy, efforts and policy formulation and the promotion of research on priority health issues and problems in order to identify more effective interventions.

39. The principal trends that will be dealt with within the areas of technical cooperation related to health and human development during the biennium in the Region of the Americas are the ongoing process of economic globalization and the strengthening of subregional trading blocks, along with the consolidation of hemispheric and iberoamerican political summit processes, which have provided a consensual regional framework that defines the prevailing national models for economic growth, social development and political governance. The overall socio-economic scenario in the Region is one of moderate economic growth with historically low inflation, reduced overall public expenditure, but a relative and absolute increase in public investment in human capital (health and education); this model of economic growth has yet to significantly affect the uneven distribution of income which continues to characterize Latin America and the Caribbean as the most inequitable region in the world. Poverty levels in relative terms have remained stationary in the Region as a whole, and are still higher than those existing in 1980. Health conditions measured in terms of mortality trends and life expectancy

continue to improve overall, but the gaps in health condition between countries and between population groups as defined by location, sex, income levels, education or ethnicity, are either constant or tend to increase. These trends require strengthening the countries and the Region's capacity to obtain and establish reliable data and information on health conditions in the Region, as well as to develop more comprehensive frameworks to identify and analyze the interactions among the determinant and conditioning factors within and outside the health sector that affect the health situation of the people of the Americas and that are an obstacle to improving equity in health outcomes.

40. Public policy in the Region has been characterized by the trend towards modernization and reform of the state and the privatization of previously publicly operated essential services. With regards to the health sector, environmental and sanitation services, including the provision of water in urban areas, are in an advanced process of privatization. Many countries in the Region have formulated or are implementing health sector reforms (HSR) initiatives, which include various schemes for increasing decentralization of the responsibility for public health services, more involvement of the private sector in the provision of publicly funded personal health care services and diverse modifications, including privatization, of national health financing models.

41. One particular area of development, that of women's health across the life cycle and gender issues in health, has established itself as a legitimate area of interest and action in the Region. Current thinking on this topic is to shift away from a focus on woman as a vulnerable group, giving way to an empowerment approach combining a response to women's specific health needs with strategies whereby gender roles, responsibilities and power can be redistributed, thus increasing women's control over internal and external factors that affect their ability to protect their health. Governments, civil society and donors have acknowledged the existence of gender inequities in health and human development and are avidly searching for concepts, methods and means to redress this imbalance. In response to the above situation, the demand for technical cooperation has increasingly been focused on "the development of a conceptual framework and methods for the incorporation of a gender perspective

in the design, analysis and evaluation of the complete spectrum of health policies and programs."

42. The national health research and development institutions and policy formulating bodies have been forced to redefine their roles and missions in view of the diminishing role of government and the corresponding emergence of the private sector, the diversification of national and international sources for research funding, and the establishment and consolidation of new channels for access to and transfer of scientific and technical knowledge, particularly those linked to the new information technologies that are unevenly accessible among countries and groups in the Region. In addition, the changing roles within the health sector both of governmental agencies and private actors, as well as the increasing complexity of the health system and the interactions between internal and external factors that determine health conditions are evincing the need to incorporate new topics, disciplines, approaches and methodologies in health research, as well as to establish better means for the dissemination of knowledge and technologies in order to increase the effectiveness and impact of the practice of public health.

43. Not least among the new disciplines being called upon to enhance the knowledge and practice of public health is that of bioethics, which has become a growing area of study and concern in view of the emergence of new ethical dilemmas caused by rapid scientific and technological advances in health sector reform. It is particularly crucial to strengthen national capabilities for incorporating a bioethical dimension in the areas of health research and patient care.

## *Technical Cooperation Strategy*

### *Office of the Director/Deputy Director (D/DD)*

44. There will be increased emphasis on the ideals of equity, of Pan-Americanism, and on PAHO's unique international role --as a common enterprise and a joint mechanism for collective action addressing problems which are perceived as relevant to all the partners in this association of sovereign Member States. Specific goals derived from the SPOs will continue to be fleshed out throughout the period.

Likewise, the Organization will address specific health situations impinging upon the health of the peoples of the Americas, and contributing to the equity gap.

*Office of Analysis and Strategic Planning (DAP)*

45. The Office of Analysis and Strategic Planning (DAP) will continue to support the Office of the Director of PAHO in developing its management policies, plans, and standards. To this end it will seek alliances with all the units of the Organization at the global, regional, and country level in order to promote adoption of the new global policy in health to fulfill the goal of HFA, evaluate and develop the SPO, and seek the technical cooperation modes that best respond to the various needs of the Member States.

46. In exercising its functions DAP will continue to support the Director's Cabinet and the Subcommittee on Planning and Programming of the Executive Committee, ensuring that both entities are supplied with adequate information on the work of the Bureau and the environment in which it operates for the purpose of decision-making. In this regard it will continue to refine the process of planning, programming, monitoring, and evaluation of technical cooperation (AMPES) and to prepare evaluative and analytical reports for the Office of the Director and the Organization's Governing Bodies.

*Office of Legal Affairs (DLA)*

47. The Office of Legal Affairs shall Provide effective general legal services to the Directorate, Governing Bodies, PWRs, Specialized Centers, and technical and administrative units in matters affecting the legal status and general operation of the Organization. Particular consideration will be given to the privileges and immunities PAHO enjoys in its Member States and the assurance that the Basic Agreements granting PAHO special status as a public international organization be ratified and respected by the Member Governments.

48. Prompt and effective legal advice to the PWRs and Specialized Centers on the negotiation and drafting of legally binding instruments will be provided. Manuals, model agreements and contracts, according to the subject matter of the technical cooperation will be developed.

49. DLA will negotiate, prepare review and approve technical cooperation agreements with Member States, external donors, bilateral cooperation agencies, international lending institutions and other entities.

50. It will coordinate closely with the Office of the Legal Counsel of WHO on matters of common interest, represent the Organization in dealings with legal departments of other international organizations, and coordinate legal strategies as necessary. Furthermore, DLA will represent the Organization before the ILO Administrative Tribunal and other judicial bodies; explore possible options regarding other Administrative Tribunals; exchange ideas and information with other Administrative Tribunals to better defend the interests of PAHO.

51. It will be necessary to refine and update the present "Agreement Database" and correspondence control system.

52. PAHO policy on issues related to intellectual and industrial property rights will be implemented and advice and legal orientation to local legal counsel in Member States and to local lawyers in matters regarding relations with the host country, federal/national agencies and local state officials will be provided.

*Program of Staff Development and Training (APL/SD)*

53. The purpose of a human resource development program is to support the achievement of the Organization's mission by contributing toward the development of critical competencies of all staff and a productive climate of work in which those competencies can be utilized to the greatest advantage for the countries. To be effective, the actions of the program must be supported internally by other human resource development and personnel initiatives. In view of the decentralization of the staff development actions to the various units in the organization and the establishment of training focal points and committees, the role of the Staff Development Program has evolved to emphasize internal consulting on human resource issues, in a partnership approach, as a main function. Since staff development is a continuous process that provides greater capacities to understand, respond, and influence the ever-changing environment, we should

continue to prioritize the following areas for training and development: policy formulation, leadership, and management skills; integration process of staff members to the Organization and/or to new duties to include initial and second-level orientation and disengagement from the Organization; teamwork around strategic axis; individual and cluster project design with stakeholders, management, and evaluation which should include mobilization of resources, tools for programming, and the analysis of alternative approaches to problems addressed by the projects; performance planning and evaluation system (PPES); communication and language; university assistance.

54. Specific strategies for program implementation will be working in partnership with other organizational units, training of trainers, collaboration with institutions of excellence, and long-distance learning.

#### ***Office of External Relation (DEC)***

55. In the spirit of Panamericanism and in the search for equity, DEC's Technical Cooperation Strategy will be directed to strengthen the Organization's presence and influence in the international community, to ensure that the health development issues and the regional and country health priorities are present in the global and hemispheric political agendas, and that the necessary resources are allocated for the improvement of the health conditions of the Latin American and Caribbean populations.

56. The Office of External Relations will concentrate its work on establishing contacts with relevant external agencies and countries, to gather information on their policies and activities and on their impact on health priorities in the Hemisphere, and to influence policy making in favor of Health for All.

57. It will also seek continued international interest in social and health issues from the donor community, making every effort to sustain current levels of donor support, identifying other potential partners in this endeavor, and improving PAHO's performance in project design, implementation, and overall management.

#### ***Office of Public Information (DPI)***

58. The office of Public Information (DPI) strategy for the new millennium will seek to build a critical mass, utilizing advanced communications techniques, multimedia, electronic mail and imaging, video, graphics, and words to create name recognition among PAHO's varied publics. The office's work will reflect the philosophy of equity and Pan Americanism.

59. DPI's guiding principle will be to present the strength and vitality of an almost 100-year-old Organization as it moves into the new century, more relevant and important than ever in the intertwined global world of rapid transit. We will focus on new public health issues, such as violence or tourism, while maintaining our contact with reemerging diseases and health promotion. The unit will work as a team, creating strategies to cultivate and attract new audiences. These strategies will be targeted to specific groups, aimed at attracting maximum impact to not only the issue but to the Organization's point of view on the issue.

60. DPI will expand the purview of its messages to new audiences and utilizing new venues through its Speaker's Bureau, a data base for the magazine and newsletter, and attendance at non-traditional exhibits. Marketing efforts for PAHO videos will be increased throughout the Americas, as will activities related to radio programs.

61. A significant portion of resources during this biennium will be dedicated to PAHO's 100th anniversary. DPI in conjunction with all stakeholders, will come up with approaches and products to commemorate the event. The goal will be to create a lasting and ongoing vision while reflecting on the past and looking toward the future.

#### ***Department of Management Information Support (ACS)***

62. The Department of Management Information Support (ACS) provides support to corporate information systems deployed in PWR Offices, Centers and units in Headquarters, provides support to end-users in Headquarters and maintains the computer and communications infrastructure which is used by all units throughout the Organization.

63. In 2000-2001 a number of new, important system development projects for ABF will be undertaken. These include: replacing the Payroll system and reengineering the Budget Planning and Budget Execution systems.

64. Upon completion of those projects only two system will remain in the PAHO mainframe: ADPICS and FAMIS.

65. Following the conversion to Windows of the OMIS and AMPES systems in 1999, ACS will continue to support those two systems in 36 field offices and add new functionality meet user requirements.

66. ACS will continue to purchase the necessary Office 97 software updates and maintain the standard office automation software on the LAN for all PAHO Headquarters users.

67. With the growing emphasis on corporate data communication systems ACS will increase its assistance to field offices especially in configuring the field office LANs, electronic mail systems and in the area of Internet services.

68. ACS's End User Support team will continue to service and repair PCs and printers, and resolve LAN problems reported by the users. ACS will attempt to build a network of mentors in the Divisions and units in HQ (whom ACS will train and support) who would provide "primary technology care" to their colleagues and refer more complex problems to ACS.

#### *Office of the Assistant Director (AD)*

69. The mission of the AD's office is to provide guidance to the field offices in the execution of their technical cooperation programs by ensuring policy coherence; promoting the development of effective work plans; and advancing operational efficiency.

70. To achieve this mission it will be necessary to accomplish the following: ensure due process; i.e., participation of national counterparts and field offices in policy development at the regional and global level; promote participative formulation of BPs, i.e. process for establishing national priorities for technical cooperation; review, approve and evaluate the proposed country programs and their Expected Results; monitor program execution at the

country level; improve administrative capacity at country level; improve managerial capacity at country level; promote, endorse and evaluate proposals for technical cooperation among countries (TCC); and strengthen managerial, administrative and operational functions within the Office of the Assistant Director.

#### *Office of Emergency Preparedness and Disaster Relief (PED)*

71. The coming biennium PED will further strengthen and institutionalize this effort, both at the country and the subregional level. It will focus primarily on the basic responsibilities of the health sector in disaster situations: protecting public health, providing primary health and medical care, and ensuring the availability of the water supply.

72. These activities will strengthen the local capability of the health sector as a whole: the Ministry of Health as head of the sector; the social security system; and the medical services of the armed forces who may play an important role in some countries in the response to major disasters. This will be accomplished by: encouraging Ministries of Health to assign or increase a budget line item for emergency preparedness activities; ensuring that national authorities give appropriate recognition to this program by positioning it appropriately within the organizational structure (access to the decision-making level); establishing or strengthening national committees with the active participation of NGOs and the international community; familiarizing national health disaster coordinators with modern management techniques and tools.

73. While the primary focus will be on our traditional core constituency (the health sector) it is recognized that disaster preparedness and mitigation are multisector tasks that require the active participation and collaboration of a wide variety of actors at the national level, including Civil Defense, Foreign Affairs, the Red Cross and other NGOs, and universities.

74. The Program will continue to take advantage of windows of opportunity that present themselves, in terms of funding, new technologies, or joint cost-sharing initiatives.

***Office of Publications and Editorial Services (DBI)***

75. DBI will continue to improve the content and presentation of PAHO publications through quality control measures, seek cost savings through competitive bidding, explore partnerships with other entities to optimize its publishing and distribution efforts, and use quantitative evaluations of the usefulness of PAHO publications.

76. PAHO Internet and Intranet services will be the communications media for integrating all of the Organization's information material through a common interface and in such manner that outside users and PAHO personnel at Headquarters and in the field will have real-time access to information ranging from policies to publications, databases, videos, tutorials, and training programs.

77. The Publications Program will make every effort to ensure timely, efficient, and cost-effective distribution of PAHO publications, both in printed and electronic formats, to the Organization's core constituency; expand awareness of, and accessibility to, PAHO publications among its target audiences; increase sales of PAHO publications as a means of financing reprints and supporting new projects by employing consistent and strategic promotional activities; and monitor the utilization of PAHO publications as a means of informing future editorial decisions.

78. To achieve these ends, the PAHO Publications Program will monitor and reinforce PAHO Publications Centers in each country so that ready access to its books and journals is widespread; identify and strike agreements with sales agents throughout the Region taking into account the potential of the Internet; promote bulk institutional purchases of specific titles; decentralize the production of select titles as a means of reducing costs and increasing penetration; provide guidelines to ensure the best mix of electronic and print products; expand its promotional efforts to include electronic means of promotion and communication; and revise the sales agreement with WHO, seeking complementary means of reaching readers outside the Americas.

79. The PAHO HQ Library will concentrate on capturing, analyzing, filtering, organizing, assuring quality control, preserving, accessing, and

disseminating external and internal information (especially the institutional memory), and on educating staff on the effective use of new technologies.

***Division of Health and Human Development (HDP)***

80. In order to convert this concept of health and human development into strategic orientations for technical cooperation, the following lines of action for all HDP technical units have been identified as common project orientations that will provide common areas of program interaction and synergism in the coming biennium, not only for the HDP programs, but also for other technical units, including the field offices:

81. Measurement and Monitoring of Equity in Health. Goal: To improve the collection and analysis of information on gaps in health care and health outcomes, between and within countries, for better decision making and resource allocation. Priority Areas of Technical Cooperation: Core data and country health profiles, regional reports on health situation and vital statistics, evaluation of impact of health sector reform on equity, health surveillance systems, training in epidemiology and biostatistics, training and research in the application of the gender approach and bioethics to health equity.

82. Health, Poverty and Economic Growth. Goal: To develop and apply methods for the analysis and monitoring of the reciprocal interactions between health, income distribution and economic growth, in order to favor health economic and social development policies. Priority Areas of Technical Cooperation: National health accounts, health and socio-economic linked data bases, health economics and financing networks (REDEFS), research on health investment and economic growth, health, poverty and economic growth, health reform and poverty reduction, regional integration and health, gender equity and health sector reform.

83. Governance and Health (Strengthening Social and Political Participation in Health). Goal: To increase the amount and effectiveness of participation by hemispheric, subregional and national level political and social stakeholders in the definition and implementation of public policies affecting health. Priority Areas for Technical Cooperation: Regional

civil society and health forum, hemispheric parliamentary network for health, advocacy for health issues in regional and subregional integration fora, hemispheric health legislation network, development and application of geographic information systems for local and regional community, networks for the prevention of domestic violence, and promotion of women's health.

84. Evidence and Action in Public Health. Goal: The improvement of the production, dissemination and utilization of information in the practice of public health for the attainment of sustainable human development. Priority Areas for Technical Cooperation: Multicenter studies on priority public health issues, development of qualitative methods for HS evaluation, national health R&D policies for public health, training in health research, gender, bioethics and public health issues, institution-building health R&D centers, WHO/PAHO collaborating centers, dissemination of information for public health action, regional virtual health library.

### ***Objectives for General Program Development and Management***

85. Promoting the establishment of a common agenda for health for the Region of the Americas.

86. Promoting Panamericanism in health actions.

87. Coordinating international health in the Americas.

88. Including Health in the agendas of the Inter-American activities through the various presidential summits, the Summit of the Americas, the First Ladies Summits, the Iberoamerican and European-LAC Summits.

89. Developing a technical cooperation program that will respond to regional policies and country needs.

90. Making PAHO, SPO and countries health policy and priorities known among other international and national institutions as well as local organizations.

### ***Expected Results***

91. Networks and alliances for health with the participation of national and international institutions will be established.

92. New initiatives addressing the reductions of inequities will be supported.

93. The goals and objectives of the SPOs will be achieved.

94. The Technical Cooperation Planning, Programming, Monitoring and Evaluation System (AMPES) will be adapted to streamline the managerial processes.

95. The Organization and its work will be promoted to a broad, general public as well as specialized groups.

96. Working relations with UN Agencies will be strengthened and the articulation with private, public and NGO sectors will be improved..

97. Funding from traditional and new donors will be maintained and/or increased.

98. Initiatives of technical cooperation among countries will be promoted.

99. Internal audit and legal counsel will have provided input for the effective and efficient management of the Secretariat.

100. Management of Country Offices will effectively support technical cooperation program.

101. Management of the Publications and Editorial Services of PAHO .

### ***Objectives for PAHO's Technical Cooperation***

102. To consolidate health situation analysis, among and within the countries of the Region and in the Secretariat to document inequities and gaps in health and to disseminate this knowledge.

103. To increase the production, dissemination, and utilization of knowledge on improving and reorienting public health practice toward sustainable human development.

104. To emphasize the importance of women's health and the relationship between women, health, and development, and to raise awareness about issue of gender at all levels.

105. To strengthen the countries' capacity for monitoring, analysis, and management of the relationship between health and the other components of sustainable human development with equity.

106. To strengthen the capacity of the State, the private sector, and civil society to participate in health in terms of the formulation and implementation of policies with regard to equity in health.

107. To collaborate with institutions working in fields related to health so that they apply bioethics criteria in evaluation.

108. Creation and development of the Virtual Health Library (VHL) for Latin America and the Caribbean, based on the new technological information paradigm, decentralized production and operation of printed and multimedia sources of information in health sciences, articulated in networks and providing universal and direct access without geographical or time limitations as a database of scientific and technical knowledge in health, organized and stored electronically in the countries of the Region in a format that is compatible with international bases.

109. Strengthen the health sector disaster institutions in the Region to manage the health consequences of natural and man-made disasters more efficiently and effectively.

110. Collaborate with the countries of the Region to assess their post-disaster health needs, following the recommendations and guidelines accepted by the international community, and efficiently manage the aftermath of disasters.

## *Expected Results*

111. *Cooperation networks, alliances.* In epidemiology, demographics, and health statistics with the population and statistics divisions of the United Nations, CELADE, IDB, IBRD, INCLÉN, FETP, DATASUS/DANE/INEGI, CDC, LRDCDC, and the Xunta de Galicia. Intersectoral networks at the subregional, national, and local level, including the public and private health sectors, to support policies aimed at reducing inequities in health (gender, social condition, age, ethnicity) and promoting human development in general; and with health sector disaster professionals to provide them with the materials and the opportunities to exchange ideas and work together.

112. *Surveillance and information systems.* On documentation and dissemination of information on gender, health and development; and public health at the decision-making levels of the Member Governments and the Secretariat. For monitoring, analysis, and management of the relationship between health, trade, and regional integration; between health and the economy; between health inequities and poverty; and on bioethics; in health sciences realigned for integrated operation in the Virtual Health Library; and for computerized publication of scientific and technical literature on health developed and organized in hypertext databases.

113. *Standards and guidelines.* On disaster reduction.

114. *Research and evaluation studies.* On relevant, regional public health problems, for orienting and evaluating policies and interventions; on epidemiology and the health services and on evaluation of the effectiveness of public health interventions; for new conceptual and methodological developments in health research from a gender perspective and on gender inequities in health and their relationship to development. On the relationship between health, trade, and regional integration; between health and the economy; between health inequities and poverty; and on bioethics.

115. *Plans, projects, and policies.* Regional, national, and institutional health research for the execution of effective short-, medium- and long-term public health actions; for the implementation and operation of

news services and discussion lists on health information and the development of the Virtual Health Library; and that safeguard the physical and functional vulnerability of health institutions and human settlements. Projects to mobilize funds in support of post-disaster needs.

116. *Methods, models, and technologies.* For health situation analysis and the analysis of health inequities for actions and interventions in health and development; for health research and the education and training of investigators in aspects of public health; for the dissemination and utilization of scientific and technical knowledge and information to guide policies and activities in scientific and technical information; of a legal, ethical, and social nature that guarantee health protection and health services for the entire population; to analyze and evaluate public policies and the relationship between macroeconomic policies and health and the operation of the health sector; for health research and the education and training of investigators in aspects of public health; and for the dissemination and utilization of scientific and technical knowledge and information to guide policies and activities in scientific and technical information; for the development and operation of multimedia and methodological instruments of support for ongoing education, distance learning, and decision-making;

for the operation of decentralized services of "Push"/Selective Dissemination of Information (SDI) in health, oriented to the information needs of specific communities of users; and for the development and dissemination of tools to integrate the components and sources of information provided by the Virtual Health Library.

117. *Training programs.* In epidemiological and biostatistical analysis, as well as health situation analysis, and in the evaluation of inequities and gaps in health; and for human resources involved in the production of knowledge and the implementation of public health activities; and in bioethics and for health sector disaster professionals in the Region.

118. *Promotional campaigns and advocacy.* For incorporating health more fully into the national and regional political agenda; for harmonizing national health legislation; and for incorporating specific topics in bioethics; to promote the Virtual Health Library in the countries, in PAHO, and in the Region as a whole.

119. *Direct support.* For strengthening the analytical capacity of the Secretariat in health situation analysis and documenting the inequities and gaps in health; and for integrating the gender perspective into the analysis and evaluation of public policies in health.

**HEALTH IN HUMAN DEVELOPMENT  
PROGRAM BUDGET DISTRIBUTION BY LOCATION**

Location	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Direct Cooperation with Countries	49,629,900	53,648,300	23,301,200	4,611,100
Intercountry Programs	32,287,500	34,188,500	4,738,300	2,259,700
Centers	1,611,000	1,647,700	3,687,700	2,850,000
Technical and Administrative Direction	9,647,600	8,539,800	1,010,600	825,000
<b>Total</b>	<b>93,176,000</b>	<b>98,024,300</b>	<b>32,737,800</b>	<b>10,545,800</b>

# HEALTH SYSTEMS AND SERVICES DEVELOPMENT

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## *Health Situation*

1. The principal challenges that the Region faces in the development of health systems and services are to secure equitable access to quality health services for all the inhabitants in the countries of the Hemisphere; to ensure that the public and private investments made in health by societies in the member countries have a rational basis, entail assumable costs, use criteria of proven effectiveness, and constitute complementary and noncompetitive efforts; and finally, to address the growing demand for health services delivery to respond to the population's precise needs, for it to contribute to the improvement of their quality of life, and for it to be tied into mechanisms that will guarantee the protection of consumers and social participation in decision-making.
2. These challenges have led the countries of the Region to invest considerable effort in introducing structural and functional changes in their health systems and services (generically referred to as the processes of health sector reform), guided by the principles of equity, efficiency, quality, sustainability, and social participation. To a greater or lesser extent, these processes are the foundation of the national health policies that the Member States are trying to implement, and they occupy an important place on the agendas of State reform and modernization of the public sector in the Americas.
3. During the 2000-2001 biennium, health systems and services development in the countries of the Region, within the framework of health sector reform, will have to address a series of specific problems concerning the organization of health systems and services, especially the following:
  4. Insufficient development of steering capacity in the ministries of health; Fragmented organization of health care systems, which leads to duplication of effort and insufficient coverage; Inequitable access to health services; Inefficiency in the allocation of resources and the management of services; Need to orient health care models so that they will respond to changes in the demographic structure, the epidemiological picture, and health technology; Shortcomings in terms of the effectiveness and quality of health care provided by the services; Insufficient development of organization and management in the service networks; Lack of articulation between the sector's education and training efforts and the changes taking place in the health systems and services; Imbalances and inequities in the composition and distribution of human resources in health; Inadequate infrastructure of health information systems for decision-making; Need to improve the availability, quality, and rational use of drugs and essential medical supplies.
  5. With regard to the organization and management of health systems and services, the countries of the Region of the Americas continue to need and call for the development of models for the organization, operation, and management of national health systems at the different levels that will enable them to achieve better health conditions for all their peoples by overcoming the traditional problems of inequitable access, inefficiency, and poor quality health services delivery. At the same time, efforts are being made to overcome the weakness and dispersion of managerial capacity and the inability of current operations to respond comprehensively not only to the traditional health problems but also to a set of emerging problems stemming from the shifting population dynamic in which people are living longer and chronic diseases are on the rise.
  6. In addition, modernization, democratization, and decentralization are posing new challenges for a sector which is already focused on the major reforms involved in adapting to new frames of reference for the direction, organization, provision, resource management, and administration of health services delivery—all this viewed as an essential component of national development.
  7. Many of the countries have initiated processes for reforming the sector and strengthening the network of public health services with financial

support from the regional banking institutions. In light of these initiatives, the countries of the Region need to clearly redefine the situation of the sector and their service networks, identify their weaknesses, establish criteria for orienting the changes that lie ahead, and define the key areas that should be strengthened through the redirection of operational expenditures and investments in health.

8. These national efforts are taking place in a health sector that is poorly articulated, both internally within the public subsector and between it and the other subsectors—public/private partnerships, the private subsector, and NGOs—whose health institutions are suffering from serious deficiencies in their organization, operation, and management as well as limited social participation, with duplication of efforts and significant gaps in coverage. This situation has led to a high concentration of services in a few sectors at the expense of greater vulnerability of the neediest groups and consequent unjustifiable inequities in the quantity and quality of the services provided to different social groups. The current health care models have inconsistencies and major gaps in the organization and direct delivery of basic services as well as some of the critical health services, resulting in lack of comprehensiveness and continuity of care.

9. This situation is also characterized by poor quality services and evident dissatisfaction on the part of both the users and the providers. Problems have failed to be addressed in regard to the incorporation and utilization of new technologies and the evaluation of their impact on the effectiveness and quality of the services and on health expenditures.

10. In addition, the styles and tools used in the administration of health systems and services have a strong centralist tradition characterized by relative inefficiency, high production costs, and little transparency and social control. The management systems in the sector's various institutions are obsolete or inefficient, based on rigid planning and programming models and limited by a lack of decision-making capacity at the actual operational level, with the budget cycle dictated mainly by expenditures. Mechanisms for monitoring and evaluating the utilization of resources and the results achieved are poorly developed and applied very little in actual practice.

11. In the area of health human resources, the next biennium will see a continuation of the current trends in the economic, State, and sectoral reforms under way throughout the Region. However, the foregoing characterization shows how important it will be to adopt a comprehensive intersectoral perspective in order to follow these trends and anticipate the problems that they will entail. The development of human resources in health will be affected by the decisions that are taken within the context of evolving national economies and their increasing globalization, and of reforms in education, labor, and public administration—and not only those that affect the health sector directly.

12. In light of this situation, technical cooperation, especially cooperation involving PAHO, needs to include efforts directed toward ensuring that the agendas of those responsible for making decisions in the areas mentioned above, and not just decisions pertaining to health, take human resources into account as a critical factor in the development and sustainability of sectoral reform.

13. It is to be expected that, as a result of changes in the markets for health services, in the assignment of populations to various forms of coverage, and in the redefinition in the health care models, some of the existing imbalances will persist or be aggravated and that new ones will be generated in the structure, composition, and distribution of health personnel.

14. The emergence of new problems in the area of health human resources, interacting with existing issues that have not yet been solved, will call for the development of national and regional processes that include research and monitoring and that address the important problems in this area with a strategic approach.

15. With regard to the orientation of national labor reforms, it is to be expected that more flexible arrangements will characterize labor contracts, labor stability, the management and evaluation of performance, and the conditions under which health personnel are separated from service. Other trends foreseen include the further consolidation of short-term, temporary, and third-party contracting; increased development of flexible public service career models; the generalization of incentive models (both fixed and negotiated); and the use of collective bargaining by institutions at the local level.

16. These trends imply major institutional transformations in terms of both organizational cultures (with the consolidation of entrepreneurial and competitive cultures) and the development of new managerial styles and skills, and the planning of services, especially the services of personnel. The public services must respond to these changing circumstances effectively and on a timely basis. It is up to the Organization to contribute to these challenges through the strengthening of national and institutional capacity for strategic management in the area of human resources.

17. The new health care models growing out of the reforms in the financing of health institutions, the new forms of personnel interaction that emphasize contracting and the cutting back of permanent staff, the contracting out of services to third parties, and the promotion of generalist approaches, among others, are affecting the quality of the care being delivered to the population as well as the work of health personnel as a whole. It is here where it is seen most clearly that the reform processes need to include, among their essential components, policies on human resources development and new institutional formats and types of interaction for interventions in this area.

18. Thus it is imperative for PAHO to help build and consolidate institutional and national capacity for dialogue and negotiation, situational planning, effective local management (especially the capacity to regulate job markets, the professions, and employment and working conditions), and the training of health personnel.

19. The trends toward consolidation of the decentralization process in health and toward higher levels of participation in the management of services, together with the increasing complexity of the health sector—in the sense of forms of organization, the number of institutions that comprise it, and the growing autonomy of these institutions—pose challenges for the development of health sector management models, the creation or strengthening of areas of decision-making and planning (regional, local, and institutional), and the types of interactions that take place both within and outside the health sector.

20. The foregoing calls for the promotion of operations research and strategic monitoring of the problems that arise from this situation, the capture of successful experiences, and the development of methodologies and instruments aimed at improving the management of health personnel at all levels, especially the operational levels.

21. In terms of education, the rapidly changing services and the active labor markets are sending clear signals to the training institutions that teaching profiles need to be reformulated in order to keep up with the changes described above. The curricula need to be changed, and the missions of the training institutions need to be redefined in order to increase their integral participation in the health development process and to generate continuing education programs for the benefit of graduates already in practice.

22. The reform processes under way in the Region are going to require a restructuring of the work force that will involve, in particular, new forms of interaction between the generalist and specialist practices, as well as new roles for technicians and auxiliaries. Demographic and epidemiological changes and the consequent consolidation of health care models that give priority to preventive and promotional care and to ambulatory modalities, and of management models based on managed care arrangements, will lead in turn to a growing demand for the formation of generalists that have the capacity to work in community settings. This requirement will be particularly important for medical, nursing, and technical personnel.

23. This trend calls for the Program's technical cooperation to be oriented toward encouraging a generalist approach in professional education processes and programs, promoting the capacity to work at the local level, and strengthening models based on generalist practice.

24. Concern about improving the quality of education in training institutions will continue to lead to changes in educational processes and academic structures, but at the same time quality and efficiency in education will also have a powerful role in the new systems of regulation and accountability being adopted not only by the States but also by corporations and interested actors. At the same time, the progress of economic integration, and along with

it the prospect of integrated job markets, is generating concern about the quality of education and the technical capacity of professionals.

25. In this context, it is to be expected that there will be an increased demand for technical cooperation to develop schemes for the accreditation of teaching institutions, the certification of professional practice, and the regulation of job markets.

26. All this poses a serious challenge for educational institutions in the fields of health and related disciplines. Some of the changing trends will have been consolidated—for example, the new models for the organization, financing, and delivery of health care—as part of a coherent process of decentralization of the services. The schools of public health, in turn, will be more dependent on external financing and on the demands of the market, which will lead to the reformulation of institutions and programs based on new forms of organization and more flexible educational programs centered around the direct delivery of services by the training institutions themselves.

27. What is needed is to strengthen public health practice, education, and research, with all of them oriented toward developing the essential functions of public health within of a comprehensive process of committing society to the development of a culture of life and health.

### *Technical Cooperation Strategy*

28. The summit of the Americas, held in Miami in December 1994, reaffirmed the commitment of the governments of the Region to regard health sector reform as a means of guaranteeing equitable access to quality health services. The leaders supported universal access to a guaranteed plan of preventive and curative services, priority care for the most vulnerable groups, strengthening of the public health services infrastructure, the search for alternative approaches to financing, management, and the delivery of quality health services that incorporate effective forms of social participation. PAHO cooperation will continue to be concentrated during the next quadrennium on support for sectoral reform processes in the member countries aimed at achieving greater equity, quality, efficiency, sustainability, and social participation in the actions

of the sector. To this end, it will focus on providing cooperation in three broad areas: the strengthening of sectoral steering capacity, the organization of systems and services, and the financing of health sector actions. Accordingly, its fundamental strategies will include the systematic and periodic exchange of national experiences, the development and dissemination of methodologies and instruments that support the strengthening of analytical capacity in the institutions, the formulation of policies, the implementation and evaluation of programs of sectoral reform, and the implementation of a regional system for monitoring the dynamics, content, and impact of the reforms undertaken.

29. The processes of State reform, modernization of public administration, and decentralization of the powers and the public services, coupled with the emergence of new actors in the public and private subsectors, have made it a high priority for the countries of the Region to redefine the roles of the sector's institutions, especially the role of the ministry of health, in order to ensure that it exercises its steering function in the processes of sectoral reform. The fundamental responsibilities of the State in the area of health are undergoing major transformations in light of the growing trend toward separation of the functions of financing, insurance, and services delivery, and at the same time there is need for greater in-depth capacity in the management, regulation, and development of the essential public health functions that are characteristic of the health authority.

30. In the coming years PAHO will give special attention to the strengthening and development of steering capacity on the part of the ministries of health as one of the bases of the sector's institutional development. To this end, it will concentrate at both the regional and country level on the programming of cooperation activities geared to the construction, dissemination, and promotion of a conceptual and operational frame of reference for the steering role of the ministries of health; on cooperation with the member countries on reorganization and institutional strengthening of the ministries of health in the Member States, so that they can exercise their steering role in the context of the new situations in the sector; on the development of methodologies and instruments for consolidating the institutional development of the ministries of health in the

countries of the Region; and on the dissemination and sharing of national experiences in this area.

31. With regard to the reorganization and management of health systems and services, PAHO will concentrate its efforts in the next quadrennium on technical cooperation in the following areas of activity:

32. Development of analytical capacity in regard to the organization and operation of the sector; Strengthening of integrated sectoral approaches to the coordination of external assistance; Redefinition of the roles of the central, regional, and local governments in the organization and management of public health services and personal health care within the framework of the decentralization processes; Development of national, subregional, and regional capability for the assessment of health technologies; Improvement of analytical capacity in regard to expenditures on health and the allocation of resources based on the criteria of equity, efficiency, and effectiveness; Strengthening of the capacity to formulate policies and strategies, develop master plans, and prepare specific proposals for investments in health; Strengthening of the operating and problem-solving capacity of the services at the different levels of care as part of the comprehensive development of service networks; Comparative analysis and dissemination of experiences with various forms of payment to providers; Redefinition of health care models that support the reorientation of services based on the criteria of promotion and prevention and on improvement of the quality and comprehensiveness of interventions; Promotion and support of the development of quality assurance programs for health care services; Normative and operational strengthening of programs and services in the areas of oral health, care for the disabled, and eye health; Strengthening of the processes aimed at improving the health of indigenous peoples; Strengthening of the sector's institutional capacity to define and implement information systems on programs and services with a view to providing support for their planning, management, and evaluation; Development of performance indicators for health systems and services that will contribute to informed decision-making in the sector.

33. With regard to human resources development, during the next quadrennium PAHO will undertake the development of technical cooperation activities in the following areas:

34. Strengthening of national capacity for planning and management of the sector's human resources; Development of programs aimed at improving the performance of health personnel; Strengthening of institutions and comprehensive processes in public health education; Support for reorienting the education of health professionals and the continuing education of workers already employed in the sector; Strengthening of national and subregional capacity to regulate human resources development.

35. With regard to essential drugs and technology, PAHO actions in the next four years will revolve around the following areas:

36. Support for subregional and regional mechanisms to standardize the regulation of essential drugs and supplies; Strengthening and development of efficiency and quality in pharmaceutical services; Support for the development of supply systems that emphasize cost control and increased availability; Strengthening and development of programs for the planning, operation, maintenance, and renewal of physical and technological infrastructures in the health sector; Promotion and development of quality assurance programs in radiation medicine; Adoption of basic international safety standards for protection against ionizing radiation and for guaranteeing the safety of radiation sources; Development and improvement of public health laboratories and national, subregional, and regional networks of diagnostic laboratories; Improvement of the safety and quality of blood bank operations; Promotion of telemedicine programs for greater coverage of the population.

37. To fulfill the mandates and priorities established by the Governing Bodies in the specific areas under the responsibility of the Division, in response to the problems that are considered most important in the prospective analysis of the situation, and taking into account the predominantly intercountry and regional scope of HSP programs, the strategies for the implementation of cooperation through the application of functional approaches would be:

38. Mobilization of resources and formation of strategic alliances, mainly in terms of political support, and the provision of information and sources of financing, in order to increase and strengthen the capacity of PAHO cooperation with the countries and subregions in health systems and services development, sectoral reform, and the strengthening

of institutions so that they can perform their function of steering the sector; Development, exchange, and dissemination of needed and appropriate methodologies and tools for promoting and supporting health systems and services development, and for increasing and strengthening capacity for regional and country cooperation in the areas under the responsibility of the Division; Orientation and strengthening of institutions and processes for human resources development in health, directed toward meeting needs in connection with the integration and development of health systems and services in the countries and subregions; Promotion, orientation, and strengthening of institutions and processes concerned with research in health systems and services development in order to provide elements for technical cooperation efforts in support of the transformation of health systems and services and the strengthening of institutions so that they can perform their role of steering the sector; Orientation, ancillary support, and strengthening of the capacity of the Representative Offices to provide direct technical cooperation in health systems and services development; Evaluation and enhancement of the experiences and processes under way in the countries, comparative analysis of processes and building upon them, promotion and facilitation of alliances among institutions, groups, and individuals from both academia and the services; Active participation in research and development projects that sustain or lend viability to health sector reforms in the countries of the Region from the standpoint of human resources development; Identification, strengthening, and active involvement of centers of excellence in research, education, and educational technology as collaborators in technical cooperation at the regional, intercountry, and national level; Renewal of approaches and forms of cooperation, taking advantage of technological progress in electronic communication, educational technology, and multimedia and mass communication.

### ***Objectives for PAHO's Technical Cooperation***

39. Collaborate with the countries in the design, implementation, and evaluation of their sectoral reforms; to design and implement the organizational models and operations of their health systems, using an intersectoral approach, with efficiency, quality, and effective social participation, in order to reduce

inequities in access to services and improve the health of their populations.

40. Assist the countries in the orientation of health investment and expenditure, seeking equity, solidarity, and quality through greater efficiency, and optimizing rationality in the allocation of their resources for health care.

41. Cooperate with the countries in developing the capacity to organize their health services, applying the criteria of equity, efficiency, and quality in health care delivery.

42. Promote and participate in human resources development in health, within the framework of the sectoral reform, in order to improve equity, effectiveness, productivity, and quality in meeting the needs of the population in the countries of the Region.

43. Strengthen health information systems and the development of health indicators in the countries to support the organization, operation, and management of the health services and their programs.

44. Assist the countries in improving the quality and efficiency of inputs and the specialized health services in the areas of drugs, medical equipment and installations, laboratories, blood banks, diagnostic imaging, therapy, and physical infrastructure.

45. Support the strengthening of the regulatory agencies to ensure the effective and safe use of the relevant technologies, taking the current context of subregional and regional integration into account.

### ***Expected Results***

46. *Cooperation networks, alliances.* For the sharing of experiences and cooperation among countries in sectoral reform; on matters of drug regulation involving the public sector, the regulatory authorities, and the private sector (pharmaceutical industries), with the participation of teaching entities (universities) and consumer representation; to set up quality assurance programs in radiological health, with the collaboration of the Inter-American College of Radiology (CIR), the Ibero-Latin American Circle

of Radiation Oncologists (CRILA), and the Latin American Group on Brachytherapy and Radiation Oncology (GLAC-RO).

47. *Surveillance and information systems.* For the sharing of experiences in sectoral reform; and for management of the health services.

48. *Standards and guidelines.* That support education and information for the rational use of drugs; for patient radiation protection; for blood banks; for quality assurance programs; for the regulation of equipment and medical devices.

49. *Research and evaluation studies.* On the impact of the sectoral reforms on equitable access; on profiles of the country health systems; and on technologies for health information systems.

50. *Plans, projects, and policies.* On quality assurance in health services; on the regulation of human resources development; on drugs, that respond to regional and global criteria and priorities; for radiological emergencies and radioactive waste management; for the development, conservation, maintenance, and renewal of the physical infrastructure and technology of health services; for the proper selection, procurement, incorporation, use, maintenance, and upgrading of technology.

51. *Methods, models, and technologies.* For the analysis, implementation, and monitoring of the sectoral reform; for the management of human

resources and in-service training aimed at improving the performance of health workers.

52. *Training programs.* For health workers, based on meeting the needs of the population; fostering science and technology development; assigning greater value to the essential public health functions and sectoral reform; for managing the information systems of the health services.

53. *Direct support.* To strengthen the sectoral steering role of the health authorities; to develop the capacity to analyze health expenditure from the standpoint of equity; to formulate, negotiate, and evaluate master investment plans and draw up specific proposals for investment in the health sector; to increase the capacity for analyzing and effecting changes in the provider payment mechanisms; to strengthen the operating capacity and problem-solving capabilities of the health services at the different levels of care; to strengthen the development of oral health services; to promote the normative and operational strengthening of programs and health services for the disabled, as well as rehabilitation programs; for programs and services in ocular health; to strengthen the countries' capacity to attend to the health and well-being of indigenous peoples; to improve the delivery of public health services within the framework of the essential public health functions; for integrating laboratory services into the major national programs as part of the reform processes, and for establishing regional networks.

54. *Others.* Management of the PAHO/WHO Fellowships Program and the Program for Training in International Health.

**HEALTH SYSTEMS AND SERVICES DEVELOPMENT  
PROGRAM BUDGET DISTRIBUTION BY LOCATION**

Location	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Direct Cooperation with Countries	26,315,900	24,883,100	46,102,200	14,179,200
Intercountry Programs	16,068,500	16,403,700	849,600	708,400
<b>Total</b>	<b>42,384,400</b>	<b>41,286,800</b>	<b>46,951,800</b>	<b>14,887,600</b>

# HEALTH PROMOTION AND PROTECTION

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## *Health Situation*

1. Execution of the biennial program budget for 2000-2001 will take place in a context of transition, uncertainty, and, at the same time, optimism. As we enter the new century, we are looking at a single world and a global economy, with revolutions in computers and technology creating opportunities for rapid change. The United Nations, for its part, is undergoing full-scale reform, and international banking and bilateral cooperation are increasing their investments and their portfolios in social development projects. At the same time, however, the capital market is not free of influences that may adversely affect it, and more than likely the Region will be threatened by renewed investment constraints in the social sectors. WHO, in turn, has new leadership. It, too, is being restructured, and in 1998, at the 50th World Health Assembly, its member countries approved renewal of the commitment to health for all in the twenty-first century. In the Americas, the 25th Pan American Sanitary Conference, in addition to reelecting the Director of the Pan American Sanitary Bureau, approved the Strategic and Programmatic Orientations for the period 1999-2002. Health promotion is one of the most important strategies for reducing inequities in health, and it is also considered a good investment from the standpoint of cost-effectiveness.
2. At this time, most of the member countries are in the midst of sweeping transitions—epidemiological, demographic, technological, lifestyle, and health, the latter influenced by changes in living conditions, health determinants, health care profiles, and the reform processes. It should be emphasized that these transitions do not take the same form in all the countries or even within the same country. On the other hand, there have been positive changes that go beyond the expected trends—namely, the changes that are coming about as a result of advances in medicine, public health, improvements in social conditions, and modification of behaviors and lifestyles that impact on health.
3. Until now, programs in the area of health promotion, and even sectoral reform itself, have been limited, and in most of the countries the results have been reflected more in the process than in actual impact.
4. Depending on the stage of demographic transition in the respective countries of the Region, the following patterns may be distinguished: Bolivia and Haiti are still in an incipient phase of transition; El Salvador, Guatemala, Honduras, Nicaragua, and Paraguay are in moderate transition, characterized by high fertility and moderate mortality, coupled with high annual population growth; and finally, half the Latin American and Caribbean countries, including Brazil, Colombia, Costa Rica, Dominican Republic, Ecuador, Jamaica, Mexico, Panama, Peru, and Venezuela, which together are home to the majority of the population in the Region, are in the advanced stages of transition.
5. The population of the Americas will reach some 825 million by the year 2000. Mortality, with rare exceptions, will continue to decline, while life expectancy at birth will continue to rise. The challenge will be to achieve quality of life. Life expectancy at birth is likely to surpass the regional target of 70 years by the year 2000 and reach 72.5 years by 2001. Infant mortality will continue to fall and is expected to meet the regional target of 30 deaths per 1,000 live births. However, 14 countries of the Region still have rates that are over 40 per 1,000. In relative terms, the rate will decline more in countries with higher income levels. Mortality in the group aged 65 and over will increase, especially in the lower-income countries. A survival rate of 970 per 1,000 live births for the first year of life is a clear indication of the great challenge that lies ahead for society in fulfilling its obligation to provide better opportunities for health promotion and conservation. These opportunities will make it possible for the population to experience adequate growth and development, which in the course of the life cycle will take society to higher levels of economic, social, and intellectual development. Health, nutrition, and education are the pillars on which this outcome rests.

6. A large proportion of children living in poverty and acute social deprivation suffer from stunted growth and physical, emotional, and social development. In 17 countries, perinatal disorders, which are closely linked to low birthweight, have moved to first place as the cause of disease, disability, and death. The synergy between malnutrition and infection in children under 5 continues to be a major factor, while abuse and accidents also contribute significantly to deaths in this age group.

7. Despite the impressive progress that has been made in lowering infant mortality, increasing contraceptive coverage, and improving care during the reproductive process, reproductive health indicators continue to be worrisome and their use limited. Eleven countries of the Region still have maternal mortality rates in excess of 100 per 100,000 live births. Maternal mortality continues to be about 100 times higher than in the most developed countries, and it is especially high in the neglected groups, whose social and demographic conditions and technical and educational level vary enormously. Other factors that affect the situation are place of residence, housing conditions, occupation and household income, and, especially, geographical access to health services.

8. Adolescents and young adults represent about 31% of the 137 million people in Latin America and the Caribbean, and 80% of them live in urban areas. This age group is not explicitly addressed in the political agendas of the countries of the Region, and this is reflected in the lack of social policies, the limited economic resources allocated to this group, and the lack of intersectoral articulation. There is little concept of their role as citizens and their participation in the social development of their countries and communities.

9. The indicators show that the way in which this population's needs are being met does not contribute to integral development: only 50% of the population 15 years of age are in school and the majority drop out in order to work. Unfortunately, some 19 million minors will join the Region's work force, most of the time without any protection. The health indicators point to the serious problems that young people face: daily violence, which is the leading cause of death for this age group in most of the countries; high fertility rates, which, even though they are generally

on the decline in the majority of countries, do not reflect a reduction in the number of births to teenage mothers; contraceptive use by only 10% of unmarried sexually active young people, thus increasing the risk of STD and HIV; malnutrition (especially obesity); substance use (tobacco, alcohol, and other drugs); depression; suicide; and infectious diseases, all of which continue to be problems in the countries of the Region.

10. The challenge for the promotion of human development and adolescent health is to get policies, plans, and programs established that will promote protective factors, including the capacity for adaptation; reduce risk factors and risk behaviors among adolescents and young adults; and support the acquisition of skills for healthy living in protective and safe environments. The participation of young people in the community and in social development, as well as in their own self-care in health, is the concept that underlies activities in and links with the "Healthy Schools" and "Healthy Municipios" initiatives.

11. Protecting adolescents in Latin America and the Caribbean and empowering them will be the foundation for securing their basic needs.

12. By the year 2000 the United States and Canada together will have a total population 50 million people aged 60 and over, and in Latin America and the Caribbean persons in this age group will number 42 million. In almost all the Latin American and Caribbean countries the aging index will double in the next two decades, making for an unprecedented change in the population structure.

13. The aging of the population brings changes in the prevailing types of diseases. Ischemic heart disease and cerebrovascular disease are the leading causes of death in older persons, followed by neoplasms and respiratory diseases, mainly pneumonia. As the proportion of older persons increases, so does the percentage of the population suffering from chronic diseases and disability; more health resources are needed for the care of people suffering from chronic diseases, while at the same time the costs of curative care for acute cases remain relatively constant.

14. The socioeconomic dimensions of the aging of the Latin American and Caribbean population are

amplified not so much by the magnitude of this phenomenon as by the rate at which it is happening. Governments are faced with the short-term challenge of investigating the magnitude and impact of aging on their country's development; preparing national plans, training human resources, and getting activities under way to promote active and healthy aging. The health indicators reveal the serious problems of equity that older persons face. Health in old age depends to a large extent on exposure to risk factors, access to health protection and promotion throughout life, and the availability of family and mutual social support networks in which the individual can participate.

15. Promoting active aging is vital to the development of the countries of Latin America and the Caribbean. This challenge calls for strengthening regional collaboration networks for the design and evaluation of program and services in three specific areas: (a) comprehensive community programs that provide a whole range of contexts for healthy aging, together with programs designed to support family care activities, protection of the dignity of older persons, and the avoidance of unnecessary internment of those in fragile health in health care facilities; (b) programs for strengthening capacity at the primary care level; and (c) programs that encourage autonomy and socially productive activities, as well as programs designed to generate income for older persons.

16. In mental health, the epidemiology of psychosocial disorders reveals an overwhelming situation. Recent studies in several countries of the Region indicate that about 30% of the population suffer from some kind of psychiatric problem during their lifetime. According to World Bank estimates, 8% of the disability-adjusted years of life lost in Latin America and the Caribbean are attributable to mental illness. Moreover, a precipitous rise in affective disorders is expected in the next 20 years, a situation that will imply a heavy economic and social burden. In addition, epilepsy represents a significant burden, since it affects 17 out of every 1,000 persons in Latin America.

17. Cancer of the pharynx and lung in the Americas continues to increase with the prevalence of smoking. The population of smokers is estimated at some 25% to 45% of the total population over 15 years of age. About 50% of the population consumes alcoholic beverages, and 20% of those who drink do so to

excess. Mortality from cirrhosis of the liver in several countries, such as Mexico and Chile, is the highest in the world. Intrafamily violence, especially against women, and child abuse are highly prevalent in our Region, and it is sometimes culturally acceptable. Educational programs are needed that will forestall behaviors of this kind and their harmful risks to health.

18. Unhealthy lifestyles, insufficient or unbalanced food intake, and lack of physical activity are all on the rise. The various forms of malnutrition remain at high levels in our Region. On the one hand, there are problems with inadequate breast-feeding practices and the feeding of children under 2 years old in general, ranging from protein-energy malnutrition to specific iron, folate, vitamin A, and other micronutrient deficiencies etc. In addition, obesity is increasing, which, as it exists side by side with nutritional deficiencies in disadvantaged groups, makes the epidemiological profile more complex. Anemia remains a serious problem in the Region, especially in women, and pregnant women in particular.

19. The urbanization process continues in the Region, while rural areas increasingly deteriorate. However, the slowdown in the growth of the major metropolises is expected to continue, and medium-sized cities will be experiencing greater growth. International migration will continue to overwhelm the social and health services of the receiving countries.

20. Physical and social conditions, as well as lifestyles, are important factors in the promotion and conservation of health, as are deficiencies in the quality of life, especially in neglected groups. Other important determinants are high mortality and morbidity from noncommunicable diseases, accidents, and violence, which reduce the productive and creative life of the population in the Americas. This situation requires the Organization's technical cooperation in the area of health promotion and protection to build and consolidate technical capacity for teamwork, strengthen interdivisional work, and, especially, develop models for monitoring and following up of the main processes of health promotion. These latter processes include social participation and working with NGOs; the formulation of intersectoral public policies; and the creation of healthy environments, especially through

the "healthy municipios," "healthy schools," and "healthy workplaces" initiatives.

21. For all of the above, the member countries continue to request technical cooperation to build their capacity to implement strategic plans for health promotion in various areas. The Organization needs to strengthen and extend its technical expertise to respond to the growing demand and take advantage of this unique opportunity to exercise leadership. Teamwork, intersectoral action, the formation of interdivisional functional nuclei, social participation, health education, and mass communication are still weak areas in the Organization, and they are precisely the technical areas that need to be strengthened in order to build the capacity to promote health in the places where people live, study, work, and play. The Organization's consultants responsible for health promotion at Headquarters and in the Representative Offices have heterogeneous profiles, and they need to be more fully trained in this area. More systematic and sustained support for this effort is essential, as is strengthening the work with the Organization's Centers, which are also initiating activities in the area of health promotion. This calls for a program to train and update human resources at all levels of the Organization, and for a new set of profiles in the social and behavioral sciences.

22. Technical cooperation for health promotion requires strategic alliances with new partners. For a greater impact, it will be necessary to develop and apply new models, skills, and competencies to forge alliances and maintain the existing networks for exchange, enlisting new partners, advocating health promotion, building consensus, developing social pacts for health, and mobilizing resources and commitments to improve the determinants of health and human development. It is also necessary to ensure adequate organizational structure, procedures, and management styles to support and nurture these models and competencies.

23. The Organization has a challenge and an exceptional opportunity to position itself and exercise its leadership in health promotion in the new millennium, and to work jointly with the member countries to create opportunities that favor not only health but development and human well-being.

## *Technical Cooperation Strategy*

24. To create, jointly with the countries, a new culture of health promotion and protection in which these areas become a social value entails preparing individuals, communities, and public, nongovernmental, and private institutions to take upon themselves, individually and collectively, the responsibility for constantly preserving and improving their state of health and well-being through technical cooperation; for evaluating the role of health promotion as a tool for building skills; for advocating its importance in the regional forums of presidents, heads of State, first ladies, mayors, and municipal health secretaries; for promoting the formulation of policies, plans and programs, standards, and tools for making health promotion operational; for adopting healthy public policies; for supporting operational and cooperative research; for disseminating and applying the results of health promotion through the network of collaborating centers and other institutions; for continuing with the design and strengthening of methodologies and models for the evaluation of programs and interventions in health promotion; for developing healthy spaces initiatives for the home, the school, the workplace, recreational areas, and municipios; for consolidating the networks of mayors, municipal health secretaries, and consortia of schools to work to improve health; for developing strategies for intersectoral work; for mobilizing technical, scientific, political, social, and financial resources in support of health promotion; for forming networks in all these fields, including strategic partnerships between PAHO and the international community, as well as between PAHO and the relevant institutions and organizations in the countries; and, finally, for promoting the use of social communication in health, especially through the mass media.

25. Since the operationalization of health promotion strategies and programs is relatively recent in most of the countries, and there are solid indications that it is an absolutely indispensable strategy that should be part and parcel of all health actions, PAHO and HPP have decided to devote efforts to: disseminating technical and scientific information on health promotion among the largest possible number and variety of actors working in public health in the Region, while at the same time developing the national capacity for analysis and utilization of this information; promoting the processes of evaluation--

of inputs, processes, and the short- and long-term effects of using health promotion--and documenting and disseminating information on national experiences, pointing out their cost-effectiveness in contrast to actions for the recovery and rehabilitation of health; promoting the adoption of healthy lifestyles and risk prevention through anticipatory behavior; promoting utilization of gender-based, family-based, and life-cycle-based approaches; working to ensure that the reorganization of services includes strategies for interventions in health promotion and making integrated health care a reality. In order to contribute to the viability of human development and health promotion and disease prevention throughout the life cycle, the following aspects will be addressed: in regard to family health and population, giving priority to stimulating and monitoring growth and development at the different ages, including programs for perinatal health, child health, health of adolescents, health of adults--with emphasis on reproductive health--and the health of older persons; and in the area of food and nutrition, placing emphasis on appropriate feeding, food fortification with micronutrients, supplementation, supplementary breast-feeding, and nutritional guidelines for the different age groups, the result of which will be food security.

26. The technical cooperation strategy will support the monitoring of social participation in the formulation of national and local plans and strategies for health promotion, including the formulation of healthy public policies, the creation of healthy environments, mass communication, and health education for the development of skills and healthy lifestyles, as well as the monitoring and evaluation of plans and programs of action. This strategy involves reorienting the organizational structure and strengthening the operating capacity of the health systems and services and of the Organization itself, in a way that will allow for: consolidating functional, interprogram, and interdivisional teamwork; promoting and monitoring the processes that characterize health promotion; strengthening technical capacity and the ability to initiate and build partnerships; supporting the regional networks of municipios, schools, and training centers in order to implement new competency-based curricula; building and strengthening the technical and operational capability of the Organization and the countries at all levels; strengthening networking with collaborating centers and technical committees,

especially for the development of innovative models, instruments, and materials for analyzing and/or formulating public policies, setting up information systems and epidemiological surveillance and evaluation systems, and facilitating the exchange of knowledge and experiences.

### ***Objectives for PAHO's Technical Cooperation***

27. Improve nutrition, physical activity and healthy lifestyles throughout the life cycle.

28. Strengthen the Countries' ability to prevent and control malnutrition problems.

29. Improve health conditions in the environments in which people live, study, work, and play.

30. Promote the recognition of health as a social and individual good and as a resource for development.

31. Increase and improve national, regional, and local technical and operational capacity for developing policies and plans and for upgrading their skills and advancing in the diagnosis, design, operationalization, monitoring, and evaluation of policies, legislation, plans, and programs in sexual and reproductive health and the health of adults, older persons, school children, and adolescents, using a family approach.

32. Improve national and local technical and operational capacity to develop policies, plans, and programs to support the development and health of adolescents in LAC.

33. Improve the Countries' capacity to prevent disease, promote health, and provide health care for older persons.

34. Develop greater capacity to coordinate and manage programs, projects, and activities for the development of child and family health as integral components of health and development

35. Strengthen the Countries' capacity to coordinate and manage programs, projects, and activities among the different sectors, with a view to promoting reproductive health and reducing reproductive risks.

36. Strengthen country programs to improve household food security to prevent the main nutrition-related diseases.

37. Implement strategies which strengthen the nutrition program to prevent and control the diseases of undernutrition, obesity and its co-morbidities.

38. Enhance the efficient management of technical cooperation in food and nutrition programming among 18 member countries.

39. Optimize the quality of maternal-perinatal information in the countries of the Region to make it easier for them to be apprised of its current situation, and carry out continuous monitoring to support decision-making with regard to planning and programming activities in perinatal health.

40. Consolidate technical groups in the countries to form a regional network to maximize the operational efficiency of the available perinatal structures.

41. Train health workers and the communities of the countries in methodology and perinatal subject areas that will enable them to optimize the planning of their activities and improve their results.

42. The nutritional situation of population at highest risk has been improved through the consumption of a better diet and improved delivery of maternal and child care services.

43. A contribution has been made with the Member Countries to the promotion of food and nutrition security through the education and training of human resources with roles in building food and nutrition security (FNS), incorporation of the FNS approach into local development plans, and monitoring and evaluation of the FNS situation.

44. Ensure of the effectiveness of INCAP technical cooperation through the optimization of management, the strengthening of institutional human resources, and the promotion and advocacy of FNS.

### ***Expected Results***

45. *Cooperation networks, alliances.* Among programs within PAHO and institutions outside PAHO; on healthy municipios, health promoting

schools, and with the Inter-American Consortium of Universities and Centers for Training in Health Promotion and Health Education; for development of the key components of reproductive health, with the participation of: national public health institutions; NGOs and private organizations; technical and financial cooperation agencies; people and institutions working with adolescents; organizations of older persons; and universities and other NGOs working in health promotion and health care for older persons; and for intersectoral work in areas of child and family health. CLAP: For improving perinatal health through an interconnected system of institutions that participate in multicenter activities dealing with priority issues.

46. *Surveillance and information systems.* To access educational material and information through publications and the Web; for decision-making on aging and health; for information on and monitoring of the activities and changes in reproductive health to sustain decision-making; with the communications media so that they transmit information and engage in ongoing activities to disseminate information on sexual and reproductive rights and on the services available. CFNI: To identify high risk communities with nutritional disorders; to strengthen national/regional nutrition communication programs and publications and provide relevant culture-specific information on food and nutrition; with updated Caribbean database on nutritional diseases among school children; and for food and nutrition surveillance to monitor nutritional diseases. CLAP: For randomized clinical research to facilitate the implementation of randomized clinical trials; on maternal-perinatal literature, participating in the Cochrane review group on Pregnancy and Childbirth.

47. *Standards and guidelines.* To implement the WHO/UNICEF Breastfeeding Counseling Course; to develop national strategies for breastfeeding and complementary feeding practices; for the development of national dietary guidelines including the "best buy"; and for the promotion of healthy lifestyle during aging; for monitoring the health situation, the quality of the services, and the evaluation of the comprehensive adolescent health programs; for the care of older persons in long-term care facilities; for implementing the evaluation of care for comprehensive child and family

development that includes estimates of the effectiveness of health activities.

48. *Research and evaluation studies.* On the promotion of healthy behaviors; for example, early stimulation and the reduction of risk behaviors in connection with smoking, substance abuse, and the various forms of violence, especially against children; on the health status and well-being of the older adult population; on comprehensive child development; and on ways of incorporating the family in health promotion for its members. CFNI: On food consumption; and on nutrition intervention programs for vulnerable groups. CLAP: Of the association of different maternal-perinatal variables that make it possible to optimize health care; on quality evaluation and the degree of use of the data collected by the institutions that utilize the Perinatal Information System; on the behavior of families with regard to child development, the results of which may serve as a basis for regulation.

49. *Plans, projects, and policies.* To promote health at all levels and spheres of activity; for health promotion; for the development of attitudes and skills (personal and community) fostering health promotion and health care; to formulate and implement national and provincial/state policies: a) for the promotion of mental health and the psychosocial development of children; and b) for mental health care, to ensure community alternatives and safeguard human rights, with special emphasis on controlling depression and epilepsy; for comprehensive adolescent health; for protecting and promoting the health of older persons; that reflect the importance of early intervention in promoting good health habits for the comprehensive development of boys and girls, incorporating the family as a key element in the health of its members; on the importance of the family in achieving health; that promote, monitor, and supervise health promotion activities for boys, girls, and the family, in addition to preventing harm. CFNI: For a Caribbean Food Composition Database; for food and nutrition; for healthy diet and lifestyle in at least 3 schools per country; to promote national and household food security; of supplementation and dietary modification for micronutrient and anemia control in high risk groups; for regional nutrition labeling of all packaged food for local consumption or export; and for quality assurance on dietary services. CLAP: on priority events in the Region in the perinatal area, whose results may serve as a basis for health plans and policies.

50. *Methods, models and technologies.* For monitoring, surveillance, and quality assurance for micronutrient fortification programs; for national policies to prevent and control obesity; for national programs to aim optimal nutrition during pregnancy and lactation, and early childhood; to formulate, implement, and evaluate policies and plans of action on health promotion in the areas where people live, study, work, and play; on risk behaviors in the health surveillance and information systems; on healthy public policies; on services that provide health promotion and protection programs, based on current evidence to address the different aspects related to the prevention and control of tobacco use and alcohol consumption, as well as other substance abuse and addictions; for life skills in health promoting schools and programs for adolescents in healthy municipalities; for intersectoral coordination for the implementation of national policies on aging and health; and for promotion, monitoring, and supervision of quality in reproductive health services. CLAP: For perinatal epidemiological surveillance (PEV) to determine the characteristics of the maternal and child population of the Region, categorize the level of care, and evaluate its results. INCAP: Oriented toward nutritionally improved food production and INCAP flours, food fortification, and assurance of food quality in order to improve the availability of deficient nutrients in the diets of the population at greatest nutritional risk in the subregion; to promote the consumption of wholesome food; to provide food and nutrition to mothers and children in the institutional and community services; to promote sustainable human development, the reduction of the poverty in neglected *municipios*, and the maintenance of conditions of well-being in territories with more advanced levels of development through the integration of FNS into local development processes.

51. *Training programs.* In health promotion and health education; in comprehensive adolescent health at the undergraduate and graduate level and in the services, using distance learning; with a continuing education approach in sexual and reproductive health for training personnel in the services and for human resources education; in gerontology and geriatrics; in comprehensive child development and family health for personnel in the services, training programs, and the mass media. CFNI: To strengthen food and nutrition coordinating bodies; to improve the quality and safety of foods offered in institutions, i.e. schools, restaurants and by street food vendors; f local health workers to

motivate and support women to breastfeed; and in nutrition and dietetics. CLAP: In evidence-based medicine, based on evidence, research methodology, and information management, and on the methodology for detecting adequate and inadequate interventions in the maternal-perinatal area. INCAP: To promote programs and projects that increase accessibility to food for the Central American population, particularly the populations at greatest risk; human resources specialized in food and nutrition, and unspecialized resources in academic and service institutions with an integrated approach for the increase of FNS.

52. *Promotional campaigns and advocacy.* To promote a regional strategy for the prevention and control of obesity; for healthy aging; for organizing activities in child health promotion; for raising

awareness and promoting social mobilization to achieve the passage of legislative proposals that favor the exercise of sexual and reproductive rights, health rights, and advocacy in adolescent health promotion.

53. *Direct support.* To formulate and implement policies and programs on mental health and addictive behaviors aimed at indigenous peoples, with their active participation and that of other units of PAHO. CFNI: To improve effectiveness of protocols on dietary management of chronic diseases. INCAP: In order to incorporate the food and nutrition component into the process of health sector reform at every level; and to strengthen institutional capacity to carry out advocacy activities with political leaders for the establishment of strategic alliances and the mobilization of financial, political, human and technological resources to promote FNS as a priority policy in the country and the subregion.

**HEALTH PROMOTION AND PROTECTION  
PROGRAM BUDGET DISTRIBUTION BY LOCATION**

Location	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Direct Cooperation with Countries	9,921,200	10,113,700	6,618,800	2,030,900
Intercountry Programs	7,481,700	7,738,800	548,700	575,600
Centers	9,989,400	10,105,100	2,304,500	1,800,200
<b>Total</b>	<b>27,392,300</b>	<b>27,957,600</b>	<b>9,472,000</b>	<b>4,406,700</b>

# ENVIRONMENTAL PROTECTION AND DEVELOPMENT

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## *Health Situation*

1. The effects of the immediate physical-biological environment on human health in the Region are visible to the naked eye. Less visible but no less real are the effects on health of the environmental changes taking place all over the planet. Between these two extremes there are many environmental conditions that impair human health, with serious consequences for the quality of life and the development of countries.
2. The problems caused by deficiencies in basic sanitation in the Region continue to undermine the health of millions. The present need is to solve those problems and at the same time to move in the direction of controlling the increasing exposure of people to hazards such as environmental pollution from waste generated by human activity and to an ever-growing number of toxic chemicals that are part of everyday life.
3. Information furnished by the countries of the Region in 1995 (the last regional evaluation carried out by HEP, "Mid-Decade Evaluation of Water Supply and Sanitation in Latin America and the Caribbean," HEP/PAHO-1997) indicates that barely 73% of the population has access to water either in the home or closer than 200 meters away. The information also shows that programs to expand of service coverage are progressing more slowly than had been hoped. A critical problem in all the countries of Latin America and the Caribbean is the discharge of untreated wastewater. Less than 17% of all collected wastewater undergoes any treatment, and that treatment is frequently inadequate. The five leading difficulties detected include lack of an appropriate policy for the sector, limited financial resources, inadequate institutional arrangements, lack of an adequate cost recovery system, and obsolete legislation.
4. The cholera outbreak—which during the period 1991-1999 produced more than 1.3 million cases, of which more than 11,500 were fatal—alerted the countries to the shortcomings in the water supply systems, especially the ineffectiveness of disinfection practices. Today, after intense promotion of disinfection, only around 61% of users receive water treated to some level of acceptable bacteriological quality. Largely because of this deficiency, diarrhea in Latin America still claims the lives of 80,000 children a year. The annual cost of water disinfection is less than US \$1.00 per person, and scientific reports indicate that the combination of safe water and sanitation with health education can yield a 25% reduction in diarrheal disease and a 29% reduction in ascariasis, in addition to a 55% reduction in total infant mortality (AAEL/PAHO, Benguigui, J. Eckenberg).
5. Each of the urban inhabitants of Latin America and the Caribbean produces about 0.92 kg of solid waste per day, which results in some 360,000 tons of refuse to be managed daily. Approximately 75% of this waste is collected and disposed of, often improperly. Thus, every day at least 90,000 tons of refuse are simply dumped into the environment, serving as food, shelter, and a breeding ground for large numbers of rodents and mosquitoes that transmit a variety of diseases.
6. According to data from ECLAC (*Statistical Yearbook of Latin America and the Caribbean*, ECLAC/1995), 39% of households in Latin America and the Caribbean live in poverty and 18% are destitute. Hence, 37% of housing units are unsuitable for human habitation. Indeed, only 21% of them can be made habitable. This situation creates a number of public health problems, including Chagas' disease, ARI, allergies, and even violence. Despite all these sanitary implications of housing, Latin America and the Caribbean have neither technicians nor institutions specializing in the subject of health and housing. Besides, most of the countries have no clear plans or policies in this respect.
7. The international commitments assumed by the countries in recent years at the United Nations Conference on Environment and Development (UNCED, Rio de Janeiro/92), the UN Conference on the Sustainable Development of Small Island Developing States (SIDS, Barbados/94), the Summit of the Americas (Miami/94), the Pan American Conference on Health and Environment in

Sustainable Human Development (Washington/95), the Hemispheric Summit of Conference on Sustainable Development (Santa Cruz de la Sierra, Bolivia/96), and other events show that the protection and preservation of health and the environment are central concerns in the new development model to be promoted by the countries of the Region. This model, called "Sustainable Human Development," is defined as development with special emphasis on the human dimension, or "people-centered development." Implementation and compliance with the agreements and plans of action require coordinated multisectoral action to ensure that the different sectors shoulder their share of the responsibility for acting on the environmental health problems in their respective areas. This requires a broad effort to ensure that health issues have their proper place in the national and sectoral development plans and processes. It also requires the development in the health sector of capabilities to lead and advise in environmental health issues. One of the most important aspects of efforts to achieve sustainable development is to promote active participation by the community and its organizations. Thus, strategies must be developed and implemented that make it possible for the community to participate in the analysis of its own needs and devise potential solutions and innovations.

8. The urbanization of the population in Latin America, associated with the expansion of both urban and rural industrial activity, has become a growing problem for the public health and demands that action be taken before it becomes uncontrollable. While most of the countries have regulations of some sort on the discharge of industrial waste, enforcement is ineffective and does not involve the country's health authorities. Motor vehicles and certain industrial activities that burn gasoline have been shown to be the principal sources of lead responsible for impaired learning abilities in children. The generation of quantities of photosynthesizing derivatives of combustion has produced respiratory infections in many populations in the principal cities of the Region. For early action to be taken against these health risk factors, the health authorities must participate in the setting of quality standards. They must also interpret assessments of the impact of development projects on the environment and human health. Both capabilities must be created or strengthened in virtually all the countries.

9. In the Region the quantity and variety of chemical substances in the environment continue to grow, with adverse effects on health that are

increasingly intense and frequent. Some of these substances, which are being used in large quantities for different purposes throughout the Region, occur as contaminants in more than one medium at a time, subjecting the population to multiple exposures. Acute pesticide poisonings have been reported by the countries of the Region at levels of 60 to 120/100,000 inhabitants. These acute and other chronic effects of pesticides have been drawing the increasing attention of public opinion and the health authorities in several countries. Meanwhile, the use of agricultural chemicals in the Region has increased 2.5 times in the past four years.

10. In Latin America and the Caribbean, industrial activity, mining, and health services generate a high volume of residues that are potentially harmful to human health and the environment. The textile industry, tanneries, the chemical industry, and foundries are the industries that have been identified as generating the largest volumes of hazardous waste. Battery factories and gold mining are responsible for the vast majority of lead and mercury poisonings. The lack of measures to minimize the production of waste, coupled with the almost total lack of experience in the management and proper disposal of this waste, have permitted the exposure of large populations to these substances. The consequences for the health of these populations have not been fully determined, among other reasons, for lack of sufficient number of specialized professionals such as epidemiologists and environmental toxicologists, as well as clinical toxicologists.

11. The working-age (15-64 year-old) population in Latin America and the Caribbean—about 300 million people, not including children under 15 or older adults—suffers about 5 million accidents in the workplace annually, resulting in nearly 90,000 fatalities. Shocking as these figures are, the magnitude of the problem is still underestimated. There are major economic and social inequities in the labor sector. It is estimated that about 55% of this population are informal workers and 10% are farmers. For 20% to 40% of the employed population, the income they receive is insufficient to purchase the basic market basket. Women earn only 71% as much as men for the same work. It is estimated that 19 million children have joined the Region's work force and are greatly affected by their social circumstances, biological characteristics, and work-related risks. Working conditions in both the formal and informal sectors involve a growing number of harmful agents and risk factors. They are

joined by others, such as makeshift prevention and promotion programs, or none at all, and limited health care and rehabilitation services. In the developing countries only 5% to 10% of the workers have access to health services through social security. The multiple effects on workers' health derive from an accumulation of new work-related diseases (occupational cancer, occupational asthma, occupational stress, and reproductive, immunological, and neurobehavioral problems), other re-emerging diseases (malaria, leptospirosis, tuberculosis) and the traditional occupational diseases (asbestosis, silicosis, occupational deafness, and poisonings from pesticides, heavy metals, and organic solvents). Another aggravating factor is the workers' ignorance about the hazards to which they are exposed in the workplaces.

### *Technical Cooperation Strategy*

12. The Division of Health and Environment will carry out its technical cooperation within the framework of the Strategic and Programmatic Orientations 1999-2002, the Tenth General Program of Work of WHO, the mandates of Agenda 21, and the Summits of the Heads of State and Governments of the Hemisphere, as well as the guidelines furnished by the Plan of Action of the Pan American Conference on Health and Environment in Sustainable Human Development. In addition, due consideration will be given to the mandates issued by the Governing Bodies of PAHO and WHO. Heavy use will be made of all the strategic elements of direct technical advisory services, human resources education, research, support for policy-making, and mobilization of resources. The emphasis will differ, however, depending on the countries and the issues. In the course of the biennium there will be heavy reliance on the capabilities of the Collaborating Centers and on the promotion of projects for technical cooperation within and among countries.

13. The Division's general strategy will be to cooperate with the ministries of health in order to strengthen their capabilities, to enable them to carry out their functions properly as leaders, advisers, and participants in the management of environmental health issues and enhance their potential for influencing decision-making on development plans and projects through advocacy in public health. Similarly, the Division will try both to work with other sectors so that they will make due provision for

public health in their sectoral policies, plans, and projects, and to promote intersectoral cooperation in health, including assessments of the impact of development projects on health.

14. In the course of the biennium the Division will intensify its activities within the context of "Health for All," so that communities will have environments that promote the health of all—environments whose quality protects against risks and ensures that all have an opportunity to participate actively in the identification of their needs and in finding the solutions to meet them. The strategy of primary environmental care will be promoted in this context.

15. In the area of water supply and sanitation, work will go forward on three fronts relating, respectively, to the expansion of service coverage, improvement of the quality of water for human consumption, and intensification of measures to improve water supply and sanitary disposal of wastewater and excreta in urban and rural areas and for indigenous peoples. Emphasis will be placed on regulatory, technical, and technological aspects that help to improve the disinfection of water in water supply systems and households. To contribute to the expansion of urban and rural services, HEP will work intensely to promote PIAS and collaborate in sectoral studies, reform and modernization of the sector and its institutions, as well as in the formulation of priority projects, and mobilization of the necessary resources.

16. To improve the management of municipal solid waste, bearing in mind the rapid pace of decentralization and privatization, institutional strengthening will be promoted, and, through it, the sector's regulatory and organizational capabilities. HEP will collaborate, through its activities under PIAS, with the sectoral studies on solid waste (including hospital waste)—studies that will make it possible to identify needs for financial investment. The strategy will include formulation of the respective investment proposals to facilitate the search for financial resources.

17. HEP will continue the systematic use of the "Healthy Environments" strategy, characterized by multidisciplinary activities and community participation, to simultaneously address a series of risk factors for health. This strategy will be carried out through specific projects such as "healthy schools," "healthy markets," "healthy homes," "healthy workplaces," etc.

18. In accordance with Agenda 21 and the guidelines of the Plan of Action of the Pan American Conference on Health and Environment in Sustainable Human Development, HEP will support the strengthening and development of the countries' capabilities for intersectoral coordination, community mobilization, and basic and specialized training of human resources in epidemiology and environmental toxicology, as well as for the operation and maintenance of systems and services. Mass communication will receive special attention as an effective instrument for the mobilization and participation of communities and nongovernmental organizations.

19. The action in the principal program areas of HEP will be structured in regional plans that will mobilize coordinated, complementary actions among other regional and subregional agencies and mechanisms such as ILO, UNEP, CARICOM, NAFTA, MERCOSUR, AIDIS, CCAD, ACH, ADC, SICA and others.

20. Workers' Health will continue to employ a multifaceted view in which measures will be structured along four axes: legislation and regulation, promotion and prevention, care in health services and quality of the work environment. To this end, operations involving the Collaborating Centers will be intensified.

21. The collection and dissemination of specialized technical information in environmental health will remain a priority for HEP. Work will continue to be devoted to building up the "Environmental Health" information system, merged with the LILACS system and strengthened through strategic alliances with specialized databases in others agencies and Regions.

22. HEP will continue to participate in interprogram and interdivisional activities and to support and promote the health-environment dimension in subregional initiatives by sharing with other subregional initiatives the experiences and successes of the MASICA Program of Central America. Aspects of environmental health in activities along the U.S.-Mexico border will continue to receive attention in support of the agreements concluded between the health authorities of the two countries.

## ***Objectives for PAHO's Technical Cooperation***

23. Increase the coverage and quality of drinking water and sanitation services in urban, peri-urban, and rural environments, both densely and sparsely populated.

24. Develop the national capacity for policy-making and sectoral planning, as well as the local capacity for urban and rural strategic planning in the solid waste management and health in housing sectors and for creating healthy municipios and healthy spaces.

25. Improve health and the quality of life, through a healthy and sustainable environment.

26. Develop the capacity of the countries to manage, protect, and conserve the quality of their natural resources from the standpoint of human health.

27. Develop institutional capacity in the ministries of health and the health units of institutions in other areas (environment and labor) for risk assessment, development of environmental quality criteria and standards, and monitoring of the epidemiological situation and chemical safety in the countries.

28. Improve managerial capacity in the institutions working in the field of workers' health with a view to improving work environments and working conditions.

## ***Expected Results***

29. *Cooperation networks, alliances.* The Inter-American Network of Health in Housing Centers will have expanded its sphere of action to include more countries and will be functioning, conducting research, disseminating knowledge, and exchanging information; the Pan American Network for Environmental Waste Management (REPAMAR) will continue to operate effectively, and the Pan American Network of Environment and Health Laboratories will be established.

30. *Surveillance and information systems.* On chemical safety and the control of risks and health hazards in the workplace.

31. *Standards and guidelines.* For developing and strengthening the environmental health units of the ministries of health; and for adapting WHO guidelines on the control of environmental risks for the development of national standards and guidelines..

32. *Research and evaluation studies.* On technology development in the areas of: production, water treatment and disinfection, control of water losses, wastewater treatment, excreta disposal, and the elimination of arsenic in drinking water. For identifying the health risks posed by environmental contaminants, especially air pollution, in at-risk populations to support decision-making and plans for control.

33. *Plans, projects and policies.* On the reform and modernization of the sector; for regulating services and mobilizing the necessary resources to increase coverage and improve quality; to organize and develop the solid waste sector; to promote the Primary Environmental Care Strategy (PEC) as a contribution to "Health for All"; to improve air quality; to gradually eliminate lead in gasoline; to control the quality of water resources; to train health

sector personnel in environmental and health impact assessment (EIAS); and to monitor and control the harmful effects of pesticides on health; to promote healthy municipios and healthy spaces, including projects with a gender approach and projects directed toward indigenous populations.

34. *Methods, models and technologies.* For developing national plans and projects on water quality; for monitoring and assessing outcomes; for developing and implementing a sectoral information system that includes performance indicators for the management of drinking water and sanitation services; for training of municipal workers on municipal solid waste; for the operation of the Network for Monitoring Municipal Solid Waste Management (SIM-RESOL) in Latin America and the Caribbean; for fulfillment of the commitments assumed in Agenda 21, the COPASADHS, and the Miami Summit; for the collection, analysis, and utilization of environmental indicators; for training human resources in chemical safety; for healthy workplaces and comprehensive workers' health services, with emphasis on promotion and prevention; and for information and sensitization for decision-making.

<b>ENVIRONMENTAL PROTECTION AND DEVELOPMENT PROGRAM BUDGET DISTRIBUTION BY LOCATION</b>				
Location	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Direct Cooperation with Countries	10,668,100	10,719,500	15,704,700	8,229,800
Intercountry Programs	4,459,700	4,604,400	374,700	385,000
Centers	5,409,600	5,473,700	4,202,000	1,908,300
<b>Total</b>	<b>20,537,400</b>	<b>20,797,600</b>	<b>20,281,400</b>	<b>10,523,100</b>



# DISEASE PREVENTION AND CONTROL

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## *Regional Situation*

1. Within the mandate of the Pan American Health Organization (PAHO), the Division of Disease Prevention and Control (HCP) has primary responsibility for technical cooperation regarding communicable diseases, including HIV/AIDS, non-communicable diseases, and veterinary public health, including food protection and zoonoses. In addition, the Division provides epidemiological and lab support to the English speaking countries of the Caribbean through the Caribbean Epidemiology Centre (CAREC) located in Port-of-Spain, Trinidad.

2. The overall goal of the Division is that the capacity of member countries to eradicate, eliminate, prevent, and control disease is strengthened. This implies that the technical cooperation provided aims at having a health impact which is sustainable by the countries of the Region.

3. The development of sustainable capacity to effectively address health problems requires: good data concerning the health problem; policies and plans which are based on evidence available; sufficient financial resources allocated to support effective interventions; human resources with the proper training to implement plans; successful operation of pilot or demonstration programs; good quality programs in place throughout; ongoing evaluation and quality control to ensure effectiveness to address changing needs.

4. Programs with these characteristics have a positive health impact. The technical cooperation provided by the Division of Disease Prevention and Control assists countries at each of these levels, depending on the health problem being addressed and the existing capacity and commitment of the country. Programs which have been in existence for a longer time are more likely to focus on implementation issues. "Newer" programs are more likely to require the collection of good data and sound policy development.

5. Many of the countries in the Region are undergoing an epidemiological transition. While communicable disease has been a major health

problem in the past and continues to have a major health impact, non-communicable diseases are contributing increasingly to the disease burden.

6. In this section, the main functional approach to be used is listed with each program activity.

7. *AIDS and Sexually Transmitted Diseases.* Infection with Human Immuno-deficiency Virus (HIV) and AIDS continues to increase in the Americas (more than 900,000 AIDS cases reported) but at a slower rate than is being seen in Africa or South East Asia. Disease epidemiology varies in different parts of the Region. It remains primarily a disease of homosexual transmission in most countries. However, a heterosexual pattern is now predominant in some countries of the Caribbean and injecting drug use is responsible for an increasing number of infections in the Southern Cone. There are an estimated 40 to 50 million cases of sexually transmitted diseases (STDs) in the Region annually. The presence of an STD facilitates the transmission of HIV. There have been improvements in the tests which are available for diagnosis and some treatments have shown to be effective both in preventing perinatal transmission as well as delaying the onset of AIDS post-infection.

8. The strategy for HCA programs will be to help countries improve their surveillance of AIDS by including HIV sero-surveillance, molecular surveillance, mortality indicators, and behavioral sentinel surveillance. The program will assist countries in the development of policies particularly with regard to the provision of AZT to prevent perinatal transmission, the counseling and testing of pregnant women, the safety of blood and blood products, and access to anti-retroviral drugs. It will help countries managerial and health policy issues such as strategic planning and design implementation and evaluation of specific interventions. It will develop and recommend effective prevention programs focusing on behavior modification by specific target groups as well as comprehensive models of care for persons living with HIV/AIDS appropriate to the region.

9. There will be special emphasis on improving early detection, treatment and reporting of sexually transmitted diseases to reduce the burden with specific attention paid to syndromic management of STDs and the monitoring of anti-microbial resistance. The program will collaborate closely with the numerous official agencies and Non-Governmental Organizations (NGOs), and the private sector, in addition to Ministries of Health addressing this group of diseases.

10. **Noncommunicable Diseases.** The disease burden due to non-communicable diseases (NCDs) continues to increase in this Region. It now accounts for over 70% of the total estimated mortality and disability in the Region. HCN will continue to identify priority areas based on the health impact in the Region, and the potential for reduction of the disease burden. At present, cardiovascular disease accounts for approximately 45% of NCD mortality. There are 25,000 deaths due to cervical cancer per year. Injuries are responsible for over 17% of year's loss to disabilities.

11. This program uses an integrated approach which includes primary prevention, health promotion, and secondary clinical prevention, with the participation of a range of health service providers as well as the community.

12. There will be ongoing surveillance at the regional level to establish priorities and technical cooperation provided to Member Countries for analysis of national non-communicable disease priorities.

13. Attention will be given to expanding CARMEN (Conjunto de Acciones para la Reducción Multifactorial de las Enfermedades no Transmisibles) in the countries of the Region. CARMEN provides an integrated approach to addressing the risk factors which are common for many non-communicable diseases.

14. The demonstration sites for cervical cancer control programs will be evaluated and expanded within the framework of the Cancer Regional Initiative. This approach offers an excellent opportunity to reduce a major cause of death through better management of existing resources. A 60 to 70% decrease in mortality has been achieved elsewhere in the world. It also provides a platform

for the development of health services for middle age women who are often bypassed by existing services.

15. The Declaration of the Americas (DOTA) has been accepted by Member Countries and provides guidelines for the management of diabetes control. While effective control programs are new to the Region, this condition has been shown in some studies to be preventable in 50% of the cases. Effective treatment can reduce complications by an additional 50%. HCN will encourage and assist countries in the development of policies to effectively implement diabetes control programs.

16. Injury prevention programs have a clear record of effectiveness. HCN will help countries to identify effective strategies. HCN will also analyze data concerning violence as a public health problem and identify priority areas and partnerships for intervention programs.

17. **Communicable Diseases.** Communicable disease continues to have major health impact in the Region as new infectious disease agents continue to be discovered and antibiotic resistance increases. Globalization and urbanization are factors which facilitate the transmission of infectious disease, while decentralization and integration of health systems have caused a reorientation of communicable disease control programs. Meanwhile, new techniques have been developed for diagnosis and treatment of communicable diseases which facilitate effective control.

18. Surveillance and communication have emerged as important international issues. New International Health Regulations (IHR) are being proposed which will include more diseases, syndromic reporting, and faster interventions. The Amazon Region and the Southern Cone Region will each develop laboratory surveillance networks with common protocols to identify emerging infectious diseases threats in the Region. Training will emphasize identifying antimicrobial resistance. Likewise, new partners are being identified for the sharing of information concerning anti-microbial resistance.

19. Several diseases respond to eradication or elimination efforts. HCN will work to prevent transmission through blood transfusion of five infectious diseases: syphilis, HIV, hepatitis B, hepatitis C and *T. cruzi*. Internal and external quality

control measures will be promoted. 18,000,000 people are thought to be infected with *T. cruzi*, the agent which causes Chagas disease. Interruption of transmission of Chagas disease has been certified for Uruguay. Support for the eradication of Chagas disease from the Southern Cone by attacking the vector *T. infestans* will be continued. HCT will promote the development of programs in Central America to attack a major vector of Chagas disease there, *Rodnius prolixus*. The campaign to eliminate leprosy as a public health problem (prevalence less than 1/10,000) will continue. In recent years, there has been a 75% decrease in the prevalence of leprosy in the Region. Special efforts will be made to help Brazil, the only country exceeding this level, to reach this goal. In addition, pockets with high prevalence within countries will receive special attention. Efforts will be made to integrate leprosy control activities into the general local public health services to promote sustainability. HCT will continue to support onchocerciasis elimination programs. Onchocerciasis is endemic in Brazil, Colombia, Ecuador, Guatemala, Mexico and Venezuela. HCT will continue to support its elimination using Ivermectin. Bancrofti filariasis exists mainly in Brazil, Guyana, and Haiti. HCT will stimulate the countries to eliminate this disease based on the WHO Resolution with the provision of Albendazole.

20. **Control Programs.** The Integrated Management of Childhood Illness Program (IMCI) has been very well accepted by most countries. This program addresses the major causes of childhood illness including acute respiratory disease, diarrheal disease, intestinal parasitism, malaria, malnutrition, and measles. These cause 60% of consultations at health services and more than 40% of hospitalizations for those under five years of age. Inequity is a central issue as the infant mortality rate in some countries is 10 times greater than in others. There are great differences seen within countries as well. Primary health care centers are given the resources to promptly and correctly diagnose these conditions. HCT will focus on the 9 countries which have infant mortality rates greater than 40 per 1,000 in the Region and will extend technical cooperation activities to the community and local levels. Mobilization of resources and the establishment of new partnerships will be critical to the success of this program. Prevention of parasitism in children through the provision of Mebendazole will be promoted in Central American countries and extended to others.

21. Tuberculosis can be effectively controlled using the directly observed treatment strategy (DOTS). HCT will continue to promote the strategy in the Region. Countries in the Region that apply the DOTS strategy have a cure rate of 81% for new smear positive cases. Countries that do not apply the strategy, however, have a cure rate of only 32%. TB remains a major killer in this Region, responsible for approximately 300,000 cases per year and 75,000 deaths per year. It is the major cause of death in patients suffering from HIV.

22. The new global strategy on malaria has proven effective in this Region reducing mortality by approximately 20% where it is applied. The incidence of malaria remains at 1 to 1.3 million cases per year. The strategy is based on early diagnosis and treatment of infected persons. Most countries affected by malaria have already started its implementation. HCT will continue to promote the strategy throughout the Region, and also to promote the monitoring of anti-malarial drug resistance.

23. Dengue continues to be a major problem in the Region as the number of reported cases continues to increase each year. Over 700,000 cases have been reported in 1998. All four serotypes are present in the Region and their presence continues to expand. This increases the risk of dengue hemorrhagic fever. HCT will continue to encourage countries to implement national plans for dengue control.

24. **Food Protection.** WHO estimates up to 75% of diarrheal disease in children under five year of age is caused by contaminated food. INPPAZ has begun collecting and analyzing data on food-borne illness. In this early stage (1995 to 1997) over 2,200 outbreaks with close to 7,000 cases and 173 deaths were reported. The signing of the World Trade Agreement and the use of the Codex Alimentarius as the international standard for food exports has focused attention on the importance of food safety and has stimulated countries to improve in this area. PAHO will provide technical cooperation to assist countries in meeting standards and ensuring that these standards also apply to food that is consumed internally. The program will operate along five lines of action.

25. **Integrated programs.** The diversity of institutions involved in food production, transformation and commerce require an integrated

approach to guide the actions from a variety of institutions toward comprehensive objectives in improving food safety at national and international markets. National and/or local intersectorial committees will be promoted and supported. Legislation is a main issue within this component. INPPAZ will promote the establishment of legislation and policies based on multisectoral participation. INPPAZ has collected existing legislation from the Southern Cone countries for information sharing. INPPAZ will continue this effort in the Andean countries and Central America.

**26. Laboratory services.** INPPAZ will support the work of the regional laboratory network for food analysis. This network aims to harmonize protocols, establish equivalent standards, and ensure transparency of procedures. This should assist countries with regard to trade issues.

**27. Food inspection.** Hazard Analysis Critical Control Point (HACCP) has been widely accepted as the method of choice for the inspection of food processing and food handling. HCV Program has conducted several training courses in the Region and will continue to promote the utilization of this method throughout the Region.

**28. Surveillance.** The reporting and investigation of outbreaks of food-borne diseases is essential to improve food safety and to protect human health. Focal points have been identified in all countries and training sessions have taken place. The reporting of food-borne illness has improved but significant challenges remain.

**29. Consumer protection.** Education and dissemination of information will be the principal tool to obtain social participation in food safety programs. Comprehensive socio-cultural studies will be required to guide the educational programs. INPPAZ will develop educational materials and provide training programs for education of the public and street vendors.

**30. Zoonosis.** Countries of the Region have made major gains in the reduction of human rabies. The mortality rate has come down from 1.3 in 1989 to 0.1 per million inhabitants in 1998. Most reported cases now come from areas with populations of 20,000 or less. PAHO will continue to promote massive dog immunization campaigns and to extend this to areas

which have not yet been covered. Effort will be initiated to recognize rabies free municipalities. In addition, PAHO will support the development of laboratory consortium for the diagnosis of rabies and will begin assessment of the problem of sylvatic rabies.

**31.** With the transfer of zoonoses functions to PANAFTOSA, new efforts will begin to address bovine tuberculosis and brucellosis.

**32.** Equine encephalitis remains a significant threat in the Region. PAHO will continue to encourage equine immunization programs in countries of risk and to assist countries to gain the capacity for effective laboratory diagnosis. Technical cooperation for hydatidosis control will also be provided.

**33. Foot-and-mouth disease.** The area of the Region which is free from foot-and-mouth disease continues to expand. Chile and Uruguay and Uraba region in Colombia have been declared free of foot-and-mouth disease; Argentina, Paraguay, and southern states in Brazil have been declared free with vaccination. PANAFTOSA will work with countries to ensure that areas which are free of foot-and-mouth disease continue to be so. New efforts will be made in the Andean Region to reduce the incidence of foot-and-mouth disease. Special emphasis will be placed on the formation of local community groups and on ensuring that the border areas are free of foot-and-mouth disease.

**34. Caribbean Epidemiology Center.** CAREC has a mandate to provide epidemiological and laboratory services to the English speaking countries of the Caribbean. The Caribbean islands provide a special situation in that the population numbers are not great and the physical separation causes different patterns of disease transmission so that different types of collaboration are required. To deal with this issue, CAREC will establish sentinel sites for diagnosis of communicable disease and will utilize modern communication techniques for transmission of this information. CAREC will support the development of a laboratory network for the diagnosis of tuberculosis and will work to strengthen the laboratory services throughout the Caribbean through the introduction of standardized protocols and effective quality control measures.

35. Rates of noncommunicable diseases are increasing. To address the epidemiological transition in the Caribbean, CAREC will introduce non-communicable disease control programs beginning with behavioral risk surveillance and the identification of priority non-communicable diseases.

36. Tourism is extremely important to the Caribbean Region, being responsible for 25% of jobs in the subregion. CAREC will utilize a "Health Hotels Program" in partnership with private industry and governments to help countries reduce the risk of illness for visitors to the Caribbean.

### ***Technical Cooperation Strategy***

37. During 2000-2001, HCP will use all 6 functional approaches.

38. Resource mobilization will continue to be very important in all programs. External financial support has been well established in the delivery of HCA, HCT and HCV Programs. HCN will continue to build on recent support. The development of new partnerships will also continue. Specific examples will include the continued expansion of the Integrated Management of Childhood Illness (IMCI) Program with particular emphasis on the 8 priority countries with high infant mortality rates and the aim to extend activities to the local or community level, and the establishment of a laboratory consortium for the diagnosis of rabies.

39. The development, promotion, and implementation of policies, plans and norms will be fundamental to the elimination and control strategies as well as to initiatives that stimulate activities in new areas. Examples include the establishment of models of care for people suffering from HIV infection and the prevention of perinatal transmission of HIV, the establishment of a laboratory network for analysis of food specimens based on harmonization of methods, equivalency of standards, and transparency of procedures, and the promotion of effective policies for injury prevention.

40. Direct technical cooperation will be conducted in partnership with PWR offices and it will be carried out by all programs. Examples include the

implementation of surveillance methods to comply with the new International Health Regulations, the establishment of local committees to address foot-and-mouth disease in the Andean countries, and the planning and introduction of cervical cancer control programs.

41. Training is often a step that follows the development of norms and policies and therefore it is a main component of the already well-established programs. Examples of training include Hazard Analysis, Clinical Control Point (HACCP) for inspection of food processing and food handling and the syndromic management of sexually transmitted diseases.

42. Information dissemination will be carried out by all programs. It is the key to inter-country activities. Examples include the CARMEN project, the surveillance program for anti-microbial resistance, AIDS, and tuberculosis.

43. In the area of research, emphasis will be placed on collection of data (violence) and the evaluation of interventions such as HIV education activities, as well as on the more traditional areas of tropical disease research.

### ***Objectives for PAHO's Technical Cooperation***

44. Develop effective intersectoral programs to reduce the transmission and impact of HIV infection and sexually transmitted diseases.

45. Collaborate with Member countries to adopt feasible and cost effective policies, strategies and programs for prevention and control of NCD's.

46. Interrupt the vector-borne transmission of *T. cruzi* and the transmission of blood-borne diseases through the transfusion of blood or blood products; and to eliminate leprosy, onchocerciasis and filariasis.

47. Improve surveillance systems for taking timely action for prevention and control and for rapidly identifying outbreaks/epidemics of communicable diseases.

48. Achieve a 20% reduction in the infant mortality rate (IMR) in the Region of the Americas.

49. Implement an integrated control of tropical diseases.

50. Collaborate with the Member Governments to improve their technical-administrative capacity to guarantee food safety.

51. Collaborate with the Member Governments to improve their programs for the prevention, control, and eradication/elimination of the zoonoses of importance for public health, including foot-and-mouth disease.

52. Cooperate with projects on conservation of neotropical primates to ensure their availability for biomedical research, especially in the development of human vaccines.

53. Control and/or eradicate vaccine preventable diseases.

54. Develop regional self-sufficiency in matters of vaccine research, development production and quality control.

55. Strengthen the capacity of CAREC Member Countries (CMCs) to manage and provide sustainable services for the prevention, control and care to persons infected and affected in their communities strengthened.

56. Strengthen the capacity of CAREC Member to undertake effective surveillance, prevention and control of emerging and re-emerging infectious diseases, including Tuberculosis, nosocomial infections and antimicrobial resistance, and ensure a timely, effective response to identified threats.

57. Increase availability and more effective use of information and information technology in support of health promotion and disease prevention

58. Improve the quality and competitiveness of the tourism industry through the establishment of standards-based systems and registrations designed to ensure healthy, safe and environmentally conscious products and services for guests and staff.

59. Improve the competency and skill of all levels of public health staff to translate epidemiologic knowledge into the management of public health problems

60. Improve the quality of Laboratory Services provided at CAREC and in CMCs in support of disease surveillance and control.

61. Expansion of the areas/regions free of foot-and-mouth disease in accordance with PHEFA

62. Support of programs for the control and eradication of bovine and caprine brucellosis, and of bovine tuberculosis.

63. Reduce in cases of human rabies.

64. Develop effective control programs for Venezuelan equine encephalitis.

65. Conserve neotropical primates to ensure their availability for biomedical research.

66. Develop national food protection programs to prevent the contamination of products for national consumption and export and to reduce outbreaks of foodborne diseases.

67. Established reference laboratories for the diagnosis and quality control of reagents and vaccines for rabies, tuberculosis, and brucellosis.

### ***Expected Results***

68. *Cooperation networks, alliances.* To provide, generate and promote relevant epidemiological information for policy decision making to reduce the economic and social burden of NCD's; for the elimination of transfusion-transmitted diseases and evaluation of serological screening; for the surveillance of emerging infectious diseases (EID), including resistance to antibiotics, and for early detection and prevention; for conducting activities to monitor resistance to malaria drugs; for laboratory analysis of food in Latin America and the Caribbean; to establish national control authorities (NCA) at country level, with different degrees of complexity, based on local vaccine production capabilities, and in compliance with the six basic functions for vaccine: licensing, clinical evaluation, lot release system, lot

testing, GMP inspection and post-marketing surveillance; and to establish a network of vaccine research and development laboratories together with vaccine producers in the Region for the development of polysaccharide based vaccines (S.typhi, N. meningitidis group C., S. pneumoniae. To establish national control authorities (NCA) at country level, with different degrees of complexity, based on local vaccine production capabilities, and in compliance with the six basic functions for vaccine: licensing, clinical evaluation, lot release system, lot testing, GMP inspection and post-marketing surveillance. To establish a network of vaccine research and development laboratories together with vaccine producers in the Region for the development of polysaccharide based vaccines (S.typhi, N. meningitidis group C., S. pneumoniae. CAREC: Intersectoral and Inter-agency (UWI, CPC, CFNI, FAO) for public health action; with Member Countries, intra and extra regional agencies, in support of effective disease prevention and control; with other national (non-health), regional and extra-regional organizations forged in an effort to promote intersectoral cooperation in the campaign against injuries; with major regional and national agencies of mass communications to advocate for disease prevention and control; and for a regional laboratory network for disease surveillance and control.

69. *Surveillance and information systems.* For surveillance, decision making, and monitoring of the HIV/AIDS/STD epidemics in the countries; for transfusion-transmitted diseases; for the monitoring of EID; on national IMCI activities in priority countries of the Region; on the prevalence and/or incidence of tropical diseases; for epidemiological surveillance of FBD; and for vaccine-preventable diseases. For vaccine-preventable diseases. CAREC: To provide laboratory support to: HIV/STD program, food/water-borne diseases program, vector-borne disease surveillance and control program, vaccine preventable disease program, emerging infectious diseases program (including TB/nosocomia), for outbreak investigation in CMCs. To strengthen the sensitivity of the HIV/AIDS/CSTD surveillance systems to generate effective data for decision making, planning, implementation and evaluation; for food and waterborne illnesses; for VBDs in CMCs; for the prevention and control of injuries; of selected chronic non-communicable diseases (CNCDs), including mental disorders; on the epidemiology of selected CNCDs, including mental

disorders; on health care in the Andean and Amazon countries, and in Brazil; for timely and adequate epidemiological surveillance in the Andean and Amazon countries, and in Brazil; for epidemiological surveillance of equine encephalitis and its active incorporation into the hemispheric epidemiological surveillance system; on foodborne diseases; in laboratories for the detection and monitoring of microbiological and chemical contaminants; and for reference laboratories for rabies, brucellosis, and tuberculosis.

70. *Standards and guidelines.* To develop and expand appropriate models of HIV/AIDS care at the national level; to support the network for the prevention and control of EID; and to ensure the sustainable introduction of vaccines of public health importance to national immunization programs. To ensure the sustainable introduction of vaccines of public health importance to national immunization programs. CAREC. For vehicle operator/occupant protection; and for the effective conduct of surveillance of communicable diseases.

71. *Research and evaluation studies.* To monitor and evaluate processes and outcomes of NCD prevention and control strategies; and to improve vaccine-producing countries's capabilities to evaluate technical, managerial and economical feasibility aspects of producing quality vaccines. To improve vaccine-producing countries's capabilities to evaluate technical, managerial and economical feasibility aspects of producing quality vaccines. CAREC: Of national injury; health and environmental needs assessment.

72. *Plans, projects and policies.* For the prevention and control of HIV/AIDS/STD with a multisectoral approach and a sound health component; for the use of WHO's STD.PAC Strategy in order to strengthen national STD control activities; to improve the quality, effectiveness, and efficiency of interventions to prevent the sexual, blood-borne and perinatal transmission of HIV and STD; for cancer, cardiovascular, injury, and diabetes and to address violence as a public health problem; for tuberculosis control (DOTS) in the Region; with the IMCI strategy; for executing the different stages of the global malaria strategy; for improving control programs, and for implementing the Hemispheric Plan for the Eradication of *A. aegypti*; for requesting financial support from international agencies; for

integrated food protection programs; for the surveillance and prevention of equine encephalitis; for the control and/or eradication of bovine tuberculosis and brucellosis; for the prevention and control of emerging and reemerging zoonoses; and to improve policy environment relating to sustainable delivery of immunization programs. To improve policy environment relating to sustainable delivery of immunization programs. CAREC: For reduction of childhood gastroenteritis; for food and water quality testing and monitoring in CMC's; for elimination of lymphatic filariasis (LF) launched in Guyana; for lymphatic filariasis certification in 7 countries; and for strengthened surveillance and monitoring of emerging infectious diseases; for the national public and private veterinary services of free countries in activities to prevent and eliminate the establishment of foci; for control and eradication of bovine and caprine brucellosis, and of bovine tuberculosis; for the elimination of rabies transmitted by dogs; for the control of sylvatic rabies; and for vaccination for Venezuelan equine encephalitis; for integrated national programs with adequate intersectoral coordination, up-to-date legislation, and with standards and codes for food hygiene based on the recommendations of international organizations such as Codex Alimentarius, AOAC, and IFT, among others.

*73. Methods, models, and technologies.* For the HACCP strategy for food inspection; and for logistics and cold chain, to ensure the safe and efficient use of quality vaccines in national immunization programs. For logistics and cold chain, to ensure the safe and efficient use of quality vaccines in national immunization programs; for food inspection and protection to guarantee food safety.

*74. Training programs.* In IMCI for technical staff in charge of child health at the different levels in each country in the Region; for the control of vector-borne diseases; for research; and to strengthen country capabilities in delivering quality and effective immunization programs. To strengthen country capabilities in delivering quality and effective immunization programs. CAREC: To develop, implement and evaluate behavioral and communication interventions targeting vulnerable populations; for clinical and diagnostic management in health institutions to deliver services with a client oriented focus; for investigation and control of food

and waterborne outbreaks in CMC's; for management of DHF in CMCs.; in epidemiologic surveillance, both at the CAREC and country levels, to facilitate the early detection, reporting and timely response for effective prevention and control measures for emerging and re-emerging infectious diseases; for public and private sector; for training of trainers; in epidemiology for in-country training at the basic and intermediate level; for regional lab personnel for QA program implementation; and for decision makers involved in policy formulation, planning, implementation and evaluation of HIV/AIDS activities.

*75. Promotional campaigns and advocacy.* CAREC: For eco-tourism related diseases e.g. malaria, cutaneous leishmaniasis highlighted for prevention by education in 3 CMCs, Guyana, Suriname & Belize; for the involvement of communities to provide care and support to persons infected and affected by HIV/AIDS; to increase awareness and practices of communities of CMCs of their role in preventing the reproduction of *Aedes aegypti* vectors; and to support an active involvement of governments and other key stakeholders in furthering health promotion and disease prevention and control efforts at national and sub-regional levels; for the expansion of disease-free areas in countries where foot-and-mouth disease still exists, with the active participation of all community actors; for transborder programs for the eradication of foot-and-mouth disease; for vaccination in the indicated areas; and to promote community participation in the Andean and Amazon countries, and in Brazil, in activities for the eradication of foot-and-mouth disease; to promote food protection through community participation.

*76. Direct support.* To promote mass communication as part of the measures to control *Aedes aegypti*; for social and private sector participation in food protection and food handling; for the prevention and eradication of foot-and-mouth disease; for consolidating the elimination of rabies, for maintaining the countries' status as free of canine-transmitted human rabies; and for the administrative and technical development of veterinary public health and animal health services. CAREC: To strengthen laboratory capacity for detection and characterization of pathogens by advanced techniques; to mobilize resources for the

conduct of applied research; to demonstrate the benefits of the use of insecticide impregnated bed nets for malaria; for mapping of significant Anopheles production sites (GIS) in at least 3 non-malaria endemic countries but where introduction occurred in 1997/98 - T&T, Bahamas, Cayman Islands by CMC & CAREC; to strengthen laboratory

capacity; both at the CAREC and Member Country levels, to facilitate accurate and rapid diagnoses of emerging and re-emerging infectious diseases; to mobilize resources in support of the prevention and control of emerging and re-emerging infectious diseases; and to seek funding for intensification of CNCD surveillance activities.

**DISEASE PREVENTION AND CONTROL  
PROGRAM BUDGET DISTRIBUTION BY LOCATION**

Location	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Direct Cooperation with Countries	12,686,600	13,376,500	30,265,400	14,562,700
Intercountry Programs	14,732,700	14,878,000	2,474,100	2,029,500
Centers	11,915,300	10,346,500	5,689,400	4,359,600
<b>Total</b>	<b>39,334,600</b>	<b>38,601,000</b>	<b>38,428,900</b>	<b>20,951,800</b>



**ADMINISTRATIVE SERVICES  
PROGRAM BUDGET DISTRIBUTION BY LOCATION**

Location	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Technical and Administrative Direction	25,959,200	27,123,200	8,869,800	7,256,000
<b>Total</b>	<b>25,959,200</b>	<b>27,123,200</b>	<b>8,869,800</b>	<b>7,256,000</b>







# ANTIGUA AND BARBUDA

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## *Health Situation*

1. Over the past two years, Antigua and Barbuda (ANI) have experienced an unexpected increase in population due to the relocation of Montserratians from their volcanic-stricken island. About 3,000 nationals of Montserrat have settled in Antigua in addition to the continuing trend of migrants from neighboring Caribbean islands, the United States of America and the United Kingdom. Among these are returning nationals with the expected high prevalence of the chronic diseases found in the Caribbean. The size of the migrant population from the Dominican Republic is now significant enough to require special planning by the Health and Education sectors.

2. The 1996 mid-year estimate of 68,612 shows 30% (20,986) under the age of 15 years, with those 65 years and over constituting 8.3% of the remainder. Life expectancy in 1996 was 71 years for males and 75 years for females. For the second successive year the number of registered live births rose and 1,459 were recorded in 1996 giving a crude birth rate of 21.3. The crude death rate was 6.3 per 1000.

3. The leading causes of mortality in 1996 remained malignant neoplasms, heart diseases, hypertensive diseases, cerebrovascular diseases and diabetes. Whereas death due to gastroenteritis is rare, there has been an increase in those due to asthma.

4. Given the small number of births the infant mortality rate for single years is expected to be unstable. In 1996 it was recorded to be 25.4/1,000. The perinatal mortality rate will also fluctuate. Three year rolling average IMR yield rates ranging from 25.7 - 27.7 /1,000 over the five-year period 1992-1996. Respiratory infections remained the major cause of admission into hospitals for 1-4 year olds.

5. Antigua GDP rose to 4.8% in 1997, lower than 5.8% in 1996. It represented a sharp recovery from the devastation by hurricanes Luis and Marilyn in 1995. The main contributors to this economic growth continue to be tourism and construction. Tourist arrivals and stay-over visitors increased by approximately 4.5% between 1996 and 1997, but the latter has not achieved the previous high level of 1994. The housing stock for lower and middle-

income families is to be boosted by several public and private sector developments.

6. Agriculture production continues to be mostly directed to the domestic market. The manufacturing sector is due to get a boost from proposed initiatives with the Republic of China to manufacture electronics and pharmaceuticals.

7. The rate of unemployment continued to be low at 7% in 1997 in spite of the influx of Montserratians. While the consumer price index for all items was reduced in 1997, medical expenses was among the components that increased.

8. The health sector is poised to benefit from the increased in public sector investment with the construction of a new hospital. CDB reports that the medium-term outlook is for continued economic growth based on "increased buoyancy in the construction center and further recovery in the number of stay-over tourist arrivals."

9. With tourism responsible for 68% of the GDP, the country has become acutely aware of the need to improve surveillance, and more importantly, the capacity to monitor and manage environmental health conditions. A pilot surveillance system initiated in the hotel industry in 1996 will need to be evaluated prior to expansion to the entire industry. The problem of liquid waste remains critical in the unsewered capital of St. John's and for the hospital as well. The anticipated improvement in waste disposal with the execution of the World Bank Project for waste from cruise ships is proceeding slowly. Food safety practices need to be improved, particularly in hotels and among itinerant vendors.

10. The effects of promotion of healthy lifestyles remains fragmented by cause and sector. High levels of obesity and substance abuse among the youths are recorded. The pilot adolescent health project has floundered since withdrawal of funding, and plans to expand coverage to the national level and integrate services with other levels and sectors have not been achieved. In addition to hypertension and diabetes, health services now have to deal with cataracts and glaucoma among the elderly population. There still remains a need for developing a comprehensive

program for prevention and control of non-communicable diseases and articulation of a policy and program for the elderly.

11. The Government has given priority to planning for the health sector in a systematic way. The Health Planner has been appointed, a national health policy approved by Cabinet by 1997 and a draft national health plan is now being finalized, the costing of which will be important to select sustainable options.

The Government has identified the following areas for technical cooperation:

12. Improvement of physical facilities including construction of a new hospital, polyclinics, and a drug rehabilitation center.

13. Modernization of the organization and management of the health system. This will include, but not be limited to, decentralization of authority for hospitals through the creation of a Statutory Board, definition of a new role for the central level of the Ministry of Health, review of the health financial system and development of modern organization for environmental health management.

14. Improvement of information systems.

15. Rationalization and strengthening of community based health systems.

16. Improvement of environment policies - solid waste disposal, food safety, water quality and vector control.

17. Increasing health promotion for the adoption of healthy lifestyles for control of diabetes, hypertension, cancers of the cervix, breast and prostate, substance abuse and AIDS.

18. Advocacy for workers' health issues.

19. Disaster preparedness.

20. The Ministry of Health is placing emphasis on health promotion and needs to increase its capacity in this area, including strengthening the health education unit and collaboration with other sectors including NGOs.

21. Other general supportive policy thrusts include adopting modern legislation, human resource development and infrastructural development.

### ***National Priorities for PAHO's Technical Cooperation***

22. Administrative Reform and implementation of decentralization policy; Quality of life enhanced; Health Sector Reform - revision of National Health Policy Plan, creative approaches to health care financing, improved availability and use of health information, reorienting health services, drafting of legislation to support rationalization of service; Community environment and lifestyle improved; Mental health/Drug abuse; Strengthening national capacity in Health Education; Health Promotion skills: formulating healthy public policy, social mobilization, communication, counseling, community participation, empowering communities to achieve well being; Environmental health technical areas (vector control, food safety, institutional sanitation and water quality); Drug supply and management; Essential health research; Leadership/management skills, including team building; Commissioning new hospital, equipment maintenance; Emergency medical services, traffic accidents; manpower planning; Quality of care; AIDS/Family planning/Reproductive Health; elderly services; Maternal and Child Health; chronic Diseases/Cancer screening; Food and Nutrition.; ral Health; Services for the disabled

### ***Technical Cooperation Strategy***

23. Over the biennium 2000 - 2001, the technical cooperation of PAHO CPC will be delivered through three projects: Healthy Community, Maintenance of Healthy Lifestyles, and Organization and Management of Health Services. Delivery will occur at both bilateral and subregional levels, will seek to enhance complementarity including that of CCH II. This program of action calls for collaboration of all PAHO units and PAHO CPC. Collaboration with regional institutions, other agencies and community-based organizations will also be pursued. Emphasis will be on building capacity and in particular on ensuring sustainability at both the ministry and local institutions (school of Nursing), as well as regional

24. All functional approaches: mobilization of resources; training; development of policies, plans and norms; dissemination of information; direct technical assistance and research will be employed in delivery, with personnel training remaining the single most frequently employed functional approach.

25. The priority areas of the yet to be ratified CCH II initiative are congruent with the areas of this work plan. Therefore, no change is anticipated following the introduction of the CCH II.

### ***Objectives for PAHO's Technical Cooperation***

- To improve the health and well being of the population.
- To increase the capacity to carry out activities of daily living.
- To better manage the health care system.
- To develop training programs to increase capacity to provide quality services for the elderly.

### ***Expected Results***

26. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

27. *Plans, projects and policies.* To strengthen capacity of community and health personnel to manage healthy settings approach.

28. *Surveillance and information systems.* To design and install selected components of management information systems.

29. *Plan, projects and policies.* To control programs for selected NCDs, to strengthen Health Information System and capacity to use information.

30. *Methods, models and technologies.* To strengthen capacity for community development approaches.

31. *Direct support.* To establish cooperation networks and alliances for community empowerment, to strengthen services to reduce STDs, HIV/AIDS and unwanted pregnancies, for human resource development in mental health, and for Human Resources development and promotion of Health Sector Reform.

<b>ANTIGUA AND BARBUDA PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health Systems and Services Development	106,000	99,300	0	0
Health Promotion and Protection	0	45,500	0	0
Environmental Protection and Development	38,700	0	0	0
Disease Prevention and Control	38,000	52,900	0	0
<b>Total</b>	<b>182,700</b>	<b>197,700</b>	<b>0</b>	<b>0</b>



# ARGENTINA

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## *Health Situation*

1. Argentina has had a fully democratic system for 15 years. The current administration is in its second term of office, following its reelection in 1995. The 1990s have witnessed deep structural macrotransformations in the country, marked by political stability and economic growth. Various far-reaching structural reforms have been consolidated, including the Convertibility Plan, the amendment of the Constitution, and social security and state reform. In short, it can generally be stated that the country is moving rapidly toward a development model based on the principles of post-modern economic neoliberalism. In this model there has been a strengthening of globalization, the free international market, and integration into subregional blocs, with the concept of the State as regulator supplanting that of the welfare state. The country's foreign policy plan depicts Argentina as an important ally of Pan Americanism and the United Nations system.
2. Since 1992, the National Executive Branch has set state policy for the health sector through Decree 1269/92, which defined the national health policies. The continuity of the administration of the Ministry of Health and Social Action, now in its seventh year, has been maintained.
3. The national policies have been aimed at: (i) promoting credibility and the inclusion of health issues on the political agenda of other government organs and society as a whole; (ii) transforming the model of medical care into one marked by efficiency, effectiveness, and quality to make the most rational use of available resources; (iii) focusing activities and resources on priority health promotion and protection programs to maximize the social and health impact in terms of the morbidity, mortality, and quality of life of the population; (iv) achieving central institutional reform and restructuring and modernizing the Ministry of Health to enable it to operate as the steering and regulatory organ of the sector.
4. Specifically during this period, several projects for strategic transformation of the sector were developed and implemented, namely: (i) the promulgation of a new body of laws and standards that redefines the relationships between financing entities, suppliers, and health care providers in the country; (ii) the Self-Managing Public Hospitals Program, which increases the managerial and financial autonomy of the public sector; (iii) the National Program for Quality Assurance in Medical Care, which introduces new criteria and operating standards for all health services delivery subsystems; (iv) the Compulsory Medical Program, which establishes a basic package of services for all provider subsystems; (v) the National Health Insurance Administration, to oversee the system for medical care; (vi) the National Food, Drug and Medical Technology Administration (ANMAT), which oversees health monitoring in the country; (vii) the National Health Institutes and Laboratories Administration (ANLIS), which coordinates and supervises diagnostic and epidemiological control activities; and (viii) INCUCAI, which oversees organ transplants.
5. At the same time, these projects have been supported through major infusions of external financing from the World Bank and the IDB, including, most notably: (i) PROMIN 1 and 2, which repairs the infrastructure for maternal and child programs and nutrition; (ii) PRESSAL, which is geared towards institutional strengthening of public sector management; (iii) the Health Infrastructure Rehabilitation Program, aimed at modernizing the installed capacity of the public sector; (iv) the Structural Transformation Plan for the *obras sociales* employee benefits plan and the PAMI, which emphasizes actuarial, financial, institutional, and administrative improvement of compulsory social security providers; (v) the Primary Health Care Program, which supports the adaptation of health care models; (vi) LUSIDA, which bolsters the intervention capacity of the National AIDS Program; and (vii) VIGLA, which restructures the country's epidemiological surveillance and disease control system.
6. Regarding the epidemiological, social, and health situation, Argentina still has good indicators within the Region of the Americas, exhibiting a clear

downward trend in communicable diseases and a marked prevalence of chronic diseases. However, significant gaps and disparities among the country's subregions can still be observed, and emerging and reemerging diseases are on the rise.

7. In short, the scenario outlined above leaves no doubt that health sector reform is in an advanced stage, which is why the health authorities are continuing with the national policies and priorities already in place for health activities in the near future.

8. With regard to international technical cooperation (TC), Argentina is classified as a country with special characteristics that does not require large volumes of TC. Resources are aimed instead at supporting very specific projects related basically to governance, institutional development, and technology transfer.

9. This same approach has been adopted for the health sector. The authorities in that sector have been applying the following guidelines in international TC: (i) complementarity among agencies, especially in investment projects involving external financing, with PAHO/WHO participation essentially restricted to the project development stage; (ii) giving priority to the mobilizing, coordinating, and normative role of PAHO/WHO internationally and subregionally, targeting projects for cross-border initiatives and technical cooperation among countries; (iii) systematic strengthening of the steering role of the Ministry of Health as a channel for negotiation and coordination, both inside and outside the sector; (iv) developing high impact strategic projects for change, discouraging initiatives that address only the structure of the supply of international TC and/or the economic climate; (v) allocating human resources according to the criterion of mobilizing the best available "technical expertise," at both the national and international level, making rational and efficient use of the mechanisms for hiring consultants for a given period of time; (vi) coordinating TC activities exclusively through the institutional channel of the Ministry of Health; (vii) strictly applying the standards governing prior notification of the country about TC initiatives and actions, including the mobilization of consultants and advisers; (viii) institutional and managerial upgrading of the PAHO/WHO Representative Office in the country to act as international liaison, instead of a national technical complementation unit.

10. Regarding the areas for future PAHO/WHO technical cooperation, the Joint Evaluation of the period 1992-1997 has established the following basic framework for the Organization's technical cooperation:

11. The TC should respond to the national health policies established in the corresponding Decree of the National Executive Branch described above;

12. The programming and budgetary structure of the TC should be adapted insofar as possible to the lines of action and their strategic programs, which coincide with the Strategic and Programmatic Orientations (SPO) of PAHO/WHO.

### ***National Priorities of PAHO's Technical Cooperation***

13. National Program for Quality Assurance in Medical Care; Self-managed public hospital; Human resources development; Development of primary health care; Development of programs for medical care; Project for Health Sector Reform/IBRD; Project for the transformation of *Obras Sociales*/IBRD; Program for Infrastructure Rehabilitation/IBRD; Epidemiological surveillance and control of prevalent diseases; Immunization; National AIDS program; Control of chronic diseases; Health promotion; Education for health; National Maternal and Child Program; Environmental health; Occupational health; Monitoring of food, drugs, and technology; National institutes for research, education, and production; National Health Statistics Program; Sectoral planning and coordination; Regional integration of technical cooperation; Institutional strengthening of the ministry of health; Health information; Health surveillance

### ***Technical Cooperation Strategy***

14. Overall, the PAHO/WHO technical cooperation strategy for the coming period should continue to involve a rethinking of the above-mentioned TC model implemented in recent years.

15. In this regard, interagency coordination with the United Nations system will be expanded to consolidate the UNAIDS and Environment Groups, in which PAHO/WHO is increasingly acting as a lead agency, and also the structuring of the core data and

documentation and information services under the principles of the virtual library. The integration of common administrative services and use of the Internet with the UNDP will also be intensified.

16. With regard to technical cooperation projects with the country, under the current guidelines, the basic strategy to be applied for all projects will focus on institutional strengthening of the Ministry of Health.

17. Thus, bearing in mind that the basic objective is to strengthen the steering and regulatory role of the Ministry of Health, PAHO/WHO technical cooperation projects to support the strategic programs listed by the Ministry should focus on activities to support: (i) the coordinating and negotiating role of the Ministry of Health, inside and outside the sector, through the holding of national and international coordination and technical meetings and meetings to promote strategic partnerships with national councils, committees, and chambers of commerce and industry; (ii) the mobilization of missions comprised of national and international experts to prepare the necessary policies, plans, standards, and investment proposals; (iii) the development and organization of information systems and databanks with high value added to sustain the macroplanning, supervision, and regulatory functions in the subsector; (iv) the training of leaders and multipliers in critical areas of knowledge and technology transfer; and (v) the conducting of studies, research, and innovative pilot projects to meet the challenges of the new functions of the Argentine State.

18. Within that general strategic framework, the following projects merit special consideration:

19. Technical cooperation among countries. This should be strengthened and activated, with the goal of expanding coordination in fields other than controlling border outbreaks. Joint projects are to be conducted with Venezuela and Colombia in health services management and quality and with the MERCOSUR countries in food and drugs, with the support of INPPAZ and ANMAT.

20. Medical care. The goal will be to develop the operating capacity of the Health Insurance Authority and the National Program for Quality Assurance in Medical Care.

21. Sanitary control and regulation. The goal is to develop the operating capacity of the ANMAT's Medical Technology Department.

22. Human resources. Efforts will concentrate on completing the review of legislation governing the exercise of professional activity and the development of the accreditation system for medical schools.

23. Health Statistics and Monitoring. The approach will be aimed at consolidating the core data of Argentina and the health information electronic data transmission network.

24. Disease protection, prevention, and control. The main objective is to conclude and implement the VIGIA project, in coordination with the World Bank.

25. Health institutes. Institutional development of ANLIS will be promoted, with a view to expanding its capacity to manage and supervise the laboratory system.

26. Environment. Efforts to organize the regulatory entities of the water and sanitation system should continue, as should the work to strengthen the air quality control and chemical safety networks.

### ***Objectives for PAHO's Technical Cooperation***

- To strengthen the institutional capacity of the Ministry of Health to steer, guide, and manage health sector reform.
- To develop mechanisms to ensure the operations of the Representative Office in support of local and regional projects for technical cooperation and linkage with the agencies of the system.
- To strengthen national health institutions for the mobilization of external resources for development and regional integration.
- To strengthen the institutional capacity for the analysis, processing, and dissemination of health information.
- To strengthen the capacity of the Ministry of Health to plan, standardize, and regulate the system for medical care.
- To strengthen and develop the steering role capacity of the Ministry of Health for human health resources planning and regulation.

- To develop the institutional capacity of the Ministry of Health to regulate and monitor health conditions and activities.
- To develop the country's capacity to formulate and develop plans and programs for the prevention and control of prevalent diseases in the country.
- To develop proposals for healthy public policies and national strategies to promote health.
- To promote intersectoral action and strengthen the institutional capacity to evaluate environmental risks to human health, formulate policies and plans for their management and minimization, carry out programs and actions geared toward controlling these risks, and permit sustainable human development.
- To strengthen institutional integration for the production, dissemination, and utilization of scientific and technical information on health.
- To strengthen the institutional capacity of ANLIS and the decentralized agencies of the Ministry of Health.

## *Expected Results*

27. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

28. *Cooperation networks, alliances.* For technical cooperation with regard to the steering role and management of the health sector, at the subregional level; for groups to analyze health data at the national and provincial level; for development of the National Program for Quality Assurance in Medical Care; between service institutions to develop plans and projects for medical care and institute reforms in the health sector and transformations in the *Obras Sociales*.

29. *Surveillance and information systems.* For statistics; for health documentation; for human resources; for chronic noncommunicable diseases; for regulation and control of water quality; for monitoring and control of air quality and its impact on health; for responding to emergencies and disasters.

30. *Standards and guidelines.* To develop the health services in terms of primary care; to manage human

resources for health; to accredit training programs in health specialties and train mid-level technicians to strengthen health inspection and transportation in border areas; to strengthen and expand the Epidemiological Surveillance System (SINAVE); to reinforce National Plans and specific programs such as IMCI and the program for Vaccine-preventable Diseases; to coordinate nongovernmental organizations; to establish cooperation networks for scientific and technical information and communicating for health.

31. *Plans, projects and policies.* For strengthening the activities of ANLIS; on the decentralized agencies of the Ministry of Health; for the development and coordination of activities in science and technology; to strengthen both the Ministry of Health's sectoral coordination capacity and international health relations; to strengthen and coordinate the Ministry of Health's communications with academic, scientific, and professional entities, and business and professional associations of the sector. For technical cooperation among countries in the area of disease prevention and control. Strategies and plans for the updating, systematization, analysis, and dissemination of health information; for restructuring of the system for the registry, certification, and inspection of health facilities and health services; for development of the subregional and national system for certification and recertification of professional practice in health; for development of the system for the monitoring of drugs, food, and medical technology. For disease prevention and control, including the eradication or elimination of priority pathologies in the country. For programs to strengthen the institutional capacity of the National AIDS and STD program. For the definition of public policies designed to promote healthy lifestyles with regard to accidents, violence, tobacco use, and drug addiction; for mental health, health education, and public health; for the monitoring and evaluation of the goals outlined to promote child health and reduce maternal mortality; for chemical safety.

32. *Methods, models and technologies.* For evaluation in order to supervise and promote self-managed public hospitals; for the strengthening of sectoral planning; for training at the undergraduate and graduate levels; for the upgrading of nursing personnel and regulation at the national level; for application of the Occupational Hazards Law, and for

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improving work environments and working conditions.

33. *Training programs.* In continuing education and management, with extended fellowships abroad and training in epidemiology and management; in planning and management; in perinatology, comprehensive adolescent care, and nutrition.

34. *Direct support.* For managing municipal programs for hazardous solid waste; for improving solid waste management and health in housing conditions, and creating healthy spaces; for strengthening multisectoral action on health, the environment, and sustainable human development, with emphasis on primary environmental care.

<b>ARGENTINA PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health in Human Development	3,082,000	2,991,600	163,600	165,000
Health Systems and Services Development	1,615,600	1,853,000	0	0
Health Promotion and Protection	193,400	0	30,000	0
Environmental Protection and Development	573,700	562,200	0	0
Disease Prevention and Control	222,800	297,700	80,300	0
<b>Total</b>	<b>5,687,500</b>	<b>5,704,500</b>	<b>273,900</b>	<b>165,000</b>



# BAHAMAS

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## *Health Situation*

1. The population of the Bahamas was estimated at 282,971 in 1996. About one-third of the population is under 15 years of age and about 5% over 65. The annual population growth was 1.97% annually between 1980-1990, while urban growth increased at 2.35%.

2. The population continues to experience improvements in many areas of health. Life expectancy at birth has steadily increased from about 60 years in the early fifties to approximately 73 in the early nineties, with gender specific estimates of 76 years for females and 69 years for males. The crude death rate was 5.4 per 1,000 population in 1996 and the crude birth rate was 20.7 per 1,000 live births. Total fertility in 1996 was estimated at 2.83.

3. The major causes of mortality and hospital admissions are related to diseases that are largely preventable by lifestyle changes. Hypertension, diabetes, heart attacks, strokes and cancer account for approximately 45% of all deaths in the country. The second leading cause of death is heart disease, with a death rate of 94.4 per 100,000 population in 1996. The prevalence of obesity (48.6%), diabetes (11%) and hypertension (13%) were confirmed as serious public health concerns in the 1998/89 National Health and Nutrition Survey. A three-year National Plan of Action for Nutrition has been developed, and a Food and Nutrition Policy is being finalized. The promotion of proper health practices including good nutrition and regular exercise has been given high priority by the Ministry of Health. It is the chief strategy for preventing and reducing the impact of these diseases. The Ministry of Health has identified nutrition/chronic diseases, food safety, teenage pregnancy, AIDS/STDs, drug, alcohol and other drug abuses, and violence as priorities for action. Adolescents have been targeted for intervention strategies. PAHO is being asked to cooperate in the identification of gaps in the delivery of programs aimed at youths, development of an integrated program and initiation of a "Healthy Schools" initiative.

4. In relation to nutrition and chronic diseases, PAHO's input is required in the development of dietary guidelines and the design of fitness programs. Continued support will also be given to the community based rehabilitation programs.

5. AIDS has had a significant impact on health services and the economy of the Bahamas, with a death rate of 97.2 per 100,000 inhabitants in 1996. It is now the leading cause of death in the general population. Furthermore, it has become the single leading cause of death among all males and among all persons 15-44 years of age. AIDS reporting began in 1985. As of 31 December 1997, a total of 2,868 cases have been reported, with a 65% death rate. In the Bahamas, the disease occurs primarily among heterosexuals, with a male-female ratio of 1:4:1 affecting predominantly those in the sexually active age group, and 75% of all reported cases since 1985 occurring in the 20-49 age group. The rapid increase in the death rate from this disease among women aged 15-44 years indicates that young women are at particular risk. A seroprevalence study carried out in 1992 indicates that about 3% of antenatal clients are HIV positive. The increasing number of HIV positive babies being born has stimulated the AZT treatment program for HIV positive pregnant women, which in turn has resulted in a sharp decrease in HIV perinatal transmission.

6. A strong AIDS program, in place since 1989, focuses its educational activities primarily on reduction of sexual transmission, targeting young people, women and individuals with multiple sexual partners. In recent years there has been a decrease in the rate of HIV infections. A "National Response" three-year plan is being developed and UNAIDS funding will be sought to supplement the national effort. PAHO has not been asked for any specific assistance in this area.

7. Malignant neoplasms stand as the third leading cause of death in the overall population (the second leading cause of death among females is AIDS, with a death rate of 84.3/100,000). In 1996, the disease-

specific death rate attributable to disease was 69.7/100,000 among the general population, and 56.5/100,000 among females. Cancer also ranks among the leading causes of hospital morbidity. A hospital-based cancer registry is scheduled to be established by mid-1998.

8. Another crucial concern is the level of trauma experienced, particularly injuries resulting from acts of violence. In 1996, accidents, violence and poisonings ranked as the fourth leading cause of death. The former is a leading cause for emergency room visits and admissions to hospitals, where they are secondary only to pregnancy complications. The problem is more significant among men 15-44 years of age and children up to age 15 years. The Bahamas is to be included in the IDRC funded injury surveillance project being carried out by CAREC. Furthermore, a conflict resolution/violence prevention program is being piloted in one of the secondary schools with the intention of extending this throughout the school system over the next two years. PAHO is cooperating with the national authorities in this initiative and will continue to do so over the biennium.

9. In terms of other infectious diseases, tuberculosis, which had been declining in recent years, is again on the rise, and a large percentage of these cases are associated with AIDS. Trends in the incidence of other sexually transmitted diseases, notably syphilis and gonococcal infections, have shown a decrease since 1985. Food borne illnesses remain a concern. The outbreak of seafood related illnesses seen in intermittent years since 1991 has evoked a response of strengthened programs for food handlers' education and vending site inspections, particularly in the harbor areas. PAHO has been asked to continue cooperating towards development of training materials and surveillance training.

10. Indications are that infant mortality is starting to decline, moving from 30.2 in 1986 to 18.4 in 1996. Conditions originating in the perinatal period have been the principal cause of infant deaths. In 1996, congenital anomalies ranked second and AIDS third. Rounding out the picture, there was a stillbirth rate of 12.9, and perinatal and neonatal mortality rates of 17.4 and 5.3, respectively. An infant mortality

reduction project was initiated in 1994, aimed at strengthening prenatal care and management of perinatal events. The institutionalization of the SPCR is an integral part of this program.

11. In the area of child morbidity, acute respiratory infections, particularly pneumonia and asthma, are the leading cause of admission to hospital in the under five population, and diarrhoeal diseases continue at a high level. The program proposes to review the protocols for the management of these diseases, update medical and nursing staff, and target parents, childcare workers and day care centers. PAHO will provide assistance in this area.

12. Immunization coverage of children under one year of age for DPT and polio remain relatively high in spite of the decrease from 91% in 1993 to 87% in 1995 for both coverages. Measles elimination is being handled through the regular immunization program and there are no current plans to have "mop up" campaigns. In 1995, there was 90% coverage for one year olds for MMR. There is, however, a growing "measles susceptible" population and PAHO is to assist in the identification and targeting of this group. PAHO will continue to facilitate the country's participation in the Vaccine Revolving Fund.

13. The issue of child and spousal abuse is not quantifiable at this point, but it is of great concern to the national authorities. The Crisis Center (an NGO highly subsidized by government) operates a full time clinic and counseling service and a hotline to deal with victims of abuse. A priority is to design and implement prevention programs, and PAHO will assist in developing an instrument to help assess the problem.

14. Alcohol and other substance abuse remain unacceptably high. It is estimated (1991) that approximately 5.65% of the population has used cocaine at least once in their lifetime, with the prevalence of use being as high as 15.9% among young males 18-29 years of age in urban areas. An active demand reduction program is being managed by the National Drug Council with funding from UNDCP.

15. Teenage pregnancy continues to be a matter of concern in the country. The teen birth rate in 1996

was 22.4 per 1,000 females 10-19 years. While provisions are made for essential needs of adolescent mothers, the problem of adolescent pregnancy continues to be addressed through education and counseling.

16. A program has been established to address the reproductive health of the country. The program targets postnatal mothers and the general population, offering family planning services, including education and counseling. A comprehensive national level program is scheduled to be launched in early 1997. PAHO will cooperate in the educational aspects of the program looking at behavior change in men and boys and negotiating skills of women and girls.

17. The country's environmental issues are addressed by the Department of Environmental Health Services. As a tropical country with a large number of visitors and immigrants, the Bahamas has to be vigilant about vector control. While malaria is not indigenous, the alert for this and dengue must remain high. The *Aedes aegypti* house index was estimated in one area of New Providence (Yellow Elder) at 30.4% (1993) and in areas of Grand Bahamas at 25%. An integrated vector control program was initiated in 1993. It is estimated (1995) that 70% of the urban population (i.e. the population of New Providence and Freeport) have regular collection of solid waste. In addition to the services provided by the solid waste collection and disposal unit of DEHS, a number of private collection companies operate to service the business and private communities. Other concerns of this department include health inspectorate, and environmental monitoring and risk assessment.

18. Potable water and sewerage systems are managed by the Water and Sewerage Corporation. It is estimated that 88% of the urban population has potable water through house connections and a further 8% has access to public sources of potable water. Among the rural population, 86% has reasonable access to potable water. The majority of households (approximately 84% in the urban areas) have individual systems of excreta disposal. Public

sewerage systems are available to 16% of the urban population.

19. The organizational structure of the Ministry of Health is still in transition, with efforts being made to finalize the implementation of the hospital devolution process, and expansion of local health systems. The management structure of the hospitals has been changed in order to accommodate the introduction of resident specialist and management teams, and selective privatization.

20. The integration of health services within the local government system must be achieved. PAHO will continue to support the Ministry in its development of LHS.

21. In general, the use of data for decision-making, planning and management is still not the norm. There continues to be weakness in the analysis and use of data at the point of generation. There are a variety of information systems under development and/or consideration by the Ministry, and there is a need for these to be prioritized.

22. PAHO's input will aid in the review and updating of the reporting systems of selected programs and identification of appropriated technologies.

23. Limited systematic and coordinated mechanisms are in place for dealing with the demands of a growing and changing health care environment. The Ministry has therefore established a Planning Unit, and although a head has been appointed, the unit is not yet fully operational. It is recognized that untimely planning has to be carried out at all levels, and, in addition to supporting the establishment of the Planning Unit, PAHO will continue to favor the institutionalization of planning within the LHS.

24. It is perceived that the inconsistencies and inadequacies which exist in the health care system are in part due to the lack of and/or departure from established policies and procedures. In a constant

effort to improve the operations and delivery of quality health care the Ministry proposes to introduce a Total Quality Management Program during 1997 focusing initially on the Princess Margaret Hospital. The Accident and Emergency Department, Pharmaceutical Services and the Biomedical and Plant Equipment program are to continue to receive special attention. PAHO's cooperation is required in these areas.

25. Current health legislation has not kept pace with the growth of the health care industry, technological advances or the many environmental concerns the country faces. New categories of staff and new types of facilities especially within the private sector have to be accommodated. Although some work has been ongoing in the area of environmental health, much has still to be done in that area and in others. PAHO is to identify and source suitable expertise to facilitate the process of review and redrafting/drafting of legislation.

26. The scattered nature of the islands presents a logistical problem in the delivery of emergency medical services. At island level there is a lack of first response capability and there is a need to assess the availability of all communities of appropriate skills to complement the efforts of the local health team. PAHO has been asked to support this effort.

### ***National Priorities for PAHO's Technical Cooperation***

27. Organizational strengthening of health education and health promotion services, and capacity building in the areas of program development and intervention strategy evaluation. Further strengthening of the Maternal and Child Health Services with continued emphasis on infant mortality reduction, and development of early childhood initiative. Development of programs that reflect life cycle changes and needs. This will include continued strengthening of the adolescent health program with special emphasis on nutrition and exercise, teenage sexuality and violence prevention; and issues related to the aging population. Continued expansion of the reproductive health/family planning services. Strengthening of disease surveillance capabilities at

both the central and local levels. Control of communicable diseases with special attention to HIV/AIDS and food borne illnesses, and maintenance of the control over imported diseases and diseases controllable by immunization. Continued development of a National cancer treatment and prevention program, with particular attention to the Cancer Registry and cancers in women. Continued improvement to the injury surveillance system and development of a national trauma prevention program. Control of lifestyle related non-communicable diseases with emphasis on hypertension and diabetes. Particular attention is to be placed on the nutritional aspects. Strengthening of mental health programs with emphasis on community based services and on reduction of substance abuse. Expansion of the community -based rehabilitation program. Strengthening of oral health programs in New Providence, Grand Bahamas and the family islands. Assessment of the health and socioeconomic status of, and development of, appropriate comprehensive programs for the older population. Continued strengthening of disaster preparedness capabilities and of first response capabilities in the family islands. Strengthening of the health services through continued health sector reform initiatives, including health care financing issues, strengthening of specific program areas, and management support systems. Further development and strengthening of local health. Systems and expansion to an additional four family islands. Establishment/strengthening of national systems for professional and service/facilities standards. Development of a mechanism for integration of programs or human and social development. The continued strengthening of the information systems, both epidemiological and managerial, and in its design and utilization, so that technical and managerial decisions are made on the basis of hard data. Continued development and improvement of the National Pharmaceutical Services. Upgrading of the physical plant at the three national hospitals and at selected community clinics, and continued strengthening of the capacity for the maintenance of biomedical equipment. Strengthening of the infrastructure to support the UWI clinical program. To develop a national human resource database to guide human resources development and planning for the health sector, and to provide continuous training opportunities that will upgrade and maintain knowledge and skills of health professionals. Strengthening of the planning unit, and of the strategic planning capabilities of staff within

that and other units, for the efficient functioning of the health services. Establishment of mechanisms for the monitoring and enforcement of legislation related to establishment of the hospital board, and registration of health professionals and facilities. Environmental conditions have improved and associated health risks are reduced.

### ***Technical Cooperation Strategy***

28. Technical cooperation will be delivered through six projects: Health Infrastructure Strengthening, Control of non-communicable diseases, family health, health information system strengthening, environmental health, and control of communicable diseases. With only two technical officers, monitoring of these projects will be a challenge. Technical officers will be given responsibility for specific expected results, rather than for projects, and an attempt will be made to share the responsibilities as equitably as possible. However, it is envisaged that the bulk of the responsibility will lie with the PWR, unless staffing of the Representation changes.

29. Each officer will work closely with the identified national counterpart in the implementation of the particular expected result. Wherever appropriate, the involvement of other stakeholders inside and outside the Ministry including NGOs will be encouraged during the planning stage of the implementation phase of activities.

30. Six monthly projections will be prepared with more detailed tri-monthly work plans.

31. Most of the technical cooperation will be in the form of support to training at the local level in the areas of information systems, surveillance, planning, and management of selected clinical areas. TC will include curriculum development, preparation of training materials, support for tutors and the conducting of courses/workshops. Overseas fellowships will also be offered in those areas, which are not available locally.

32. A series of studies will be carried out to determine existing conditions for planning remedial actions, for establishing baseline data for evaluation purposes and for evaluation programs/systems, which were established during 1998-1999 biennium.

33. Operational norms, guidelines and manuals will be developed to facilitate the provision of quality care and service in areas of health promotion, chronic diseases and care of the elderly.

34. Information dissemination will be the basis of the health education/promotion thrust, but will also be of avail in promoting regional cooperation in PAHO priority areas, and initiatives.

35. Direct technical assistance will be provided in the areas of health planning, local health systems development and environmental health.

36. In terms of infrastructural development, advantage will be taken of expertise available elsewhere in the region to assist the Ministry in formalizing and implementing its quality improvement program initiatives.

### ***Objectives for PAHO's Technical Cooperation***

- To strengthen the delivery of health care in the areas of both clinical and preventive services, with particular attention to quality care at both hospital and community levels.
- To put in place systems to reduce the morbidity and mortality from selected chronic non-communicable diseases, particularly those that are nutrition and injury related.
- To have in place programs that address the needs of vulnerable family members.
- To strengthen national capacity for communicable disease surveillance and control.

## ***Expected Results***

37. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

38. *Surveillance and information systems.* For the monitoring of the National Oral Health Plan.

39. *Standards and guidelines.* For the development of a National Oral Health Plan, for the development of a resource unit and the design of a utilization database, completed for the establishment and evaluation of a Teen Drop in center, for family and health care workers in the care of the elderly at home and in the community, for monitoring efficiency and effectiveness of National Pharmaceutical services made available to national authorities, and for operations of national system for epidemiological surveillance and outbreak investigation (and the dissemination of these guidelines).

40. *Research and evaluation studies.* To assess the relationship between the devolved hospital management structure and primary health care services; of educational programs targeting prevention of teenage pregnancy; of consistency of utilization of protocols for assessing health issues for development of health education/promotion interventions and for evaluating intervention strategies; to assess the utilization of nutrition and management guidelines and protocols for persons living with diabetes, hypertension and coronary heart disease; to extend violence prevention program to other schools in New Providence and the family islands; of a program which fosters independence, self-reliance and dignity in the elderly; assessing the situation of orphans of parents who died of AIDS; of the pilot project for establishment of a Regional Health Services System; of operations of national system for epidemiological surveillance and outbreak investigation; of alternative systems of health care financing; and of operations of national system for epidemiological surveillance and outbreak investigation.

41. *Plans, projects and policies.* To address the social needs and emotional growth of AIDS orphans, to develop new management protocols for other risk factors for coronary heart disease and cancers, for use in primary health care and community programs, to initiate health and human resource development and needs planning, to develop Healthy Community project in selected communities, for the functioning of LHS, to table recommendations of alternative systems of health care financing, and to develop new materials for educational programs targeting prevention of teenage pregnancy.

42. *Training programs.* For personnel to implement strategies and plans for the functioning of LHS; for management staff in program planning and in the utilization of data for program monitoring; for personnel in the guidelines for monitoring efficiency and effectiveness of National Pharmaceutical services; for staff in the production of audio-visual materials; for staff in updated disaster plans; for selected persons in health and health related agencies, to facilitate the incorporation of health education/health promotion interventions in their routine activities; for multipurpose rehabilitation workers for working in the community; for two family islands in identification, evaluation/assessment, initiating programs/interventions for persons providing CBR Services; to update nutrition staff on current approaches to management of nutrition related diseases; in violence prevention for adolescents and persons working with adolescents, in and out of the school environment; for persons to care for the elderly; to update skills of staff involved in preventing teenage pregnancy; for collection, collation and analysis of relevant data for the development of a national mental health plan; for National oral health plan database; and for HI&RU staff in monitoring disease trends, diagnosing reports on and implementing control measure for disease outbreaks.

43. *Promotional campaigns and advocacy.* Of integration of the elderly in society and of community based rehabilitation through audiovisual materials.

**BAHAMAS  
PROPOSED BUDGET ALLOCATION**

Appropriation Level	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Health in Human Development	640,000	731,000	0	0
Health Systems and Services Development	128,400	113,500	0	0
Health Promotion and Protection	94,200	71,900	0	0
Environmental Protection and Development	295,000	336,800	0	0
Disease Prevention and Control	45,600	30,300	0	0
<b>Total</b>	<b>1,203,200</b>	<b>1,283,500</b>	<b>0</b>	<b>0</b>



# BARBADOS

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## *Health Situation*

1. As expected, Barbados experienced its fifth consecutive year of economic growth in 1997. The slight decline in real GDP during that year was due to the fact that sugar productivity did not match the phenomenal rate of increase in 1996. The tourism sector continues to perform well. The other sectors which are expected to contribute to continued economic growth in the medium term are off-shore banking and construction, the latter due to several major projects in the tourism sector.
2. The education plans for Barbados will ensure that its citizens are prepared for the technology-driven future, especially the use of the Internet. The Government of Barbados is prepared to self-finance a multi-million dollar computer project (EDUTECH), if external funding is not forthcoming at the expected level. If successful, this project will provide a vehicle for innovative health education/promotion applications in and out of school.
3. The housing stock of Barbados continues to improve significantly as mortgages have become more accessible. The transportation network remains one of the best in the Caribbean.
4. Unemployment was 19.7% in 1995 and has continued to fall. A new Prices and Income Protocol has been signed by all the social partners and this is expected to continue to play an important role in keeping wage growth inline with productivity and the rate of inflation at around 2.5%.
5. The Government continues to direct its attention towards environmental management issues. There are incentives to reduce and recycle solid waste, and funding is already available for the creation of a second landfill. The South coast is being sewered and the compulsory connection to houses will make this large investment worthwhile. Policies and legislation have been established to address Barbados' water-stressed condition: low-flow devices are provided free of cost, new buildings over 3000 sq. ft. must be equipped with water storage tanks; and the government will start building a desalination plant in 1998. Monitoring the quality of water remains a challenge, as does the need to increase the capacity to manage wastewater, especially in residential subdivisions and hotels. The government is in the process of discussing legislation to support its coastal zone management program.
6. Monitoring of air quality on a regular basis has proven to be difficult for the Ministry of Health. Moreover, the government is determined to decrease the incidence of ill health due to poor food safety practices, particularly in hotels and large institutions.
7. There have been no major changes in the philosophy governing health in the last five (5) years, particularly as it relates to policies in support of the principles of Health for All. The actions that have been taken in order to ensure the enhancement of the health sector are mostly managerial and infrastructural.
8. The basic objectives of the Ministry in regard to health, health services and the environment are: continued emphasis on primary health care; continued development of a cadre of well-trained professionals; broad community involvement in the development of health plans, policies and health care; wide public sector collaboration; centering health care services more around programs; and implementation of a solid waste management plan for waste minimization and recycling.
9. Health service delivery is divided into seven (7) program areas: (1) primary health care; (2) acute, secondary, tertiary and emergency care on a 24 hour basis; (3) mental health care; (4) care of the elderly, including rehabilitative services; (5) drug service; (6) assessment services and rehabilitative services; (7) health promotion.
10. For the last seven (7) years, chronic non-communicable diseases have been the leading causes

of morbidity and mortality. It is estimated that two (2) in every five (5) Barbadians over 40 years of age suffer from hypertension; 20,000 from diabetes; 75 - 100 need open heart surgery annually; and an average of 400 people die from cancer every year. In 1990 Barbados had the highest rate of prostate cancer per 100,000 males. The most frequent type of cancer in women 15 years and older was breast followed by cervix.

11. The aging population, 65 years and over, is one of the major challenges facing the health care system. Chronic non-communicable diseases such as arthritis, hypertension and diabetes mellitus continue to be the main health disorders among the elderly. The dominant causes of death in this age group are heart disease and cardiovascular disease. The most common disabilities affecting them are blindness and poor vision. There is now an excess demand for geriatric care beds in public institutions. The government has implemented a policy to encourage the provision of domiciliary services for the elderly in the private sector through a cost-sharing mechanism.

12. Substance abuse has become an increasing cause for concern in the 15-24 years age group. Statistics show that more males than females suffer from drug addiction and seek treatment at the Psychiatric Hospital's Rehabilitation Unit. Marijuana and cocaine continue at the top of the list of substance abuse. Violence, including domestic violence, has been reported on the rise, and motor vehicle accidents continue to claim an increasing number of lives. While there is an outreach component to the mental health service, there needs to be a shift towards goals of rehabilitation.

13. Environmental health issues are addressed through projects on water quality, disposal of solid and liquid waste, air quality, noise, pollution and control of hazardous chemicals. Control of communicable diseases, including vector control and Dengue fall under this division. An active surveillance program is under implementation in order to facilitate early detection of outbreaks since the epidemics experienced in 1996/7. A structured program for food handlers is now underway and the

government is currently revising related health legislation.

14. With the increasing demand for tertiary care, there is an urgent need to reform Queen Elizabeth Hospital and improve its plant, the equipment and capacity to execute preventive maintenance programs, implement management information systems and train personnel to manage. Similar upgrading of the community approach through the polyclinics will optimize the Government's investment in health.

15. A Health Services Rationalization Study has yet to be completed and remains critical to assist planning in 3 major areas: 1) Chronic care, rehabilitation and health promotion; 2) policies and programs for financially sustainable primary, secondary and tertiary care and 3) improving the efficiency level of the health care system.

16. In the area of health promotion, the Ministry is aiming to strengthen linkages with stakeholders, as well as to outline strategies and a plan of action to consolidate and expand the health promotion initiatives that already exist. The MOH should take advantage of the NGO sector input towards better health.

17. The Healthy Lifestyle program is an innovative combination of making health appealing to the interests of the media, other for-profit groups such as gyms and NGOs with interest in chronic diseases and road safety. The government is supporting the UWI Chronic Disease Center and hopes to launch a health promotion project in the near future.

18. The National HIV/STD Committee is currently preparing to begin its third national Medium Term Plan (1998-2002) which is intended to provide a working framework for the government, NGOs and private institutions. The priority attached by BAR to controlling this problem is exemplified by the significant funds provided for AZT therapy for HIV infected pregnant mothers and establishment of a residence for AIDS patients. There is a need for behavior change interventions targeted at high risk groups.

## ***National Priorities for PAHO's Technical Cooperation***

19. Health status of the population improved. Prevention and control of communicable diseases. Development of Health Systems and services. Chronic non-communicable diseases. Family health, including the elderly and adolescents. Environmental health, including vector control, food safety, solid and liquid waste, water quality, pollution control surveillance and occupational health. Mental health and substance abuse. Strengthening of health systems, including HIS, equipment maintenance, health care financing, quality assurance and research. Efficient management of technical cooperation.

## ***Technical Cooperation Strategy***

20. The strategy for technical cooperation with Barbados is based on the results of the Joint Evaluation Review which was held in late 1997. It seeks to improve efficiency as well as effectiveness in cooperation.

21. Over the biennium 2000 – 2001, technical cooperation will address the six priority areas identified through four projects: Environmental health, health promotion and lifestyles, family health, and health sector reform. The health promotion and lifestyle addresses the areas of chronic disease control, prevention and control of communicable diseases and mental health; the main human resource development issues are included in the health sector reform project.

22. Barbados will benefit from technical cooperation through the bilateral approach as well as through subregional projects. Since the priority areas for Barbados are congruent with the CCH priority areas, maximum use will be made of the latter, especially when regional activities take place in Barbados.

23. The strategic approaches to be used aim to increase the sustainability of the national objectives

and include: collaboration with PAHO Centers in the Caribbean and regional institutions, in particular CAREC, CFNI, UWI, CEHI and the Caribbean Health Research Center; building training capacities through cooperation with national institutions; collaboration with NGOs, especially those with infrastructure for project implementation; promotion and facilitation of multi-sectoral action, particularly for health and tourism activities and health promotion projects; and increased use of TCC to bring relevant experiences of other Caribbean countries to Barbados and share the experience of its efforts with other countries. The latter provides ongoing motivation for excellence.

24. All functional approaches: resource mobilization; training; development of policies, plans and norms; dissemination of information; direct technical assistance and research will be utilized in delivery, with personnel training remaining the single most frequently employed functional approach.

25. While emphasis on training supports the Ministry of Health philosophy to train professionals at a technical international level, there will be use of in-service training to introduce systems and upgrade managerial skills.

26. The development of guidelines, standards and policies also features heavily in the program of cooperation, reflecting the concern nationals have to improve quality of services delivered. Evaluations and research activities are to be executed in support of improvement in program effectiveness, in the areas of dental, perinatal and adolescent health.

27. The following strategies will be used in the execution of technical cooperation.

28. Environmental health strategies: support programs for the improvement of food safety; collaborate with nationals in strengthening the integrated vector control programs; support programs for the improvement of waste management; strengthen systems to monitor pollution; and support the development of occupational health programs.

29. Health sector reform strategies: support quality monitoring programs at Queen Elizabeth Hospital and polyclinics; support strengthening of programs for the disabled; evaluate the vulnerability of an institution to disasters; strengthen health information systems; develop human resources; and implement a drug utilization program.

30. Health promotion and lifestyle strategies: strengthen systems, develop and implement health promotion strategies; provide support for CNCD programs; strengthen mental health and substance abuse programs; and strengthen cervical cancer programs.

31. Family health strategies: assisting in the development of programs for the elderly; strengthening of oral health programs; supporting perinatal and adolescent health programs; and strengthening tuberculosis and STD/HIV/AIDS programs.

32. Delivery efficiency of technical cooperation will be enhanced.

33. PAHO will be working on a day-to-day basis with an officer designated by the Ministry of Health in order that he/she can: be accountable for each PAHO project; have more frequent meetings with Ministry of Health senior management team; and share AMPES reports with Ministry of Health and Ministry of Health reports with PAHO.

### ***Objectives for PAHO's Technical Cooperation***

- Environmental health conditions improved.
- Improved capacity of MOH to manage integrated health care services.
- Utilization of health promotion strategies in prevention and control of CNCDs; mental health; and other lifestyles-related disorders strengthened.
- Health Services improved in selected areas.

### ***Expected Results***

34. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

35. *Surveillance and information systems.* Two additional MIS modules installed at QEH, including personnel, one in each year.

36. *Standards and guidelines.* For different risk category of itinerant vendors; for monitoring hydro-carbon products; and for A&E.

37. *Research and evaluation studies.* On healthy lifestyles among 7-9 year olds in 4 primary schools, using MOH zones; of food practices in the hospitality sector; on health related problems associated with occupational health; on the association of asthma and other respiratory conditions and selected environmental risk factors; on mental health services; on adolescent health; on service and training needs for effective ADH services; to evaluate the efficacy of DOTS; on current legislation for TB control; on KAPB related to STD/HIV/AIDS; on vulnerability of geriatric hospital; to identify most effective ways of integrating other selected CNCDs into diabetes protocol; and on HIV and TB co-infection.

38. *Plans, projects and policies.* For a CBR pilot program; for three community-based strategies, including one for emotional and social support to the elderly; for a plan of action based on perinatal mortality study; to improve perinatal care supported; for risk assessment and prevention of HIV/TB in HCW; for national EPI; and for Pap smear screening.

39. *Training programs.* For users of mental health services; for auxiliary central officers; for integrated vector control management; in gas emission control; in waste minimization strategies; in toxic and hazardous waste management; in management of air pollution monitoring; for polyclinics management teams to use reports for management decision making; for pharmacist in all polyclinics and QEH to understand program objectives; to implement community-based strategies; for health personnel and

key partners on skills to work more effectively with adolescents; to promote healthy lifestyles using the Caribbean Charter for Health Promotion; in modern preventive therapy; and in EIA.

40. *Promotional campaigns and advocacy.* To prevent injuries from motor vehicle accidents; and for selected public and private primary schools and two church groups regarding risk factors for substance abuse.

<b>BARBADOS PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health in Human Development	195,000	213,200	0	0
Health Systems and Services Development	360,000	309,100	0	0
Health Promotion and Protection	166,900	176,100	0	0
Environmental Protection and Development	79,000	96,200	0	0
Disease Prevention and Control	0	6,300	0	0
<b>Total</b>	<b>800,900</b>	<b>800,900</b>	<b>0</b>	<b>0</b>



# BELIZE

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## *Health Situation*

1. Belize is a Caribbean country located in Central America. Belize lies in the outer tropics or subtropical geographic belt. It is bordered by Mexico in the North, Guatemala in the West and the South, and the Caribbean Sea in the East. The total land area is 22,700 km (8,867 square miles), which is divided into six administrative districts with varying size, population and ethnicity. Belize is a sovereign state governed by the principles of parliamentary democracy based on the British Westminster system. The Cabinet, which constitutes the executive branch of the Government, consists of Ministers and Ministers of State who are appointed by the Governor General on the advice of the Prime Minister. The total population of Belize at the time of the 1991 Population Census was 189,392. The midyear estimate for 1996 is 222,000. Out of the total population, 42% is below the age of 15 years and 61% is under 25 years of age. The 1996 figures show an urban population of 51% and the rural segment to be 49%. The country has an open, simple structured economy primarily based on agriculture and services. The stable currency, the Belize Dollar (BZ\$2.00 = US\$1.00) is one of the main attractions for foreign investors. The per capita income in 1996 was BZ\$4,615 (US\$2,308), as compared to BZ \$3,328 (US\$1,164) in 1989, a growth of 38.7% at current prices. The GDP at current prices increased by 67.0% between 1989 and 1996, while the population grew by 20.6%.

2. The disaggregation of per capita income, levels of literacy, state of employment, and access to basic services at the micro level indicate the existence of "poverty pockets", where large numbers of Belizeans live in very poor conditions. A 1995 Poverty Assessment Report conducted by the Caribbean Development Bank considers 33% of Belizeans to be poor, with 13% falling into the very poor category. The unemployment rate in 1996 was 13.8%, showing an increase of 1.3% percentage points since 1995. 100% of the urban population are served by a safe and adequate supply of potable water, while only 69% of the rural population have these provisions available. Sanitation coverage is lower; only 39% of the total population is served with adequate sanitation facilities. Belize has a basic literacy rate of 75%, according to the 1996 Central Statistics Office National Survey. Functional literacy, however, is far below this figure. Limited information is available which disaggregates economic and demographic data by sex. Attention to gender issues in development is

a relatively recent phenomenon which has made important strides. It is largely reflected in increased education, lower fertility rates, increased organization of women, and the establishment of a Population Unit.

3. The analysis of the available data during the 1993-1996 period indicates that Belize is going through a transitional period where communicable diseases are not yet controlled; chronic conditions are becoming the leading cause of morbidity and mortality; and emerging and re-emerging pathologies are surfacing as significant public health problems.

4. While the country is still battling with infectious diseases, e.g., acute respiratory diseases, gastroenteritis, pulmonary tuberculosis, HIV, and rubella, among others, old diseases such as leishmaniasis, dengue, and rabies have reappeared in the health arena. The situation is further complicated by the increasing number of deaths and injuries caused by road traffic accidents, particularly among males. Teenage pregnancy, abortion, acts of preventable violence, including domestic violence, drug abuse and other dependencies have also increased significantly. High prevalence of problems related to quality of care, as is evident in the causes of maternal and perinatal mortality, still prevails.

5. There has been measurable improvement in the health status of the population as reflected in the increase in life expectancy at birth and the reduction in infant mortality. Maternal mortality has remained stable. The country is in the process of being declared iodine deficiency free, malaria is decreasing, the incidence of cholera has decreased significantly, and no cases of measles and polio have been reported since 1991.

6. Notwithstanding the improvement in these indicators at the national level, the analysis identifies problem areas that demand attention, including those aspects that deal with health promotion and disease prevention. Certain disparities and inequities still exist among districts and population groups including gender.

7. The main causes of mortality in the under - 1 age group were conditions originating in the prenatal period. Among these conditions, asphyxia was responsible for the highest number of deaths, followed by low birth weight. Males accounted for 62.1% of all infant deaths. The districts with the highest IMR, in descending order, were Orange Walk, Stann Creek and Toledo.

8. Infectious diseases ranked second as a cause of mortality in this group, and were the leading cause of hospitalization.
9. The 1-4 age group experienced an increase in mortality rate. External causes were the leading cause of mortality, accounting for 24% of all deaths in the period. The second cause of deaths was infectious diseases, of these, 65% was due to respiratory conditions.
10. Malnutrition, measured as weight for age, occurred in 6.2% of children at the national level. In a study conducted in the Toledo District in 1992, 15.5% of children under five attending health clinics were found to be undernourished.
11. In the 5-9 age group, external causes and injuries and poisoning accounted for 42% of all deaths during the period. More males (61.9%) than females (38.1%) died from external causes, injuries and poisoning. The leading cause of morbidity in this group was respiratory diseases, followed by injuries and poisoning; and fractures ranked third. These three conditions accounted for 43.7% of all hospitalizations.
12. The mortality rate among the 10-19 age group was stable, with an average of 6.2 deaths per 10,000 persons. The mortality rate was higher in males (8.6 deaths per 10,000 persons) than females (3.55). The leading cause of death was external causes. It was responsible for 37.1% of all deaths. Males accounted for 79.6% of all deaths due to external causes and 72% of deaths due to Road Traffic Accidents (RTA). Belize District had the highest number of deaths due to RTA, followed by Orange Walk; Toledo District had the lowest.
13. Among females, pregnancy complications (including abortions) was the leading cause of hospitalization, while injuries and poisoning rank number one among males.
14. Important differences can be observed in the epidemiological profile of men and women in terms of magnitude, trends and types of health problems affecting the 20-49 age group. Crude mortality rate is twice as much for men than for women; this higher mortality rate among men is attributed to road traffic accidents while in women it is attributed to heart disease. Complication of pregnancy and abortions accounted for more than half of all female hospitalizations.
15. Deaths due to heart disease were almost twice as high among females than males. The trend among females is toward the increase, having risen from 12.8% in 1993 to 23.8% in 1996.
16. The 50 and above age group had the highest mortality rate over the past five years. Heart diseases, respiratory diseases, neoplasm and cerebrovascular diseases were the four leading causes of mortality; they accounted for 50% of all deaths. No significant differences in terms of major causes of death were observed between males and females. The four leading causes of hospitalization were respiratory diseases, heart disease, diseases related to the digestive system and diabetes.
17. Even though malaria continues to be a public health problem, there has been a decrease in the incidence of this disease over the past three years. The total number of cases went from 9,413 cases in 1995, to 4,200 cases in 1997. Plasmodium Vivax was responsible for 95% of all cases. The three districts with the highest transmission rates were Cayo, Toledo and Stann Creek. Together they accounted for 80.9% of all cases occurring in the country.
18. Since the detection of the first case of AIDS/HIV in 1986, there have been a cumulative total of 195 cases up to December of 1996. There has been an increase from 18 cases of AIDS in 1994 to 38 cases in 1996; 80% of the cases were registered in the 20-44 age group. The male to female ratio decreases from 13:1 in 1989 to 1.6:1 in 1996.
19. Cholera and other intestinal diseases have been declining steadily. The last outbreak (16 cases) occurred in 1997, compared to 159 cases in 1992.
20. Respiratory diseases were the number one cause of hospitalization in the 1993-1996 period. It accounted for 12.4% of all admissions during the period. Chronic lung diseases, pneumonia and influenza together accounted for 74.5% of all respiratory diseases. The district with the highest rate was Stann Creek and the lowest Toledo.
21. Respiratory diseases were the second leading cause of mortality in the general population. Pneumonia was responsible for 69% of all deaths attributed to respiratory diseases.
22. Malignant neoplasms were among the three leading causes of mortality during the period, particularly in the 50 and above age group. No significant difference was observed between males and females. Neoplasm was also the leading cause of morbidity in the 50 and above age group.
23. Diabetes accounted for 2.4% of all deaths. The rate among males was consistently lower than that of females. Even though the true prevalence of diabetes is unknown, data shows that 9% of all blindness was related to diabetes retinopathy.

24. Anemia was found in 51.7% of pregnant women attending the prenatal clinics during the year 1995. Vitamin A deficiency was also found in children of the Toledo District. A nutritional study among adults in 1995 gave indications of over-nutrition problems.

25. In the category of accidents and violence, external causes were among the five leading causes of death, accounting for 8.8% of all deaths. Seventy nine percent of these deaths were among men. RTA was responsible for 40.8% of deaths in the external causes grouping. Deaths due to RTA increased from 10.7 to 16.7 in the general population, while among men the increase went from 14.4 to 26.1 in the period. The increase among females was minimal.

26. The magnitude of domestic violence is unknown. A study conducted in the Orange Walk District in 1996 identified minimal medical response, weak networking, increased utilization of the legal system and a significant need for support services, particularly in counseling, data registration and management protocols.

27. Even though there has been a decrease in deaths due to abortion in the period, it is likely that some of the deaths attributed to pregnancy complications may have been abortions. There was also a reduction in the number of hospitalizations due to this condition; 7.0% in 1993 to 4.8 in 1996. The age group 10-19 was responsible for 19.7% of all admissions due to abortions.

28. The Government of Belize is the main provider of health services. Government health services, including the provision of pharmaceuticals, have for the past years been practically free, funded by Central Government. The basic structure for health care delivery is provided by a national network of 7 district hospitals, 34 health centers and 17 health posts.

29. Health care management is basically centralized, although the trend has been for more district autonomy in the decision making process. As per April 1997, finances have been decentralized, giving more control to the district level. Nevertheless, guidelines for budget distribution and management have not been provided to the local level as yet. The budget allocated for health, with respect to the national budget, has decreased from 9% in 1992 to 8% in 1995. Traditionally, there exists a wide communication gap between curative (hospital based) care and preventive (program based) care. The relative allocation of resources within health shows an emphasis on second level of care (27.7% of 1995 budget allocated to Belize City Hospital). Only 17% of the budget was allocated to public health programs, which include malaria; dengue; rabies;

water and sanitation; maternal and child health; mental health and oral health, among others.

30. Budget structure remained the same over the past 4 years. Personnel consumes over two thirds of MOH expenditure (75% in 1995) and this portion has been increasing in recent years. Drugs and medical supplies consume about 20% (17% in 1995). Over two thirds of MOH capital expenditure is offset by foreign aid and very little funding is available for routine maintenance.

31. Although both the public and private sectors contribute to the production of health care services, there is no clear definition of their respective roles. No formal coordination exists at the health sector level, even though the MOH is responsible for the design of health policies and informal arrangements between public and private institutions and providers, such as the utilization of government hospitals by physicians for their private practice.

32. In addition to inadequate financial resources, inefficiencies in resource allocation and use are contributing to the deterioration of the quality and quantity of services provided by the MOH and are also compromising equity as identified by Gererd Laforgia (1993) and IDB/MOH Health Policy Reform Project (1995).

33. Among the problems which require managerial attention are:

34. Absence of a written Resource Allocation Policy for the Ministry of Health

35. Using curative/second level services for health problems that could be treated at first level care facilities at a relatively low cost.

36. Low-cost recovery level which is influenced by inadequate legislation of user fees, faulty means tests, ambiguous exemption mechanisms, and tax billing and collection procedures.

37. Low productivity of physicians, especially noticeable in specialists. In contrast, general practitioners and nurses who staff health centers appear to be overwhelmed with patients.

38. Government subsidization of private medical practice, by allowing specialists to admit private patients to MOH facilities. The government subsidizes private practice through the free or near free provision of hotel, operating room, nursing, diagnostic and administrative services. Similarly, by paying government contracted specialists a salary while they practice privately during regular working hours, the government is granting them an income

subsidy. Sources within the hospital estimate that between one-third and one-half of surgical and maternity cases are private. Data about the true volume of private patients is not available.

39. Low productivity of hospitals and low demand for hospital care:

40. According to the data provided by the Medical Statistics Office, the total number of discharges decreased from 19,480 in 1993 to 16,557 in 1996; occupancy rate decreased (average for the country) from 44.2% in 1993 to 37% in 1996; the total number of consultations decreased from 218,993 in 1993 to 178,016 in 1996; specialists consultations were down from 19,364 in 1993 to 14,115 in 1996. Even though in the same period the amount of human resources increased, particularly physicians under the specialists category, services provided, coverage and productivity decreased. In 1996, with an average occupancy rate of 37%, based on data provided by the Medical Statistics Office, some productivity indicators are as follows: a) 0.60 discharge/physician/day; b) 0.23 C-section/obstetrician/day; c) 0.78 major surgeries/surgeon/day and d) 0.04 emergencies/physician/day.

41. Contrary to what is generally accepted, productivity is found to be lower in the Karl Huesner Memorial Hospital than the average of the other district hospitals during the last four years. Nevertheless, the project for refurbishing and upgrading three district hospitals to regional hospitals (Stann Creek, Orange Walk and Belmopan) is in the last phase of implementation.

42. Routine maintenance is compromised due to limited budgetary allocation and a lack of protocols and guidelines.

43. The public health system in Belize is going through a critical stage. A rapidly growing population and structural changes, coupled with inefficient health services organization and delivery, are not only contributing to the deterioration of the quality and quantity of services, but also to the expansion of "the health inequity gap".

44. The concentration of financial and human resources in hospitals creates a big gap between rural and urban areas, and between the Belize District and the rest of the country.

45. Distribution rate of physicians is 23 times higher in the urban areas than in rural areas; and three districts (Belize, Toledo and Stann Creek) do not

even have one physician in their respective rural areas.

46. Approximately 60% of health centers/clinics (outpatients services) are in the urban area and 63.5% are in the Belize District.

47. Mobile clinics, which account for about 40% of health center service deliveries, have been reduced owing to budgetary constraints.

48. None of the district hospitals have physicians on active duty for 24 hours, neither do they have for inpatient or emergency services.

49. Only 3 districts have specialized clinics (obstetrics, pediatrics surgery and internal medicine). San Ignacio has an obstetrics clinic occasionally; Stann Creek only has an internal medicine clinic. Toledo does not have any specialized clinic and outpatients are seen by a general practitioner.

50. In practice, access to many MOH facilities is often delayed due to informal rules that deter and circumscribe entry into the Health System. It is common knowledge that the quickest way to gain access to Karl Heusner Memorial Hospital ward is through the specialist private clinic. Once admitted to the hospital, private patients are also given preferential treatment through greater physician contact (General La Foriga). The private practice not regulated within the public facilities is an important contributor to inequitable access to quality care. Again, rural populations and persons who cannot afford private practitioners will be the most affected.

51. The above indicates that equitable access to the first level of care (both preventive and curative) is very much compromised. The situation is worst regarding the second and third level of care.

52. There are numerous variables which can be used to determine the quality of health care that is provided. A recent Hospital Accreditation Study states that accreditation for hospitals in Belize is not yet obtainable and the need for quality measures is of grave concern, especially in light of the leading causes of mortality and morbidity.

53. Specific medical care concerns are the lack of mechanisms to guarantee the continuity of patient care, coupled with the lack of quality assurance programs and procedures or written protocols. Administrative concerns were the substandard condition of sample records. More than 50% of the records that were checked had poor legibility, no

medical doctor signatures and/or no discharge diagnosis.

54. Other significant quality of care issues are chronic inconsistencies in registering death certificates, non-integrated information system and data not always disaggregated by sex. Maternal mortality causes respond to the category of direct obstetrical causes and are basically avoidable. Pediatric care shows 4.2 neonatal deaths per 1,000 live births due to sepsis in the first six months of 1995.

55. In the health sector, the National Health Plan 1996-2000 accompanies a health policy reform process and together they represent a transcendental approach to consolidate the need for equity and efficiency within the sector. General Parliamentary Elections will take place in 1998, the outcome of which may affect the implementation of the National Health Plan and the reform process. Similarly, public policy regarding privatization of certain health services, development of private sector in health and the regulation of private practice within public facilities, e.g. public hospitals, as well as the responsibilities of other sectors such as education, agriculture and human resources, in dealing with basic health determinants, are critical issues that must be addressed. One of the key assumptions underlying the proposed changes in the health system is that the government will understand and accept the responsibility and role inherent in the different sectors, in order to achieve the ultimate vision of a healthy society. Immersed within this assumption is the need for the implementation of the National Health Plan and the strategies therein. The National Health Plan was launched by the Prime Minister in November 1996, but its implementation is becoming a lengthy process.

56. The ongoing Health Policy Reform Project is guided by the direction in which the Ministry of Health is heading, as expressed in the vision statement. Nonetheless, the values defined in the vision statement such as "... equity, affordability, accessibility, equality and sustainability, in effective partnership with all levels (sectors)..." are not always expressed in clear operational terms in the policy options being proposed. Sustained intersectorial participation in the reform process continues to be a challenge. Areas of particular concern for the Ministry, and which the Policy Reform Project addresses, are: health, financing, health services administration, equipment/maintenance, human resources development, information systems, and institutional development and planning.

57. Today, different levels of understanding and commitment persist at the political and the technical level of the MOH regarding the processes of implementing the National Health Plan and the Policy Reform Project. Effective coordination guidance and strategic planning are some of the areas in need of improvement to overcome the source of the difficulties.

58. However, changes in the health sector will depend indeed on the pace and direction of the overall public sector and state reform. Decentralization is not a uniformed process and will require cultural and attitudinal changes. The existence of a macro political environment conducive to strong democracy and community decision making will be a must to ensure community participation in health. State reform is on the horizon in Belize and consultative and participatory processes have won new keepers in recent years.

### *National Priorities for PAHO's Technical Cooperation*

59. To develop an effective and efficient system for organizational management with emphasis on Health Sector Reform (Implementation, Monitoring and Evaluation of Reform Measures), Health Information System (National Health Information System upgrading and maintenance and National Health Information Network); Epidemiology (Health Situation Analysis, Non Communicable Disease Surveillance), Human Resources (On the job training and Health Curriculum Review), Decentralization (Local Health Systems) and Quality of Care (Monitoring and Evaluation and accreditation of health facilities). To define a comprehensive, accessible and adequate model of health care with emphasis on the development and implementation of standardized norms, procedures and management protocols in reproductive health, school health, and domestic violence. To contribute to the development and maintenance of a clean, safe and healthy environment with emphasis on vector control and rabies, water and sanitation quality control, environmental risk factors and control of pesticide intoxication. To improve the health, well-being and development of men, women and children through the provision of comprehensive health services with emphasis on Reproductive Health (Family Planning, STD/HIV/AIDS, Maternal and Perinatal Care), Communicable Diseases (malaria, dengue, rabies and immunopreventable) and Health Promotion (school health, healthy municipalities).

## ***Objectives for PAHO's Technical Cooperation***

- To support the Government of Belize, particularly the Ministry of Health, in directing and conducting the Health Sector Reform Process.
- To promote and provide comprehensive and accessible health services in the area of family life education, STDs, domestic violence and nutrition.
- To contribute to the development and maintenance of a clean, safe and healthy environment.
- To support the development and implementation of comprehensive, effective and accessible priority health programs in the Belize District, according to the National Priorities with intersectorial collaboration.
- To support the provision of comprehensive, efficient, effective and accessible health services to address priority problems with intersectorial cooperation in the following districts: Cayo, Corozal, Orange Walk, Stann Creek and Toledo.
- To contribute to health development through international technical cooperation.

## ***Expected Results***

60. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

61. *Surveillance and information systems.* For a national health information network; and a comprehensive health information system, including epidemiological surveillance and registration of vital events.

62. *Standards and guidelines.* For the provision of comprehensive reproductive health service; and for the implementation, monitoring and promotion of the school health education physical education and health services, (including mental health).

63. *Plans, projects and policies.* For a comprehensive national quality assurance program; for the promotion and implementation of primary environmental care activities with the communities' active participation in the monitoring and control of environmental risk that affect health; for implementing the global malaria control strategy, the integrated rabies and dengue control; for the implementation of the WHO water quality standards;

to strengthen local capacity to provide comprehensive health services in defined priority areas (reproductive health, school health, EPI, domestic violence and vector control); to support the local level in order to strengthen the capacity to conduct intersectorial actions for the promotion and protection of health; for strengthening local capacity for health system management; to strengthen the Toledo District Health Team capacity to provide comprehensive health services in defined priority areas (reproductive health, school health, EPI and domestic violence) to improve coverage and access; to support the local level in order to strengthen the capacity of the District Health Team to conduct intersectorial actions in health promotion and protection; and for strengthening local capacity for health system management.

64. *Methods, models and technologies.* To implement, monitor and evaluate Health Reform Measures; to reorient and restructure the health services according to emerging comprehensive models of health care and health care management within the framework of the health reform process; for Participatory Public Health Policy development, implementation, monitoring and evaluation; to provide a comprehensive model of attention for family violence; for monitoring and controlling acute pesticide intoxication; to provide comprehensive health services in defined priority areas (reproductive health, school health, EPI and domestic violence); to conduct intersectorial actions for the promotion and protection of health; for the implementation of environmental health programs in priority areas (malaria, dengue, rabies, water quality and environmental health risks); for the establishment of an efficient local health system management; for local personnel to generate comprehensive health services in the defined priority areas (reproductive health, school health, EPI and domestic violence), to improve coverage and access; to conduct intersectorial actions for the promotion and protection of health; to enhance local capacity for health systems management.

65. *Training programs.* To implement and advocate for the Caribbean Health Promotion Charter.

66. *Promotional campaigns and advocacy.* For the promotion and protection of health.

67. *Direct support.* For the implementation of the National Food and Nutrition Plan of Action; for the implementation and evaluation of the Expanded Program on Immunization; for the implementation of environmental health programs in priority areas (malaria, dengue, rabies, water quality and environmental health risk reduction); and to enhance local capacity for health system management.

**BELIZE**  
**PROPOSED BUDGET ALLOCATION**

Appropriation Level	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Health in Human Development	933,100	973,400	100,000	30,000
Health Systems and Services Development	24,500	17,900	42,000	0
Health Promotion and Protection	149,500	123,900	82,300	0
Environmental Protection and Development	17,300	29,700	210,900	140,000
Disease Prevention and Control	22,000	3,000	79,100	0
<b>Total</b>	<b>1,146,400</b>	<b>1,147,900</b>	<b>514,300</b>	<b>170,000</b>



# BOLIVIA

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## *Health Situation*

1. The overall health situation for the period should show improvement on some fronts, such as infant and maternal mortality, to which significant efforts and resources have been dedicated in recent years. In addition, the expansion of basic sanitation services is expected to help improve Bolivia's health profile. The immediate impact of these improvements, however, may be less than desired, since investments in these areas tend to produce effects that are relatively long in coming.

2. During this period, sectoral reform will continue to be the top priority for the cooperation of the Organization. The current Government, whose mandate extends until the year 2002, has proposed the Strategic Health Plan (PES), whose development should culminate in a General Law that consolidates the transformation process begun several years ago with decentralization and community participation.

3. The sectoral problems that will most likely continue to be significant during this period are related to the segmentation of health systems (Ministry of Health, social security, the private nonprofit and private for-profit sector). Alternatives for functional integration or articulation will continue to be explored, always seeking greater managerial capacity for the Ministry.

4. Health sector financing must also be a fundamental concern. Innovative strategies will continue to be formulated to improve the acquisition of health resources, along with different methods for their distribution to departments and *municipios* under decentralization. In this regard, the gradual extension of basic health insurance and its ongoing evaluation relative to administration and financing will be fundamental.

5. Another concept of special importance within the PES will be the "epidemiological shield," devised to protect against the most significant pathologies in Bolivian public health; these will attract greater political interest as the integration agreements of the

Andean Group and MERCOSUR continue to develop.

6. Territorial and institutional health management will also be a priority, increasing efficiency and effectiveness and improving the quality of service delivery. We therefore expect special priority to be given during the period to management training and performance evaluation methodologies.

7. The area of human resources, whose importance has been strongly recognized, should have made significant advances, particularly in the "public health career programs," whose implementation has been recognized as one of the pillars of sectoral reform. During the period, they will presumably be launched or their application intensified.

8. Within the framework of decentralization and participation, expectations point to a greater demarcation of responsibilities and relationships among the different levels of territorial management, together with a better definition of the sources of financing and their administration. In addition, we anticipate that health promotion, especially the promotion of "healthy *municipios*," will have uncovered successful experiences and that there will be greater freedom for their gradual extension throughout the national territory.

9. The 1992 National Population and Housing Census emphasized two demographic phenomena that have intensified in recent years: internal migration and urbanization. The average annual growth rate of the population was 2.11%, according to data from the last period between censuses, 1976 to 1992.

10. Bolivia had 7,413,834 inhabitants in 1995 and a population density of 5.84 inhabitants per km<sup>2</sup>, ranging from 0.6 (Department of Pando) to 19.96 (Department of Cochabamba). The urban population represents 58% and the female population 50.6% of the country's total population.

11. Twenty percent of the population aged 15 years or over is illiterate, with large variations among departments; in addition, the rates are always higher

in women and in rural areas. Fifty percent of the population aged 7 years or over are in the labor market, 58% of them in the informal sector.

12. The total fertility rate, according to ENDSA 94, is 4.8 children per woman, ranging from 3.8 in urban areas to 6.3 in rural areas. The average is 6.5 children for women with no formal education, compared to 2.7 children for women with intermediate or higher levels of education. The maternal mortality rate is 390 per 100,000 live births.

13. The national infant mortality rate is 75 per 1,000 live births, according to estimates of the 1992 census, with large variations between rural and urban areas (averaging 94 and 58 per 1,000 live births, respectively). The principal causes of infant mortality are diarrheal diseases (36%), respiratory problems (26%), and problems related to childbirth (13%). Mortality in children under 5 is 113 per 1,000 (146 in rural areas and 16.7 in urban areas). Maternal mortality is largely determined by problems in prenatal care and delivery (hemorrhages, toxemia, and infections).

14. Malaria has flared up from 19,031 cases in 1991 to 54,000 cases in 1997, with an increase in cases involving *P. falciparum* and a resistance to first-line drugs. Cases of dengue reappeared in 1996 after eight years without transmission, with the vector located in the eastern and southern areas of the country. Forty percent of Bolivia's total population is seropositive for Chagas' disease, and *Triatoma infestans* is present in 60% of the territory. Leishmaniasis is predominantly cutaneous and difficult to treat due to the lack of drugs. By the end of 1996, 62 cases of yellow fever had been recorded, some in localities very close to the city of Santa Cruz, where cases transmitted by *Aedes aegypti* have already been reported, and there is a risk of urbanization of the disease. Measles and neonatal tetanus are on the verge of elimination, and no recurrence of poliomyelitis has been recorded in recent years, due to vaccination efforts. Cholera has declined at the national level, with some outbreaks in specific and well-defined geographical areas. Pulmonary tuberculosis continues to be a serious public health problem; the incidence has not improved, and broad program coverage does not exist at the health services level. Human rabies

increased in 1997, with 11 cases documented by the end of the year, compared to 3 in 1996.

15. Drinking water is distributed to 81% of urban dwellings, with an average sewerage coverage of 63%. In rural areas, water supply coverage is 19% and sanitation service coverage is 17%. Eighty-seven percent of dwellings in urban areas have electricity, versus only 16% in rural areas. The person/dwelling ratio is 4.2 in rural areas and 4.5 in urban areas. Urbanization is occurring rapidly and haphazardly, with the development of large metropolitan areas and makeshift housing.

16. Health service coverage is low; only 67% of the population has access to some type of institutional care (78% in urban areas and 52% in rural areas). Approximately 0.7 consultations are made per inhabitant per year (0.4 in the public sector and 1.7 in the social security system). The average bed occupancy rate is 48%. The number of physicians per 100,000 inhabitants is 3.63 in the public sector and 10 in the social security system, with a ratio of 0.5 nurses per physician in the public sector and 1.1 in social security. Impediments to the guarantee of quality care exist due to insufficient complementary services, such as laboratory or blood bank networks. Half of all pregnant women receive prenatal care, while delivery care is provided in health institutions for 0.25 of all pending births.

### ***National Priorities for PAHO's Technical Cooperation***

17. Support for the development of the regulatory, technical support, and surveillance role of the central level and national institutes. Design and implementation of health reform through the Strategic Health Plan (PES). Strengthening and implementation of the "epidemiological shield" strategies. Development and implementation of basic health insurance. Reorganization and strengthening of Social Security. Strengthening of the health services network to guarantee coverage, accessibility, quality, and compassion in medical care. Organization and development of careers in the health field. Application of the Healthy Municipios initiative. Review of the legal framework, culminating in the Health Law. Strengthening of the intersectoral strategic approach in order to seek,

organize, and guarantee financing in health. Building of a new model of care based on primary health care and community health. Improvement of the country's epidemiological situation by applying the principles of the "epidemiological shield" contained in the Strategic Health Plan (PES), including the strengthening of managerial capacity in the programs at the different levels of care, mainly the district health level. Support for the Ministries of Health and Social Welfare, Housing and Basic Services, Sustainable Development and Planning, and Prefectures and Municipios, which are given priority in the Strategic Health Plan and in the definition and implementation of policies and programs for basic sanitation and environmental quality control. Improve the levels of health and quality of life of the population through multisectoral and community efforts aimed at promoting communication and education in health, improvements in physical-social environments, and healthy individual or collective lifestyles and behaviors, geared toward risk prevention and health promotion, mainly during childhood and adolescence, in women and groups at greater biological and social risk.

### *Technical Cooperation Strategy*

18. Support for the implementation of the various strategic components of the PES will be provided as follows:
  19. To regulate and supervise the rational use of health resources through mobilization of the country's own resources and international cooperation.
  20. To strengthen the Ministry of Health and Social Welfare so that it may regain its legitimate role in the health sector reform process and guarantee the application of State policies within the sector directed toward combating poverty.
  21. To develop and strengthen the four levels of management, administration, and territorial jurisdiction with multiple service providers, defined on the basis of territorial, demographic, accessibility, and care-related criteria.
  22. To develop and strengthen sector subsystems, especially those considered essential, such as: the national administrative-financial system; the national supervision and evaluation system; the national drug and supplies system; the national information and epidemiological and nutritional surveillance system; the infrastructure, equipment, and maintenance system; and the human resource system.
23. To institute the model of care that will guarantee universal access to the Bolivian health system through primary health care with the family and community health program, the pillars of which are family medicine, the epidemiological shield, basic health insurance, the public health career program, and the reorganization of social security.
24. To support the creation and application of the epidemiological shield, giving priority to the three principal pathologies to be addressed: malaria, Chagas' disease, and tuberculosis, implementing strategic lines of action based on: epidemiological surveillance; the laboratory network and blood banks; coordination of intersectoral and international cooperation; human resources development; community participation; and the development of mass communication and health education plans and plans for food protection and environmental health policies.
25. To support and promote the Healthy Municipios component, with emphasis on municipios selected as pilot areas for the implementation of the PES.
26. To create opportunities for consensus-building and negotiation with departmental and municipal governments (prefectures and municipios) for the implementation of the PES.
27. To incorporate an intercultural and gender-based approach in the operational actions of the PES.
28. To support education and health promotion activities as a key element in preventing damage to health, reducing the mortality rate, and raising the standard of living of the population.
29. To support the incorporation of civil society in activities in health, development, and social control of management.
30. To support a review of the country's legal framework to ensure that it permits the

implementation of the PES and culminates in the Health Law.

31. In light of this scenario, the technical cooperation strategy of PAHO will center on consolidating the sectoral reform process and strengthening the steering role of the Ministry of Health; at the same time, it will technically and operationally strengthen the departmental health units and management entities at the health district level in order to guarantee that the reform process will reach the first levels of care, which include the health areas with their respective health posts. The health district will play an important role in operationalizing national health policies and coordinating with the municipal governments in their geographical area.

32. At the regional level, support will intensify in the search for mechanisms that guarantee fulfillment of Southern Cone or MERCOSUR initiatives for the eradication of foot-and-mouth disease and the elimination of Chagas' disease, as well as cooperation for cross-border activities with Chile, Peru, Brazil, Argentina, and Paraguay.

### ***Objectives for PAHO's Technical Cooperation***

- The Ministry of Public Health and Social Welfare will have institutionalized and legitimized its authority in the management, regulation, and exercise of authority in health, as well as the monitoring and evaluation of the Bolivian health system, within the framework of the Strategic Health Plan and its policies.
- Access to health services coverage will have increased through primary health care, with family and community medicine serving as the point of entry to the national health system, thereby overcoming economic, geographical, and cultural barriers.
- Progress will have been made in implementing the Strategic Health Plan (PES), mainly the "epidemiological shield," IMCI, and veterinary public health components, in order to address the prevalent, emerging and reemerging, and chronic diseases of the country, within the framework of health reform and family medicine.

- Partnerships have been forged between local authorities and civil society for implementation of the Healthy Municipios Initiative as strategy for health promotion.
- Development of the capacity of national institutions to administer, protect, and conserve the quality of their natural resources from a human health perspective.
- The managerial capacity of the Ministry of Health in mobilizing the exchange of technical, scientific, methodological, and procedural resources with other countries has been developed.
- The national capacity in water supply and sanitation in the country has been developed.

### ***Expected Results***

33. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

34. *Cooperation networks, alliances.* Involving intersectoral, national, departmental and district/municipal; national service networks consisting of four levels of management and care that guarantee the quality of the services; networks to support the priority programs of the "Epidemiological Shield," and those of at least 100 municipios with intersectoral programs, with the participation of civil society, to promote healthy lifestyles and prevent environmental and behavioral risks.

35. *Surveillance and information systems.* Pertaining to the scientific/technical aspects of health in sector libraries; epidemiological surveillance of prevalent and emerging and reemerging diseases in the country, including veterinary public health; and monitoring of food and nutrition security in homes in all the municipios, for prevention and surveillance of cardiovascular disease, diabetes, other prevalent chronic diseases, and intentional and unintentional injuries.

36. *Standards and guidelines.* For the control and prevention of prevalent communicable, as well as

emerging and reemerging, diseases; and to strengthen operating procedures and technology in the national network of laboratories and blood banks.

37. *Research and evaluation studies.* On the national experience gained in the implementation and impact of the model of care based on family medicine, and improvement of the standards and strategies of the communicable diseases programs.

38. *Plans, projects and policies.* For consensus-building and the implementation and monitoring of the Bolivian health system's financial/economic model; for the prevention and control of communicable diseases; for consensus-building, implementation, and monitoring for the reorganization and strengthening of social security; for developing and strengthening the municipal governments' capacity for strategic management and leadership to promote the "Healthy Municipios initiative," and efficiently execute the "basic activities" spelled out for them in the Strategic Health Plan; for the adjustment, expansion, and strengthening of models of care based on family medicine and primary care; for consolidating the departmental committees for human resources development; for promoting the health of women, children, adolescents, and young adults in the municipios with reproductive health services, and actions to prevent intrafamily violence, and promote IMCI; and for improving the quality of water in the municipios declared healthy and selected by the PES, in coordination with the DIGESBA (under the framework agreement between the MSPS and the VMSB); for the proper management of chemical substances, research and evaluation of environmental health risks, and the provision of basic sanitation.

39. *Methods, models and technologies.* For management, administration, and territorial jurisdiction, as a part of the institutional and organizational strengthening of the MPH and within the framework of the Strategic Health Plan; for strengthening the role of the MPH in setting standards, regulation, mediation, evaluation, and inspection; for ensuring a sustainable, efficient and low-cost supply of essential drugs linked with the health insurance systems; and that permit an increase in the coverage of basic services in rural areas, through community and NGO participation.

40. *Training programs.* Involving education and ongoing training of human resources in order to develop and strengthen capacity for strategic management of services and health programs; for the Regional, District, Area, and Sectoral levels on standards and procedures related to programs on the prevention and control of prevalent, emerging, and reemerging diseases; in graduate-level programs in sanitary engineering and environmental health at the national universities; and in low-cost technologies for water and sanitation services in rural areas.

41. *Promotional campaigns and advocacy.* In health in the national and departmental health communication systems, with the application of urban and rural information and education programs and strategies; in health promotion, through the PEC strategy, in the healthy municipios selected by the PES; and in the national program for disaster preparedness.

42. *Direct support.* The procurement of inputs and the contracting of specialized personnel; for the creation and development of the Environmental Health Unit of the MPH; and for the development of a collaborating center.

**BOLIVIA**  
**PROPOSED BUDGET ALLOCATION**

Appropriation Level	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Health in Human Development	1,480,600	1,512,900	299,300	5,000
Health Systems and Services Development	1,260,800	1,166,800	2,868,300	654,200
Health Promotion and Protection	440,000	596,600	81,900	10,000
Environmental Protection and Development	443,500	414,900	1,265,200	20,000
Disease Prevention and Control	1,032,000	984,500	255,700	110,000
<b>Total</b>	<b>4,656,900</b>	<b>4,675,700</b>	<b>4,770,400</b>	<b>799,200</b>

# BRAZIL

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## *Health Situation*

1. According to the Brazilian Institute of Geography and Statistics (IBGE) the total population of Brazil will reach 165.2 million by the year 2000. Distributed over a territory of 8.5 million km<sup>2</sup>, 43% of the population is concentrated in the southeast of the country, 29% in the northeast, 15% in the south, 7% in the north, and 6% in the central-west. Demographic projections for the year 2000 point to a crude birth rate of 18.2 births per 1,000 population, with a crude death rate of 6.7 deaths per 1,000 population, annual population growth of 1.2%, and a total fertility rate of 2.1 children per woman. The urban population is estimated at 80.2%, the dependency rate at 60% and life expectancy at birth at 67.9 years. Projections for the year 2000 indicate that there will be 13.1 million inhabitants over the age of 60. Economic growth in recent years has been characterized by regional disparities that affect large sectors of the population.

2. The Unified Health System (UHS), for which regulations were issued in 1990, is requiring the gradual upgrading of management models, with a view to improving their capacity to coordinate institutional efforts in formulating and implementing strategic policies and actions. Development of these models will contribute to the dynamic application of the Basic Operational Guidelines of the UHS currently in force (NOB-96).

3. Implementation of the UHS presents a new and challenging scenario for human resources policy in health, namely: a growing need for educational and professional certification; increasingly difficult labor relations; administrative decentralization; and management autonomy in an environment marked by serious financial constraints, an area of growing political importance that is raising concerns among the majority of managers in the health services.

4. Demographic and epidemiological transition are well advanced in the country, resulting in higher rates of chronic degenerative and noncommunicable diseases (cardiovascular disease, cancer, and diabetes), with implications for living conditions and lifestyles, particularly for the urban sector.

5. Tuberculosis and vector-borne, parasitic, and sexually transmitted diseases, with high morbidity and mortality, remain a cause for concern. The incidence of emerging and reemerging diseases, coupled with deficient epidemiological surveillance for their detection, is also a problem.

6. The principal zoonoses remain a public health problem, as do foodborne diseases (FBD). Wider dissemination of information on FBD is needed, together with improvements in food safety and the quality of food for local consumption.

7. There is a shortage of drugs, chiefly in outpatient facilities, as well as inappropriate and unnecessary use of these products. The regulatory capacity of the State to guarantee the quality of pharmaceuticals from the manufacturer to the consumer is another matter of serious concern, not to mention the challenges posed by global economic integration, with all its attendant risks.

8. The Ministry of Health is seeking greater participation by the collegiate organs of the UHS central administration--for example, the National Health Council and the Tripartite Interadministrative Commission, as well as the national councils of state and municipal secretaries of health.

9. The Integrated Health Information Network is being developed through joint action by PAHO and the Ministry of Health. Forty representative entities with the capacity to prepare data and indicators and conduct situation analysis and trend assessment are participating in this network.

10. The country has made progress in recent decades in the fields of reproductive health, fertility regulation, and certain health problems of children and adolescents; however infant and maternal mortality must be reduced in the areas of highest risk. The current government is promoting the reduction of infant mortality, with emphasis on basic sanitation in the north and northeastern regions of the country. It has also launched a program for cervical cancer control.

11. Controlling vaccine-preventable diseases has been one of the main goals of public health policy in Brazil in recent decades. Thus, in 1994 Brazil,

together with the other member countries of the Region, was declared free of the circulation of indigenous wild poliovirus, a situation that has held steady thus far. Major progress has been made in eliminating other vaccine-preventable diseases.

12. In recent years a significant improvement in water supply, wastewater, and excreta disposal services has been confirmed, in terms of quantity and quality, but greater efforts are needed in this regard. There are still major challenges for improving the quality of the environment in order to achieve sustainable environmental development, taking human health hazards in the work environment into account.

13. The demand for technical cooperation among countries has increased dramatically in recent years as a result of Brazil's technical expertise and the interest that Brazil and other countries of the Americas have shown, especially those along its borders and the Caribbean countries.

### ***National Priorities for PAHO's Technical Cooperation***

14. Development and enhancement of the capacity to formulate and implement health policies, including the national systems for health information, science and technology support, professional deliberation, and community participation in the Unified Health System (SUS). Decentralization of health activities and services; information systems for epidemiological and management surveillance for disease prevention and control to state and municipal levels; and for the elimination of diseases (vector-borne transmission, T. cruzi, rabies, schistosomiasis, filariasis, and congenital syphilis), with emphasis on the decentralization of health activities and services; information systems for epidemiological and management surveillance. Elimination of leprosy as a public health problem. Promotion of the integrated approach to health and nutrition for women, children, adolescents, and families, and in governmental proposals for restructuring the health services. Strengthening of the institutional capacity of SUS managers in regulating human health resources; this includes improvements in the quality of work and professional education in health, in the availability of

information, and in analytical capacity with respect to human health human resources. Formulation of policies, strategies, and actions aimed at producing, distributing, and utilizing the immunobiologicals necessary for the National Immunization Program. Inclusion of new vaccines in the National Immunization Program. Increased vaccination coverage and better disease control through the use of quality-controlled immunobiologicals. Implementation and improvement of pharmaceutical assistance models under the National Drug Policy, training of human resources, and improvement of health surveillance instruments. Improvement of the quality and efficiency of the health system through changes in the model of care and in the modalities for financing managerial services; the rational use of human, technology, and financial resources; and decentralization of management. Development of managerial and technical capacity for zoonosis control and improvements in food protection. Promotion of the intersectoral cooperation network, especially with regard to agriculture/health, for zoonosis control and food protection, strengthening joint technical assistance with PANAFTOSA and INPPAZ. Intensification of scientific exchange and/or technology transfer among the Latin American and Caribbean countries to increase Brazil's installed technical capacity in the area of health. Development and implementation of health promotion policies within the strategies of healthy physical areas, self-reliance in health, and community action. Development of programs that employ a comprehensive, integrated approach to health, the environment, and development in all economic and social sectors; optimization of information systems on environmental risks to health, ecosystems, and sustainable development; and promotion of cleaner technologies to control environmental risk.

### ***Technical Cooperation Strategy***

15. The PAHO/WHO Representative Office in Brazil is concentrating its efforts on strategic projects or activities coordinated with the country, with the support of Headquarters and the centers. It also addresses problems as they arise and utilizes the strategic cooperation model, which will help to ensure the success of its activities in the medium term. The current trend is to establish interactive

work modules in the Representative Office, based on the following strategic lines of action essential for providing technical cooperation:

16. Joint efforts by professional institutions for the production and analysis of data and indicators to be used in the management process; health situation analysis and trend assessment; and scientific and technical assistance.

17. Systematization of the activities of government agencies and non-governmental organizations for the development of a decentralized, tiered, health services model that is user-friendly to provide care in childbirth and for the newborn, thereby contributing to a reduction in maternal and infant (perinatal) mortality; development of technical resources for disseminating public awareness messages and engaging in activities to prevent risk behaviors in adolescents and young adults; integrated health and nutrition activities for children, women, and adolescents that facilitate the reorganization of the services and articulation with the community, preferably in the regions of the north and northeast.

18. Coordination with public and private academic institutions in the preparation of methodologies and tools to improve the management and quality of the health services; development of managerial capacity in the decentralization processes and in microregions; support for technical and administrative management of health investment proposals through REFORSUS; support for projects geared toward the use of information for managing the services; analytical profiles of the health services; and assessment of the impact of sectoral reforms.

19. Technical and institutional consensus-building that facilitates the development of concepts, standards, and procedures for administering pharmaceutical assistance; prioritization of decisions and efficient decentralization of pharmaceutical assistance activities; adaptation of the professional profile of pharmacists to their role as health agents; strengthening of the State's capacity to regulate and monitor pharmaceuticals and to mobilize resources with integrated cooperation projects.

20. Promotion aimed at diverse institutions working on developing policies on human resources for health to engage in activities of mutual interest, as well as dissemination of information on events, management research and methodologies, and improvement of

education in both the health services and the educational system.

21. Mobilization of national resources (human, financial, material, and scientific and technical information) in the production and control of biologicals and for vaccination of the population.

22. Collaboration in activities employing an integrated approach aimed at reducing the risk factors for chronic, communicable, and non-communicable diseases, systematizing health promotion, disease prevention, research, and clinical studies; the formation of technical support networks for training human resources, developing standards, monitoring, and evaluating activities in disease surveillance and control; and modernization of the information system, with action to promote analytical and decision-making capacity at the federal, state, and municipal level for the surveillance, control, and/or elimination of diseases.

23. Development of a network for intersectoral cooperation, especially in agriculture and health, for zoonosis control and food protection, as well as technical cooperation to meet the demands of the sector.

24. Technical cooperation among the countries of Latin America and the Caribbean for information exchange and/or the transfer of technologies and resources, and the mobilization of scientific, technical, and material (basic supplies) resources.

### ***Objectives for PAHO's Technical Cooperation***

- Control zoonoses and improve food protection, reducing health risks.
- Promote technical cooperation between Brazil and the Latin American and Caribbean countries in the health sector for priority problems that require PAHO support with funds from Technical Cooperation among Countries (TCC).
- Promote the coordination of national institutions trained for implementation of the policies and strategic actions of the SUS.
- Consolidate intersectoral partnerships and scientific, technical, and community networks in order to devise policy instruments and strategic actions related to health and the environment.

- Promote the articulation of institutions at the national level for health promotion and the prioritization of technical proposals in SUS programs and health activities.
- Increase the political and technical-operational capacities of SUS institutions in regulating professional work and practice in the health services; and train human resources in the institutions of the educational system.
- Strengthen programs for the elimination of leprosy at the national, state, and municipal level.
- Improve technical capacity at the various levels of the SUS to raise the quality of the prevention, control, and surveillance of diseases based on integrated and articulated intervention models with clearly defined responsibilities for each structure involved.
- Cooperate in national efforts to enhance policies and activities for the control, elimination, and/or eradication of vaccine-preventable diseases, reducing their morbidity-mortality rates.
- Cooperate in national efforts for the production of vaccines and biologicals, using good manufacturing practices (GMP), for the procurement of quality immunobiologicals, and for quality control of the vaccines utilized by the National Immunization Programs.
- Contribute to a change in the model of care, increase equity of access to basic family health services, and optimize the use of resources in outpatient, emergency, and hospital networks.
- Articulate the three spheres of government for the decentralization of pharmaceutical assistance and the improvement of sanitary drug monitoring.

## ***Expected Results***

25. During the biennium 2000-2001, PAHO is committed to developing, jointly with the country, the following expected results:

26. *Cooperation networks, alliances.* Among institutions for the identification of lines of action and activities to prevent risky behaviors by adolescents and promote healthy intersectoral agriculture/health environments in terms of zoonoses and food protection; for information, situation analysis, and science and technology development in

health; among institutions for including priority environmental risks into their plans and programs on health and environmental policy; for training, health promotion, and the prevention, surveillance, and control of diseases; for the management and quality of health systems and services; to promote decentralized managerial capacity in microregional and municipal systems and services; and for the networks to act on the demand for the formulation of policies and preparation of plans, projects, standards, and procedures related to pharmaceutical assistance and the sanitary monitoring of drugs.

27. *Surveillance and information systems.* On foodborne diseases and for sanitary food inspection; to improve the quality of environmental control; and for the management of health systems and services, facilitating decision-making and the preparation of analytical profiles of health systems and services.

28. *Standards and guidelines.* For regulating management procedures and professional practice and training in health; for micronutrient and nutritional guidelines; and for quality production and control of lots of the immunobiologicals used in Brazil.

29. *Research and evaluation studies.* On the regulation, management, and training of human health resources; on national programs for the elimination of transfusion-transmitted Chagas' disease, onchocerciasis, filariasis, congenital syphilis, and *T. infestans*; for the improvement of manufacturing procedures for the immunobiologicals currently produced and the development of new techniques for the production of new vaccines.

30. *Plans, projects and policies.* For health sector activities between Brazil and other countries that require PAHO support with TCC funds; in strategic areas agreed upon with the SUS; to increase vaccination coverage in all municipalities; for investment in the Unified REFORSUS Health System; to improve the managerial capacity of the state secretariats and the management organs of the system; and for the emergency, pre-emergency, and disaster preparedness network.

31. *Methods, models and technologies.* For the veterinary public health services; to improve the quality of prenatal, delivery, and newborn care; and of municipal pharmaceutical services.

32. *Training programs.* In strategic areas to strengthen the SUS.

33. *Promotional campaigns and advocacy.* For the dissemination of health information in the principal mass communications media and for creating awareness among decision-makers.

34. *Direct support.* For the implementation and consolidation of good manufacturing practices in all national laboratories that produce immunobiologicals; for the immunization of vulnerable populations with quality vaccines,

adequately transported and conserved; for the strengthening of the National Epidemiological Surveillance System with regard to programs for the eradication of poliomyelitis, measles, and neonatal tetanus; for the development of a more efficient epidemiological surveillance system for other immunopreventable diseases, such as whooping cough, diphtheria, accidental tetanus, yellow fever, viral hepatitis, and meningitis; and for national laboratories to increase the necessary actions for national production of immunobiologicals of sufficient quantity and quality to satisfy national demand.

<b>BRAZIL</b>				
<b>PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health in Human Development	4,775,600	4,903,500	349,800	0
Health Systems and Services Development	1,645,000	1,575,300	11,707,600	600,000
Health Promotion and Protection	1,539,500	1,558,200	106,500	0
Environmental Protection and Development	627,500	605,400	29,500	0
Disease Prevention and Control	2,098,200	2,043,400	6,641,800	4,408,500
<b>Total</b>	<b>10,685,800</b>	<b>10,685,800</b>	<b>18,835,200</b>	<b>5,008,500</b>



# CANADA

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## *Health Situation*

1. By 1997, there were 30,286,596 people living in Canada. The 1995-1996 increases in population led to a 1.2% growth rate lower than the 1.7% average annual rate for the 1991-1995 period. Census figures for 1991 revealed the self-identified Aboriginal population to be 1,002,675, or 3.6% of the total Canadian population. There were nearly 602,700 registered Indians, of whom 346,291 lived on-reserve and 256,400 lived off-reserve. According to the 1991 census, 60.5% of the population reported English as their mother tongue, 23.8% reported French, and 13% reported a mother tongue other than English or French.
2. The majority of the Canadian population is concentrated in two provinces: Ontario (37%) and Quebec (25%). Twenty-nine percent lives in Alberta, Saskatchewan, Manitoba, and British Columbia, compared with 9% in New Brunswick, Nova Scotia, Prince Edward Island, and Newfoundland. The vast differences in provincial population size are illustrated by the ratio of the largest (Ontario) to the smallest (Prince Edward Island), which is 81:1.
3. Canada's population is highly urbanized. From 1991 to 1995, the percentage of the population residing in rural areas declined from 23% to slightly less than 20% and by 1995 over 80% of the population lived in larger urban areas, and the rest in smaller urban centers.
4. The infant mortality rate for the general Canadian population has declined significantly, reaching 5.6 per 1,000 live births in 1996. The First Nations infant mortality rate has also fallen from 27.6 per 1,000 live births in 1979 to 10.9 per 1,000 in 1993, but it still remains 1.7 times higher than the national average. Although the First Nations neonatal mortality rate was 61.7% higher than the Canadian rate from 1979-1981, it has declined more sharply than the Canadian rate, and by 1991-1993, rates reached an average of 4.7 deaths per 1,000 live births, a rate that was 14.6% higher than the Canadian rate for the same period.
5. Lifestyle choices such as alcohol and tobacco use affect the health of young Canadians. Alcohol-attributable mortality remains a significant cause of death, particularly among youth in Canada. While overall tobacco consumption declined by 27% from 1970 to 1990, it has remained steady since 1990. In 1994-1995, 29% of Canadians age 12 and over smoked. Among those in the 15-19 year age group, 29% (261,000) of girls and 26% (244,000) of boys were regular or occasional smokers. While smoking by teens in the 15-19 year age group is not as prevalent as among those 20-44 years old, teen smoking is distinctive in a number of ways. Most significantly, the rate of current teen smokers increased substantially between 1991 and 1995, from 21% to 29%. Teenage females were more likely than males to smoke. For example, in the 12-14 year age group, 15% of girls are current smokers --three times the rate of boys the same age.
6. The population age 65 and over experiences activity limitations that are almost three times that of younger age groups. Twenty-nine percent of seniors 65-69 years old experience chronic pain. The number increases to 35% for those 75 years and over. The severity of pain increases with age, being severe for 17% for those 65-74 years old and 20% for those 75 and over. Types of chronic pain include migraine headaches, arthritis, rheumatism, angina, and vascular disease. Among both age groups, women were more likely to report chronic pain than men (34% and 27%, respectively).
7. In 1994, 80% of the population or 23.5 million Canadians were living in a family settlement. While more families are being formed, fewer births are taking place; in 1995, average family size was 3.0. Thirteen percent were single-parent families. Although this percentage has remained steady since 1986, it represents an increase of 4% since 1971. Men headed only 17% of all single-parent families.
8. What has come to be known as "Medicare" comprises 12 interlinked health plans administered by the provinces and territories, which have constitutional authority for health care. Medicare's two major components are the Hospital Insurance Program and the Medical Care Program. The

Hospital Insurance and Diagnostic Services Act of 1957 led to all provinces and territories providing their residents with comprehensive coverage for hospital care by 1961. This was followed by the federal Medical Care Act in 1968, and by 1972, all provincial and territorial health care plans insured physician services. The 1984 Canada Health Act consolidated the previous legislation on hospital and medical care insurance and defined the broad national standards that provincial plans must meet to qualify for federal funding.

9. In October 1994, the federal government launched the National Forum on Health. The Forum's mandate was to advise the federal government on ways to improve the health system and the health of the Canadian population. In 1997, after numerous public consultations, the Forum released its final report, "Canada Health Action: Building on the Legacy." The Forum emphasized that strategies to improve population health status must address a broad range of health determinants: social and economic environments, physical environments, personal health practices, individual capacities and coping skills, as well as the availability of health services.

10. In 1997, the government announced several initiatives to improve population health. These include the establishment of a Health Transition Fund, which will provide Can\$150 million over three years to support provincial and territorial projects and innovative approaches to modernize the health care system. The Fund will consider specific projects such as nationally insured pharmaceutical and home care services, primary care, preventive health, and evidence-based decision-making. The Canadian Health Information System aims to strengthen Canada's health surveillance network and develop a population health information database and a First Nations health information system. The Community Action Plan for Children and the Canada Prenatal Nutrition Program build on constructive partnerships with provinces, territories, and stakeholders to provide community-based support that families at risk need to help ensure the health of their children. The Canada Foundation for Innovation will help generate funding for innovative and progressive research in various sectors, including health. Six Networks of Centers of Excellence oriented toward health science (i.e., the Canadian Bacterial Diseases Network, the Canadian Genetic Diseases Network, the Health Evidence Application and Linkage Network, the Respiratory Health Network, the

NeuroScience Network, and the Protein Engineering Network) will receive annual funding of close to Can\$50 million to support the work of health researchers.

11. In 1998, Canada spent an estimated Can\$80,013 million on health care, which represents 9.1% of the gross domestic product and a per capita total health expenditure of Can\$2,613. Public expenditures accounted for about 70% of total national health care spending. In 1996, federal transfers accounted for 22% of the expenditures; disbursements by the federal government for health care services geared towards special groups such as First Nations and Inuit peoples, Armed Forces personnel and veterans, and expenditures for health research, health promotion, and health protection accounted for 4%; provincial expenditures for those insured accounted for 44%; and private funds accounted for 30%. One of the components that contributes heavily to the cost of health care is the aging of the population. In 1996, health expenditures for the population 65 years and older represented almost 40% of the total spent.

12. Beginning in April 1996, federal transfers to provincial and territorial governments for their health, post-secondary education, and social assistance/social services programs were combined into Canada Health and Social Transfer (CHST), which is a single block transfer of cash and tax points. The need to contain costs in the health systems has resulted in an increase of 13% in total health expenditures between 1991 and 1996, compared with a 26% increase between 1989 and 1991.

13. The 1999 federal Budget affirmed that the health of Canadians and the future of the Canadian health care system are among the federal government's highest priorities. Total federal support for health under the Canada Health and Social Transfer (CHST) will increase by \$2 billion in 1999-2000 and in 2000-2001, and by \$2.5 billion in each of the following 3 years. As a result of the Budget, provincial and territorial governments will receive a total of \$28.4 billion (in cash and tax points) in federal transfers through the CHST in 1999-2000 to support their health, post-secondary education and social services/assistance programs. By 2003-2004 this amount will have grown to \$31.4 billion.

14. The increased federal funding for health will be used by provinces and territories, at their discretion,

to provide immediate improvements to the health system.

15. As part of the 1999 Budget, the Canadian Institute for Health Information (CIHI) will receive additional funding to improve Canada's national health information system. One of the outcomes will be the production of regular, independent reports on the health system. A number of other health areas will also be strengthened. These include: the development of a National Health Surveillance Network, innovations in the delivery of rural and community health programs, a Prenatal Nutrition Program, enhanced food safety programs, a Diabetes Prevention and Control Strategy and increased funding for health research.

16. Canada's external technical and financial cooperation in health includes ongoing cooperation with other countries through institutions such as the Pan American Health Organization, the World Bank, the Organization for Economic Cooperation and Development, and the World Health Organization. Canadian health regulators have initiated efforts to encourage harmonization of regulations, standards, and labeling requirements related to foods, pharmaceuticals, and medical devices within trading blocs and between countries.

17. The Canadian International Development Agency (CIDA) is a federal agency responsible for managing approximately 80% of Canada's Official Development Assistance (ODA). CIDA pursues the following programming priorities: basic human needs; women in development; infrastructure services; human rights; democracy and good governance; private sector development; and environment.

18. CIDA's "Strategy for Health" was launched in 1996. This document presents a comprehensive and integrated approach to health and development. Top priorities are to strengthen national health systems and improve women's health and reproductive health. Other priority objectives include improving children's health; decreasing malnutrition and eliminating micronutrient deficiencies; prevention and control of major pandemics that causes more than 1 million deaths per year (HIV/AIDS, tuberculosis, tobacco use, malaria, trauma, and violence); and support for the introduction of appropriate technologies and special initiatives.

## ***National Priorities for PAHO's Technical Cooperation***

19. To cooperate in public health and development in the Americas by making available Canadian support and expertise, particularly in the areas of: - Health sector reform; -Disease surveillance; -Health and environment; -Health promotion. The above priorities will take into account the following major cooperation themes: Increase Canadian awareness of and involvement in PAHO activities; Mobilize Canadian expertise to respond to requests for assistance on diverse health issues; Engage in bilateral projects utilizing PAHO expertise to facilitate technical cooperation.

## ***Technical Cooperation Strategy***

20. The cooperation strategy between PAHO and Canada involves the use of Canadian expertise and resources to support health development in the Region of the Americas. Conversely, regional experience and resources could be applied to Canadian health sector issues and health problems encountered in selected populations in Canada. Mobilization of resources, dissemination of information, and direct technical cooperation are the basic functional approaches that will be used. A special feature of the PAHO-Canada cooperation is a contractual arrangement between the Organization and a Canadian NGO, the Canadian Society for International Health. Under this agreement, CSIH acts as PAHO's "technical representative" in Canada for the purpose of increasing Canadian knowledge of PAHO program activities as well as participation in them.

## ***Objectives for PAHO's Technical Cooperation***

- To mobilize Canadian expertise to respond to cooperation request on various issues, and to facilitate bilateral cooperation activities utilizing PAHO expertise.
- To obtain a greater degree of involvement on the part of professional, institutional, and financial resources of Canada in the programs of PAHO, while simultaneously increasing Canadian awareness about PAHO and its activities.

***Expected Results***

21. During the biennium 2000-2001, PAHO is committed to developing, jointly with the country, the following expected results:

22. Development of cooperation networks, surveillance and information systems, plans and

policies with involvement of Health Canada and Canadian expertise.

23. Canadian awareness of, and involvement in PAHO.

24. Canadian participation in PAHO's program activities will tangibly increase, together with an increase in Canadian coverage of PAHO, and PAHO-related issues.

<b>CANADA PROPOSED BUDGET ALLOCATION</b>				
Appropriation Level	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Health in Human Development	0	57,500	0	0
Health Systems and Services Development	847,800	841,300	0	0
<b>Total</b>	<b>847,800</b>	<b>898,800</b>	<b>0</b>	<b>0</b>

# CARIBBEAN

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## *Health Situation*

1. At the beginning of the new millennium, the Caribbean will continue to enjoy political stability. The trend to change the political guards associated with the previous two decades can be expected to continue. Countries with significantly multi-racial populations are being challenged to make national unity a reality.

2. The regional integration movement has gathered momentum and countries are making efforts to adjust national processes accordingly: 1) With Suriname and Haiti as new members and the acceptance of Cuba as a partner in the development of the region, the Caribbean Community has truly become multi-lingual, multi-cultural and multi-ideological. The community is working intensely towards its goal of a common market with a single currency by the year 2000 and its governing bodies have been streamlined for effective action at the global, regional and national levels. The multi-sectoral composition of the new Council of Human and Social Development (which replaces the Conference of Health Ministers) provides a forum for planning and uniting the needed multi-sectoral actors for health; 2) the new Association of Caribbean States, which was spawned by CARICOM, has already begun to create programs and agreements to increase functional and economic cooperation among its twenty-five (25) member countries which have borders with the Caribbean Sea; and 3) the countries of the Organization of Eastern Caribbean States have begun negotiations to include Barbados as a member.

3. The region has begun to adjust to the liberalization and globalization of economies worldwide. While the WTO ruling against the European Union's (EU) preferential price regime for bananas caused a contraction of the affected economies in 1997 -- resulting in negative growth in Dominica and very small increases in GDP in Saint Lucia and St. Vincent and the Grenadines -- there are

records of successful initiatives to diversify the economies. Exports of non-banana agricultural products (citrus in Belize and nutmeg in Grenada) have increased significantly and the Windward Islands have been experiencing annual improvements in earnings from the tourism sector over the last three years.

4. Several countries have strengthened their position in the offshore-financial services and informatics markets (the Bahamas, Barbados, British Virgin Islands, Cayman Islands and Saint Lucia). The Caribbean still needs to improve the performance of its manufacturing sector.

5. The Caribbean has now become the most tourism-dependent region in the world, with the sector contributing 25% of the GDP in all countries, except Trinidad and Tobago, and providing direct or indirect employment for one (1) in every four (4) persons in the labor force. The need to pay more attention to health and tourism issues has become clear with the increasing reports of ill-health among tourists due to diarrhea, the ongoing threat of dengue fever and the stringent liabilities now placed on European tour operators for the health and safety of visitors. Other environmental health concerns to be given priority within CCH include water quality monitoring, workers health, and strengthening of public health capacity.

6. Poverty remains at unacceptable high levels in almost all Caribbean countries and regional governments are looking for innovative ways to foster employment opportunities outside the public sector and provide a social net to protect the poor. A common trend among the different countries is growth of the informal and micro-enterprise sectors. In 1994, the percentage of this workforce component was greater than the government employees component in four (4) English-speaking countries. This trend is relevant to health in light of the fact that women account for a high percentage of this group;

food and drink processing is a common area of choice and activities often include travel within and outside of the subregion.

7. Education reform is taking place in many countries and it is enabling the school-aged population to make healthy lifestyle choices. If this were to be maximized there would have to be a reduction in the number of dropouts and education of children will have to be judged by more than the examination of the "three R's". The focus on HRD by the Ministers of Health and the Conference of Heads of Government augers well for the development of Caribbean people ready to address the challenges of the 21st Century.

8. Demographic trends point to an increase in the numbers of elderly and youth and adolescents in the Caribbean at the start of the new millennium. Likewise, epidemiological trends indicate that chronic, non-communicable diseases, intentional and unintentional injuries, mental illnesses and substance abuse will continue to be issues which Caribbean governments must address if they are to improve the health of their people. Evidence exists to indicate that pre-conceptional and perinatal care are important in reducing not only childhood mortality, but also developmental disorders and chronic illnesses in adulthood; that the school drop-out rate is related to risk-taking behavior among youth and adolescents; and that many of the chronic non-communicable diseases have several social and behavioral risk factors in common, and are thus amenable to common approaches. Inadequate use is made of health promotion strategies in a systematic way and the potential of the multi-sectoral approach has been given lip service.

9. The aging of the population is slow overall, but in some countries the elderly population makes up more than 10% of the total population (Barbados, Montserrat and Dominica). In all cases, the time is right for introducing a plan to handle this phenomenon.

10. In the Caribbean, while the major causes of death and illness are chronic non-communicable

diseases, the re-emerging problem of tuberculosis and malaria, as well as AIDS, also has to be addressed. Diabetes, hypertension with the high levels of the common risk factor, obesity, and cancers of the cervix, breast and prostate are the major causes of mortality. An important risk factor for many of the chronic, non-communicable diseases and their complications is smoking. Although smoking prevalence in many Caribbean countries is lower than in other sub-regions in the Americas, efforts must be made to reduce it further by preventing smoking initiation and facilitating smoking cessation.

11. Efforts to reform the health sectors continue, as well as the priority of human resource development, quality improvement, financing, disaster management and maintenance of equipment.

12. The need to review and update training programs in order to ensure continued attention to the changing needs and linking these more directly to performance is still a priority. Management training at all levels in the context of reform and decentralization is urgent. The Ministry of Health needs to strengthen planning. Ministries of Health also require assistance to change and strengthen their role in the reorganized services, in particular in relation to moving away from involvement in the day to day management of services and assuming responsibilities for planning and monitoring the services.

13. Many countries have been discussing health financing and seem to be focusing on national health insurance along with limited user fees as the main sources of revenue to finance the services. However, information on costs remains patchy and difficult to obtain; and countries have yet to define benefit packages and conduct cost analysis on the method of collection and administrative mechanisms.

14. The introduction of preventive maintenance programs has proven difficult to sustain, due both to shortages of staff and inadequate levels of existing staff. Investment in expensive equipment, with only a limited working life proves a significant drain on the resources allocated to health.

15. Hurricanes, earthquakes and volcanic eruptions remain the most serious threats to the region. Strengthening of emergency medical services in order to maintain a state of preparedness for accidents and man-made and natural disasters has emerged as a new area of concern. In the area of man-made disasters, given the importance of tourism, the countries need to focus on building capacity to deal with airplane crashes.

16. Efforts to increase the capacity to produce information in a timely manner have met with differing results. While countries appreciate the need for information units, very few have made the necessary budgetary arrangements to establish the capacity for managing information and making arrangements for maintenance of hard and software. Ministries continue to make inadequate use of available information for decision-making. In the meantime, there is a critical and urgent need for managers to master the rapidly changing technological and communications environments and put these into use for benefit of communities and individuals.

### ***National Priorities for PAHO's Technical Cooperation***

17. Health status of families and communities improved. Health status of the Caribbean population improved. Use of IS/IT and communications for better health improved. Effectiveness of cooperation improved. Increased quantity and efficiency of health services.

### ***Technical Cooperation Strategy***

18. This subregional BPB seeks to support the objectives within some of the priority areas in the CCH Phase II. However, the projects have been consolidated to gain synergy from activities of naturally affiliated sub-areas. Four (4) projects have been developed: 1) Strengthening of Health Systems - covers the priority areas of human resources development and health sector reform; 2) Environmental Health and Tourism - covers all the sub-priority areas of environmental health, but retains

the orientation to tourism in order to promote a better understanding of the linkages; 3) Community and Family Health - includes the control of chronic diseases, mental health and selected components of the family health priority areas; and 4) Information and Communication for Health project addresses the supporting area of the production, dissemination and use of information as well as some of the communication approaches to support the health promotion approach.

19. The six strategies of the Caribbean Charter for Health Promotion have been applied in the design of the projects in order to promote HP as an approach and not as a program.

20. The CCH priority area of control of communicable diseases is covered by the CAREC BPB and that of Food and Nutrition by CFNI. It is anticipated that by the beginning of the period, CCH will be known to all key stake holders and the CPC Office will then focus on the following functions of the CCH Secretariat: project development and resource mobilization in collaboration with the CARICOM Secretariat (CCS), and providing technical assistance for the implementation of the regional and national project activities. Technical cooperation among countries will be heavily promoted and a database of such activities and projects will be implemented. PAHO will promote at least biannual meetings of national program managers in each priority area as part of the process for monitoring the initiative, and it will seek to initiate the first evaluation near the end of 2001.

21. The projects have been developed in response to problem-tree analysis, thereby reflecting multi-disciplinary approaches and interventions to be executed by teams of advisors. For these reasons, efforts will be placed on team building for effective project execution. This will include training in project management in collaboration with CDB. Furthermore, the Office of Caribbean Program Coordination will coordinate PAHO's resources in the Caribbean especially among projects which have components in more than one unit. Joint programming, execution and monitoring will be undertaken as far as possible. On the other hand, CPC will support multi-country programming at the Eastern Caribbean level to address the peculiar needs of the mini states as well as Pan Caribbean programs.

22. With the increased momentum of the integration movement, CPC will increase participation in regional fora seeking to have health and development issues integrated from the beginning and it will identify opportunities for collaboration with other regional and international agencies including CTO and ACS. Cooperation with the UWI will be more coordinated in order to increase impact on needs of countries. CPC will expand collaboration with NGOs at the national and regional level to include religious institutions and thus increase health promotion thrusts. We will seek to use these NGOs for execution where capacity is appropriate and undertake training programs for others to improve their capacity in strategic planning and project design and management. In addition, collaboration between national NGOs and Ministries of Health will be stimulated through the Healthy Community Award.

23. Emphasis will be placed on prior identification of resources critical to sustainability of interventions at country level and mechanisms used to phase activities so that countries are forced to complete all requirements for sustainability at each phase. In the application of TCC, countries with advantage will be encouraged to provide medium term support to develop capacity in other countries. TCC will be integrated in several projects thereby reinforcing this as a strategy rather than a separate project area.

24. Training will be used in all projects. While fellowships overseas will be supported through national programs in this project, PAHO will collaborate with national sub-regional institutions to mobilize resources and develop innovative approaches to address the need to train large numbers of persons in the priority areas of health and hospital planning and management, geriatrics and oncology and the allied health areas.

25. Dissemination of information, critical to all the projects, will go beyond transmittal of documents. National managers/technical officers will be guided by the reviews of documents which will highlight the relevant sections. Modern technology will be introduced to link the databases at/through the CPC Office more directly to the Ministries of Health. Information about the health situation in the

Caribbean and on current technical approaches will be provided to countries through the network of PAHO Publications Centers in the countries, the Documentation Center at CPC and through PAHO websites. Appropriate vehicles will be identified to provide a forum for sharing national experience on public health matters. Much more use will be made of the UWIDEC facilities, and as soon as possible there will be access to the Internet for delivery of technical cooperation.

26. An important contribution of this regional project will be the development of model legislation, policies and procedures and guidelines for program development and quality monitoring. In the case of information systems, PAHO will insist that management of the environment, including skills of supervisors, be improved as a prerequisite or complement to systems development. Technical cooperation will need to be complemented by country support for capacity to maintain software.

27. Research promotion will continue through collaboration with CHRC and support of managers to undertake health services research. Social communication programs will only be developed after evaluation of the knowledge, attitudes and practices of target groups. The bioethics area will be a focus in collaboration with PAHO's Center for Bioethics, CHRC and UWI.

28. The provision of supplies and equipment will be de-emphasized particularly in the Health Information Systems Project. Supplies and equipment will be provided where logical to support the achievement of expected results. This approach will not apply in the case of disasters or epidemics.

29. Within the broader context of health sector reform, the BPB deals with two areas of priority. On one hand, the implementation of quality improvement as a management tool at all levels and strengthening the role of the Ministries of Health in this respect, and on the other hand, assisting the implementation of new methods of financing health services, while ensuring that the basic tenets of equity and access are protected.

30. In support of these, the Project has strong components in the traditional areas of priority, human resource development, maintenance of equipment and disaster management. In the case of human resource development, the Project will review/implement performance monitoring in countries undergoing health sector reform, and at the same time, linking this to training, use of new technologies in education and new approaches to interdisciplinary training. The assistance in the priority area of maintenance of equipment will place emphasis on the development of a subregional capacity for maintenance of relatively sophisticated equipment while supporting the development of the national capacity to maintain basic critical and essential equipment through training. Disaster management will continue to focus on mitigation and preparedness while strengthening the response capacity subregionally and nationally.

31. Thus, the strategy for technical cooperation will continue to emphasize assistance, leading to sustainable change and building the capacity of the sub-region in the areas of training and research.

32. The health promotion approach demands that the six strategies outlined in the Caribbean Charter for Health Promotion be applied as indicated to enable persons to adopt behaviors conducive to health and to provide equitable social and economic environments. Health and health-related programs, which target individuals from as early as the perinatal period through adolescence into adulthood, will have significant impact as they grow older. Programs for the new millennium will not only address the critical issues outlined, but will also build on work already done, incorporating the expertise of the specialized agencies in order to increase the capacity of countries to use the results of various studies for decision-making. Data will be analyzed to address information gaps and countries will be assisted in the definition of programs which are multi-sectoral and sustainable. Countries will also be assisted in the monitoring and evaluation of programs.

33. The management of knowledge, the dissemination of information, the importance of communication as a process fundamental to

management, are all key component of this integrated approach. Additionally, while IS/IT are normally part of Health Systems Development, this project seeks to go beyond mere technological capability to actual usage and mastery of the technology to improve health.

34. In this biennium, the capacity building project for education of the community/public will come to an end. However, in support of the health promotion approach modern social communication approaches will continue to be applied and the partnership with the media will nurture in light to the key role that this social partner must play in the in-putting of health on the public agenda and complementing strategies which are critical to the improvement in the prevalence of chronic diseases and AIDS.

35. The Environmental Health project will be executed in collaboration with additional partners in the Caribbean Tourism Organization, The Caribbean Hotel Association and local hotel; associations reflecting the tourism thrust and the need for alliances for better conditions.

36. Capacity building of Environmental Health departments needs to be intensified through model legislation, organization structures and standards for monitoring. PAHO will seek to increase the region's capacity for training of environmental health Officers and conducting of post basic training. Ministries of Health will be supported in the regulatory role critical to the monitoring of healthy environments, including those of hotels. This project will complement the Healthy Hotels Project and execute the CTO agreement. PAHO will support strengthening of CEHI through collaboration on specific projects, activities and the sharing of technical information. Activities in waste management, especially training will be reduced in light of the large training component of the subregional OECS waste management project.

37. The CPC office will establish indicators for monitoring efficiency of TC delivery and continue identifying ways to increase resources for health in the Caribbean.

## ***Objectives for PAHO's Technical Cooperation***

- Increased efficiency in and quality of health services demonstrated.
- Management of selected health issues in the population improved.
- Environmental health conditions improved in the Caribbean.
- Increased use of IS/IT and communication strategies in health promotion and health service delivery programs demonstrated.

## ***Expected Results***

38. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

39. *Surveillance and information systems.* On a regional database of professionals, services and training programs; for hospital management information; for selected issues in community and family health, including risk factor surveys among vulnerable groups such as adolescents and youth, addressing issues such as smoking prevalence and, tobacco control strategies; for assessment of the cost-effectiveness of interventions; and for effective vector surveillance.

40. *Standards and guidelines.* For upgrading disaster response plans to include psychosocial component; on mitigation for health facilities; for quality monitoring at Ministry of Health/Headquarters central level and model QI plan; for young child feeding; for the use of selected pharmaceutical agents in the elderly; for certification of wastewater treatment of plant operators; for management of selected hazardous wastes; for sub-regional water quality standards; and for auditing work place health hazards.

41. *Research and evaluation studies.* To review and harmonize food legislation/regulation in six countries; on the application of HACCP to safe street vending; for a regional inventory of hazardous materials; and in Phthalate esters for drinking water tanks.

42. *Plans, projects and policies.* To test the new SUMA version; for a sub-regional health insurance system; for application of on site disposal system; in health care financing; for integrated child care; for implementation of the adolescent plan of action; for the prevention and management of selected chronic diseases, including mental disorders and using model legislation and policies to foster national and regional frameworks; for integrated vector control management; for appropriate on-site disposal technology; for monitoring recreational water; for Health Promotion with religious institutions; for a subregional healthy cities program; and health disaster plans.

43. *Methods, models and technologies.* For preventive maintenance programs; for performance monitoring system linked to training and compensation in countries undergoing health sector reform; for costing health services; for improving quality of MCH services; for regulation of homes for the elderly; and for Environmental Program (policies, roles and functions) within health sector reform.

44. *Training programs.* In food safety for food handlers; in model preventive maintenance programs for life support and X-ray equipment; in two underserved areas using innovative technology including distance learning, computer based training, internet, etc.; in health management and planning; for environmental health personnel; for hospitality facility personnel to implement Healthy Hotels and standards and Ministry of Health Inspectors; on food borne disease surveillance and outbreak investigation; for hotel workers to operate systems; in the principles and use of IS/IT and communication strategies; in using, acquiring, analyzing, interpreting, applying and sharing information for decision-making; in Health and Environmental journalism; and in QI for at least 15 Ministry of Health senior staff and health care providers in four countries.

45. *Direct support.* To develop and strengthen national cancer control programs; to plan and implement healthy lifestyle programs, emphasizing exercise; nutrition; and control of weight, tobacco, substance abuse and STDs among youth and adults, in various settings and in collaboration with various partners.

**CARIBBEAN  
PROPOSED BUDGET ALLOCATION**

Appropriation Level	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Health in Human Development	2,790,000	2,812,700	2,051,200	445,000
Health Systems and Services Development	1,620,100	1,604,400	32,000	0
Health Promotion and Protection	979,800	1,254,400	238,000	0
Environmental Protection and Development	472,600	486,600	388,600	150,000
Disease Prevention and Control	906,600	850,500	98,200	0
<b>Total</b>	<b>6,769,100</b>	<b>7,008,600</b>	<b>2,808,000</b>	<b>595,000</b>



# CHILE

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## *Health Situation*

1. Chile has an area of 756,626 km<sup>2</sup> and is divided into 13 regions and 335 communes. The 1992 Census shows a population of 13,348,401 inhabitants, 86% of whom live in urban areas.

2. Its macroeconomic situation is marked by sustained growth and declining rates of extreme poverty. However, the gap between the richest and the poorest segments of the population is widening. Indicators of wealth reveal sharp disparities between regions. The birth rate shows a decline linked with a drop in the fertility rate, which was 2.65% for the five-year period 1985-1990. Mortality has declined, stabilizing at around 5.4 per 1,000 individuals.

3. The principal causes of mortality are diseases of the circulatory system (27.8%), malignant neoplasms (20.7%), injuries and poisoning (11.8%), and diseases of the respiratory system (11.4%).

4. Infant mortality is 11%, and life expectancy at birth is 72 years. For the AVISA, the most significant causes of infant mortality were: birth defects (7.53%), ARI (5.23%), ischemic heart disease (4.9%), and cerebrovascular diseases (4.19%).

5. In the infant population, the leading causes of hospitalization are respiratory diseases, neonatal disorders and injuries. The surveillance, coverage, and cold chain of the EPI system are very beneficial.

6. Some 40% of adolescent consultations are for psychiatric services. Substance abuse and unwanted pregnancies also account for a high percentage. Maternal mortality is stabilizing at 2.5 per 10,000. One in four women is the victim of physical or psychological abuse.

7. There is significant underreporting with respect to workers' health, although it is estimated that 68% are covered by job health insurance.

8. Concerning the health of indigenous populations, efforts are being made to adapt services to the various ethnic groups. Chagas' disease is expected to be eradicated in the next two years. Steps are being

taken to prevent the reemergence of malaria and dengue. There has been a positive reaction with regard to Hantavirus. Hepatitis is the disease most frequently associated with sanitation, with a rate of 90.8 per 100,000 population in 1994. In 1996, a total of 1,456 cases were reported, of which 92% were men, with 909 deaths and 2,203 HIV carriers.

9. Malnutrition is not significant in Chile, but obesity from poor eating habits has reached alarming proportions, affecting 25% of women and 17% of men.

10. The prevalence of dental caries is greater than 90%, with an average of 12 cavities per person and an early incidence (34% of schoolchildren).

11. Environmental factors are becoming increasingly relevant, due to abuses in the exploitation of natural resources (such as arable land, forests, minerals, and fisheries), the use of agrochemicals, and improper waste disposal.

12. The basic challenges for Chile for the coming period will continue to be promoting dialogue and partnerships with respect to health policies, spelling out the expected results of the Reform not only in administrative management but programs as well, achieving user satisfaction, seeking equity not only in access to curative services but also for well-being, which means that work on health determinants should be intensified. These challenges also include developing health promotion and mass communication, seeking balance and complementation between the public and private systems, consolidating the decentralization of health and environmental services, consolidating information for decision-making on health, environmental, and administrative management issues, making evidence-based decision-making fundamental in the quality of care and technology management, achieving a coherent human resources plan, consolidating national management of environmental and health matters, developing epidemiological surveillance and research systems, and consolidating chronic disease control programs.

## ***National Priorities for PAHO's Technical Cooperation***

13. Ensure satisfaction of users and their full participation in the management of the health services. Define and strengthen the roles of the public and private sector to create a harmonious health system. Increase Chile's response capacity and use the new situations it is experiencing as a result of subregional trade and the country's regional and subregional outreach in the formulation and execution of policies for the development of health policies and actions. Promote legal and regulatory modernization compatible with subregional initiatives. Improve and decentralize information systems and the epidemiological analysis and decision-making capability. Create centers for epidemiological analysis at the national, regional, and local level. Promote the steering role of the Ministry within the framework of decentralization, community participation, and the intersectoral approach. Study solutions arrived at in other countries to strengthen the steering role of the Ministry of Health with regard to decentralization, community participation, and the intersectoral approach. Support decentralization activities with the development of strategic management methodologies and services activities. Analyze national and international experiences to improve this process in Chile. Develop specific areas such as the formulation and discussion of a reference health plan, disaster response capability, clinical laboratory, and blood bank. Continue the discussion and design of social and management mechanisms to be employed in setting up an instrument of this nature to guide the steering role. Support activities in national and local health promotion and the control of risks and specific problems of violence and drug abuse. Design and implement community activities and healthy environments, within the framework of the regional health services. Develop intra- and intersectoral institutional capacity for coordinated response to environmental risks and problems. Support interinstitutional and intersectoral projects in response to environmental risks and problems, including knowledge of international experiences. Formulate and carry out decentralized activities in the prevention, control, and eradication of communicable and chronic diseases. Develop mechanisms for the evaluation and control of risk factors for disease in the health services. Improve,

decentralize, and integrate the country's information systems to support financial, epidemiological, and programming management.

## ***Technical Cooperation Strategy***

14. To direct cooperation resources toward health development processes and not toward specific or complementary activities.

15. To promote transparency in PAHO activities, making proper use of their evaluation vis-à-vis the expected results.

16. To decentralize PAHO cooperation in support of national health policies.

17. To maximize cooperation resources, forming national groups to address specific problems, and mobilizing local financial resources to carry out projects with PAHO cooperation.

18. To create opportunities for negotiation and consensus on important issues in the development of health.

19. To encourage the presence of Chile in international public health and to support Chilean programs with resources from other countries.

20. To strengthen the operations of the Representative Office and to improve its environment with respect to organization.

## ***Objectives for PAHO's Technical Cooperation***

- Improve of national and regional managerial capacity with regard to the interactions among health, work, disasters, and the environment by strengthening the health sector at the central, regional, and local level through decentralized management of environmental health that promotes intersectoral work and citizen participation.
- Develop health promotion and improve the quality of life and care for priority groups through the application of adequately evaluated strategies at the primary care level.

- Support human resources education in health promotion with new educational technologies such as distance learning.
- Develop social communication and participation as tools for health promotion.
- Develop AIDS prevention activities within the framework of the GTO UNAIDS theme group.
- The country's information systems will have been improved and integrated in such a manner that it will be possible to obtain data from standardized and integrated basic sources to support management, financing, epidemiology, and programming at the local (health facilities), intermediate (regional health services), and national level (Ministry of Health) on individual health care, laboratories, and measurement of environmental aspects that affect health.
- Improve the national and local capacity of the health sector to utilize health situation analysis and epidemiology as tools for decision-making.
- The internal information systems will have been optimized in the technical and administrative areas of the Representative Office, and models for team work will have been designed that incorporate applied technology in communications and computational applications.
- Strengthen and expand the technical, political, and administrative capabilities of the PAHO/WHO Representative Office in Chile in support of national health development.
- The strategic proposals will have been implemented for human resources and health services development to respond to the changing needs of the population.
- Strategic development and strengthening of the leadership of the Ministry of Health to contribute to the coordination of a harmonious sector in improving the quality of life of the population.
- Improve the capacity for the formulation of policies, plans, and programs, the delivery of services, and the monitoring and regulation of health programs at the national and local levels to reduce the incidence and prevalence of chronic and communicable diseases in the country.

### ***Expected Results***

21. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

22. *Cooperation networks and alliances.* For a national surveillance network in public health based on national standards, including standardized communication channels and trained operators in the Ministry, the health services, and the Institute of Public Health to monitor conditions related to the people, the laboratories, and the environment; to maintain and broaden opportunities for dialogue and analysis of the strategic areas of sectoral reform, with the participation of international institutions and national cooperation centers; to enrich the national debate on the public health approach in the area of national development as a framework to orient health sector policies; for political, technical, and administrative coordination of the sector, and to harmonize strategies among the regional governments (SEREMIS), health services, and municipios, including the promotion of public health in Parliament; for coordination and the sharing of experiences with neighboring countries in specific areas of public health, within the framework of the Healthy Borders strategy.

23. *Surveillance and information systems.* For public health surveillance to process information generated locally and at the national level in standardized computer language; for managerial, financial, epidemiological and programming systems at the national, intermediate, and local level; for managerial information to support decision-making in hospitals and in the head offices of the health services.

24. *Research and evaluation studies.* On models for the measurement of user and staff satisfaction and the organizational climate; on the strategic proposal for human resources development in Chile; on health promotion; on issues and functional approaches, instruments, and practices in the delivery of technical cooperation; on monitoring, prevention, and control of emerging, and reemerging diseases in the country (Hantavirus, cholera, TB, etc.).

25. *Plans, projects and policies.* For public and private development of health promotion at the various levels of the system, using an intersectoral approach; to incorporate at least five regional health services into the Chilean Carmen Network during the biennium; to complete program reform at the central level and in the country's health services; to conduct epidemiological research and human resources development, as well as training in the use and approach to the techniques and methods for

epidemiological analysis; for strategic analysis to engage in negotiation and the search for consensus; and to support programs for the eradication and elimination of priority vaccine-preventable diseases and Chagas' disease.

26. *Methods, models and technologies.* For the accreditation of health facilities and service networks.

27. *Training programs.* For decentralization of the national disaster preparedness system; and for epidemiologists in the health services and at the central level.

28. *Promotional campaigns and advocacy.* To promote an environmental health policy with citizen participation and the primary environmental care strategy; to strengthen the implementation of

promotional programs in the country's health services, stimulating the development of initiatives for healthy environments, particularly in municipios and schools; to promote the development of social communication as a tool for implementing health promotion strategies; to promote healthy lifestyles and prevent risks in vulnerable populations and in adolescents through local surveillance systems.

29. *Direct support.* For a decentralized management model to respond nationally and locally to environmental risks and specific priority problems; for national policies for the management and control of hazardous chemical substances and of solid and liquid wastes from manufacturing and household activities; and for the development of environmental health at the various levels of the system, using the intersectoral approach.

<b>CHILE</b>				
<b>PROPOSED BUDGET ALLOCATION</b>				
Appropriation Level	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Health in Human Development	1,168,600	1,256,400	138,400	0
Health Systems and Services Development	1,114,200	767,500	13,900	0
Health Promotion and Protection	40,800	195,500	0	0
Environmental Protection and Development	132,700	165,800	0	0
Disease Prevention and Control	164,200	235,300	96,200	0
<b>Total</b>	<b>2,620,500</b>	<b>2,620,500</b>	<b>248,500</b>	<b>0</b>

# COLOMBIA

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## *Health Situation*

1. Colombia has a land area of 1,141,815 km<sup>2</sup>. It is made up of a mountainous area with three branches of the Andean range, two coastal regions (the Atlantic and the Pacific), the island region, the eastern plains, and the Amazon jungle. It is divided politically and administratively into 32 departments, 4 districts, and 1,088 municipios. The estimated population as of 30 June 1998 was 40,826,816 inhabitants. The population of children under 5 is estimated at 11.7% and that of persons 65 and over, at 4.6%; 60.9% of the population is urban, and 39.1% is rural; 50% of men and 48% of women have a primary education, and 31% of men and 35% of women have a secondary education, whereas, 8% of men and 7% of women have pursued higher education. The average years of study for men over the age of 5 is 5.3 years, and for women it is 5.5 years. The literacy rate (in persons 15 and over) is 89.4% (89.5% in women and 89.5% in men). In 1993, the illiteracy rate in the population 15 and over was estimated at 10.6% (3).

2. Poverty has been decreasing gradually in recent years. The percentage of poor people in 1995 was 24.2%, down from 29.8% in 1991. In 1995, the proportion of poor people in urban areas was 14.3%, compared to 38.3% in rural areas. The Atlantic Coast region has a high proportion of poor people (35.9%, with 54% in rural areas) followed by the Pacific Coast with 24.7%. Notwithstanding the reduction in poverty rates, the gaps between well-to-do and marginalized sectors have broadened. For the seven principal metropolitan areas in the country, the rate of unemployment in March 1998 was 14.5%, and the seasonally adjusted employment rate in four metropolitan areas was 53.4%.

3. Colombia has a longstanding democratic system, and all authorities are elected by popular vote. The democracy, however, is affected by the serious armed conflict and social violence in the country.

4. Life expectancy at birth has improved markedly in the past 50 years. The estimate for the period 1995-2000 is 67.25 years for men and 74.25 for women. There are major differences from one

geographical area to another that are directly related to poverty levels. In the Department of El Chocó, for example, life expectancy at birth is 62.76 years for men and 69.50 for women, compared to 68.52 and 75.23, respectively, in Bogota. The infant mortality rate (IMR) for the country in the period 1990-1995 was 28 per 1,000 live births (26 per 1,000 in urban areas and 32 per 1,000 in rural areas). The 5-year estimated infant mortality rate (IMR) for the period 1995-2000 is 34 per 1,000 live births for men and 26 per 1,000 live births for women. Differences among regions in the country are also observed. In the more developed areas, such as Bogota, the estimated IMR for 1998 was 32.51 per 1,000 live births for men and 23.74 per 1,000 for women, while in poorer areas, such as El Chocó, the estimated IMR for 1998 was 99.49 (men) and 82.91 (women) per 1,000 live births. If current conditions persist, it is estimated that in 2005 the IMR will be 26 per 1,000 live births in Bogota and 89.4 in El Chocó.

5. Violence is the principal public health problem in Colombia, and homicide and intentional injuries are the leading cause of death in both urban and rural areas, with a rate of 110.9 (men) and 8 (women) per 100,000; 69.8% of violent deaths were from intentional injuries (homicide and suicide). Of the 38,483 homicides recorded in 1995, 93.4% were men, with a male/female ratio of 14:1; 34.6% were in the group between 15 and 24 years of age, followed by the group between 25 and 34, with 32.7%. The homicide rate also varies from region to region within—for example, from 8 per 100,000 in the Department of El Chocó to 179 in the Department of Antioquia. Observing the trend in the years of healthy life lost indicator per 1,000 population for the entire country in 1989, 1992, and 1995, it can be seen that out of all causes, homicides posed the proportionately greatest burden in terms of years of healthy life lost as a result of premature mortality and disability (1,012,854 per 1,000 population).

6. In 1995, the next most important causes of mortality were: heart disease (with a rate of 56.1 per 100,000 population in men and 44.1 per 100,000 population in women), other diseases of the respiratory tract (38.9 per 100,000 population in men and 32.8 per 100,000 population in women),

cerebrovascular diseases (30.0 per 100,000 population in men and 33.9 in women), and traffic accidents (24.8 per 100,000 population in men and 6.5 per 100,000 population in women). When the different causes of disease are grouped together, it is observed that proportionately, chronic degenerative diseases represent the group of diseases with the most years of healthy life lost due to premature mortality and disability (2,579,671 per 1,000 population), followed by injuries (1,627,227 per 1,000 population) and perinatal, maternal, nutritional, and infectious disorders (1,392,534 per 1,000 population). One exception is in the poorer regions, where there are a high number of years of healthy life lost due to premature mortality and disability from perinatal, maternal, nutritional, and infectious disorders. The average maternal mortality rate (MMR) for the period 1991-1995 was 100.33 per 100,000 live births, with major differences between the different regions of the country. In the poorest regions, this rate reached 681.31 per 100,000, while in the most developed regions it was 44.47; 69% of maternal mortality is attributable to preventable causes (toxemia 38%, abortion 16%, and hemorrhages 15%).

7. In the past three years, the incidence of malaria has increased; 131,000 cases were reported in 1996 and 160,000 in 1997, and in 1998 it was again on the rise. In 1998, 74% of the cases reported were along the Pacific Coast. In contrast, the rates of morbidity and mortality from cholera during the period 1991-1997 have dropped significantly, with mortality of 0.08 per 100,000 population and morbidity of 3.9 per 100,000 population in 1997. Again, those rates are higher along the coasts where drinking water coverage is inadequate.

8. Dengue and dengue hemorrhagic fever increased in 1997 and 1998, mainly in west central Colombia. During the first four months of 1998, 12,440 cases were reported in that region, with a rate of 601.2 per 100,000 population in the Department of El Quindío.

9. A study conducted by the National Administrative Department of Statistics (DANE), with PAHO/WHO cooperation, based on the results of the 1993 census and data on mortality for that year, showed the relationship between mortality, as an indicator of health impairment, and socioeconomic variables, primarily poverty as measured by unmet basic needs. Evidence of

inequities is seen in the inverse relationship between unmet basic needs and the level of development of each municipio. For example, undiagnosed mortality is greater in the most neglected municipalities and in the lower socioeconomic strata, and the institutionally certified mortality is found mainly in the more developed municipios and upper socioeconomic strata. In addition, deaths from communicable diseases, such as acute diarrheal diseases (ADD), occur in higher proportions among the population in the lower socioeconomic strata, while deaths from chronic diseases, acute myocardial infarction, and degenerative diseases occur in higher proportions in the higher socioeconomic strata.

10. With regard to other public health indicators, there was a decline in vaccination coverage from 1996 to 1998. In children under 1, immunization exceeded 90% for DPT3 and OPV3 in 1994 and 1995. In rural areas, vaccination coverage falls to 71% for DPT3 and OPV3, which is 10 percentage points lower than in urban areas. In the departments of Cauca and Nariño, coverage of DPT3 is 61%; in the departments of Guajira, César, and Magdalena it is 75%; in Tolima, Huila, and Caquetá it is 68%, while in urban centers, such as Cali and Medellín, it is 85% and 90%, respectively.

11. In 1998, the goal of eliminating iodine deficiency was achieved.

12. The 1980s saw the beginning of an institutional transformation process. In 1990, the health sector introduced Law 10 on the municipalization of health, aimed at strengthening the sector's territorial entities. This initiative was taken into account in the new Constitution of 1991. The mandate was issued in Law 60, which governs matters relating to the authority and resources of the territorial entities, and it culminated in the enactment of Law 100 in 1993, which created the General Social Security System for Health (SGSSS). The new system strengthens the social welfare mechanisms by providing all Colombians with access to a comprehensive health plan that aims to reach the definitive goal by the year 2001. The system provides universal service coverage and is gradually expanding the benefits provided and the number of beneficiaries. The SGSSS is a mixed organization with two systems: a contributory one and a subsidized one. The segment of the population that is still not covered by either system is called "affiliated" and is temporarily being

served by public hospitals through supply subsidies, until its enrollment in one of the two systems.

13. In addition, Law 100 stresses the basic package of services in health promotion and disease prevention, as well as new organizational and financing procedures. Among the latter are demand subsidies and the transformation of public hospitals into state social enterprises (ESEs). The subsidized system is financed by the Solidarity and Guaranty Fund, which is composed of four subaccounts: compensation, solidarity, promotion, and catastrophic expenses. All persons with an income of more than twice the minimum wage are required to support the system with contributions, while the poor, the unemployed, and campesinos must join the subsidized system.

14. Two subaccounts are incorporated into the social security system: Compulsory Traffic Accident Insurance, which receives payments from every automobile owner in the country and channels them into the emergency network to care for the victims of hit-and-run accidents, and the Work-Related Accidents and Occupational Diseases account, which covers occupational risks and is fed by employer contributions based on the degree of risk to which their workers are exposed.

15. The Ministry of Health (MS), the National Health Authority, and the National Institute for the Surveillance of Food and Drugs (INVIMA) have actively participated in the implementation of the new SGSSS. In order to meet the challenges set forth in Law 100, the MS has three cooperation projects for reforming the system, financed by external loans (World Bank and IDB) for: hospital improvement; municipal health systems, and support for reform.

16. The National Council on Social Security for Health is a professional group that represents the main actors and managers of the system, under the leadership of the MS. It is responsible for standardizing, regulating, controlling, and directing the system. The Ministry of Health relies on the sectional health services or regional offices (one per department), district offices, and healthy municipios to discharge its responsibilities at the territorial level.

17. The complexity of a system that uses regulated competition and free choice of insurers and service providers makes strengthening the steering role of the

SGSSS an urgent matter. The MS is the steering entity, with substantial involvement by the Ministry of Labor, since health and social security are joined on enrollment in either the contributory or the subsidized system.

18. The SGSSS is administered by health promotion enterprises (HPE), which are the basic organizational nuclei of the system. They are responsible for subscribers, the basic mobilization of financial resources, organization of health service delivery, health promotion, and managing the risk of subscribers becoming ill. They are also responsible for disabilities administration, providing care for injuries or illness stemming from work-related accidents and occupational diseases, and the organization of complementary health plans. They can be public, private, collective, or mixed, and their responsibilities are determined by the number of subscribers, because the law stipulates that subscribers are free to choose their HPE. In contributory system, subscribers contribute part of the total cost of subscription. Medical care is provided through institutional service providers. The SGSSS has decentralized management. There are 17 decentralized departments and 4 districts that directly manage over Col\$ 474 billion, which represents 70% of the national allocation. There are 104 municipalities that have been certified to independently manage those payments; Col\$ 2.567 billion have been allocated for 26 hospitals, health centers, and health posts to improve care for the rural population. There are 1,254 oversight committees in place, with a total of 8,664 inspectors in 441 municipalities in 31 departments and 4 districts; 270 associations of state social enterprise users have been formed. There are 247 municipal community participation committees in as many municipalities that implement the methodology for consensus-building with the community in local health plans.

19. The model of care is comprehensive and represents an attempt to stress health promotion, disease prevention, care according to level of complexity, and rehabilitation. It is implemented through two types of plans: the Basic Care Plan (BCP) and the Compulsory Health Plan (CHP). The former corresponds to the public health, health promotion, and risk prevention component. The government is responsible for the plan, which is territorially based, free to participants, and compulsory. The Compulsory Health Plan

corresponds to the basic package of care for individuals (consultations, hospitalization, emergency care, and drugs), which also includes some group and family interventions. To make the system financially stable and guarantee full care for users, the SGSSS covers the cost of care for specified catastrophic illness (cancer, transplants, etc.).

20. Health insurance coverage has risen in the past two years. There are 5,303,277 subscribers to health promotion enterprises other than the Social Security Institute, which has 9,255,287 subscribers, thus bringing the total number of people in the contributory system to 14,558,564. In the subsidized system, the population covered is 7,026,690, making the total coverage 21,585,254 (53% of the country's population). Subscribers have the right to organize for community oversight actions, group plans, and the collective administration of the health resources for the beneficiaries of enrollment subsidies.

21. The SGSSS currently faces a major problem with regard to access by the population to health services, especially the very poor and the unemployed, who are subsidized. Under Law 60, enacted in 1993, the subsidized system relies on the following sources of financing: 15% of the municipalities' share of current national income, fiscal allocations to the departments, national income allocated to the departments, revenues from gambling, lotteries, etc., voluntary contributions from the municipalities and departments, royalties from new oil wells, contributions from the compensation funds, valued-added tax for social programs, tax on firearms and ammunition, and copayments and prorated fees from members and their families. However, the resources appear to be insufficient for financing all persons who should belong to the subsidized regimen. Another critical problem that has been detected is that employers are evading payment of their contributions. Private sector contributions to the contributory insurance system and the participation of the health sector in the GDP, not counting private expenditure, together rose from 2.07% of GDP in 1990 to 3.18% in 1994 and 4.71% in 1996. Private health expenditure by households was calculated at 3% of GDP in 1993, making health expenditure for that year just over 6% of GDP. Of that private expenditure, 40% was for drugs, 14% for outpatient consultations, 20% for hospitalization, 5% for diagnostic testing, and 20% for other expenses.

22. In 1995, Decree 677 established a frame of reference for the use and quality control of pharmaceutical products. That same year marked the establishment of the INVIMA, which is responsible for surveillance and control. The Office of the Assistant Director of Pharmaceutical and Laboratory Services was created under the MS to set sector policy and promote the development of pharmaceutical services and the rational use of drugs. There is a list of essential drugs for the compulsory health plan. In 1995, two years after the reform was initiated, essential drugs accounted for 70% of the drugs prescribed in public hospitals, and more than 60% of all generic drug prescriptions. In that same year, Colombia adopted the Good Manufacturing Practices (GMP) standards of the World Health Organization. Quality control programs for products in circulation have low levels of coverage. In recent years, hospital pharmaceutical services have improved significantly.

23. Health promotion and disease prevention are the foundations for the development of national public health policies. The Ministry of Health standard in the field of disease prevention is aimed primarily at directing the activities that institutions in the system must carry out under the compulsory benefits plans, in the form of integrated interventions at the individual and group level throughout the stages of the life cycle, taking into account the priorities set forth in the epidemiological profile. The standard is geared especially toward protecting the health of women, children, and older adults. In regard to health promotion, the largest component is aimed at the basic care plans and seeks "to integrate the activities carried out by the population, health services, health authorities, and the social and productive sectors, for the purpose of guaranteeing, above and beyond the absence of disease, better physical, psychological, and social health for individuals and communities." The basic care plans are the responsibility of the departmental, district, and municipal territorial entities. Their contents should also reflect the priority prevention activities and local public policies that promote the health and well being of the population. The national government has also established the implementation of the Healthy Municipios for Peace initiative as a nationwide policy. That initiative facilitates and strengthens activities and interventions in health promotion and disease prevention in local development plans. Similarly, it is decisively geared

toward interventions to prevent and reduce violence and promote harmonious societies.

24. As a result of Laws 30 and 115, enacted in 1994, which gave educational institutions the autonomy to create programs, there has been a proliferation of schools and educational programs of every kind and level. In this process the labor needs of the new context that led to the reform have not been taken into account, and there are no control mechanisms for such programs. The Ministry of Health programs training activities, in subject areas that correspond to major health care programs, although apparently there is no prior diagnosis of training needs, and traditional, expensive teaching strategies that require the physical presence of students are utilized, without impact assessments. There is an imbalance between supply and demand in the different occupational categories, due to the absence of a human resources planning policy and insufficient, unreliable information. There are inconsistencies among the socioeconomic, epidemiological, and occupational profiles. Despite the establishment of the National Council on Human Resources Development in 1977, there is limited recognition of the importance of ties to employment, motivation, working conditions, performance evaluations, continuing education, and training-oriented supervision to productivity and the quality of care. The Council is made up of representatives of the Ministries of Education, Health, and Labor and has a National Executive Committee and departmental committees--which are responsible for proposing policies on basic training, continuing education, and the dynamics and distribution of human resources. As of late 1998, this Council had regulated basic training for several categories of auxiliary professionals.

25. Colombia has a wealth of natural resources. However, irrational use of these resources has led to their growing deterioration, the destruction of biodiversity, deforestation, soil degradation, the drying up of water sources, the destruction of mangroves, and water and air pollution. In short, environmental degradation is affecting the current and future well being of the population. Environmental degradation, improper management of natural resources, and inadequate risk prevention are responsible for many disasters. The poorest populations are the most vulnerable, since they are located in high-risk flood areas or unstable sites on the outskirts of cities. The geological, topographical,

and hydrometeorologic characteristics and inadequate environmental management, along with the location of settlements in danger zones, make the country vulnerable to the effects of floods, mudslides, avalanches, and other catastrophes of natural and human origin. Consequently, a strategy must be consolidated to reduce vulnerability, institutional response capacity must be improved, and steps must be taken to prevent natural disasters. The effects of natural disasters in Colombia are felt to the greatest extent by the marginal urban population, as well as the rural population, in the form of avalanches, mudslides, and floods. Accordingly, government activities seek to guarantee timely management of technical, administrative, and financial resources for disaster prevention, care, and the rehabilitation of affected areas, as well as to establish institutional responsibilities that allow for fulfillment of the policy objectives.

26. The main water quality problems caused by isolated sources of contamination can be grouped as follows: household and industrial organic waste; the presence of bacteria and viruses from waste from households and some types of industries; and the presence of hazardous waste in industrial discharge.

27. Less than the 5% of the 1,088 municipios in the country treat their wastewater before disposing of it. The management of the roughly 18,000 tons of solid waste produced daily in the country is still very poor. The amount of industrial solid waste produced at the national level totals 7,000 tons daily.

28. According to the most recent data from Colombia, it is estimated that total drinking water coverage in the country reaches roughly 91.2% of the population, while sewerage services cover 81.3%. In addition, the data show that the 70% of that 91.2% of the population receives good quality water, which represents real coverage of barely 63.8%. With this estimate and an estimated population of just over 40 million inhabitants according to DANE, 14.5 million inhabitants do not have water supply or receive poor quality water. Unfortunately, this population represents the sectors in the rural and marginal areas of the country. It should be noted that, when comparing populations with over 500,000 inhabitants and small villages with populations under 2,500 inhabitants, the study revealed great inequity in water quality. In rural populations the percentage of the population receiving good quality water 9.6%,

whereas in the urban areas of cities with over 500,000 people coverage reaches 100% percent.

29. Current trends indicate that marked differences in development persist among the different population groups and regions of the country. As a result, the principal challenge for the future is to reduce the current equity gap in health in Colombia, in order to bring it closer to the goal of health for all.

30. A very important challenge is displaced persons; 900,000 people have been displaced as a result of violence over the past 10 years. This is reflected in many health care problems in the medical, health promotion and disease prevention, and environmental sanitation services. It aggravates the problems related to gender and children, since the majority of displaced persons are women, and 65% are children.

31. Without positive changes towards achieving peace, violence and insecurity will remain the country's greatest public health problem. The challenge for future decades will be to restore the value placed on life and find ways of living in harmony.

32. The comprehensive management of watersheds, with emphasis on the use of appropriate, low-cost technologies for treating residential and industrial wastewater, is the most important challenge in environmental health.

33. Other challenges include: achieving the elimination of canine-transmitted rabies and eradicating foot-and-mouth disease; ensuring that food of animal and vegetable origin designated for international trade is safe for human consumption; and achieving the consolidation of the departmental networks of healthy municipalities for peace.

34. The implementation of SGSSS reform poses serious challenges, such as: ensuring equity in access to health services; strengthening the steering role of the Ministry of Health, the regulatory function of the National Council on Social Security for Health, and the inspection and monitoring function of the Health Authority; lending continuity to the decentralization processes and providing technical, management, and administrative tools to territorial institutions and entities; ensuring the financial viability of the system

to achieve sustainability, development, and growth in subscriber coverage and service delivery; strengthening social control of the management of the system and preventing corruption through social participation; strengthening health promotion strategies, especially strategies for the development of healthy public policies to foster intersectoral actions that permit a higher level of health and well-being for the population; solving the linkage problems between health promotion enterprises, ARS, and institutional service providers, and transforming hospitals into state social enterprises; and ensuring adequate monitoring and reliable, scientific analysis of the reform process.

### *National Priorities for PAHO's Technical Cooperation*

35. To overcome the existing inequities in the health conditions of the population and to achieve universal access to the health services, with emphasis on care to the most neglected groups. To manage and coordinate the technical programs and the development of administrative management.

### *Technical Cooperation Strategy*

36. As a result of the foregoing challenges, PAHO technical cooperation in the country will be aimed at:

37. Directing all efforts and resources toward projects and activities that reduce the inequity currently observed in the country's health profile.

38. Through mutual agreement with the health authorities, prioritizing and targeting actions toward the most vulnerable regions. Intervening with health promotion and disease prevention activities in the problems with the greatest potential for improvement that are currently being ignored, and with the measures that will have the greatest externalities, jointly with other sectors. Activities to help the municipalities formulate, implement, and evaluate the basic care plans, supported by strengthening local

development plans within the framework of Healthy Municipios for Peace.

39. The health sector reform process will be accompanied by an assessment of its impact on the health of the population.

40. Among the different aspects analyzed in environmental health, the following lines of action for strengthening the sector stand out: 1) Formulation of an integrated plan of sectoral action to create a culture of teamwork; 2) Dissemination of the rates of water loss, which range from 43% and 50%; 3) Formation of municipal associations to strengthen financing and implementation in each municipality; 4) Preparation of a national water and rural sanitation plan, since the rural population is the most affected and requires more dynamic government action; 5) Consolidation of technical assistance and training for municipios and enterprises in order to find new strategies and mechanisms for increasing their effectiveness; 6) Strengthening the actions in the management plans and their expected results, so they become true tools for business management and monitoring.

41. Finally, in keeping with the priorities set by the United Nations for the country, support will be given to the processes for achieving peace and reducing social violence in all its manifestations.

42. For the implementation of the actions and activities, the policy guidelines and strategic orientations approved by the Governing Bodies will be followed, utilizing the functional approaches of the cooperation, maximizing the mobilization of resources of all kinds and the utilization of modern information and communication technologies.

### ***Objectives for PAHO's Technical Cooperation***

- To provide technical assistance and follow-up for the implementation of the Basic Care Plan (PAB) in the areas of disease prevention and the promotion and monitoring of public health and risk factors, within the framework of the General Social Security Health System (SGSSS).
- To provide technical assistance that contributes to an improvement in the quality of water and its supply, expanding waste and excreta disposal services, and improving environmental quality and occupational health.
- To achieve the goals set by the SGSSS concerning access to the health services for the entire Colombian population by the year 2001.
- To have the participating countries develop a network of healthy municipios in the interest of peace and to strengthen epidemiological surveillance in border areas, disseminating information on Colombian experiences with social security reform, together with information on the progress made by other countries.
- To satisfy the country's demands for technical assistance in order to address the principal public health problems.

### ***Expected Results***

43. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

44. *Cooperation networks, alliances.* Among the border municipios of Colombia, under the healthy borders strategy, sharing sectoral reform experiences with Andean countries and the rest of the world.

45. *Surveillance and information systems.* For the improvement, use, and analysis of epidemiological information to orient the decision-making process.

46. *Research and evaluation studies.* To explore the operation of new models of care, aimed at achieving universal insurance coverage.

47. *Methods, models and technologies.* For decentralized management of health.

48. *Training programs.* For the proper management and planning of projects, programs, plans, and policies in environmental and occupational health.

49. *Promotional campaigns and advocacy.* To promote the development of social control in the management of the EPS, IPS, ARS, ARP, and ESS; to strengthen the use of essential drugs in the SGSSS; and to foster health promotion processes that will lead to the development of healthy spaces and public policies that support the search for better health conditions.

50. *Direct support.* To strengthen activities in the prevention, control, elimination, and eradication of communicable, non-communicable, and vaccine-preventable diseases, within the framework of the

Basic Care Plan (PAB); to strengthen the steering and regulatory role of the Ministry of Health in the SGSSS; to provide assistance in adapting hospital pharmaceutical services to the standards of the SGSSS.

**COLOMBIA  
PROPOSED BUDGET ALLOCATION**

Appropriation Level	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Health in Human Development	1,877,200	1,922,300	611,200	0
Health Systems and Services Development	884,500	860,900	384,100	0
Health Promotion and Protection	417,300	145,800	8,000	0
Environmental Protection and Development	511,100	497,500	622,400	0
Disease Prevention and Control	932,100	1,195,700	341,600	14,000
<b>Total</b>	<b>4,622,200</b>	<b>4,622,200</b>	<b>1,967,300</b>	<b>14,000</b>

# COSTA RICA

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## *Health Situation*

1. Three consecutive administrations have promoted health sector reform, with the same theoretical underpinnings, objectives, principles, and strategies. The components of the sectoral reform are: a greater steering role for the Ministry of Health, upgrading of the model of care, modernization of the resource allocation system, and an institutional modernization component to make the other three components workable. Implementation of the sectoral reform reveals the persistence of problems related to uniformity and coordination. This has caused exercise of the steering function to lag behind, instead of spearheading the process at the sectoral level. The steering role is not optional, partial, or reversible. It stems from a legal and political mandate and is a technical prerequisite for the development of health at the national level. As a result, it requires resolute, dynamic, and urgent action to ensure results in the short term.

2. The new government is emphasizing development of the steering role of the Ministry of Health and is requesting PAHO cooperation in this area. The upgraded model of care is already a reality, its design is appropriate, and its implementation process has been organized. As the organ responsible for the delivery of services and, thus, for upgrading the comprehensive care model, the Costa Rican Social Security Fund (CCSS) has been organized and has allocated the resources needed to proceed with this model. At the same time, it is expanding the network of services provided and is implementing mechanisms for securing financial resources more efficiently to make it sustainable. For institutional strengthening of the CCSS, it is important to have instruments and mechanisms that will make it possible to analyze whether or not the benefits are pertinent and comprehensive and to have methodologies that will make it possible to deal with the problems that arise. The CCSS has requested PAHO contributions in this area. However, the problems that have arisen are the rate of internal development for the upgrading, their relationship to the steering role, and the need to improve supervision and evaluation and incorporate community participation into the process. Priority continues to be

given to this area, and PAHO cooperation is being requested in this regard.

3. With respect to the upgrading of the resource allocation system, the sluggish implementation of the plans to recover financial balance has been identified as a problem. Currently, this has worsened with the State's failure to make its foreign debt payments due to the diversion of funds toward the domestic debt problem. This area remains a priority, with support from the international financial institutions. All of this is occurring in the context of a change in government and the discussion and analysis of priorities and policies in which the new administration is beginning to organize its response.

4. From the demographic standpoint, there is a glaring absence of a national census (the most recent one was in 1984) that would make it possible to define the structure and composition of population groups and the specific pressures on goods and services. In addition, there are no reliable figures on the participation of immigrants in the country's economy, their impact on the job market, inequities with regard to social rights and living conditions, and pressure on access to services. Furthermore, their health profile is not known. There is international commitment to conducting a General Census in the year 2000. Regarding the issue of migrants, PAHO cooperation has been requested for conducting research and analysis and for defining intersectoral action.

5. With regard to the environmental situation, the main problems are the final disposal of solid waste, including hospital waste, the excessive and indiscriminate use of pesticides, and air pollution. Despite high rates of water supply, shortcomings remain in terms of quality and timeliness. Gaps between urban and rural areas persist in terms of the supply of sewage services, as do major deficiencies in wastewater elimination, which is the greatest problem. The current administration proposes strengthening the responsible institutions, exercising a steering role, and increasing the coverage and quality of the services, with cooperation from PAHO.

6. Concerning morbidity and mortality, cardiovascular diseases are a priority for the current administration. They are the leading cause of death

and are on the rise; moreover, they put a strain on the health services. It is estimated that 15% of the population is hypertensive. According to the 1992 survey, hypertension was the second leading cause of outpatient consultation in both men and women. Diabetes ranked eighth as a cause for consultation in men and fourth in women. It is the fourth leading cause of hospital discharge, and the majority of those affected are women. One strategy for facing this problem will be the implementation of the CARMEN project and the strengthening of health care services, with the support of PAHO. The second leading cause of death is neoplasms, which are also on the rise. The overall incidence of cancer has remained stable since 1985. In the past decade, there has been a reduction in cancer of the stomach, neck, and lungs in women and an increase in breast cancer; in men the incidence of prostate and lung cancer has risen and that of stomach cancer has fallen. Neoplasms were the fifth leading cause of hospital discharges in the 1988-1995 period. However, despite this trend, the new authorities have made cervical cancer a priority. Along this same line, emphasis will be placed on care for women at the intersectoral level, with efforts directed by the Office of the First Lady and the Ministry of Women's Issues.

7. Dengue remains a serious problem and has recurred basically along the Atlantic coast. The incidence of malaria remains high. For both diseases, ongoing efforts must be planned, rather than one-time activities to deal with a particular situation. The activities of the Basic Comprehensive Health Teams (EBAIS) and the inclusion of social participation as a fundamental element are considered of the utmost importance, as is PAHO support. There are high levels of substance abuse involving alcohol, tobacco, and narcotics. PAHO support is therefore considered essential for reducing this incidence.

### ***National Priorities for PAHO's Technical Cooperation***

8. To consolidate the steering role of the Ministry of Health through exercise of the strategic leadership and management role in a way that permits the establishment of the national health system; To develop a health surveillance system with an intra and extrasectoral approach as the basis for decision-making; To strengthen the development of the model and the quality of the care provided, including health

promotion, disease prevention, and rehabilitation; To consolidate the strategic regulatory function in health, involving civil society in the process, for quality assurance in health service delivery; To strengthen activities aimed at protecting the personal environment to contribute to sustainable personal development; To consolidate the organizational development and strengthening of project-based work processes for the delivery of quality cooperation; To strengthen the coordination and integration of subregional activities in health areas of the Central American region.

### ***Technical Cooperation Strategy***

9. The evaluation and analysis of cooperation needs permitted a review of the mechanisms for defining and managing technical cooperation at the national level. In response to that process, the PAHO/WHO Representative Office in Costa Rica took up the challenge of providing more effective cooperation, based on the relevance and potential impact of the national processes. Its approach to execution is decentralized. In order to achieve this decentralization, a proposed mechanism for coordinating cooperation activities has been developed. It is comprised of three groups and entities. The first group is the general management, which is a political entity for decision-making and strategic orientation of the cooperation process. This group includes the country's highest authorities and the PWR. The second group, a technical policy entity, is a permanent forum for analysis and monitoring of the technical cooperation processes. This group includes the Directors of the five technical offices of the Ministry of Health and a group of PAHO consultants. The third group is a technical body for implementing specific cooperation projects. It is made up of all the consultants and their counterparts.

10. This proposal has been analyzed, and a consensus has been reached with national authorities that has led to the institutionalization of the process for organizing, programming, monitoring, and evaluating technical cooperation. The technical cooperation has been programmed concurrently with the definition of the main intervention areas for the technical cooperation. Five major intervention projects have been organized through a joint process with national authorities and the teamwork of the consultants from the Representative Office.

11. The five projects defined and agreed upon are: health monitoring; leadership and management; regulation; personal health care; and environmental protection and development. For decentralized execution, a manager will be appointed for each project. This individual will be in charge of organizing the technical groups of consultants and mobilizing and managing resources. The entire team of consultants is responsible for defining, developing, carrying out, and evaluating the projects. The responsibilities will be detailed in the corresponding PTS at the level of tasks, monitoring mechanisms, and staff performance evaluation.

### ***Objectives for PAHO's Technical Cooperation***

- To increase the national capacity for interpreting data and identifying gaps in health for decision-making.
- To help to increase the capacity of the Ministry of Health to lead the development of health in Costa Rica.
- To contribute to the development and implementation of the integrated health care model at all levels.
- The development of the country's capacity to integrate and conduct intra- and intersectoral activities for the regulation of health.
- To contribute to the development of a sustainable, efficient, and comprehensive system of environmental protection, utilization, and development.
- To facilitate attainment of the results proposed in the "PLAGSALUD," "PROFIN", and subregional Women, Health, and Development projects.

### ***Expected Results***

12. During the 2000-2001 biennium PAHO is committed to developing, jointly with the country, the following expected results:

13. *Cooperation networks, alliances.* On pesticides; for the prevention of intrafamily violence in the municipalities of Central America; and for the

control and reduction of environmental risks which affect health and sustainable development.

14. *Standards and guidelines.* That support and sustain effective management that minimizes environmental risks in the Central American countries.

15. *Plans, projects and policies.* Building consensus for defining national health priorities, in order to strengthen sector institutions in support of the steering role; for sustainable environmental protection and development; and for reducing the risks from pesticide use, with emphasis on the most vulnerable areas. Projects that promote the development of healthy spaces at the municipal, school, and work level.

16. *Methods, models and technologies.* For functional integration of health surveillance; for the national health information system; for strengthening health monitoring; for formulating and evaluating national health policies; for the political/technical management of the health sector; for orienting the model of care to include health promotion and disease prevention; for incorporating quality management in the delivery of services; for increasing the response capacity of the service network; for planning and operating programs to maintain and renovate the physical infrastructure and biomedical technologies; for including representative entities of civil society in the regulation of health; for facilitating the organizational development of all sectoral entities that exercise the strategic regulatory function; for updating the code related to the regulation of health; for guaranteeing quality and equity in health for environmental protection and development; for applying health and environmental criteria to pesticide use; for detecting, recording, preventing, and addressing intrafamily violence, defined and agreed on with the countries of Central America.

17. *Training programs.* For a sensitive and comprehensive approach to women's health; formal and non-formal programs that involve environmental risk aspects.

18. *Direct support.* To strengthen the national environmental management system.

**COSTA RICA  
PROPOSED BUDGET ALLOCATION**

Appropriation Level	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Health in Human Development	1,446,300	1,644,200	952,400	140,100
Health Systems and Services Development	694,800	471,500	1,752,600	600,000
Health Promotion and Protection	328,600	470,400	29,600	20,000
Environmental Protection and Development	327,400	400,600	5,460,800	4,710,000
Disease Prevention and Control	232,000	42,400	14,700	0
<b>Total</b>	<b>3,029,100</b>	<b>3,029,100</b>	<b>8,210,100</b>	<b>5,470,100</b>

# CUBA

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## *Health Situation*

1. The changes taking place worldwide and their repercussions continue to determine the changes in economics, finance, and work. Cuba's political system continues its adjustment aimed at furthering decentralization and increasing grassroots participation in the management of the State, with emphasis on the municipios and their People's Councils. The political will remains firm to preserve and improve the equity already attained and to persevere in developing universal public health and educational systems.

2. Efforts to overcome the economic crisis that began in 1989 also continue, resulting in economic growth of 0.7% in 1994, 2.5% in 1995, 7.8% in 1996, and 2.5% in 1997.

3. The main indicators of the health situation have held steady or improved, particularly in 1997, when an infant mortality rate of 7.2 per 1,000 live births was achieved. Direct maternal mortality also fell from 2.4 per 10,000 live births in 1996 to 2.2 in 1997, and low birthweight was reduced from 7.3% in 1996 to 6.9% in 1997.

4. Non-communicable diseases, especially heart disease, cerebrovascular disease, and cancer, together with accidents, constitute the leading causes of death for all ages and remain the principal problems. Mental health problems, addictions such as smoking and alcoholism, and sexually transmitted diseases are other key areas that affect the health situation. In this regard, addressing the health problems of older adults is tremendously important, given the aging of the Cuban population, as is treating adolescents and young adults for addictions and sexually transmitted diseases. Priority has been assigned to maintaining the successes achieved in the areas of maternal and child health and vaccine-preventable diseases.

5. The strategy of the Ministry of Public Health (MINSAP) is aimed at strengthening decentralization, the intersectoral approach, and social and community participation in health, as well as increasing the efficiency, effectiveness, and quality of the health system to better meet the needs of the population through the services provided by

the sector. The strategy emphasizes the need to continue encouraging activities through the municipios and the People's Health Councils to promote health, prevent disease, and uphold the principles of the Cuban health system, all within the context of improving primary health care and revitalizing and reconfiguring hospital services.

6. Concurrent with the national strategy and priorities, more comprehensive cooperation is proposed. This would be centered on two lines of action: strengthening decentralized cooperation in selected municipios through local identification of problems and intervention strategies, emphasizing the link between health and economics; and strengthening the National Health System, with its steering and management role, and its priority programs, emphasizing prevention and health promotion.

## *National Priorities for PAHO's Technical Cooperation*

7. Strengthening of the SNS for sustainable development of health and social well-being, involving local governments, the community, and intersectoral action. Continued work in the development of a culture of health, well-being, and constant improvement of personal habits and behaviors related to health. Continued orientation of cooperation toward local development in which initiatives for health and well-being are emphasized, in particular "Municipios for Health." Further study and intensification of decentralization, implementation of management by objectives, strategic planning, development of the economy and health, modernization of control systems, and evaluation. Establishing priorities in human resources development, training of SNS management teams, evaluation of competency and performance, and upgrading of health workers in priority areas. Emphasis on development of the National School of Public Health. Continued expansion of health education and promotion activities, stressing the intersectoral approach and aimed at young people and adolescents, including the family, the community, and other sectors. Continued prioritization of actions that benefit the elderly,

promoting their participation in disease prevention, health promotion, and well-being, and improving their living conditions. Increased efforts to integrate people with mental health problems into society. Strengthening education of the population on healthy habits in oral hygiene, consolidating preventive actions, and emphasizing the use of fluoride. Prioritization of micronutrient fortification of food (iron, iodine, vitamin A, fluoride). Prioritization of development of the Medical Emergency System (SIUM), emergency care, and care for the seriously ill in the health services; accreditation of pharmacoepidemiology and the principal municipal pharmacy; and research on SS and economic control. Expanding cooperation for the mobilization of financial, physical, human, information, policy, and institutional resources, encouraging local, national, and international initiatives to address national health priorities. Promotion of environmental protection and development, ensuring intersectoral action in sanitation, elimination of solid waste, protection of drinking water supply sources, and evaluation and control of environmental risks, including occupational risks. Prioritization of primary environmental care at the local level. Continued work in the area of drugs, directing efforts toward traditional and natural medicine

### ***Technical Cooperation Strategy***

8. This strategy is based on the findings of the monitoring and evaluation of PAHO/WHO cooperation with Cuba in 1991 and 1992, the JEM, which covered the periods 1994-1995 and 1996-1997, the results of the Ministry of Public Health's monitoring and evaluation at the national, provincial, and municipal level, and also the systematic analysis of the country's health situation and the strategic alternatives and capacities that PAHO/WHO has achieved to respond to the challenges posed by Cuban public health.

9. The directing of cooperation toward the local level, with the broad and active participation of communities, the organizational units of MINSAP, and other sectors and institutions, has led to new and varied dimensions of participatory management in cooperation.

10. The cooperation strategy is geared essentially to furthering the decentralization of the National Health System at the provincial and municipal level. To this

end the decentralization of technical cooperation is continuing through focal points (functional working groups) in the western, central, and eastern provinces. These groups interact with the Ministry of Public Health and the PAHO/WHO Representative Office in areas of the country where new ways of mobilizing local, national, and international resources are being discovered.

11. Decentralization goes hand-in-hand with strengthening the National Health System and developing its management and steering role in the management, coordination, and integration of national health and welfare policies.

12. PAHO/WHO cooperation with Cuba is expressed strategically in three processes: decentralization, intersectoral action, and mobilization of resources, and is executed in two key projects geared to local development and the strengthening of the National Health System.

13. In the biennium 2000-2001 greater strategic emphasis will be placed on the use of functional approaches, inasmuch as experience in development has led to significant interaction among them that will permit the further development of national policies and plans to strengthen the local level. The local level is the venue for the primary care strategy, the development of local health systems, and health promotion as comprehensive expressions of social welfare.

### ***Objectives for PAHO's Technical Cooperation***

- Strengthen local development processes through decentralization with a preponderantly intersectoral content and strong community participation.
- Support the monitoring of municipal development the projects under way and incorporate new municipalities.
- Contribute to the upgrading of selected human resources in priority areas at the local level.
- Support the development of specialized units at the provincial level.

- Strengthen the capacity of the Health and Human Development Centers linked to the basic poles of economic production in the territories.
- Intensify the work in healthy spaces and support the development of primary environmental care.
- Support the management of the focal points of cooperation in the western, central, and eastern portions of the country.
- Support veterinary public health activities at the local level.
- Acquire essential support inputs for the municipal infrastructure.
- Continue to support the SNS in the search for greater efficiency and effectiveness, taking into account decentralization, intersectoral action, and social participation in attaining the health and well-being of the population.
- Encouraging the mobilization of resources, the establishment of policies, and the development of initiatives that respond to the national priorities of the SNS.

### *Expected Results*

14. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

15. *Cooperation networks, alliances.* At the national and international level.

16. *Training programs.* To improve the analytical capacity of the SNS; upgrade the human resources engaged in the execution and evaluation of priority SNS programs; and develop the scientific and technical capacity of the SNS.

17. *Direct support.* To strengthen the SNS' subsystem of education, specialization, and human resources development and to enhance National Plans for Emergency and Humanitarian Assistance.

<b>CUBA PROPOSED BUDGET ALLOCATION</b>				
Appropriation Level	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Health in Human Development	942,700	1,034,500	273,500	169,000
Health Systems and Services Development	1,381,800	1,231,800	50,000	0
Health Promotion and Protection	100,000	223,200	0	0
Environmental Protection and Development	50,000	44,400	368,000	350,000
Disease Prevention and Control	82,500	86,100	0	0
<b>Total</b>	<b>2,557,000</b>	<b>2,620,000</b>	<b>691,500</b>	<b>519,000</b>



# DOMINICA

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## *Health Situation*

1. Dominica is unique among the islands of the Eastern Caribbean in that it has an identifiable indigenous Caribbean population (just under 2,000 persons). In 1996 the estimated population of the Commonwealth of Dominica was 75,399, compared to 71,183 at the 1991 census. The figures further revealed that 25,760 (34%) of the population is below 15 years of age and 7,003, (9.3%) 65 years and over, giving a dependency ratio of 43%.

2. Over the period 1991-1996, life expectancy at birth has improved and has increased from 68 years to 74 years for females and from 61 years to 71 years for males, contributing to an increasing prevalence of chronic health conditions.

3. Infant mortality rate has remained stable between 15-17/1000 births from 1991-1996. Neonatal death rate has fluctuated from 16/1000 in 1991 to 10/1000 in 1995, being reported as 13/1000 in 1996. Chronic diseases such as diabetes and hypertension contribute most significantly to morbidity. The MOH reports prevalence of diabetes has remained at 3.5% of the population as a whole, and 20% of the population suffering from hypertension.

4. In 1996 hypertension accounted for 8% of the total admissions to medical wards at Princess Margaret Hospital; 41% of visits in primary health centers were due to hypertension and 16% to diabetes. Approximately 38% of diagnoses at the time of hospital discharge were asthma.

5. A study in 1993 revealed that 89% of children were obese. The need for programs aimed at health promotion and lifestyle change is evident. Communicable diseases continue to compromise the health status of the population, but poor reporting hinders proper assessment of the epidemiology of notifiable diseases.

6. The incidence of HIV infection was under 20/100,000 population in 1987 and for 1995 the incidence increased to 22/100,000. In 1996 14

cases were reported (surpassed by 15 cases reported in 1993). The male to female ratio was 4.1, with the highest rate among adults 25-44 years. To address these problems, programs directed to health promotion, community awareness and counseling, which are aimed at the largest group, should be put into effect.

7. There has been a decrease in STD's such as syphilis, gonorrhea, hepatitis B and herpes, but increases have been noted for the STD's causing vaginosis such as trichomonas, clue cells and monilia. Tuberculosis continues to be a significant problem in the Carib Reserve, although incidence and mortality have declined elsewhere. Typhoid no longer poses a problem with rates of 4 and 3/100,000 for 1995 and 1996, respectively.

8. Dominica's economy rebounded after the devastation caused by the hurricanes of 1995. The GDP grew by 3.7% in 1996. However, this was followed by a contraction of 1.4% during 1997. This decline was evident in all three major economic sectors: agriculture (due mainly to the banana industry which contracted by 11%, although the rest of the sector expanded by 8.3%), manufacturing (7.7% contraction), and construction (7%). This was countered by steady growth in the tourism sector with the number of cruiseship visitor arrivals increasing by 18.3%.

9. The Consumer Price Index recorded increases of 8.5% in the miscellaneous category resulting from increased education fees, with food seeing the next largest rise in prices of 3% with the price of vegetables increasing by 10%.

10. The structural adjustment program which began in 1986/1987 has been concluded, however, the important element derived was the improvement in the fiscal performance through taxation reform and expenditure in 1991. Wages and salaries rose by 28% compared to an average of 7%. Government therefore continues to seek to restrict growth in the civil service wages and salaries.

11. The 1981 census figures revealed that the unemployment rate was 18.8% and showed a significant reduction to 9.9% in the 1991 census which seems to have been maintained in 1996 with a rate of 9.2%.

12. An estimated 25% of the population is without access to excreta disposal systems. The majority of this sector of the population is concentrated on the West Coast of the island, where 60% of houses are without excreta disposal facilities. *Aedes aegypti* infestation continues to remain a serious problem. The household index far exceeds the 1% recommended by PAHO/WHO. The inadequacy of existing food regulations hamper the effective control of handling and vending operations. The absence of abattoirs and fish markets to great extent, prevent the required inspections of these foods before they reach the consumer. New hazards in the work place and homes have emerged and there is increasing exposure to chemicals, excessive heat and noise. Solid Waste Management is not yet wholly geared at minimizing human impact on the environment. 90% of the population has access to pipe borne water however, there still remains a problem in ensuring satisfactory water quality. Port health needs to be given more special attention such that vector borne disease facilitated through international travel by ships and aircraft could be significantly reduced.

13. The health services coverage continues to be high throughout the country. The management of the Princess Margaret Hospital (PMH) remains a major problem and has been addressed through assistance from the French cooperation. With the functioning of the new hospital in Portsmouth (50% estimated occupancy rate) there has been some relief in the overcrowding of the Princess Margaret Hospital. It is of concern that the problem of overcrowding in the maternity ward will continue in spite of the construction of a new wing (with the same number of beds) due to little decentralization of deliveries continuing. This is compounded by the majority of women preferring to be delivered in a hospital. Efforts to improve the delivery of health services at the district level continue. A community mental health program has not been fully established even though there has been improved condition in psychiatric/mental health services in hospital embodying new approaches

to mental health, a day care occupational therapy program and a psycho-social worker. Further expansion of dental health care is needed to adequately cover pregnant women.

14. In order to address the health needs of the population the Government has identified the following priority areas: institutionalization of health promotion throughout the health services; improved health infrastructure at primary and secondary levels; development of preventive maintenance program to reduce rapid deterioration of infrastructure; give priority attention to the provision of basic equipment and supplies; development of human resources; development of emergency services; strengthening the management of the billing, admission and collection processes.

### ***National Priorities for PAHO's Technical Cooperation***

15. People of Dominica attain the highest possible level of health at an affordable cost. Achieving social, physical and mental well-being of all citizens. Improvement in health infrastructure at primary and secondary levels. PM hospital. Rehabilitation of health centers and construction of two new health centers. Preventive maintenance program (basic equipment and supplies). Effective and efficient delivery of health care. Lasting improvement in the quality of life. Environmental issues including excreta disposal and food safety. Chronic diseases including Mental Health. Maternal, adolescent and child health Drug prevention and user rehabilitation Care of the elderly and prevention of blindness. Prevention and control of communicable diseases including TB, HIV/AIDS. Occupational Health and Safety. Infrastructure development and health information management Disaster management and development of emergency services Human Resource development skill and knowledge enhancement in critical areas (administrative and technical). Health promotion to empower people to improve living conditions, nutrition, hygiene and general lifestyles. Forge alliances with private sector and other NGOs.

## *Technical Cooperation Strategy*

16. Over the biennium 2000 - 2001, the technical cooperation of PAHO CPC will be delivered through three projects Environmental Health and Sustainable Tourism , Health Promotion and Disease Prevention, and Health Systems and Services. Delivery will occur at both bilateral and subregional levels, will seek to enhance complementarily including that of CCHII. This program of work calls for collaboration of all the PAHO units and PAHO CPC. Collaboration with regional institutions, other agencies and community-based organizations will also be pursued. Emphasis will be on building capacity and in particular in ensuring sustainability at both the ministry and local institutions as well as regional institutions with whom we collaborate in delivering direct technical assistance.

17. All functional approaches: resource mobilization; training; development of policies, plans and norms; dissemination so information; direct technical assistance and research will be utilized in delivery, with the training of personnel remaining the single most frequently employed functional approach.

18. The priority areas of the yet to be ratified CCH II initiative are congruent with the areas of this work plan therefore no change is anticipated following the introduction of the CCH II.

19. The strategic approaches to be used in the execution of technical cooperation over the period will include: a) capacity building through in-country training to increase numbers of skilled personnel and through the use of consultants dedicated to working with the nationals over the medium term; b) promote and facilitate multi-sectoral action particularly for Health and Tourism activities and Health Promotion projects; c) increase use of TCC to bring relevant experiences of other Caribbean countries to Dominica and share pioneering experience of its efforts in the implementation of: a computerized patient classification system; healthy communities/settings projects; quality improvement program.

20. The strategies to be used in the execution of technical cooperation are listed below.

21. Health in Human Development Strategies: Mobilization of resources to contribute to education and training of human resources involved in the production of knowledge and in carrying out public health activities; Assistance in the identification of important social and political partners and promoting their participation in the debate on development issues in tourism.

22. Environmental Protection and Development Strategies: Strengthening the capacity of the Ministry to exercise leadership and advisory role in the treatment of environmental issues by training and development of guidelines, plans and policies (monitoring of waste disposal); Promoting the expansion of the implementation of national strategy for intersectoral collaboration and community participation in the planning and management of programs to combat dengue (haemorrhagic) fever.

23. Health Systems and Services Development Strategies: Development of models to support the reorientation of services with health promotion and disease prevention criteria to improve the quality and comprehensiveness of interventions (e.g. two priority areas of non-communicable diseases); Development of national quality assurance programs. It is proposed to include networking with collaborating centers; Strengthening programs for the planning, operation, maintenance and renovation of the physical and technology infrastructure of the health sector especially in respect of disaster management.

24. Disease Prevention and Control Strategies: Promoting food protection by the introduction of methods, models, and technology and mobilizing resources for the acquisition of equipment and supplies to monitor the application of HACCP in food safety.

25. Health Promotion and Protection Strategies: Design and strengthen methodologies and interventions in health promotion to increase capacity of the Ministry to introduce and manage healthy communities /settings projects including networking with collaborating centers; Promote the adoption of healthy lifestyles and risk

Prevention through anticipatory behaviors (UN/CARICOM Family Life Education Plan of Action).

**Objectives for PAHO's Technical Cooperation**

- Environmental health conditions and protection enhanced.
- Healthy Lifestyles adopted.
- Health Systems improved.

**Expected Results**

26. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

27. *Cooperation networks, alliances.* To strengthen implementation of the health and family life education program.

28. *Research and evaluation studies.* On health in tourism, to strengthen dental health program, and on disaster response capability.

29. *Plans, projects and policies.* To increase the capacity of hospital management and information system.

30. *Methods, models and technologies.* To increase the capacity of the food safety program, to strengthen Health promotion planning capacity, and to increase capacity of the Ministry to plan and manage healthy communities/ settings projects.

31. *Training programs.* To increase the capacity of the Ministry to monitor sewage and industrial waste disposal sites, and in health promotion and hospital management.

32. *Direct support.* To strengthen the capacity for integrated vector/rodent control.

<b>DOMINICA PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health Systems and Services Development	221,000	159,900	0	0
Health Promotion and Protection	41,500	72,100	0	0
Environmental Protection and Development	42,000	72,500	0	0
<b>Total</b>	<b>304,500</b>	<b>304,500</b>	<b>0</b>	<b>0</b>

# DOMINICAN REPUBLIC

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## *Health Situation*

1. In the past 20 years Dominican society has witnessed profound changes. In the economic sphere, the country has shifted from a traditional agroexport economy (with sugar representing more than 60% of the value of exports, more than 70% of industrial employment, and more than 45% of the employed EAP) to a service economy (with sugar representing just 4% of exports, and tourism, the industrial duty-free zones, and monetary remittances from residents living abroad constituting the driving forces of the economy). This economic model is considered highly vulnerable, extremely inequitable, and unsustainable in the long term.

2. In the demographic sphere, the population has become predominantly urban. Concentrated in the principal centers of development, its density is steadily increasing. According to estimates, more than 10% of the country's inhabitants migrated internally between 1980 and 1991. The population remains young for the most part (35% under the age of 15), with a growing EAP. The external migratory balance is negative, owing to the heavy flow of emigrants.

3. These changes have led to substantial growth of the population living in poverty. The sharp decline in rural and urban living conditions areas is linked to the high inflation and unemployment rates of the 1980s and early 1990s and to the serious deterioration in the education and health systems during that same period as a result of cutbacks in social expenditures and the failure to adapt those expenditures to the new economic and demographic realities. In 1991, SESPAS spent 27% of the outlay for 1980, in real terms. Although this expenditure rose slightly in subsequent years, it has not regained its 1980 levels, remaining at approximately 1% of GDP and channeling the increase basically toward the creation of infrastructure. Dominican society today is characterized by enormous social inequities, with a high potential for social conflict. The cumulative social debt in the health sector plays an important role in these inequities.

4. At the same time, the geographical location of the Dominican Republic and its intense tourism and migration patterns make the country highly vulnerable to the circulation of infectious agents. Serious efforts have been under way to strengthen the country's epidemiological surveillance system, chiefly for the most prevalent infectious diseases. This has involved the creation of a network of sentinel posts, the improvement of registries in the health services, the training regional and area epidemiologists and managers, and operations research. Especially important is the EPI surveillance system, which has achieved a significant level of development. The vital statistics registry, in contrast, has serious shortcomings.

5. The national authorities have made a priority of transforming the economy into a human development model geared especially toward reducing social inequities.

6. In the field of health, the Dominican Republic has made real progress in controlling vaccine-preventable diseases, reducing mortality from ADD, and developing a nationwide health services infrastructure. It should be pointed out that for two consecutive years no cases of measles have been reported as a result of the EPI's continuing vaccination effort. However, there are still large reducible gaps in mortality with respect to countries with similar resources, a figure that accounts for roughly 40% of the estimated deaths. More than 50% of this mortality corresponds to deaths in children under 5. Some 57% of the PYLL prior to age 70 corresponds to children under 5. The most important causes of PYLL are infectious diseases, especially ADD, followed by nutritional deficiencies. The estimated infant mortality rate is 42 per 1,000 live births, although there have been signs in recent years that the figure is stabilizing and that success will be achieved in its reduction. Another important indicator is the high maternal mortality rate, estimated at 120 per 100,000 live births.

7. This profile of reducible gaps and social inequities is evidence of the deterioration in the living conditions of the bulk of the population. One of the most important components of this situation is access to drinking water supply and sanitary excreta

disposal. Notwithstanding the efforts in recent years, nearly 40% of the population lacks household water connections, and the supply is extremely irregular in many areas. Only 16% of the nation's population has access to a sewerage system. The greatest deficiencies have been in rural and marginal urban areas.

8. At the same time, the incidence of accidents and acts of violence, as well as certain degenerative diseases (particularly cardiovascular disease and cancer) has been steadily rising. These constitute a significant cause of morbidity and mortality in adults.

9. By late 1995, SESPAS had 741 facilities (49 hospitals, with 7,234 beds). However, while the vaccination programs and several prevention and control programs have achieved a high degree of national coverage, estimates indicate that the public health services meet only 40% of the population's demand, with considerable regional and social disparities. Added to this is the low public opinion of these services and their quality.

10. Efforts to carry out major economic and State reform have aroused a heated debate in which the following priorities have been identified: restoration of efficiency and effectiveness in the health system, with reform based on the restructuring of the Ministry of Health; strengthening of the steering role of the Ministry; greater decentralization, coupled with new forms of coordination between the public and private sector to foster greater equity in access to basic services; and assigning priority to reducing the social gaps in the health situation. The debate continues, with no definition as yet of the organizational modalities, models of care, and financing mechanisms that will govern the health sector reform process.

11. For several years health sector reform has been spearheaded by a National Health Commission. Since 1995, it has gained greater impetus with the creation of Technical Coordination Office. Administratively under the Commission and linked to SESPAS, this Office operates with technical assistance from PAHO, UNDP, and AID and financial assistance from IDB and IBRD.

12. Health technology development has not been attempted in the country, although major efforts have been made to acquire state-of-the-art medical technology for private clinics and the Health Plaza, which is awaiting to be put into operation.

13. The production of biologicals for human (rabies vaccine) and animal use has reached satisfactory levels, and the country exports to several of the Central American countries.

14. In light of the above, technical cooperation that helps to strengthen SESPAS' steering role in the health sector and its capacity to spearhead the reform process is considered a priority, as is strengthening its epidemiological surveillance capacity and its capacity to identify priority problems, social groups, and neglected territories. Equally important are strengthening the managerial capacity of public health institutions and improving their programs, with emphasis on maternal and child health and basic sanitation.

15. Basically, the country requires external technical cooperation to support health services development, the training and management of health workers, the sectoral reform process, local health systems and environmental health, food protection, reproductive health and adolescence, epidemiology and control of prevalent diseases, health promotion, and social participation.

16. PAHO support is needed in all these areas, especially for service and personnel management, epidemiological surveillance, and the strengthening of decentralization to improve programs in health promotion and reproductive health, vaccination programs, the management of prevalent illnesses in risk groups, and basic sanitation.

### ***National Priorities for PAHO's Technical Cooperation***

17. To reduce the cumulative social inequities in health, improve maternal and child health, and modernize and reform the health sector.

### ***Technical Cooperation Strategy***

18. The programming of this BPB began with a joint analysis with national authorities of the country's cooperation priorities, especially areas where the process is already under way. The result was a decision to continue with most of the lines of action programmed in the BPB98-99, with greater activities but within the same processes.

19. Since the country has not changed its views about its national priorities, which are to reduce social inequities in the health sector and improve the efficiency and effectiveness of the services, the goal of the projects will remain the same.

20. Consistent with the work of the Representative Office to increase coordination among the specific areas (topics that respond to the new strategic and programmatic orientations) and to boost effectiveness by facilitating cooperation, we have decided to proceed with the implementation of four projects. Two of the projects define specific areas of action, such as national institutions or processes (e.g., health sector reform) in cooperation projects such as "Reform and Modernization of the Sector at the National Level: Development and Implementation" and the provincial and local project that distributes cooperation according to the new decentralized structure of the health sector, ratified by presidential decree.

21. In keeping with the policies of the Organization, the project for cooperation among countries will place special emphasis on Haiti.

22. The program activities are framed within the functional approaches, as follows:

23. Development of Policies, Plans, and Standards. The emphasis on the institutional development continues, in order to strengthen SESPAS as the steering agency of the health sector. To this end, there will be continued support for developing its capacity to define and implement intersectoral policies and plans that promote a comprehensive vision of health and its links with economic and social development, the goal being to reduce social inequities in the health situation and in access to basic health services. Strengthening of managerial capacity will also be supported.

24. Decentralization, strengthening, and development of local and decentralized institutions will be reinforced, as will the interaction between government and non-governmental institutions.

25. Direct Technical Cooperation: Ongoing technical assistance will be provided to high priority areas, as will temporary advisory services, when necessary, to strengthen specific aspects. Priority will be assigned to the following areas: health services; water and environmental sanitation; epidemiology;

health promotion; maternal, child, and adolescent health; human resources; and scientific and technical information. The priority assigned to the cooperation activities of each project will be based on the goal established in this strategy.

26. Training: Cooperation will be provided for strengthening the national capacity to formulate and execute policies and plans aimed at the integral development of human resources for the health sector. Educational activities will be coordinated among the various projects. Strengthening of educational institutions will be supported at the undergraduate and graduate levels.

27. Mobilization of Resources: Interaction and mutual support in the field of health will be promoted in the United Nations system and among the multilateral and bilateral cooperation agencies. Development of the national capacity to formulate and execute investment proposals will be fostered, along with the capacity of the PWR to participate actively in the mobilization and execution of external and extrabudgetary resources. Emphasis will be placed on projects that contribute more to the established goal.

28. Research: Efforts will be made to strengthen the national institutional capacity to design and execute research projects related to priority health problems, with emphasis on program and service administration, epidemiological surveillance, and disease prevention and control. Support will be provided for strengthening the national health sciences community.

29. Dissemination of Information: Access by health workers to up-to-date, specialized scientific and technical information will be promoted, as will the strengthening of an institutional network of health documentation centers and the development of our center as a virtual library.

### ***Objectives for PAHO's Technical Cooperation***

- To reform and modernize the health sector, with special emphasis on the primary care strategy, which helps to reduce social inequities.
- To establish cross-border cooperation projects and projects with other countries of the Region

to address priority needs in the Dominican Republic.

- To carry out the PWR cooperation program in a coordinated manner, in keeping with the SPO and the country's cooperation priorities.

## ***Expected Results***

30. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

31. *Cooperation networks, alliances.* To develop specific projects for priority programs with Haiti, Cuba, and Panama as follow-up to the programs of the 1998-1999 biennium for health sector reform, with special emphasis on the steering and management role of the ministries of health in the sector.

32. *Surveillance and information systems.* For an integrated epidemiological surveillance model adapted to the reformed health system that incorporates the equity and gender approach to health.

33. *Standards and guidelines.* For the country's problems and priority programs, with interinstitutional and interagency participation, that develop the steering role, management, and sectoral regulation of SESPAS and are adapted to the provincial level and to the national priority programs, with emphasis on improving the health and nutrition of women, children, and adolescents.

34. *Research and evaluation studies.* In national priority programs (on the health of women, adolescents, and children, and on nutrition to reduce infant and maternal mortality).

35. *Plans, projects and policies.* For modernization and reform of the water and sanitation sector that envisage the reduction of social and gender inequities and strengthening of the healthy municipios strategy; modernization and reform of the sector using the equity and gender approach; intersectoral reform of health and tourism in priority tourist areas; healthy environments (healthy municipios) with Haiti, Cuba, and Colombia; and emergency and contingency services with the institutions working in the border area to ensure disaster preparedness.

36. *Methods, models and technologies.* For universal access and financing; for effective management of the institutions working in health and the environment, within the framework of current policies to reform the environmental sector. This will make it possible to execute provincial health plans and evaluate their effectiveness in addressing social and gender inequities, in the context of reforming the management of services and priority programs (mental health care, community-based rehabilitation, nursing, laboratories, drugs, and oral health, among others); for effective management of health and environment institutions, within the context of the current reform policies; for disaster preparedness in hospitals; and for projects for mitigating the impact of disasters on hospitals.

37. *Promotional campaigns and advocacy.* In health that include DIGPRES priority programs that employ the equity and gender approach.

38. *Direct support.* For the reform and modernization of the health and drinking water and sanitation sectors; for the Virtual Health Library (VHL), with national sources of specialized health information; and for the dissemination of health information.

<b>DOMINICAN REPUBLIC PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health in Human Development	1,742,200	1,764,600	943,500	0
Health Systems and Services Development	823,800	853,500	54,200	0
Health Promotion and Protection	270,000	248,500	0	0
Environmental Protection and Development	469,500	497,400	0	0
Disease Prevention and Control	72,000	49,600	96,000	1,000
<b>Total</b>	<b>3,377,500</b>	<b>3,413,600</b>	<b>1,093,700</b>	<b>1,000</b>



# EASTERN CARIBBEAN

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## *Health Situation*

1. Anguilla, British Virgin Islands and Montserrat are three British Overseas Territories with respective populations of 10,302 (1995), 16,644 (1991 census) and 10,444 (1991 census), respectively.

2. As a result of the voluntary evacuations caused by the activity of volcano, Lang Soufriere, Montserrat's population was reduced to approximately 3,500 at the beginning of 1998. The population has been relocated from the capital and surrounding areas in the South, to a 'safe zone' in the North.

3. In Anguilla, approximately 50% of the population is under 20 years of age with 33% of school age. In the general population, 10% is over 65 years. In the British Virgin Islands, 26% is under 15 years of age and approximately 59.6% of the population is between 15-64 years.

4. The situation in Montserrat has changed as a result of the ongoing volcanic activity since July 1995. The economic base has been disrupted. The number of visitors has been reduced because of fewer cruise ships. The construction industry is regaining some of its pre-1995 momentum as the population left behind seek homes.

5. Since the introduction of the Voluntary Evacuation Scheme, overcrowding has been reduced considerably. The job market is fairly good in some areas, as many skilled workers have migrated. However, rice milling and other manufacturing plants have relocated to other islands. Everyday living activities and social activities have been reduced substantially. Persons who were independent farmers or entrepreneurs are now dependent on the state for housing and food.

6. Education of children is ongoing. There is less overcrowding, but the health and education sectors have suffered from the departure of professionals, including those trained in health management through the USAID/HPM project, which ended in 1996.

7. Additional environmental health risks have arisen. While control of *Aedes aegypti* has been maintained, mosquitoes pose a problem in the newly populated areas. Transportation for control and monitoring is very limited. The Ministry is concerned with the food safety practices of the increasing number of food establishments whose facilities were not intended for that use.

8. Water quality is stable, with microbiological analysis routinely conducted and the chlorination program in place. The monitoring of unusual 'radicals' in the water is also being carried out.

9. Solid and liquid waste disposal is cause for concern. While garbage collection has improved as a result of privatization, the relocation of the population forced a relocation of the landfill operators, as well as that for liquid disposal to an area designated for hotel development at Little Bay. This area is low-lying and near the coast, and the environmental risks are further exacerbated by treatment of the liquid waste. Also, there is an inadequate capacity for liquid waste, storage and collection in the shelters and newly populated areas. The number of pit latrines has increased substantially in some of the areas with a high water table.

10. The national health policies in Montserrat have basically remained the same, based on primary health care strategies with increasing emphasis on health promotion. A National Health Plan has been approved for Montserrat and will require external assistance for its implementation. However, the plans for health sector reform are now on hold and some of the issues, e.g. health care financing, may have to be reviewed because of the modified economic situation of the population. Funding for national health development is primarily from the British Government. The latter has undertaken a comprehensive review of the health services in order to develop a more appropriate delivery system supported by relevant policies. Discussions are underway to have PAHO's assistance in administering and monitoring the new program for health care.

11. The hospital has been relocated and is being rebuilt along with upgrading of the other three health

centers. However, the demand for public services continues. The need for improving mental health services in the traumatic environment is recognized. Referral services are provided by neighboring states, in particular Antigua and Barbuda, St Kitts and Guadeloupe.

12. In Anguilla and the British Virgin Islands, the improvement of the environment continues to be a priority because of the relationship with the main industry, tourism. Vector control, food protection, water quality and solid waste management are priorities with respect to the environment.

13. Construction and financial services are the other major forces within the economies of Anguilla and BVI and together with tourism make for good economic prospects in the medium term. BVI has built up an international reputation for yachting, an industry not without its potential for playing a role in the substance abuse challenge.

14. The level of social amenities are good in Anguilla and BVI. A high percentage (over 80%) of the labor force has a secondary education and the housing stock is good. Unemployment hovers around 7%.

15. The inadequate human resources to address some of the problems in health systems and services remain a concern. The limited capacity for management and planning of health services has been a challenge to the governments.

16. Anguilla and the British Virgin Islands are in the process of reorganizing health services through a 'home grown' decentralized process to improve the efficiency and quality of health services.

17. In Anguilla, HIV/AIDS is the communicable disease of most concern and will be addressed in part through the Health Promotion program.

18. Hypertension and diabetes continue to affect many individuals, and there is an increase in bronchial asthma among children and adults. Mental illness is on the rise and it is likely to increase further with the availability of illegal drugs. Prevention and rehabilitation programs need to be strengthened.

19. Tourism remains the most important commercial sector. Environmental health continues to be a priority. Areas of importance include vector control, waste management, water supply and food safety.

## *National Priorities for PAHO's Technical Cooperation*

20. To improve the health status of the population. To reduce morbidity and mortality from selected CNCDS and other selected disorders. Adolescent Health. STD/HIV/AIDS. MCH/Perinatal care. Nutrition. Diseases in men (Anguilla, BVI). Care of the Elderly (BVI, Montserrat). Promoting healthy lifestyles (Anguilla, BVI). Disabilities. Chronic diseases - diabetes mellitus, hypertension and bronchial asthma. Mental health -development of consensus on protocols. Violence - domestic abuse, child abuse, training and development of protocols BVI. Rationalization of health services - health planning services - Montserrat. Human resource development - manpower training, manpower planning and training needs. Health financing - feasibility studies of NHI implementation. Quality improvement. Support of QI initiatives and develop standards and protocols. Health information systems - develop epidemiological surveillance system. Disaster management - Update disaster plans and pre-hospital emergency care. Plant and equipment maintenance.

## *Technical Cooperation Strategy*

21. Over the biennium 2000 - 2001, PAHO CPC technical cooperation will be delivered through three projects: Environmental Health, Health Promotion and Disease Prevention, and Development of Health Services. Delivery will occur at both the bilateral and subregional level and will seek to enhance complementarity, including that of CCH II. This work program calls for collaboration of all PAHO units and PAHO CPC. Collaboration with regional institutions, other agencies and community-based organizations will also be pursued. Emphasis will be on building capacity and in particular on ensuring sustainability at both the ministry and local institutions as well as regional institutions with whom we collaborate in delivering direct technical assistance.

22. All functional approaches: resource mobilization, training, development of policies, plans and norms; dissemination of information; direct technical assistance; and research, will be utilized in delivery, with personnel training remaining the single most frequently employed functional approach.

23. The development of guidelines, standards and policies feature heavily in the program of cooperation, reflecting nationals' commitment to improving the quality of the services delivered. Evaluations and research activities are also in demand as a means of ensuring the effectiveness of work products.

24. The priority areas of the yet to be ratified CCH II initiative are in tone with the areas of this work plan; therefore, no change is anticipated following the introduction of the CCH II.

25. The strategic approaches to be used in the execution of technical cooperation over the period will include: a) capacity building through in-country training in order to increase the number of skilled personnel and through the use of consultants to work with nationals over the medium term, b) Promotion and facilitation of multi-sectoral action, particularly for health and tourism activities and health promotion projects. c) increased use of TCC to bring relevant experiences of other Caribbean countries to Anguilla, British Virgin Islands and Montserrat and share the experience of its efforts in the implementation of: healthy communities projects (BVI), waste minimization; and continuous quality improvement program.

The following strategies will be used in the execution of technical cooperation:

26. Environmental health strategies: Fostering programs for health promotion through integrated vector control programs; Promoting food protection along lines of action suggested by PASB; Developing policies for solid waste minimization and liquid waste management.

27. Health promotion and disease prevention strategies: Reorientation of services with health promotion and disease prevention control criteria that strengthen the operational capability of selected CNCD services and injury prevention and control; Strengthening of nutrition and oral health programs.

28. Health services development strategies: Promoting the improvement of health planning

capability; Human resources development; Provision of standards and norms for quality improvement; Development of epidemiological surveillance systems; and Development of policies and plans for disaster management.

### ***Objectives for PAHO's Technical Cooperation***

- To improve environmental health conditions.
- To increase the effectiveness of management of programs for prevention and control of selected CNCDs and other selected disorders.
- To improve management of health services.

### ***Expected Results***

29. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

30. *Standards and guidelines.* For prevention and control of food borne disease and for quality improvement programs.

31. *Research and evaluation studies.* To strengthen nutrition program.

32. *Plans, projects and policies.* To strengthen programs for selected diseases.

33. *Methods, models and technologies.* To improve the capacity for environmental risk assessment and pollution control and to strengthen capacity to plan and implement comprehensive programs for selected groups.

34. *Training programs.* To strengthen capacity in integrated vector control.

35. *Direct support.* For program to control intentional and unintentional injuries; to conduct oral Health program evaluation, and to improve the health planning capacity in Anguilla, Montserrat and BVI.

**EASTERN CARIBBEAN  
PROPOSED BUDGET ALLOCATION**

Appropriation Level	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Health Systems and Services Development	155,500	124,700	1,800	1,500
Health Promotion and Protection	71,000	0	0	0
Environmental Protection and Development	46,400	60,000	0	0
Disease Prevention and Control	0	88,200	72,500	0
<b>Total</b>	<b>272,900</b>	<b>272,900</b>	<b>74,300</b>	<b>1,500</b>

# ECUADOR

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## *Health Situation*

1. Ecuador is in the throes of a profound crisis marked by virtual economic and productive stagnation, a situation due in part to the decline in oil prices, which has reduced government revenues, and further exacerbated by the social and economic impact of El Niño. This was the context for the recent presidential election, whose winner will govern from 1998 to 2002. The most outstanding features of the interim government that took power in February 1997 after the overthrow of the Constitutional President were the referendum held to consolidate the legitimacy of the regime at the national and international level, the formation of an anti-corruption commission made up of delegates from civil society, the restructuring of the judiciary, the call for a National Constitutional Assembly, and the peace negotiations with Peru. The most important event in the sphere of health took place within the Assembly, where topics such as social security reform, the strategic resources of the State and recognition of its multiethnic nature, and political and economic reform led to confrontations inside and outside the Assembly, in addition to social protest, and pronouncements by the National Congress. Even the Interim President took a stand. A new political constitution was nevertheless drawn up in August 1998 that includes a section on health. In it, health is considered more than the mere provision of health care; a basic public health agenda is postulated in which programs and interventions are provided free of charge by the State. Furthermore, recognition is given to the need for prioritizing education on sexual and reproductive rights and for a national health system directed by the State in a deconcentrated and decentralized manner.

2. The demographic profile of the Ecuadorian population is one of transition. Estimated at 12,174,628 in 1998, it has been growing at an annual rate of 1.9% in the period 1995-2000. Ten percent of the population lives in predominantly indigenous areas, mainly in the Amazon region and Andean rural areas. Migration is occurring from the areas of extreme poverty toward urban centers, with the accompanying lack of resources and services and consequent deterioration in health and living conditions. Inequities persist in access to basic

services, including health services: 30% of the population does not have any type of institutional health coverage; such services are barely accessible to major segments of the population, particularly indigenous groups, and are ineffective in meeting demand.

3. The epidemiological profile exhibits the problems related to underdevelopment, together with other major problems associated with contemporary lifestyles. Among the former are: High infant mortality rates: 20.4 per 1,000 live births in 1995; estimated at 44.0 per 1,000 in 1994; High maternal mortality: 62.7 per 100,000 live births; estimated at 159 per 100,000 in 1994; Malnutrition: 13.3% weight deficit in infants < 1 year of age and 26% in children 1 to 4 years of age at the national level; Chronic malnutrition: 45.3% in children < 5 years of age; anemia in 69% of infants < 1 year of age and 37% of school-age children; and vaccine-preventable diseases: 141 cases of measles, 25 of neonatal tetanus, 21 of diphtheria, and 235 of whooping cough in 1997; as of 7 July 1998: 120, 13, 17, and 133 cases, respectively.

4. The main problems associated with contemporary lifestyles are: For mortality per 100,000 inhabitants in 1996: cerebrovascular disease, 23.1; hypertension, 19.3; traffic accidents, 15.8; diabetes mellitus, 15.4; homicide and other intentional injuries, 13.4.; Morbidity from malignant neoplasms, incidence registered in Quito: prostate cancer, 14.1 per 100,000 men; invasive cervical cancer, 22.3 per 100,000 women; Unhealthy behaviors: prevalence of smoking in adults, 21.6%, with a 2.4/1 male/female ratio; and excessive alcohol consumption, 19.7% of the population aged 12 to 49.

5. Reemerging diseases linked with El Niño and other natural disasters are a growing problem, particularly in Ecuador's border areas with Colombia and Peru: malaria, 16,530 cases in 1997 and 9,428 as of 7 July 1998, 33.5% of them from *falciparum*; classical dengue, 3,871 cases in 1997 and 3,589 as of 7 July 1998, both problems concentrated along the coast; yellow fever, 31 and 7 cases, respectively, concentrated in the Amazon region; human rabies, 17 and 3 cases, respectively; cholera, 65 cases in 1997 and 2,313 cases as of 1 July 1998, 984 of which have already been confirmed by laboratory, with three

deaths; leptospirosis, 17 cases in 1997 and 342 confirmed by laboratory as of 1 July 1998, with 10 deaths; pneumonic plague, 13 cases between February and April 1998; foot-and-mouth disease, a persistent problem, affecting livestock production at a rate of 2.95 per 10,000 in infected herds.

6. The main risk factors for health are the nationwide housing shortage of 1,200,000 units, together with the low coverage of basic sanitation services: population with drinking water service, 69.7% of the total (81.5% in urban areas and 50.9% in rural areas); population with sewerage service, 41.7% of the total (61% in urban area and 10.4% in rural areas); population with latrine service, 15.7% of the total (9.1% in urban areas and 26.3% in rural areas); and poor water quality (coliform bacteria, sediments, and industrial waste).

7. The PAHO/WHO Representative Office in Ecuador is proposing four general cooperation areas for 2000-2001: health in human development; development and strengthening of the national health system, including the steering role of the Ministry of Public Health; health and environment; and health of the people, with the cross-cutting themes of communication and social mobilization for health, together with the gender approach.

### ***National Priorities for PAHO's Technical Cooperation***

8. To strengthen the steering role of the Ministry of Health in the country, which involves State management, regulation, coordination, control, and evaluation of the activities carried out and the health services provided by public and private entities, and development of the essential public health functions, which includes substantive tasks in the exercise of the health authority at the provincial and local levels. To promote and accord special importance to health promotion in order to create favorable living, working, and health conditions jointly with other actors of civil society, emphasizing the broadest possible participation and shared responsibility of individuals, families, and communities, while respecting ethnic, cultural, and gender values and the human rights of the various population groups living in Ecuador. To contribute to guarantee equitable access to health care by developing the National Health System. To improve the health of the

population by reducing pollution in various human environments, and to improve water, sanitation, and food protection services. To carry out prevention, control, and surveillance activities with respect to biological, occupational, and psychosocial risks and diseases that affect the health of specific population groups, with special emphasis on emerging and reemerging diseases and the epidemiological situations resulting from El Niño and other natural disasters. To control environmental pollution by increasing the coverage and quality of drinking water services, sanitation, and pollution control. To prevent and mitigate the impact of natural disasters and to rebuild the health infrastructure in the aftermath of El Niño.

### ***Technical Cooperation Strategy***

9. In response to the national situation, the PAHO/WHO Representative Office in Ecuador has outlined a basic cooperation strategy, as follows:

10. To consider the principle of equity from a social perspective, using the gender approach as the core of the cooperation strategy and project activities. This principle will permeate the entire cooperation proposal.

11. To continue to strengthen interagency coordination, especially through the Interagency Committee to Support Reform (CIAR).

12. To support bilateral cooperation and technical cooperation among countries within the framework of TCC projects.

13. To further health promotion at the national, provincial, and local level, assigning special importance to intersectoral action, community participation, and the gender approach.

14. To continue to support health sector reform with emphasis on decentralization, especially at the intermediate and local level.

15. To mobilize financial and human resources for cooperation.

16. To continue decentralizing technical cooperation.

17. To continue providing technical cooperation for recovery from the aftermath of El Niño.

18. To support national, intersectoral macro processes with key agents such as the National Congress, the National Health Council, the universities, the Ministry of Public Health, and other ministries and institutions associated, inter alia, with the environment, education, culture, and food. Cooperation will assign priority to healthy public policies, legislation, the creation of healthy environments, bioethics, and mass communication.

19. To support local intersectoral processes, with the participation of the governments and other relevant community agents at the local level.

20. To support the organization and development of the National Health System, with a broad, intersectoral perspective and the participation of the public agents that make up the sector, placing emphasis on health sector reform. Cooperation will concentrate basically on strengthening the intermediate and local levels of the National Health System, centering mainly on the development of a model of care that assigns special importance to public health activities for health promotion, disease and risk prevention, and the development of service networks.

21. Technical cooperation with priority processes and components for health, such as: Health information and surveillance; Scientific and technical information; Communication for health; Nutrition; Maternal and child health; Control of prevalent diseases; Environmental sanitation; Disaster prevention and mitigation; Programs for improving the quality of the services; Equipment maintenance; and Human resources and health research.

### ***Objectives for PAHO's Technical Cooperation***

- To develop health promotion plans and projects with intersectoral and community participation in terms of execution, with emphasis on healthy spaces and lifestyles and the reduction of inequities.
- To strengthen the steering capacity of the MPH in the sector and the delivery of its health services.
- To reduce morbidity and mortality from the diseases and problems that have a serious impact on the health of the general population and specific groups.
- To increase the capacity of the authorities to evaluate and control environmental health risks and to improve water and sanitation services.
- To coordinate and orient support for the development, management, and administration of the technical cooperation programs in the country, by establishing procedures to disseminate information and provide training and instruction to technical and administrative personnel in the standards and regulations of the Organization.

### ***Expected Results***

22. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

23. *Cooperation networks and alliances.* With a view to increasing the coverage of programs for controlling disease and priority health problems, improving the operating capacity of services, and promoting policies targeted toward specific groups, laboratories, and blood banks.

24. *Surveillance and information systems.* On environmental and workplace pollution.

25. *Standards and guidelines.* For health promotion and the surveillance, prevention, and control of diseases and priority health problems.

26. *Research and evaluation studies.* On emerging and reemerging diseases.

27. *Plans, projects, and policies.* On health promotion and sectoral integration that include the existing information and epidemiological surveillance systems in order to program, monitor, and coordinate health and mass communication activities; that will increase the coverage and quality of basic services by promoting community participation; and that will strengthen the capacity of the authorities and the community to prevent or mitigate the health impact of disasters; and that will establish the legal framework for the national system.

28. *Training programs.* Training, continuing education, and human resources management to upgrade the human resources involved in the

promotion, surveillance, prevention, and control of diseases.

29. *Methods, models and technologies.* To prepare and implement plans and projects with a health promotion approach; to improve the diagnosis and care of the diseases with the greatest impact; to improve the quality of the health services; and to strengthen national capacity in the planning, operation, maintenance, and overhaul of physical and technological infrastructure in MPH services.

30. *Training programs.* On environmental and occupational health and health promotion.

31. *Promotional campaigns and advocacy.* Promotion of citizen participation in health and activities related to health and the environment.

32. *Direct support.* To forge ahead with the execution of the institutional development plan of the Ministry of Health; to develop national programs of essential drugs; comprehensive projects under way to improve human environments.

<b>ECUADOR</b>				
<b>PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health in Human Development	1,370,200	1,629,000	470,800	70,000
Health Systems and Services Development	887,200	734,900	1,653,600	657,000
Health Promotion and Protection	249,300	202,900	709,500	652,100
Environmental Protection and Development	542,200	502,100	146,300	0
Disease Prevention and Control	489,700	469,700	193,400	4,200
<b>Total</b>	<b>3,538,600</b>	<b>3,538,600</b>	<b>3,173,600</b>	<b>1,383,300</b>

# EL SALVADOR

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## *Health Situation*

1. The Government of El Salvador has proposed the following as major national objectives under the Public Modernization Program: consolidation of a stable political environment, facilitation of full human development, attainment of economic autonomy, and promotion of a spirit of national reconciliation.

2. In this context, the general policy established by Ministry of Public Health authorities is "to improve the level of health of the Salvadorian people through the modernization of the sector and the development of interinstitutional programs that focus on comprehensive health care for individuals and the reduction of risks and damage to the environment."

3. The following have been identified as the main strategies for developing the different programs: decentralization, operationalized through the creation of health systems; social participation; interinstitutional coordination; and development and strengthening of the steering role of the Ministry of Public Health. The aim is to establish a modern health sector that will articulate the interests of society, where the Ministry would play a role in subsidizing populations whose socioeconomic characteristics limit their access to a better quality of life. It will also encourage the participation of private enterprise in the delivery of efficient, effective, and equitable health services, thus improving the overall health of the population.

4. Poverty is the principal determinant of the problems in the health sector. The 1994 Household Survey revealed that 52.4% of the population was poor, with 23.9% living in extreme poverty and 28.5% in relative poverty.

5. It is estimated that El Salvador will have a population of 6,276,037 inhabitants by the year 2000. Of this number, approximately 60% will reside in urban areas; 51% will be women, mostly of childbearing age; 35.6% will be under 15 and, of this group, 36.0% will not have reached the age of 5. This

means adolescents and children make up the largest population group.

6. The crude birth rate has declined from 30.1 per 1,000 individuals in 1990 to 28.5 per 1,000 in 1997. The population growth rate held steady in the last 5-year period (2.1%). Total fertility for the period 1995-2000 will be 3.2 children, with greater fertility in women aged 20-24 living in rural areas. The population aged 65 and older will be 5.0% by the year 2000.

7. The current epidemiological profile reveals high mortality and morbidity rates. Diseases characteristic of poverty and of the epidemiological transition continue to predominate, a situation made worse by inadequate access to medical care.

8. This latter point results in underreporting of mortality and morbidity statistics, with an estimated 21% of deaths unreported for 1994.

9. The mortality rate from malignant neoplasms (of the stomach, lung, breast, and cervix) is equally significant.

10. With regard to morbidity, the National Family Health Survey (FESAL-93) found that 22.8% of children under 5 presented low height-for-age, indicating that they live in socioeconomic and environmental conditions that adversely affect their development. In rural areas, 28.1% of children suffered from chronic malnutrition.

11. In children under 1 year of age, coverage with three doses of both DPT and OPV reached 100% and 96% respectively in 1997. Coverage for measles was 97% for that age group. Two doses of tetanus toxoid were given to 82% of women of childbearing age. In addition, the measles surveillance evaluation verified that the natural virus was not in circulation, and that the country has an efficient epidemiological surveillance system for early detection of this disease. Likewise, evaluation of the neonatal tetanus elimination program revealed a decrease in high-risk municipios, that is, from 97 to 21 in 1996 and 23 in 1997. Some 92% of the monitoring indicators for flaccid paralysis in children under 15 were complied with.

12. In 1997, two cases of whooping cough were reported, with no deaths, and two cases of neonatal tetanus, with one death. There were no cases of measles that year. In 53 cases of flaccid paralysis in 1997, wild poliovirus was not detected. There were 331 cases of meningoencephalitis recorded in children under 5 for 1997, with 33 deaths (a 10% case-fatality rate). Of these cases, 7 were attributed to viruses, 4 to tuberculosis, 7 to meningococcal infections, 5 to *Haemophilus influenzae* type b, and 298 to other causes.

13. The level of vitamin A deficiency found by the 1988 Food and Nutrition Situation Assessment (ESANES) made El Salvador the country with the highest prevalence of this deficiency in Latin America.

14. The prevalence of endemic goiter in schoolchildren and nutritional anemia are widespread, due to a diet low in iodine, iron, and folic acid, the latter aggravated by the high incidence of intestinal parasitism. In 1994 UNICEF reported that 43% of pregnant women suffer from some degree of anemia. In 1997, 98% of the population nationwide had access to iodized salt.

15. Tuberculosis of the lung is a serious health problem. Estimates put the incidence rate at around 60 to 80 per 100,000 individuals, placing the country in a high-priority category for this disease in the Region. Malaria and dengue remain the principal vector-borne communicable diseases, constituting a significant health problem. The former is influenced by external and internal migration, and the latter, by a history of prior infection with several serotypes. In 1998, only serotype 3 has been detected in circulation. There are also high indexes of *Aedes aegypti* infestation, which has caused an increase in cases in 1998 and the sporadic appearance of dengue hemorrhagic fever. Currently, *Aedes albopictus* infestation is also a problem.

16. Reflecting the lack of access to services in 1997, hospital births accounted for 59.2% of all births; the figure for prenatal care in facilities run by the Ministry of Public Health and Social Welfare was 55.5% in 1996, with a 5.1% average for prenatal care. Pregnant women without coverage reside in rural or peri-urban areas. Cervical cancer remains the leading cause of death from malignant neoplasms.

17. FESAL/93 estimated the infant mortality rate at 41 per 1,000 live births. Premature birth and low birthweight were the leading causes of neonatal morbidity, while diarrheal diseases and acute respiratory infections led postneonatal morbidity. In 1995, the Ministry of Public Health pointed out that the three leading causes of death in children were, in descending order: premature birth, sepsis, and acute respiratory infections.

18. Maternal mortality in the country for the period 1987-95 was estimated at 140 per 100,000 live births. In Ministry of Public Health facilities in 1997, that figure was 60 per 1,000 live births, and the three leading causes of direct death were: hemorrhage (44%), toxemia (22%), and sepsis (14%). The greatest number of maternal deaths occurred in women aged 20 to 34, which implies that the majority of these deaths are preventable with adequate and timely prenatal check-ups, delivery care, and intergenetic spacing.

19. Cardiovascular diseases and stroke, conditions that are closely linked with hypertension, are among the leading causes of death. In 1994, external causes of mortality ranked third, regardless of age or sex, and first for adult males, due to violence and accidents.

20. Typhoid fever remains endemoepidemic, and no cases of cholera were reported for 1997 and 1998. Outbreaks of food poisoning continue, primarily due to improper food handling. There is also a high incidence of pesticide poisoning in some departments.

21. The trend for HIV/AIDS infection is clearly rising, and human and canine rabies are still a health problem, although in 1998 a short-term mass vaccination campaign for canine rabies was conducted, achieving coverage of around 71%.

22. With regard to health and the environment, there is a low supply of drinking water and sanitation services, especially in rural areas. However, some progress has been made in this area.

23. Air pollution has arisen, representing another important change in the environment.

## ***National Priorities for PAHO's Technical Cooperation***

24. To improve the health of the Salvadorian population. To contribute to improving the health of the Salvadorian population through public policies to promote participation by the local levels and civil society in the formulation, execution, and evaluation of plans, programs, and projects to promote and protect reproductive health and food and nutrition security for specific groups and populations at risk. To reduce the environmental risks to the health of the Salvadorian population. To improve the control of communicable and chronic noncommunicable diseases, as well as accidents and violence, reduce their risk factors, and promote healthy lifestyles.

### ***Technical Cooperation Strategy***

25. In this context, having considered the health problem and the priorities of the country and the Organization, technical and financial cooperation for the biennium 2000-2001 has been programmed based on the following components:

26. Health in Development and Health Systems: This program will target its efforts mainly through the development of policies, plans, and standards that favor: a) conducting and strengthening modernization processes and their articulation with broader projects for sustainable human development; b) supporting the development of a vision of change in the sector that would bring about the necessary institutional transformation and respond to the principles of equity, effectiveness, and efficiency; c) promoting external and internal mobilization of resources and focusing on cooperation in management training, and strategic and epidemiological planning applied to the services; in the implementation of social participation strategies in healthy spaces; in the prevention and control of endemic, new, emerging, or reemerging diseases, accidents, violence, and pesticide poisoning; in the promotion of healthy lifestyles, mental health, health of the elderly, and in environmental protection and development; d) supporting initiatives that the country considers compatible with the Central American integration process.

27. Health Promotion and Protection: Research and training constitute the principal strategies of this project.

28. The Organization will promote more integrated health response mechanisms, in keeping with the complex nature of the national problem, which is characterized by new risk factors, such as violence, lack of security, and substance abuse. Demographic pressures and dense populations in communities that do not offer healthy environments have aggravated the problem. The health policy highlights the principle of health as the right and responsibility of all. The integrated response to the sanitary problem follows the same principle, based on more active participation by social and political agents. In this way, more effective environments are created so that these agents, operating in conjunction with the Ministry and other sectoral and extrasectoral institutions, can increase their capacity to respond to problems associated with lifestyles and individual and collective behaviors.

29. Technical cooperation will be geared especially toward the development of policies, plans and programs, research, human resource training, and information dissemination.

30. The concepts of healthy municipios, healthy schools, and other initiatives will make it possible to gradually implement a culture of health into the development of the Local Health System.

31. Disease Prevention and Control: To achieve the proposed results, the project will be supported by direct technical cooperation as the principal cooperation strategy. In addition, in-service epidemiology training activities and epidemiological research in priority areas will be promoted.

32. The specific policies indicated are a reduction in the morbidity and mortality rates of the most frequent illnesses. Precise strategies for the control, elimination, and/or eradication of communicable diseases are established through the strengthening of epidemiological surveillance, especially of new, emerging, and reemerging diseases. Likewise, the generation of precise, reliable, and timely data for improving technical and political decision-making at all levels of care is indicated. These guidelines coincide with those established in our Strategic and Programmatic Orientations, especially with regard to identifying the most affected population groups, strengthening local programming, and achieving

effective social participation. The country has been making steady progress within this general framework. Interinstitutional epidemiological teams have been created at the national level, together with local teams for the investigation and control of outbreaks. Vaccination coverage has increased, and the eradication of wild poliovirus is being consolidated. Activities have begun for the successful elimination of measles and neonatal tetanus, and the legal framework in the health sector is being developed through the drafting of a new sanitary code and specific legislation, such as the blood bank law and other projects.

33. Furthermore, efforts are being made to fulfill the commitment to eliminate the transmission of *T. cruzi* infection by transfusion, as well as leprosy. More is becoming known about the situation, and concrete action is being taken in that regard. There is also a production laboratory for rabies vaccines, with plans to achieve self-sufficiency in regard to this biological and to continue the necessary action to eliminate urban rabies. Dengue and malaria programs have received top priority and the same has been proposed for Chagas' disease and leishmaniasis. The Tuberculosis Control Program will receive US\$ 2,000,000.00 from AID, which will be administered largely by our Representative Office. The IMCI strategy is being implemented satisfactorily, as programmed. Major technical support has been and will continue to be provided for cross-border activities and, within the framework of Central American cooperation, surveillance and information handling. This will be influential in obtaining more timely and efficient control of new, emerging, and reemerging diseases, as well as those that are endemic to the border communities.

34. Environmental Promotion and Development: The development of policies, plans, and standards constitutes the core of the project's cooperation.

35. This effort is aimed at providing direct technical cooperation to improve the institutional capacity to efficiently tackle basic sanitation problems and expand water supply services, as well as address the problem of solid waste and excreta disposal. As strategies in sanitation, special emphasis has been placed on providing tools for quality improvement and control of drinking water.

## ***Objectives for PAHO's Technical Cooperation***

- Modernization of the health sector and the Ministry of Health has been supported to develop a new model for organization, management, and delivery of services. This has been accomplished by developing and strengthening the steering role of the Ministry, separating steering functions, the purchase and delivery of services, and organizing self-managing and self-sustaining health systems, with the participation of public and private providers in all departments in the country.
- Increase in the coverage and quality of care provided by health, food, and nutrition services to the population, especially to children, adolescents, and adult women, with emphasis on the promotion, protection, and self-care of health in vulnerable groups and risk areas.
- To promote, coordinate, and support the activities of national institutions in the prevention, identification, and control of environmental conditions that pose a risk to human health.
- A contribution has been made to the diagnostic and response capability (promotion, prevention, and control) of health workers, especially at the local and departmental level, through the proper use of epidemiology in the planning, execution, and evaluation of health programs and plans, in epidemiological surveillance, in the struggle against epidemics, and in the training of personnel for these needs in the Master's Program in Public Health at the University of El Salvador.

## ***Expected Results***

36. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

37. *Cooperation networks, alliances.* For management and social control of the health services at the national level, particularly in the departments of the eastern portion of the country and those south of San Salvador--Sonsonate, Santa Ana, La Libertad, Chalatenango, and Morazán.

38. *Surveillance and information systems.* Connected by the Internet to the other Central American countries in the following areas: health promotion and protection for children, adolescents, mothers, and newborns; for national epidemiological surveillance, including a laboratory that meets the needs for diagnosis and control of new, emerging, and reemerging diseases; resistance to antibiotics; and other health problems.

39. *Standards and guidelines.* To strengthen the technical-administrative and managerial capacity at all managerial levels of the Ministry of Health at the national level; for epidemiological surveillance to increase the capacity to analyze and evaluate the intervention measures applied.

40. *Research and evaluation studies.* For optimal operation of the Expanded Program on Immunization.

41. *Plans, projects and policies.* To strengthen the steering role of the Ministry of Health and restructure the health sector; for development of the health system in the Department of Cabañas; for the advancement of reproductive health in selected areas, employing an integrated and coordinated approach to further quality health promotion and protection at the institutional level and among the population, emphasizing the adolescent population, the healthy motherhood initiative, care of obstetric emergencies, reproductive health education, and the updating of regular information and research; to strengthen the National Solid Waste Commission; and to implement the primary environmental care strategy.

42. *Methods, models and technologies.* To formulate the food and nutrition security strategy to improve the nutritional status of the various population groups, with emphasis on food fortification, a quality control system for fortified food, methodologies for nutritional assessment, human resources development, and food and

nutrition surveillance, and education; for the development of new models for comprehensive health care, for the development of human resources in health at the various management levels of the sector, and for health promotion, disease prevention, regulation, study, and evaluation, and control of the most frequent infectious diseases in the country.

43. *Training programs.* That utilize national personnel to advance the development of technology and to establish policies, standards, and regulations to protect water resources and the quality of water for human consumption; to monitor and respond to the problems caused at the local and national level by pesticides, and to apply epidemiological surveillance standards efficiently; and for national personnel and community leaders, to increase their managerial capacity and solve environmental problems that pose a risk to human health.

44. *Promotional campaigns and advocacy.* For the preparation and execution of a National Water and Sanitation Plan.

45. *Direct support.* For the organization of an Interagency Commission to support the National HIV/AIDS Program in the promotion and coordination of intersectoral surveillance activities at sentinel sites; safe blood supply; the training of health workers and education of the population; for the development of prevention interventions, control of chronic noncommunicable diseases; the promotion, particularly of healthy spaces (schools, markets, prisons, municipios), and consolidation of the national network of healthy municipios; the adoption of healthy lifestyles, mental health, and health of the elderly; and prevention of tobacco, alcohol, and drug use, hypertension, diabetes mellitus, cervical cancer, domestic violence and the abuse of children, accidents, and pesticide poisoning.

**EL SALVADOR  
PROPOSED BUDGET ALLOCATION**

Appropriation Level	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Health in Human Development	1,209,800	1,242,600	384,900	35,000
Health Systems and Services Development	813,000	828,400	3,225,700	0
Health Promotion and Protection	44,000	33,700	0	0
Environmental Protection and Development	405,100	435,100	605,000	480,000
Disease Prevention and Control	408,900	449,000	125,100	120,000
<b>Total</b>	<b>2,880,800</b>	<b>2,988,800</b>	<b>4,340,700</b>	<b>635,000</b>

# FRENCH ANTILLES AND GUIANA

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## *Health Situation*

1. Martinique, Guadeloupe and French Guiana are French Regions as well as Departments. In 1996, the population in these Departments was estimated at 383,340, 422,090 and 151,780, respectively. The population in the continental state of French Guiana is concentrated along the coast plains. Guadeloupe includes an archipelago of some 6 islands and one of these is shared with the Dutch territory of St. Maarten. Whereas in French Guiana a high percentage of the population is under 15 years old (30%), Martinique and Guadeloupe's trend towards an older population has continued with over 12% of the population now over 60 years of age.

2. These Departments share similar mortality patterns with the mainland of France and the other English-speaking Caribbean countries, with the major causes of death being diseases of the circulatory system, tumors and accidents (motor vehicle). Perinatal mortality and AIDS are also a major concern.

3. There is little information on the morbidity patterns. Chloroquine-resistant malaria is on the rise in French Guiana and it is recognized that dengue is now endemic in all other Departments. Other major causes of illness are diabetes and hypertension and alcoholism is a major contributing factor to a large percentage of hospital admissions.

4. The Departments GDP is \$10,760 for Martinique, \$8,181 for Guadeloupe and \$10,403 for French Guiana. The three Departments share similar social problems including high unemployment rates of 29.3%, 27.2% and 22.4%, respectively, in 1996. The development of settlements by the marginal population is now evident throughout the three Departments and is no longer a suburban problem. School enrolment is close to 100% up to 16 years of age.

5. Water quality is monitored regularly and found to be satisfactory throughout the Departments and the coverage for household is about 95% in Martinique,

Guadeloupe and along the coast of Cayenne. While solid waste management services are provided throughout the Departments, the inadequate collection of some types of garbage (abandoned cars) and poor household management of water containers result in high *Aedes aegypti* indices. Public education needs to be intensified in this area. Food safety is not considered a problem in any sector of the Departments.

6. In 1992, legislation was enacted which resulted in the decentralization of responsibility for social services to the Departments including maternal and child health, immunization and prevention and counsel of STDs, with the exception of AIDS. The state responsibilities are executed by a Unit in each Department and these include social security funds, public hospitals, environmental health including vector control, mental health, alcohol and drug abuse control, epidemiology surveillance and management of epidemics. The health of adolescents in schools is the responsibility of the Ministry of Education, at the department level, and at this time it is a priority for Guadeloupe.

7. The total coverage by the national health insurance allows patients to seek care directly from any level. Primary health care provided by private general practitioners throughout the departments and public health clinics are primarily responsible for the delivery of basic preventive care. Hospital services are provided by a mix of public and private institutions with most of the tertiary specialists available at the Regional Hospital Centers located in Fort de France (Martinique) and Pointe a Pitre (Guadeloupe). These Centers provide services to a large percentage of patients from neighboring states, as high as 30% in Cayenne. The high cost of care and concern over quality has prompted to reform the system towards the model with a general practitioner as "gate keeper". The medical emergency services in Martinique and Guadeloupe have been developed to a sophisticated level, providing integrated multi-sector service to the population in those islands, as well as those in the neighboring states, and should be encouraged to participate in any related TCC Project.

8. The program for AIDS prevention and control is well developed in the departments with substantial participation of the non-governmental sector in the preventive efforts and a model program for day treatment of HIV infected persons in the main hospitals in all three Departments. The departments participated in the English speaking Caribbean AIDS Theme Group meeting and will be collaborating with CAREC in the subregional program. The laboratory and therapeutic services for the control of cancer of the cervix have been the foci of technical cooperation to countries in the Eastern Caribbean. The success of these programs serve as indices of the potential for further TCC between the francophone and anglophone Caribbean states. The programming of comprehensive services for control of diabetes and hypertension is in the early stages in all departments and will be a priority for cooperation in this biennium.

9. While health services in the health department are handled by specialists, there remains a need to ensure that adequate numbers of persons are trained in public health and substance abuse rehabilitation, and to provide opportunities for professionals to be exposed to highly successful centers in North America as well as France.

10. Significant efforts have been made to introduce the strategy of health promotion in health programs and one of the challenges is to produce behavior modification and educational modules suitable for that portion of the population that speaks Creole and other dialects.

11. Mental Health Services are extended to the community but are not community based per se. FRG played a key role in organizing and hosting the subregional Mental Health Conference in Martinique in 1997 and will continue to collaborate in this area. Dental health promotion is sporadic and there are no clear strategies to reduce the relatively high DMF indices.

12. As in all other countries, strategies have been implemented to control health expenditures. Health and demographic criteria, as well as differences in medical and paramedic staffing, must be considered when their department's health sector budgets are allocated. French Guiana will continue to be faced

with particular levels of challenge in order to re-address a rapidly increasing population as a result of migration from neighboring countries.

13. FRG has also participated in the subregional conference on Tourism and health, and has indicated a desire to further collaborate in this area.

### ***National Priorities for PAHO's Technical Cooperation***

14. Manpower training in few selected areas. Extended cooperation to English speaking Caribbean in selected areas including blood-banking, TB diagnosis and research, emergency response, hospital administration, equipment maintenance and tele-medicine. Improve capacity to target health promotion of marginal groups. Improve maternal and child healthcare in French Guiana. Expand AIDS prevention/control. Improve effectiveness of programs to control aedes aegypti. Improve substance abuse prevention and treatment program, especially for cocaine (crack) abuse. Improve effectiveness of mental health program. Decrease morbidity due to motor-vehicle accidents. Improve adolescent health. Improve capacity to participate in regional epidemiology surveillance.

### ***Technical Cooperation Strategy***

15. Emphasis will continue to be placed on French Guiana for direct technical assistance in order to improve the MCH and Environmental Health Programs as defined by the authorities in 1998. In addition, PAHO/WHO strategies for providing technical cooperation would be to support the involvement of health personnel from the French Territories in the English-speaking Caribbean health activities and to facilitate TCC between French Guiana and Suriname. In the area of health promotion, technical cooperation will consist in assisting with the development of culturally relevant educational materials, specifically for the immigrant population. Training through fellowships will be the

major plank of the strategy and will be provided in selected areas not available locally. Technical cooperation with neighboring English-speaking Caribbean states in order to improve the coverage of secondary care services will be facilitated. Use of the technical expertise available in the French Departments from Advisers, teachers and researchers in the Anglophone Caribbean will be increased. The French departments will be included in planning of shared services and encouraged to give support in emergency medicine, telemedicine projects, and in the tourism and health areas.

16. PAHO will continue to facilitate the emergency response plans between Martinique, Guadeloupe and Montserrat.

17. PAHO will address the national priorities in the areas of AIDS and epidemiological surveillance through CAREC. Cooperation in mental health will be based on the subregional plan of action developed at the meeting in Martinique in December 1997. It is

expected that Martinique and Guadeloupe will participate in the initiative to reduce mortality due to cancer of the cervix.

### *Objectives for PAHO's Technical Cooperation*

- Improve quality of selected health services and systems in French Departments and neighboring states.

### *Expected Results*

18. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

19. *Direct support.* To improve health services, to share FRG expertise with Anglophone countries and to disseminate information.

<b>FRENCH ANTILLES AND GUIANA PROPOSED BUDGET ALLOCATION</b>				
Appropriation Level	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Health Systems and Services Development	170,000	170,000	0	0
<b>Total</b>	<b>170,000</b>	<b>170,000</b>	<b>0</b>	<b>0</b>



# GRENADA

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## *Health Situation*

1. In mid-1996 the estimated population of Grenada, Petite Martinique and Carriacou was 98,900, some 4,000 more than the 1991 census. The population is young, with 11.2% being under 5 years and 37.4% under 15 years of age. The 65 year-olds and over make up 7.6% of the population. Males exceed females in each age group up to age 30 years, but there is an excess of females at all ages beyond that, so that females constitute 51% of the population and were 60% of the elderly (65 years and older).

2. After a 1.3% contraction of the economy in 1993, Grenada has experienced annual positive growth which accelerated from a rate of 2.3% in 1994, 3.4% in 1996 and 4.3% in 1997. The recent growth is attributed to increased activity in construction and tourism.

3. Contribution to the economy by the agricultural sector continues to decrease, a situation resulting from the cessation of the export of bananas due to poor quality in 1997 and slow recovery from the pink mealy bug infestation, which temporarily halted exportation during the 1995-1996 period. However, nutmeg production increased by 10.4% between 1996 and 1997, as well as sales, and Grenada was able to benefit from favorable export prices for this spice on the global market.

4. The upward trend in the economic growth is due in part to the Government's structural adjustment strategy by which it sought to reduce governmental expenditure and achieve a surplus on its current account. Its indigenous micro-enterprise initiative has contributed to the decrease in employment from 16.9% in 1996 to 15.5% in 1997.

5. With tourism playing an increasing role in the economy, the deficiencies of environmental management have been recognized as a priority by many sectors and there is an increasing level of commitment for multisectoral action.

6. Poor sewerage disposal continues to affect the coastal marine environment. While installation of

sewerage systems in the city has helped, the problem of rivers and streams run-off from agricultural lands still remains. This is increasingly important, since Grenada has embarked on an eco-tourism thrust for the island.

7. The disposal of solid and hazardous waste, particularly in agricultural areas, has been identified as a major problem and the Government has taken steps to establish a statutory authority to be responsible for improving the collection systems and landfill operations.

8. The Ministry of Health is keen to prevent epidemics of dengue fever, which have affected its neighbors. There have been no applied research initiatives in the recent past to improve the rabies situation.

9. Food protection and food handling of itinerant vendors and in large institutions continues to be a problem. Efforts have been hampered by the inadequacy of legislation and the scarcity of trained personnel.

10. In 1996, the crude birth rate fell to 21.3. The general fertility rate has continued to decrease between 1991 (124.19) and 1996 (91). The age specific fertility rate for women under 20 years of age, however, declined from 83 per 1,000 in 1993 to 63.1 per 1,000 in 1996. The total number of live births declined over the period from 1985 to 1991 by 20.3%, with an even more marked decline (34.0%) in the number of births among teenage women.

11. Life expectancy at birth was 68 years and 71 years, for males and females, respectively in 1990. The infant mortality rate was reported as 14.7/1000 live births in 1995.

12. The principal causes of overall mortality in 1995 were lifestyle-related: circulatory system diseases (37%); cancer (69%); diabetes (11%) and accidents (6%). Within the 0-5 year-old age groups, the principal causes of death are: perinatal conditions, pneumonia and gastroenteritis. The percentage of low birth weight babies varies from 5 - 9%.

13. Substance abuse and AIDS prevention and control are of particular concern, due to the initiation of unhealthy lifestyles in the adolescent years. Preliminary results of the adolescent survey indicate that a very high percentage of teenagers are sexually active. The rising number of AIDS cases among teenagers is a result of unprotected sexual activity. A focus on the adolescent population is also necessary in order to address the lifestyles related to chronic diseases.

14. The public health care system continues to be the major source of concern and the government has taken the first step in its reform program aimed at improving the quality as well as the efficiency of operation. A Statutory Board has been established to run the hospitals in Grenada, including the district hospitals. The challenge remains to make the Board operational and improve the management and information systems in support of a new performance-driven management culture.

15. It is anticipated that by the beginning of this biennium the Government will have been successful in its efforts to upgrade the hospital infrastructure, including equipment, in order to meet modern standards of health care.

16. Other components of the health sector reform process must include rationalization of the district health services, upgrading of the primary care systems and organizational development of the central level of the Ministry of Health to play its normative and regulatory role and policy analysis for health care financing. Activities during this period would be guided by the five-year health plan, which is expected to be completed in the previous biennium. A manpower development plan will be necessary.

17. The administration proposes to increase the application of the health promotion strategies to all of its programs and would need assistance to use the information from the needs assessment survey to engage the communities in a priority setting process.

18. If the pilot school health project were successful in the previous biennium, the Ministry of Health would be positioned to develop a national approach,

which takes advantage of the regional UN/CARICOM Health and Family Life Education Initiative and the CFNI Project Lifestyle.

19. The Government, seeking to upgrade the infrastructure, is committed to refurbishing the current hospital in order to meet standards of care for the population. The Government is also committed to health sector reform to make the health system more efficient and effective. The statutorisation of the Grenada General Hospital was the first and difficult step. The need for rationalization of District Health Services, organizational development of the central level of the Ministry of Health, the management of information systems and policy analysis for health care financing have been identified as critical to the reform process.

### ***National Priorities for PAHO's Technical Cooperation***

20. To maintain protected environment  
Administrative reform: Development of health services plan, improvement of the organization and management of health services, alternative financing for health services, development of integrated health information system (management information and vital statistics). Strengthen capacity to plan/manage chronic disease prevention and control programs: mental health service, nutrition, adult health (including screening and prevention of cancer) National school health and adolescent programs, growth and development of < 5 years; immunization /disease management. Human resource development. Environmental health including vector, rodent and rabies control, access to safe water, food safety, water quality monitoring, liquid waste and excreta disposal, and Occupational Health and safety. Management in pregnancy. Strengthen dental public health services. Health of the elderly. Health sector developed through program of health sector reform. Disaster preparedness and mitigation. Environmental management including: Natural disaster preparedness/ reduction of man-made hazards/forestry and water shed management/ coastal

zone management/ Land use planning, Forestry and watershed management. To reduce morbidity.

## ***Technical Cooperation Strategy***

21. The Joint Evaluation Review conducted in 1997 provided clear direction for PAHO's Technical Cooperation during the biennium 2000-2001. In addition, the Review identified opportunities for joint UN action to maximize PAHO's cooperation.

22. The Review identified four (4) areas for PAHO's cooperation and these have been consolidated into three (3) projects to be delivered over the 2000 – 2001 biennium: 1. Environmental Health; 2. Health promotion and protection (includes nutrition, growth development and human reproduction and HIV AIDS/STD; and 3. Health Sector Reform.

23. The strategic approaches to be used in the execution of technical cooperation over the period will include: a) capacity building through in-country training to increase skilled personnel and through the use of one or two consultants to work with the nationals over the medium term; b) Focus on community-based projects to effect coordination among the UN system; c) Promote and facilitate multi-sectoral action particularly for health and tourism activities and health promotion projects; d) Increase use to TCC in order to bring relevant experiences of other Caribbean countries to Grenada and share pioneering experience of its efforts to decentralize authority for the hospital.

24. Because the program areas for bilateral cooperation coincide with the priority areas for the CCH II, Grenada will benefit from complementarity of cooperation at the bilateral and subregional levels. This work program calls for collaboration with PAHO units at the regional level and in particular with the CAREC and CFNI centers.

25. Emphasis will be placed on ensuring sustainability of national institutions and the use of regional institutions as far as possible.

26. While all functional approaches will be utilized, training of personnel will remain the single most frequently employed approach. In addition,

development of policies, plans and norms feature heavily in the program of cooperation, reflecting the nationals' concern to improve the quality of services delivered. Dissemination of information and direct technical assistance will support all projects developed. Research and resource mobilization will be key to the Government's plans for the introduction of national health insurance.

## ***Objectives for PAHO's Technical Cooperation***

- To improve environmental health and protection.
- To improve personal health management.
- To improve efficiency of health care system.

## ***Expected Results***

27. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

28. *Cooperation networks, alliances.* To formulate plans, projects and policies to strengthen the capacity in mental health services.

29. *Research and evaluation studies.* In the management of environmental health programs and dental health programs and for maintenance of biomedical equipment.

30. *Plans, projects and policies.* For management of integrated vector control (IVC) programs and for sustainable financing of services and to respond to and manage disasters, and to manage an integrated health information system.

31. *Methods, models and technologies.* To plan and deliver services to children and adolescents.

32. *Training programs.* For food safety and HACCP application and basic environmental sanitation, to plan and deliver prevention and control services for selected non-communicable diseases, and to deliver care to the elderly.

33. *Direct support.* For manpower plan.

<b>GRENADA</b>				
<b>PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health Systems and Services Development	83,600	87,000	0	0
Health Promotion and Protection	34,000	39,700	0	0
Environmental Protection and Development	38,000	38,300	0	0
Disease Prevention and Control	10,500	32,700	0	0
<b>Total</b>	<b>166,100</b>	<b>197,700</b>	<b>0</b>	<b>0</b>

# GUATEMALA

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## *Health Situation*

1. Guatemala's current political, economic, and social situation cannot be understood without referring to the democratic transition and consolidation of peace that the country has witnessed over the past 15 years. In this context, the Political Constitution of 1985 may be interpreted as historical landmark that signaled the beginning of the democratic transition, since it included a series of social objectives reflecting the national desire for renewal. Among these objectives were the creation of the Supreme Electoral Tribunal, which achieved legitimacy for the presidential elections of 1986, 1992, and 1996. The Constitution made notable progress with regard to human rights with the creation of the Office for the Defense of Human Rights. This new democratic framework laid the foundation for direct talks between the government and the URNG, which led to the signing of a series of agreements culminating in the signing of the Agreement for a Firm and Lasting Peace on 29 December 1996 in Guatemala City. Concrete opportunities were thus opened for the construction of a sustainable development process.

2. During the past decade the country's GDP has not grown beyond 5%, and this growth has been only slightly higher than the natural increase in the population (2.9%); however, between 1991 and 1995 a certain recovery occurred, with growth settling at between 3.5% and 4.5%. In 1997 GDP growth was 4.1%. These figures illustrate the challenge of reaching an annual GDP growth target of more than 6%, as programmed in the Agreement on Socioeconomic Aspects and the Agrarian Situation.

3. Among the most serious consequences of the economic imbalances are unemployment (around 44% of the economically active population in 1995) and illiteracy. It is estimated that 75% of the population lives below the poverty line and 58% has an income placing it in the category of extreme poverty. Some 37% of the population was illiterate in 1995. The percentage of the poor without education is 88.6% versus with 11.4% in the non-poor population. It is estimated that the number of

disabled people may be as high as 10,000, with most of them living in the most neglected areas and without access to basic physical, mental, and occupational rehabilitation services.

4. The weaknesses in the health information system, due to the enormous underreporting and unreliability of the available data, are an obstacle to decision-making that requires the support of technical data.

5. Infant mortality has been estimated at 51 per 1,000 live births with 50% of the deaths occurring between the perinatal period and the third month of life. Infant mortality in the population living in extreme poverty in the metropolitan region is double that of the non-poor population. In the residential areas of the capital where the educational levels are higher, fewer than 10 infants per 1,000 live births die. Acute respiratory infections (ARI), acute diarrheal diseases (ADD), and perinatal causes account for 30%, 23%, and 20% of the deaths in infants under 1 year of age, respectively.

6. Vaccination coverage for infants under 1 year of age, as reported in 1997, was as follows: polio, 83%; measles, 74%; BCG, 87.8%; and PT, 82.9%. No cases of paralytic poliomyelitis have been reported since 1990, nor of diphtheria since 1991. In 1997 a pertussis outbreak occurred in Iloam, El Quiché, making it necessary to take more vigorous action in terms of epidemiological surveillance and vaccination coverage. According to the peace accords, Guatemala has committed itself to maintaining the eradication of polio and eliminating measles by the year 2000.

7. Maternal mortality is estimated at 240 per 100,000 live births (1995), and underreporting in the metropolitan area at 65%. Two-thirds of the deaths are caused by infectious, nutritional, and perinatal diseases and those derived from the risks inherent to maternity. Women's health is determined, among other things, by social, economic, political, and occupational factors. Women represent 50.7% of the total population, and 24% are economically active. The leading causes of disease in women are sexual and reproductive pathologies. The principal obstetric complications are due to pathologies during delivery

(29.7%), retention of the placenta (13.7%), puerperal sepsis (10.9%), eclampsia (10.9%), and abortion (7.3%). The fertility rate is 5.1 children per woman. According to the peace accords, Guatemala is committed to reducing maternal and infant mortality by 50% by the year 2000, compared with the rates recorded for 1995.

8. Malnutrition in children remains a major public health problem, with 33.6% of children under 3 and 54.1% of those under 6 presenting some degree of malnutrition. The prevalence of chronic malnutrition is 57.8% among children under 3 and 75.4% in children under 6. Sixty-eight percent of the children of illiterate mothers and 72% of the indigenous population are malnourished. Vitamin A deficiency is found in 15% of preschool children, and iron deficiency affects 35.4% of women of childbearing age, 39.1% of pregnant women, and 34.9% of nonpregnant women. Iodine deficiency is found in 22% of schoolchildren. Tuberculosis, malaria, dengue, and onchocerciasis remain significant problems in the marginalized population.

9. The incidence of cholera continues to decline. In 1997, 1,226 cases were reported without any recorded deaths. Acute diarrheal disease continued as an important health problem, with an incidence rate of 100.33 per 10,000 population; it was especially prevalent among infants under 1 year and children under 4 years of age, with rates of 695 and 302, respectively. With regard to dengue, as of December 1997, the cumulative number of cases was 6,174 (incidence rate of 5.9 per 10,000 population), only 8 of which were reported as hemorrhagic, with no reported deaths. In 1997, 32,099 cases of malaria were reported. Between 1985 and December 1997, 2,284 cases of AIDS and 1,648 asymptomatic HIV carriers were registered, 258 in women and 1,113 in men. During this same period 69 women and 332 men died from AIDS. In 1997, 8,000 people were reported to have been bitten by animals suspected of rabies and treated on a timely basis. Of the 4 who died, 1 received incomplete treatment, and no request for treatment was made for the other 3. Vaccination coverage of the canine population for 1991-1995 did not exceed 24%, and for 1997 was 78%. However, the canine population is considered to be underestimated. Cases of foodborne disease (FBD) in 1997 numbered 339,342, with a morbidity rate of 314 and mortality of 3.7 per 100,000 population. In 1997, 2,984 cases of tuberculosis were reported, for a rate of 28.20 per 100,000 population.

10. Among the chronic diseases, 65.35% of cases of diabetes mellitus occur in women and 34.65% in men, whereas the percentage distribution of hypertension is 68% in women and 32% in men; 61.23% of rheumatic fever cases occur in women and 38.68% in men. Gynecological cancer constitutes 42% of all cancers in the general population, and breast cancer ranks third among all cancers and second in woman.

11. In psychiatric consultations women show a greater tendency toward depressive disorders (73%), while schizophrenia is more frequent among men (62.7%). Intrafamily violence occurs in an estimated 48% of households.

12. Another factor related to the precarious living conditions of most of the Guatemalan population is inadequate basic sanitation. In 1994-1995, 64% of the population received water, although not necessarily treated. In 1996 the government estimated urban water coverage at 90%-100% and rural coverage at 55%. A little over half the population has some type of excreta disposal system: 72% in the urban areas and 52% in the rural areas. In urban areas 60% have sewerage services; this coverage is significantly lower in rural areas. Only 23 out of 329 cities have drinking water treatment plants, and only 20% of liquid waste treatment plants in the capital city are in continuous operation. No municipal seat of government has solid waste treatment, which means that they are deposited in the open air. Water, sanitation, and solid waste management are currently being addressed in the reform of the subsector, which will no doubt help to improve the critical environmental situation.

13. There has been a marked deterioration in air quality due to emissions from motor vehicles, factories, and industries, and from the burning of firewood for household use. A 1995 study showed that there were several sites in the capital where the concentration of suspended particulate matter--PM10 and ozone--exceeded the maximum values set by WHO. Work environments are inadequate and unsafe, especially for agroindustrial workers.

14. In 1997 there were 460 cases of acute pesticide poisoning, according to figures from the Ministry of Health and Social Welfare (MSPAS) and the Guatemalan Social Security Institute, (IGSS).

Nevertheless, serious underreporting is suspected, with hospital and field registries pointing to a figure in excess of 20,000 cases of poisoning per year.

15. The bases for health actions are the principles and articles of the Political Constitution of Guatemala; the guidelines of the Plan of Government 1996-2000; the Health Policies, Strategies, and Lines of Action of the Ministry of Health and Social Welfare 1996-2000; the peace accords with respect to health; and the new Health Code adopted in October 1997.

16. Guatemala's health sector is undergoing a profound transformation, the result of a situation marked by progress in democratization, the signing and implementation of the peace accords, the modernization of the State, and domestic reforms in the model for the social production of health. In this context, the Ministry of Health has been transformed both functionally and structurally, assuming new responsibilities under its steering role in the health sector--responsibilities that include administrative, financial, and technical aspects pertaining to policy, management, and planning.

17. The Ministry of Health and the Guatemalan people have made a commitment to health sector reform that responds not only to political and ideological factors, but also to those of an economic, financial, and epidemiological nature. The process seeks to take advantage of this confluence of factors to develop a more efficient and equitable health care delivery system that, in turn, responds to the modernization of the State; economic reorganization and its impact on public spending policies; attaching greater value to social aspects; the search for efficiency, effectiveness, and sustainability; and the demographic, epidemiological, technological, and cultural changes that country is undergoing at the present time.

18. The central objective of the reform process is to improve the health of the population through the design and execution of political, institutional, technical, and financial management change.

19. The health policies for the period 1996-2000 are: Reorganization, integration, and modernization of the health sector; expanded coverage and improvement of the quality of care provided by the basic health services; better hospital management; the

development of human resources for health; the promotion of health and healthy environments to improve the living conditions of the population; increased coverage and improvement of the quality of water for human consumption, and expansion of the coverage of basic rural sanitation services; social participation and control of public management of the health services; and strengthening of the capacity for the management of international cooperation.

20. As the main institutional provider of health services in the sector in 1997, the Ministry of Health had 1,191 health facilities, including 28 hospitals, 29 type A health centers, 234 type B health centers, 866 health posts, 5 peripheral emergency centers, and 15 cantonal maternity centers. Resources are heavily concentrated in the metropolitan area, where the bed/population ratio is 2.1 per 1,000, while the national average is 1.0 per 1,000. In some departments in the western altiplano region this ratio is 0.04 per 1,000 population. All the institutions, without exception, present a high rate of underutilization, even in Guatemala City where the highest concentration of resources lies.

21. One of the major barriers to service delivery is the preponderance of rural areas and their rugged topography. A study conducted in seven health areas revealed that over one-third of the users had to travel an average distance of 12 km or walk more than two hours to reach the nearest service. The sector's infrastructure has deteriorated markedly over the years; it is estimated that 30% of the primary care facilities require reconstruction and equipment replacement.

22. Recent data from a study of national financing and health expenditure indicate that in 1997 such expenditures accounted for 3.57% of the GDP. Households were the most important source of health financing (55%), followed by government (24%), business (17%), and international cooperation (5%).

23. The study indicated a moderate trend toward the growth of private or nongovernmental agents, partly as a consequence of greater participation by NGOs and private health insurance plans.

24. One of the commitments of the peace accords is to increase public spending on health by 50% by the year 2000 (1995 base year), which will make it possible to expand the coverage of quality primary

health services for the traditionally neglected population through the Comprehensive Health Care System (SIAS), thereby strengthening the decentralization of the Ministry of Health.

25. In 1997 the Executive Branch began a process of budgetary decentralization, initially transferring resources to the Ministry of Health, which in turn initiated local budget programming and authorized the 27 Area Authorities to execute their financial resources.

### ***National Priorities for PAHO's Technical Cooperation***

26. Within the context of sectoral reform, continue the reorganization, integration, and modernization of the health sector, strengthening the steering role of the Ministry of Health in sectoral management and administrative and financial decentralization for the consolidation of peace and the democratic process. Increase coverage and improve the quality of care in the basic health services through the Comprehensive Health Care System (SIAS), emphasizing the prevention and control of priority health problems, providing special care to neglected groups, and promoting public-private participation (NGOs and civil society) in the delivery of services, including mobilization of the necessary financial resources. Promote health and a healthy environment to improve the living conditions of the population, including food and nutrition security and the creation of healthy and safe spaces. Increase coverage and improve the quality of drinking water, expanding the coverage of basic rural sanitation and improving the national response capability for diagnosis, surveillance, and control of environmental pollution. Implementation of the health policies; development of the Comprehensive System Health Care System (SIAS), with quality and equity, at all levels; education and training of competent health workers for national plans and programs; and promotion of community control of the public management of the health services. Continued efforts to coordinate international cooperation so that the financial and technology resources mobilized, together with the sharing of experiences with other countries, complement the established health programs and prevent substitution of national capacity.

### ***Technical Cooperation Strategy***

27. The peace accords have mapped out certain lines of work that must continue regardless of the Administration in power. With regard to health, these agreements set forth the basic guidelines to be applied, which include health sector reform, the reduction of infant and maternal mortality, maintenance of polio eradication, and the elimination of measles.

28. The Ministry of Health, together with the various agencies of the United Nations system, has agreed upon the need to maintain continuity in the essential processes that will make it possible to reach the health goals established in the peace accords. This commitment to continuity is the central strategy of the Health Group of the United Nations system in Guatemala. PAHO acts as the lead agency and coordinator of this Group.

29. Within this context, as a result of the Joint Evaluation of PAHO Technical Cooperation 1996-1998, the Organization's technical cooperation strategies for the biennium 2000-2001 are : to strengthen the steering and sectoral management role of the Ministry of Health; to help consolidate expansion of the coverage of the services and the health care model known as the Comprehensive Health Care System (SIAS) at levels I and II through decentralized technical cooperation in nine areas of health; to strengthen national institutions in the areas of public health laboratories, essential drugs, food protection, mental health, rehabilitation of the disabled, and emergencies caused by natural disasters; to support human resources education in areas related to programs for expanded coverage; and to promote the principles of gender and ethnic equity in the various programs and health projects.

### ***Objectives for PAHO's Technical Cooperation***

- Support the health sector, through decentralized technical cooperation, in the northern and southern Metropolitan Area, in the departments of Izabal, Alta Verapaz, El Quiché, Zacapa, El Petén, and Huehuetenango, and the municipio of Ixcán in order to increase the coverage and

improve the quality of care provided by the basic health services through implementation of the SIAS.

- Contribute to the National Economic and Social Development Plan and to compliance with the peace agreements and the Peace Project Portfolio through support for reorganization of the water, sanitation, and solid waste sectors, in addition to strengthening environmental management capacity to increase the coverage and improve services for basic sanitation and control of air, water, and soil pollution, within the framework of the strategy for sustainable human development.
- Strengthen the capacity of government, nongovernmental organizations, and population groups to act in the development of a culture of health promotion, creating healthy environments, behaviors, and lifestyles to achieve individual, family, and community commitment to sustainable human development of the Guatemalan people with equity and quality, using the ethnic and gender approach.
- Support the strengthening of the Ministry of Public Health and Social Welfare (MSPAS) and civil society in the strategic activities of surveillance, prevention, and control of morbidity and mortality from cholera, ARI/DD, vector-borne diseases, tuberculosis, rabies, emerging zoonoses, foodborne diseases, pesticides, and vaccine-preventable diseases, in addition to strengthening the surveillance system for the prevention and control of cervical cancer and STD/AIDS within the framework of the health policies and the peace agreements.
- Contribute to health sector reform by developing the SIAS through strengthening the administrative capacity of the various levels of care and through technical-administrative decentralization of the MSPAS, which will assist in ensuring equitable services delivery to improve the health of the most neglected populations.
- Strengthen national health priorities by linking the country to the economic, political, and technical integration processes of Central America and to other regional blocs, as well as through binational and multinational agreements for the creation of healthy borders and support for the peace agreements.

## *Expected Results*

30. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

31. *Cooperation networks, alliances.* To provide support to the food protection program for operation at the national level, with interinstitutional coordination.

32. *Surveillance and information systems.* For managing the execution, surveillance, and regulation of health promotion; for the management and execution of aspects related to the prevention, surveillance, control, supervision, and monitoring of communicable diseases prevalent in the country and the diagnosis of cervical cancer.

33. *Standards and guidelines.* To manage the regulation, promotion, surveillance, authorization, and sanction of the environmental sanitation and health activities; and for the steering role of the MSPAS in the management, regulation, insurance, financing, and delivery of health services.

34. *Plans, projects and policies.* For preinvestment projects and/or projects for water and basic sanitation, solid waste management and control, and control of air, water, and/or soil pollution; expanding coverage; surveillance and monitoring of basic environmental services related to public health; for primary and secondary levelsof care, the MSPAS, the Guatemalan Social Security Institute (IGSS), nongovernmental organizations, health services administrators (ASS), service providers (PSS), and local governments, aimed at consolidating the SIAS, especially with regard to indigenous and migrant populations; execution of the PLAGSALUD project in six departments, with possibilities for expansion to two additional departments.

35. *Methods, models and technologies.* To support the expansion of health services coverage to different groups of women according to living conditions during their life cycles, facilitating the links between the traditional medicine used by families and the

SIAS; for human resources education, in-service training, and decentralized human resources management; drug management; the promotion of environmental health; prevention of environmental risks; and environmental education.

36. *Training programs.* For personnel in the water, sanitation, and solid waste sectors; control of air, water, and soil pollution; in gender, ethnic, and generational approaches; for furthering the technical and managerial capacity of the Ministries of Public Health and Social Welfare and Agriculture, Livestock, and Food in order to reduce the morbidity and mortality from zoonotic and foodborne diseases; to maintain the system for the prevention and surveillance of foot-and-mouth disease and other vesicular diseases in animals; for local planning; for development of the managerial capacity of health personnel at the primary and secondary levels of care, which includes attention to the special situation of women and the migrant population; and for health services management.

37. *Direct support.* To strengthen the steering role of the MSPAS to promote the principle of equity between women and men and among the various

sociocultural groups demanded by health sector reform, in addition to promoting the concept of disease prevention and health promotion among health service providers and population groups; to strengthen technical cooperation among countries through a joint approach and to maximize resource utilization for effective management of common health problems that know no borders; to strengthen the local planning system by expanding the model of care, employing the equity, gender, and ethnic approach and taking poverty into account to ensure community participation throughout the process, with emphasis on monitoring of the services received; to develop the managerial capacity of the health personnel of the MSPAS, ASS, PSS, and local governments at the primary and secondary levels of care to consolidate the SIAS, which ministers to the special needs of the indigenous population, women, and the migrant population; to support implementation of the SIAS to expand coverage and improve the quality of care in the basic health services, taking the analysis of the local situation, the epidemiological profile, and community participation into account; and to support the system of comprehensive, differentiated, and continuous health care for the migrant and indigenous populations.

<b>GUATEMALA</b>				
<b>PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health in Human Development	2,035,500	2,083,000	895,900	43,500
Health Systems and Services Development	818,800	818,500	5,270,000	1,075,000
Health Promotion and Protection	259,800	258,100	300,000	0
Environmental Protection and Development	577,700	579,300	718,800	560,000
Disease Prevention and Control	683,400	684,200	1,515,000	250,000
<b>Total</b>	<b>4,375,200</b>	<b>4,423,100</b>	<b>8,699,700</b>	<b>1,928,500</b>

# GUYANA

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## *Health Situation*

1. Guyana has shown improved performance in the economic sector. Per capita GDP (expressed in US\$) has increased from \$543 in 1990 to \$808.3 in 1997. However, the country still has a high debt burden. The HIPC (Highly Indebted Poor Countries) Initiative seeks to reduce this burden through debt forgiveness and to ensure that the benefits derived are passed on to the social sectors. It is therefore expected that total expenditure on health will reach 3.2% of GDP in 1998 and 3.8% by the year 2000. At the present time, 7.3% of the National Budget is allocated for health.

2. The health system is characterized by inadequate human resources, weak managerial systems, lack of accountability and an information system that is neither efficient nor timely. Health Sector Reform is seen, therefore, as the main priority in the health sector. The principal features of the reform are the "corporatization" of the Public Hospital, Georgetown, and the creation of Regional Health Authorities. The function of the Ministry of Health will then be to steer the delivery process through the formulation of policies, the setting of standards and the monitoring and evaluation of services and programs.

3. In the reform process, implementation of the primary health care approach will play a pivotal role. Education of the population on health matters, integration of services at the local level, strengthening of the environmental health program and provision of a school-based health service will be some of the aspects to be emphasized.

4. Evaluation of health status, cost-effectiveness and cost-efficiency will require a management information system that provides managers with the tools for decision-making.

5. PAHO will provide technical support for the health sector reform process. Other agencies will be

involved. The Inter-American Development Bank will be implementing a project in which the main components are the reorganization and strengthening of the institutional structure of the health sector; the formulation of an integrated health service delivery strategy; development of managerial capacity and human resource and institutional development of the Public Hospital, Georgetown. The European Union and Canada, through the Structural Investment Program, will support aspects of physical infrastructure improvement. The United Nations Development Program will provide assistance for the establishment of comprehensive but simple health and management information systems; fostering community participation in health; and the application of quality standards and controls.

6. The disease profile shows that the country has to grapple with the effects of chronic as well as communicable diseases. The chronic non-communicable diseases are important contributors to morbidity and mortality. The programs to address these problems are fragmented and lack effective strategies for the promotion of healthy lifestyles and consequently for the prevention and control of these diseases. PAHO has been actively involved in supporting the adoption of healthy lifestyles and in the development of comprehensive programs that involve the health promotion strategies and non-governmental organizations.

7. The country continues to bear a tremendous burden of communicable disease. Several factors are responsible, including the presence of vectors, poor environmental sanitation and often ineffective programs to address these problems. Malaria causes considerable morbidity. There are reports of drug-resistance and of the disease not being confined to the interior, but also affecting coastal areas where the majority of the population lives. Filaria and dengue fever are also of concern. All types of dengue fever virus are circulating in the Caribbean. A recent survey conducted in a small sample population has shown that more than 25% of children and about 30% of adults have microfilariae infection. PAHO

will work closely with the Ministry of Health in order to implement the WHO strategy to eliminate filariasis through mass treatment.

8. The country is not free of foot-and-mouth disease. The Government has indicated its commitment to meeting the OIE requirements for achieving foot-and-mouth disease free status. Food and waterborne diseases are important, though not well documented causes of morbidity.

9. Guyana now has one of the highest incidences of HIV/AIDS in the Caribbean. The estimated prevalence in the adult population is 3-5%. PAHO is working closely with the National AIDS Program, CAREC and UNAIDS to strengthen program activities. Tuberculosis is still a health problem and this may be attributed to poor environmental and socio-economic conditions in the home as well as the increasing prevalence of HIV. The DOTS Strategy is being implemented and PAHO has been giving support to the program, including the training of health workers.

10. The Micronutrient Household Survey, which was conducted in 1996, has revealed that there are serious micronutrient deficiencies in the population. Over 40% in all target groups showed deficiency in hemoglobin. In children 0-4 years, the percentage was 47.9 and in pregnant women 52.0. Iron deficiency appears to be increasing among pre-schoolers. Approximately 11.5% of children (0-4) were undernourished (-2.00 SD WHZ) and over 40% of adults (20+ years) were overweight. The survey also showed that iodine deficiency was a potential public health problem. PAHO, through CFNI, works closely with UNICEF and the Social Impact Amelioration Project to determine and implement strategies for nutrition improvement.

11. While the national level of food supply is adequate, transitory and chronic household food insecurity, particularly among low-income and unemployed groups, remains an area of concern. In 1997, the cost of the basic ingredients of a well-balanced diet of 2400 calories was estimated to be 60% of the public sector minimum wage. Poverty alleviation measures in the national development

strategy are among the existing interventions for improving household food security.

12. There are few statistics to indicate the extent of diseases associated with poor environmental health conditions. There are however several areas of concern. A major problem is the acute shortage of environmental health field personnel. Another is inadequate field testing equipment, and the laboratories are not equipped to carry out the tests required. Legislation is outdated. In both rural and urban areas, water supply, sanitation and solid waste disposal are inadequate.

13. Disaster management is becoming increasingly important as the country goes through periods of drought and floods.

14. Although the mental health program has not previously received appropriate attention, the increasing incidence of drug abuse and other factors have brought this program to the fore. PAHO will work with UNDP and other agencies in the implementation of a project which addresses the issue of Drug Prevention and Control.

15. Family health is another priority identified by the Ministry of Health. The program will utilize the life-cycle approach and include areas such as maternal and child health, the health of the elderly and oral health.

16. Underpinning all these priority programs is the need for equity in the provision of services and the institutionalizing of Total Quality Management and Continuous Quality Improvement.

### ***National Priorities for PAHO's Technical Cooperation***

17. Reform of the health care system to improve delivery of health care. Implementation of an effective and efficient Primary Health Care System.

Reduction in morbidity and mortality associated with communicable and non-communicable diseases. Improvement in the physical, social and mental health of the population. Development of appropriate human resources strategy and implementation program. Utilization of appropriate health information to address inequities in health. Implementation of quality assurance and continuous quality management programs. Improved management of environmental conditions which effect health. Implementation of effective programs to promote the health of the family. Establishment of a health disaster mitigation and management program.

### *Technical Cooperation Strategy*

18. The technical cooperation program in Guyana will be delivered by technical staff in the PAHO Representation, supported by expertise elsewhere in the PAHO/WHO system and in collaboration with nationals representing both the government and non-government sectors. Technical cooperation between countries will be promoted to strengthen the pool of expertise. Special attention will be given to meeting the objectives of the Caribbean Cooperation in Health Initiative. Additionally, through cooperation with the United Nations System, Inter-American Development Bank, European Union and other bilateral agencies, efforts will be made to coordinate issues on health in development. The work will be directed towards assisting the country in achieving Health For All in the 21st Century.

19. In this regard, we will continue to benefit from the resources of the PAHO specialized centers, in particular the Caribbean Epidemiology Center (CAREC), the Caribbean Food and Nutrition Institute (CFNI), the Pan American Institute for Food Protection (INPPAZ) and the Pan American Foot-and-Mouth Disease Center (PANAFTOSA), as well as support from the office of Caribbean Program Coordination.

20. The major thrust of the program for the biennium will be directed towards enhancing the adoption of healthy lifestyles and the delivery, quality and availability of services to most vulnerable groups. Emphasis will be placed on those system

improvements and health conditions which will have greatest impact on morbidity and mortality as they affect the development of a productive and participatory society.

21. To carry out the program the following technical cooperation strategies will be adopted: building of cooperation networks and alliances, improvement of surveillance and information systems, the distribution, adoption and/or implementation of standards and guidelines, completion of research and evaluation studies, development of plans, projects and policies; the introduction and establishment of methods, models and appropriate technologies; execution of various training programs; utilization of promotional campaigns and advocacy initiatives, and direct technical and resource support.

22. It is widely accepted that sustainable changes/improvements in the disease patterns and quality of life in Guyana could only come about through mechanisms which maximize the utilization of all the available resources and which empower individuals to act and contribute to both decision making and program implementation. PAHO/WHO will therefore continue to build/foster alliances and networks through expanding partnerships in programs for health and wellness. Efforts will be made to sustain leadership in coordination, collaboration, cooperation and advocacy for health by involvement of key stakeholders. This will include interaction with individuals, groups or institutions, representative of civil society, government, non-government and religious bodies. This strategy will be important to outcomes relating to environmental monitoring and management, collation, dissemination and utilization of health information, as well as the organization of programs for disease prevention and control, services for special groups such as the indigenous, disabled, elderly, etc.

23. Efficient surveillance and information systems will result in better planning, resource allocation and timely response to reduce the impact of diseases and avert crises. This activity will be directed towards the development of appropriate data sets for monitoring diseases and the implementation or enhancement of national surveillance systems.

24. Established international standards and guidelines will be distributed as appropriate, particularly for Primary Health Care strategies, communicable and non-communicable diseases, mental health and the monitoring of intentional and non-intentional injuries. These will be applied where necessary as reference for the development of national standards.

25. Research and evaluation will be conducted in relation to the impact of: the overall technical cooperation as well as in the areas of decentralized health care delivery as it effects equity; health promotion interventions; HIV/AIDS and the influence of development and increased movement between the coast and the hinterland on health and wellness.

26. The government will be assisted in the development of plans and policies for solid waste management, vector-borne diseases, establishment of regional health services and special programs for wellness for the young child, adolescent and the elderly.

27. Strategies relating to methods, models and technology will be utilized to improve the analytical capabilities in the clinical, food and drug analyst and occupational health and safety laboratories. Such efforts will also be promoted for improved management of vector-borne diseases, specifically malaria, dengue, and filaria and other communicable diseases such as tuberculosis and food and waterborne diseases. The establishment of quality assurance and total quality management will also benefit from these approaches.

28. Local and overseas training will be a significant component. Local training is part of almost every activity in the planned technical cooperation. This is in keeping with the needs to increase skills and to improve the human resource base. The training will include direct skill building, policy and management issues.

29. People empowerment and the role of the individual in the protection of his/her health is essential to the success of health for all in the 21st Century. Additionally, the contribution that health

care makes to development and a productive society cannot be underscored. The adoption of health promotion and protection strategies will be instrumental in bringing about changes in lifestyles and to keep health high on the national agenda.

30. As in previous biennium direct support will continue for the provision of short-term consultants, procurement of selected items, particularly vaccines and supplies and local wage supplements as necessary.

### ***Objectives for PAHO's Technical Cooperation***

- To improve the prevention and control of communicable and non-communicable diseases.
- To effectively administer international technical cooperation for health in Guyana.
- To deliver environmental health and occupational health services on a sustainable basis.
- To increase efficiency in the health care system.
- To enhance capacity of individuals, families and communities for improving health.
- To improve management of HIV/AIDS and other sexual transmitted diseases.
- To empower individuals and communities to take responsibility for their health.
- To sustain leadership in management and knowledge of health issues.
- To increase access to information on health and health information.
- Efficient and effective management of the PAHO/WHO office.

### ***Expected Results***

31. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

32. *Cooperation networks, alliances.* Increased intra- and inter-sectoral collaboration in environmental health issues.

33. *Research and evaluation studies.* Of health promotion interventions based on the settings

approach and of project lifestyle intervention for school-aged population.

34. *Plans, projects and policies.* To increase disaster preparedness, to develop and submit a national plan of action for improved solid waste management, for the prevention and control of communicable diseases, CNDs and intentional and unintentional injuries, to introduce integrated management of childhood illness, to establish an adequate and functional Environmental Health Information System (EHIS), and to develop comprehensive national programs for child development, adolescent health, and health of the elderly.

35. *Training programs.* Of staff in response to the increased need for expertise in respective areas of work.

36. *Promotional campaigns and advocacy.* Of healthy lifestyles through social communication programs targeted at adolescents.

37. *Direct support.* To quality assurance programs and activities; at regional level for planning and implementing intersectoral actions for promoting health; to strengthen analytical capabilities of the Environmental Health Unit (EHU), the Occupational Health unit (OHU) and the relevant laboratories; for environmental health workers to effect a reduction in vector borne, water borne and occupational diseases; for delivery of primary health care at the regional and local level; for strengthening planning and programming capacity of health workers at the regional level, and for analyzing, monitoring and evaluating the impact of decentralization.

<b>GUYANA PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health in Human Development	709,600	833,200	0	0
Health Systems and Services Development	435,000	365,600	90,300	4,000
Health Promotion and Protection	129,000	115,200	0	0
Environmental Protection and Development	342,000	339,500	0	0
Disease Prevention and Control	163,600	135,700	65,600	0
<b>Total</b>	<b>1,779,200</b>	<b>1,789,200</b>	<b>155,900</b>	<b>4,000</b>



# HAITI

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## *Health Situation*

1. The Republic of Haiti shares the island of Hispaniola with the Dominican Republic. With a surface area of 27,700 square kilometers, it occupies the mountainous third-western part of the island. In 1998, the population was estimated at 7.6 million, with an average growth rate of 2.08%. The demographic density is one of the highest in Latin America: an average of 270 inhabitants per square kilometer and 923 people per square kilometer of arable land. The population is very young. The less than 15-year old age group represents 40% of the population. Migration from the rural areas to the marginal urban areas, as well as to neighboring countries, constitutes an important characteristic of the Haitian population. The rural exodus results in precarious housing and poses a health risk, particularly in the urban marginal areas and in the shantytowns.

slow revaluation has been observed since the beginning of 1996. Access to domestic electricity is limited, rural areas being the most affected. Despite a constant increase in the schooling rate in primary education and an equitable participation of boys and girls, it is estimated that the schooling rate covers only 80% of children in the 6-12 year old age group. The coverage of water supply and basic services is very limited. In the capital city, 48% of the population has access to drinking water, while this coverage is 43% in secondary cities and 41% in rural areas. For basic sanitation services, the coverage shows a big gap between rural and urban areas. Urban areas have 47% coverage, compared to 16% in rural areas. The country crisis has not spared any area. The degradation of the physical environment is on the rise. Accelerated deforestation is reducing the level of water sources and springs; water sewage is anarchic and the atmospheric pollution is reaching levels of concern in the capital city of Port-au-Prince.
2. The Haitian economy has been in constant decline during the last ten years, especially during 1991-1994. There has been a constant reduction in the GDP and a marked increase in the unemployment rate. The economic sanctions imposed following the "coup d'etat" in September 1991, contributed heavily to the deterioration of the situation. The increase in the gross domestic product that came about after the return to a constitutional government has not permitted, so far, a recovery from the economic decline of 25% registered during the embargo of 1991-1994. In the meantime, the rate of demographic growth continues to increase, while per capita income dropped from US\$390 in 1990 to about US\$120 in 1997, placing Haiti at the top of the list of the poorest countries on the hemisphere. The consumer price index is constantly increasing, having reached 20.5% in 1996 and 16.2% in 1997 and bringing as a consequence the exacerbation of poverty among a population enduring a 65% unemployment rate. The rapid development of the informal sector is showing as the main form of subsistence. The rapid devaluation of local currency that took place during 1991-1995 is settling down. A
3. Life expectancy at birth is estimated at 58.4 years (60.2 for women and 56.7 for men). Although infant mortality has decreased in the last ten years, from 101 to 74 per thousand live births, juvenile mortality (1-5 years) remains unchanged, at an estimated 50 per 1000 population (EMMUS II 1990-1995). Compared to accepted indicators, maternal mortality is very high, currently estimated at 457 per 100,000 live births. Immunization coverage for EPI diseases in children less than 1 year of age is slightly above 30%. Infectious diseases are the dominant feature; communicable diseases are responsible for a high share in general mortality and morbidity. The main causes, often linked with infant-juvenile mortality, are diarrheal diseases, acute respiratory infections and malnutrition. Haiti is among the countries most affected by tuberculosis. This disease has reemerged in epidemic proportions since the onset and rapid expansion of the human immunodeficiency virus (HIV) and AIDS. It is estimated that 7-10% of the sexually active population is infected with the HIV virus in urban areas and 3-5% in rural areas. Among other infectious diseases, meningococemia, dengue and

anthrax are endemic. These diseases call for an appropriate strengthening of the epidemiological surveillance system supported by a nationwide, functional laboratory network. Recent data on leprosy and malaria show a moderate level of endemicity, a fact that could eventually lead to their eradication. In addition to communicable diseases, cardiovascular diseases, mostly associated to high blood pressure, diabetes, violence and traffic accidents represent an increasing cause of mortality and disability.

4. At the end of the devastating socioeconomic and political crisis that resulted from the "coup d'etat" of 1991, the Government inherited a health system in ruins and divided among, on the one hand, a private philanthropic sector covering a part of the population, but functioning independently, and on the other hand, a weakened public sector. This sector is confronted with serious difficulties: lack of human and financial resources, inadequate organizational structure and legislation, precarious physical infrastructure, unmotivated personnel and uneven distribution of institutions and resources. Globally, modern health care is available to only 60% of the population. Health care is of poor quality and is not accessible to the majority of the population. The sale of pharmaceutical products in the local market is anarchical, whereas essential drugs are still not well known and, therefore, not used by consumers. In fact, only traditional medicine offers 100% coverage to the population.

### ***National Priorities for PAHO's Technical Cooperation***

5. The Ministry of Public Health and Population, in a joint exercise with PAHO/WHO, defined the national priorities for technical cooperation from the Organization. They are as follows: Health sector reform, centering activities on the identification of alternatives for health financing, the development of the health information system (HIS), the development of human resources for health, the strengthening of the capacity for coordination of external technical cooperation, hospital reform, applied field research on local health systems,

particularly within the health communal units (UCS), integration of health services, decentralization and community participation. Reinforcement of the epidemiological technical capacity in order to identify risk factors and establish reliable epidemiological systems. Such a system based on core data will also contribute to the planning and evaluation of relevant health programs. Target priorities in this respect aim at monitoring infant-juvenile mortality as well as the incidence of emerging and reemerging diseases, communicable and non-communicable diseases and violence, particularly accidents. Development of primary health care (PHC), especially support for the implementation of a minimal package of health services, comprising training of health personnel for the treatment of acute respiratory infections (ARI) as part of the Global Management of Childhood illnesses, immunization, reinforcement of the essential drugs program and the development of the medical/surgical emergencies program. Prevention and control of communicable diseases with emphasis on training, planning and resources mobilization especially with regard to emerging and reemerging diseases, such as tuberculosis, sexually transmitted diseases (STDs) and AIDS, meningococcal infections, dengue, filariasis; control of malaria, and eradication of measles, neonatal tetanus and leprosy. Health promotion, emphasizing the development of healthy lifestyles to prevent violence and traffic accidents, to promote awareness and safe behaviors, adolescent health, the reduction of communicable diseases and prevalent chronic diseases such as high blood pressure and diabetes, and the protection of the environment. Environmental health protection, reinforcement of effectiveness of the WASAMS information system, development of norms and standards, training, development of appropriate technologies, and resource mobilization toward the following areas: access to potable water, food safety and the control and disposal of excreta, the control of atmospheric pollution, and the strengthening of national capacity for prevention and mitigation of natural and man-made disasters.

### ***Technical Cooperation Strategy***

6. During the 1998-1999 biennium, as agreed with the Ministry of Health, PAHO technical cooperation

is being focused on two axes: 1) conception of a global health sector reform, based on equity, 2) support to selected public health interventions chosen for their potential impact on the health conditions of the population; for the biennium 2000-2001, the challenge will be to expand the necessary structural reforms, while guaranteeing the equitable provision of a minimum of acceptable quality services. The 2000-2001 biennium of health promotion with the acceleration of the "healthy city/healthy spaces/healthy schools" movement officially launched in June 1998.

7. In this framework, PAHO/WHO will continue to concentrate its technical support at a more normative than executive level, cooperating in a privileged way with the Ministry of Health, but also with other Ministries such as Education, Environment and Women Affairs.

8. This principle will be reinforced by a careful application of the functional approaches at the level of each project:

9. Develop and adapt policies, legislation and norms in all areas related to the implementation of Primary Health Care and health sector reform.

10. Mobilization of national, international, financial and other resources for health promotion, and support of a rigorous and optimal management of these resources remain a priority axis of the Organization's technical cooperation.

11. Training will be considered in the more general context of human resources development. PAHO/WHO, whenever possible, will foster development of local training, with the collaboration of foreign trainers or institutions, if necessary.

12. Dissemination of information. In addition to our regular means of dissemination of up-to-date scientific and technical information, all available resources of modern technology, in particular access to information networks, will be used in order to

enhance our capacity in this regard and allow us to reach not only the public health community, but as much as possible of the other segments of society as well.

13. Surveillance and information systems: the country's program will dedicate a significant amount of human and other resources to support the Government effort in expanding and improving its information and surveillance systems.

14. Research and evaluation studies. The Representation will continue to promote operational research in health, especially in the area of communicable diseases, health systems and community participation.

15. Direct technical support is one of the main approaches to reinforce the efforts of the national authorities in the specific areas identified by the Ministry of Health.

16. Cooperation networks, alliances not only with the Ministries, but also with other partners in health, such as local authorities, the United Nations agencies, the World Bank, the Inter-American Bank of Development, bilateral and multilateral agencies, training institutions, NGO's, religious and community groups.

### ***Objectives for PAHO's Technical Cooperation***

- To strengthen the capacity of the MOH to carry out the health sector reform.
- To improve the coverage of integrated child and women health services, immunization, to reinforce the essential drugs program and to implement the program of reinforcement of obstetrical emergency management.
- To contribute to the reduction in morbidity and mortality due to communicable and non-communicable diseases through the

strengthening of epidemiology, prevention and control of those diseases.

- To support local and national mobilization for individual and community improvement with regard to their health.
- To increase efficiency/efficacy of drinking water, basic sanitation (DWS), environmental protection and disasters management national systems.
- To enable the direction of human resources to support the head of the sanitary department in managing continuing education for health workers.
- To improve the delivery of the technical cooperation.
- Enhanced national capacity in prevention, preparedness and mitigation disasters.

## ***Expected Results***

17. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

18. *Cooperation networks, alliances.* To reactivate the National Breastfeeding Committee through an active breastfeeding promotion, to extend the healthy cities to the nine sanitary departments, and between Haiti and other country and intersectorial coordination.

19. *Surveillance and information systems.* To prevent and control the transmission of communicable and non-communicable diseases, including HIV/STDs (blood, sexual and perinatal), tuberculosis and leprosy, malaria, vector borne diseases (dengue, filariasis) and zoonosis (human rabies, anthrax, leptospirosis), to coordinate (with the MOH and other partners) the control of food salubrity and drinking water at the central and departmental level

20. *Standards and guidelines.* Through legislation on occupational health (prepared and voted upon), aimed at creating a safer and healthier working environment, regulating the quality, efficacy and security of drugs available to the Haitian population,

to design care integral to the health of adolescents, and to produce reliable results of clinical biology.

21. *Plans, projects and policies.* To implement an essential drug supply system containing costs and increasing availability, to update vaccination schedule, to disseminate educational materials for the prevention and control of transmission of HIV/STDS, tuberculosis and leprosy, to effectively implement MOH's Nutrition policy in health institutions and food donor agencies, to revise and implement a National strategic plan of nutrition, to realize action for: 1) significant reduction of violence and road accidents on the major roads, and 2) hygiene promotion and sanitation in public places and schools, to elaborate on and implement a mental health plan, to design a health personnel continuing education plan in the 9 departments, and to disseminate material on the WASAMS system for sectorial planning; national plan of environmental action.

22. *Methods, models and technologies.* To improve the quality of efficiency of health care to children, women and adolescents in the public sector and ONGs, to strengthen national expertise in the field of nutrition, to reinforce the efficiency/effectiveness of the DWS sectorial institutions, and to strengthen the administrative, finance and human resource management of the PWR office in order to improve the efficiency of the delivery of technical cooperation.

23. *Training programs.* For health personnel to manage communicable and non-communicable diseases, including HIV/STDs, tuberculosis, leprosy, vector borne diseases (dengue, filariasis), malaria, and zoonosis (human rabies, anthrax, leptospirosis).

24. *Promotional campaigns and advocacy.* Of implementation of the National Plan for the reduction of maternal mortality, of active distribution of EPI materials, of administration of EPI by MOH, of a complete and timely investigation of notified cases of EPI diseases, of policies of sustainability for EPI and its technical committee, of effective participation of women in health and development activities, of a program aimed at reducing the use of alcohol, tobacco and other drugs, of ways to minimize the effects of environmental damage on health, of water and sanitation sector reform engaged by the national

authorities into the global state reform, and of environmental protection (through education of youth, public awareness and information broadcasting).

25. *Direct support.* Of health sector reform in order to provide quality care, to MOH to permit the

strengthening of health institutions and the successful and extended implementation of IMCI strategy, to improve at least the access and quality of ARI/Diarrhea services when the IMCI strategy cannot be immediately implemented, to reinforce the health institutions at departmental and local levels for better management of pregnancies, to reinforce health institutions for an increased provision of quality care.

<b>HAITI PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health in Human Development	1,974,800	2,292,100	1,100,500	91,000
Health Systems and Services Development	620,100	607,100	5,022,500	4,400,000
Health Promotion and Protection	953,500	693,500	281,900	0
Environmental Protection and Development	700,700	655,600	0	0
Disease Prevention and Control	314,000	324,800	834,300	1,000,000
<b>Total</b>	<b>4,563,100</b>	<b>4,573,100</b>	<b>7,239,200</b>	<b>5,491,000</b>



# HONDURAS

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## *Health Situation*

1. In early 1998, when a new government assumed power in Honduras, a major reform of the health sector was proposed. The main objectives of the "New Agenda Government Plan" (1998-2001) include a direct assault on poverty, with special attention to employment, education, health, nutrition, water, housing, and sanitation. In addition, the following underlying criteria for a new social policy have been identified: a) equity and solidarity; b) integrity; c) targeting; d) efficiency; and e) citizen participation.

2. Some of the priority goals of the "New Agenda," which are related to the social problem in health, are investment in human resources, education, and health; protection of the most vulnerable groups; promotion of integral family development, aimed at protecting children through adolescence; and environmental protection, in order to develop, preserve and utilize the environment to benefit the present and future generations. All of these philosophical elements should be considered when developing and executing PAHO cooperation with the country in the biennium 2000-2001.

3. Honduras has an estimated population of 5,616,000 inhabitants, with a high annual growth rate (2.8%). The fertility rate is 4.7 children per woman (1994). Urban dwellers make up 44 % of the population. The rural population is distributed among nearly 27,000 communities, some of which have fewer than 700 inhabitants. There are eight ethnic groups in the national territory, which constitute 10% of the country's total population. These indigenous populations characteristically inhabit areas that are difficult to access, are scattered throughout the territory, and have high poverty indexes.

4. The country has a high emigration rate, mainly in the 20-29 age group (-1.7% for males and -1.4% for females), due mainly to the search for better opportunities abroad.

5. Age distribution continues to reflect a predominantly young population (21% corresponds to the 15-24 age group), and 43% of the total population is under the age of 15. This poses a serious challenge for the national institutions with responsibility for comprehensively addressing the problems of these groups, without neglecting the gradual increase in the elderly population and its related chronic degenerative health problems. In addition, the trend toward children joining the household work force has been on the rise, a phenomenon that should also be addressed from an intersectoral and interinstitutional standpoint.

6. There is a high incidence of underreporting of mortality that should be corrected as quickly as possible. Until now, international cooperation has not been very effective in solving this problem. Likewise, important shortcomings in the nation's epidemiological surveillance capacity have been detected. In general, as a fundamental tool for analysis and decision-making, epidemiology should highly developed.

7. A crude death rate of 6.5 per 1,000 population has been estimated for the period 1990-1995. Life expectancy at birth for the period 1990-1995 was estimated at 65.4 years for men and 70.1 years for women. The infant mortality rate is 42 per 1,000 live births, a significant decline compared to the estimate for 1989, which was 50 per 1,000 live births. The leading causes of infant mortality are acute respiratory infections, acute diarrheal diseases, and perinatal disorders (prematurity, neonatal asphyxia, sepsis, and obstetric trauma). Deaths from vaccine-preventable diseases are on the decline. Morbidity in children under 5 is 73 per 1,000 live births. The mortality rate for women between the ages of 12 and 50 is 1.43 per 1,000, which means that a woman in this age group dies every 5 hours. The maternal mortality rate is estimated at 168 per 100,000 live births. The government has issued an urgent call to reduce this figure in the coming years, bearing in mind that it derives chiefly from preventable and controllable causes, such as hemorrhage, unrelated maternal deaths, hypertensive disorders in pregnancy, and infections. Most maternal deaths occur at the time of delivery or within the next 24 hours.

8. Vector-borne diseases constitute a primary health problem, especially malaria (96,000 cases in 1997), dengue (15,500 cases in 1997), and tuberculosis. Some 300,000 cases of Chagas' disease have been estimated nationwide. With regard to zoonoses, the health authorities, in coordination with the livestock authorities, have decided to continue strengthening programs for epidemiological surveillance and for the prevention and control of rabies, cysticercosis, and leptospirosis, which are the main problems that impact on human health.

9. Adult morbidity accounts for at least 70% of hospital discharges, according to the Ministry of Public Health. Pregnancy, childbirth, and the puerperium are the leading causes at 46.1%, followed by diseases of the respiratory tract at 8.62%, and injuries, at 8.28%. According to hospital discharges, AIDS headed the mortality profile, accounting for 5% of all deaths. AIDS is the principal problem among communicable diseases and will continue to require a great deal of support from international cooperation in the coming years. In this regard, there has been an increase in opportunistic infections, especially tuberculosis. There was a reduction in the number of cholera cases registered in 1997, compared with 1995 and 1996. However, current efforts by the control mechanisms must continue, given the potential for its reemergence.

10. Vaccination coverage is high at the national level (>90%); however, 27% of the country's municipios maintain coverage at less than 80%. For these, future work will have to be prioritized, and there will be an ongoing need for support from the international cooperation agencies.

11. Violence (especially domestic violence) and accidents in the home and workplace, as well as mental health problems, drug addiction, and substance abuse are important issues in public health, along with a troubling upswing in mortality, morbidity, and disability from these causes. In the past six years, the homicide rate has practically doubled, and deaths from traffic accidents have increased (11.8 per 1,000 inhabitants in 1995).

12. Chronic malnutrition continues to ravage the population under 5. Micronutrient deficiencies are frequent, with iodine and vitamin A deficiency the greatest problem. Disability issues are not well

known in the country; however, they are considered an area requiring greater attention.

13. In 1995, it was estimated that 79% of the population had drinking water services (91% of urban households and 66% of rural households). The service is intermittent, and bacteriological quality and water chemistry are not always adequate. Only 49% of the water consumed is disinfected in the system. Monitoring of the rural water supply systems has revealed deficient bacteriological quality in 89% of the water sources, the product of wastewater discharge or defecation in the open.

14. The Honduran health system is comprised of a public and private sector. Public services are offered mainly by the Ministry of Public Health (approx. 60% of coverage) and the Honduran Social Security Institute (IHSS), with 12% coverage. Smaller proportions of the population are covered by the Armed Forces Health System, the National Social Welfare Agency, and the Department of Occupational Medicine, Hygiene, and Safety under the Ministry of Labor. The public health system also oversees the National Autonomous Water Supply and Sewerage Service (SANAA).

15. The private system is comprised of some 56 hospitals (with an estimated 1,400 beds) and an undetermined number of private physician's offices, some of which are financed by religious groups. The public services of the Ministry of Public Health are organized into six levels of care linked in a weak referral system. There are nine health regions. The health services system does not mirror the country's political-administrative structure. The need for regional adaptation has been established, giving the departments and the municipios special priority.

16. The pharmaceutical sector is not meeting its main objectives to the degree desired. The drug supply system and its rational use, improvements in regulation and information systems, the organization and operation of hospital pharmacies, and the development of community drug funds are some aspects of this area that merit greater consideration.

17. The Ministry's network of services consists of 978 facilities, including 28 hospitals, 8 maternal and

child clinics, 214 physician-staffed health centers (CESAMOS), and 727 rural health centers (CESAR). Of the 29 hospitals, 6 are considered national referral hospitals, 7 are regional hospitals, and 15 are area hospitals. Some 60% of these facilities are in a clear state of deterioration, as are the IHSS health services. All of this poses a major challenge for the period 1998-2001, not only in terms of upgrading the physical infrastructure, but its organization and management, and the quality of the care provided, chiefly in the hospitals.

18. Exercise of the steering role in environmental health is quite weak. Monitoring is in its initial stages, regulations are lacking, and those that do exist are not enforced. There is insufficient financing. There is no control over programs at the regional and local levels, and information generated at the local level does not reach the central level. Better distribution of human resources is imperative, as is improving service delivery to make it more efficient, effective, and timely. Action is usually taken in response to problems rather than as a preventive measure. Interinstitutional coordination has improved in recent years but has not reached an acceptable level. Citizen participation in the identification of environmental problems and solutions has improved. The concept of sustainable development is still not well established. There is a need for greater numbers of trained personnel in the environmental sphere.

19. The following is a description of the water and sanitation situation: no entities regulated by law; inefficient use of resources; lack of coordination; uncontrolled NGOs; inappropriate technologies; unsustainable projects; external pressures for sectoral reform; lack of information; and insufficient and untrained human resources. At the municipal level, the situation is as follows: municipalization; lack of environmental plans; environmental units in the development stage; environmental illiteracy; insufficient and untrained human resources; financing limited to the urban area; and ignorance of environmental laws.

20. The Environmental Protection and Development Project's principal areas of work were: institutional strengthening; environmental surveillance; preparation of plans, programs and projects; training of human resources; environmental legislation and regulation; strengthening of interinstitutional coordination; promotion of community participation

and health education; support for research and for the Disaster Management program.

## *National Priorities for PAHO's Technical Cooperation*

21. Health sector reform. Response to the principal needs and demands for public health and personal health care. Education in health. Intervention in environmental risks and damage to health. Development and strengthening of a culture of life and health.

## *Technical Cooperation Strategy*

22. The key elements of the PAHO/WHO Technical Cooperation Strategy will be the policies contained in the "New Agenda Government Plan", "The New Health Agenda", and the "Detailed Implementation Plan of the New Health Agenda." PAHO/WHO Technical Cooperation should respond to the needs and priorities established in the government's policies.

23. In the policy guidelines contained in the aforementioned documents, the following general aspects should be noted: a) the regulatory role of the Ministry of Public Health; b) the reorganization of the model of care (departmentalization and reorganization of the model for health service delivery); c) the assessment of health problems and the consolidation of plans and programs; d) the upgrading of human resources; e) the development of a new drug policy; f) the development of information systems; and g) the consolidation of environment and health programs.

24. Other dynamic strategic elements of technical cooperation will be: health promotion; the guarantee and improvement of the quality of care; systematic supervision, monitoring, and evaluation; decentralization; and co-management of the health services.

25. Direct assistance will remain one of the pillars of PAHO cooperation with Honduras. Thus, one of the first priorities will continue to be developing the technical expertise of the team of professionals in the

Representative Office (international consultants and national professionals) through continuing scientific and technical education and the careful selection of any additional human resources for carrying out projects and cooperation activities.

26. The regular cooperation resources of PAHO/WHO are not sufficient to respond to the country's health problems and priorities in the best possible manner. The growing mobilization of external resources is vital for Honduran health development. This will be one of the areas in which PAHO will have to get involved in order to gain access to greater extrabudgetary resources.

27. The political decision to develop the municipios, with the passage of specific laws and the transfer of resources and responsibilities in different areas, is giving rise to new demands in the programming and execution of cooperation, making it more dynamic. It is also promoting greater interaction with institutions outside the public health sector. Work with municipal governments, NGOs, religious groups, the private sector, and other Honduran public institutions is vital for cooperation to succeed and will require PAHO's technical, political, and administrative expertise.

28. Despite national efforts, coordination among the various international health cooperation agencies is not sufficient to meet the country's needs. We will promote the greatest possible coordination from the PAHO/WHO Representative Office, taking advantage of our international prestige and leadership in health, and we will assist the Ministry of Public Health in developing its own capacities in these endeavors.

### ***Objectives for PAHO's Technical Cooperation***

- Cooperate with national institutions to develop the country's capacity to administer and sustain uninterrupted and timely operation of a national epidemiological surveillance system capable of analysis and operational response at each level of the health system (local, departmental, and central).
- Cooperate for the development and execution of sustainable plans that include specific annual activities and protocols for individual and community management to reduce the incidence of the principal communicable diseases in the country.
- Contribute to an improvement in the food and nutrition situation, supporting the country in the design and execution of strategies, policies, and actions in food and nutrition education for the population, human resources education, micronutrients, food security, and consumption of nutritionally improved food.
- Formulate, implement, and evaluate policies, plans, programs, standards, and instruments on health promotion and the adoption of healthy public policies.
- Train health workers in accordance with the guidelines contained in the health policy, the demands of sectoral reform, and the needs of the population.
- Develop the capacity of the health sector to achieve maximum coverage with quality and efficiency through a sustainable participatory planning model.
- Implement concrete programs geared toward improving the availability, accessibility, quality, and rational use of essential drugs, within the framework of a pharmaceutical policy that promotes sanitary regulation of pharmaceutical products and the reorganization and management of the drug supply.
- Contribute to improving the living conditions and health of the population, reducing inequalities among gender, ethnic, and other population groups.
- Within the Framework of the New Health Agenda, contribute to advocacy and actions aimed at preventing, modifying, and controlling all variables and risk factors likely to arise, thereby diminishing environmental health problems, and promote and/or strengthen the active participation of civil society and encourage the adoption of habits and behavior that will improve individual and collective health and well-being.
- The country will have advanced in providing timely and quality reproductive health care in the health services in: the prenatal period, delivery, the puerperium, and referral. It will also have made progress in the design and development of programs aimed at reducing maternal and child mortality.

- The country will have advanced in the development of policies designed to eliminate gender inequities in the health sector, incorporating an analysis of the impact of the reform process and health situation analysis by sex and age, in addition to implementing programs and projects designed to resolve specific gender and health problems efficiently, qualitatively, and sensitively.

## *Expected Results*

29. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

30. *Cooperation networks, alliances.* With regard to healthy schools and municipalities.

31. *Surveillance and information systems.* For quality assurance of fortified food and for food safety; surveillance of health and the environment; and epidemiological surveillance of maternal and perinatal mortality at the local, regional, and national level.

32. *Standards and guidelines.* For surveillance and improvement of the quality of the health services and for sanitary regulation of drugs and phytopharmaceutical products.

33. *Research and evaluation studies.* On positive community participation experiences to identify options to ensure sustainability; on health profiles of neglected population groups that will make it possible to devise interventions employing equity criteria; on investment in health; on the impact of structural, macroeconomic, and social policies.

34. *Plans, projects and policies.* On the prevention of priority communicable diseases in the country; communication and education on food and nutrition; food production and consumption; attention to neglected groups; the rational use of drugs at the institutional and community level; the framework of the Plan for Health and Environment in Sustainable Human Development; occupational health; incorporation of disaster preparedness into development plans and projects; reproductive health of adolescents; the gender approach; promotion of the participation of men in reproductive health

programs; and prevention and control of communicable diseases at the local, municipal, departmental, and central levels of the system.

35. *Methods, models and technologies.* To support sectoral management and reorganization of the national health system during the biennium 2000-2001; and for comprehensive treatment of the problem of intrafamily violence in the health sector.

36. *Training programs.* In food, nutrition, and food security; in methods and techniques for community participation; for incorporating communication for health; for national technical personnel in health promotion methodologies; in the priority technical fields stipulated in the health policy and sectoral reform proposals; for operation of the Secretariat's network of services, mainly at the regional and local levels; for proper management of the drug supply system at the national level; on epidemiology and the registry of vital statistics; in bioethics; and in environmental protection and development.

37. *Promotional campaigns and advocacy.* For the promotion and adoption of healthy lifestyles and mental health, especially with regard to the prevention of tobacco, alcohol, and drug use, intrafamily violence, and child abuse; to disseminate appropriate, low-cost technologies in environmental health; and to promote breast-feeding.

38. *Direct support.* For developing and strengthening the national epidemiological surveillance system; for implementing methods, models, and/or technologies that assist in combating communicable diseases; for strengthening municipal capacity for developing food security plans at the local level; for using information, education, and mass communication in the development of community promotion activities; for disseminating technical and scientific information on health promotion; for strengthening national capacity in planning, managing, and regulating the development of health workers; for developing the basic functions of institutional and community pharmaceutical services, by level of complexity; for formulating public policy in the social sector; for applying concepts and methodologies pertaining to research in the health sector and for technological development of the sector; for operating institutional networks and

promoting intersectoral coordination in environmental health; for implementing national community mobilization strategies in environmental protection and development projects; for improving the coverage, quality, and timeliness of care with

regard to family planning, pregnancy, childbirth, the puerperium, and newborns, especially high-risk pregnancies and emergencies; and for the prevention, early detection, and treatment of cervical cancer.

<b>HONDURAS PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health in Human Development	1,553,600	1,483,100	2,082,700	40,000
Health Systems and Services Development	528,500	572,100	2,676,500	965,000
Health Promotion and Protection	283,000	352,400	0	0
Environmental Protection and Development	533,500	527,400	690,400	470,000
Disease Prevention and Control	532,500	548,600	1,055,300	820,300
<b>Total</b>	<b>3,431,100</b>	<b>3,483,600</b>	<b>6,504,900</b>	<b>2,295,300</b>

# JAMAICA

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## *Health Situation*

1. A new Government has been in place in Jamaica since December 14, 1997, when the People's National Party was successful for a third term in the General Elections. The changes within the Cabinet included a new Minister of Health. However, the policies of the Government with regards to health have not been modified significantly.
2. Nevertheless, the Ministry of Health has had to re-budget and re-prioritize its strategies because of the economic difficulties being experienced by the Government. This will, therefore, have some effect on technical cooperation.
3. Health care reform still continues as a priority area and the process of implementation is increasing apace. Regional health authorities have been designated and Senior Directors appointed. However, further strengthening in management must be addressed through training.
4. The prevalence of chronic non-communicable diseases in the epidemiological profile, coupled with the fact that many are lifestyle-related, demand that health promotion be a major approach. Hence, this approach will be applied in all programs and the organizational support will be provided by the establishment of a new Health Promotion Department. Quality of Care will be a major strategy towards the achievement of increased efficiency. Hence, in all areas of primary and secondary care, Quality Assurance programs will be addressed.
5. Intentional and non-intentional injuries are a major concern, thus the strengthening of surveillance systems and the determination of risk factors to these and other chronic diseases will be pivotal for program development.
6. The Ministry has determined the need for additional resources for the health care delivery system. Thus, a National Health Insurance Plan has been proposed. The final form of this plan is now under discussion.
7. The integration of mental health into the community health services and destigmatization and development of rehabilitation programs have been identified as being pivotal to support the health reform program. In support of the health promotion thrust, high priority has been given to the settings for health promotion action: schools; hotels; prisons; markets, workplace, all contributing to the promotion of the Healthy Parish Initiative.
8. The institutional and organizational aspects of this reform are indeed a priority. Decentralization will be strengthened by integration of primary and secondary care with special emphasis on the development of health information systems; rationalization of primary health care centers; development of protocols for clinical management at both the primary and secondary level, and biomedical equipment maintenance. Additionally, all already established training programs will no longer be under the jurisdiction of the Ministry of Health, but that of the Ministry of Education. To further support the thrust strengthening, introduction of relevant curricula and equipping faculty with new skills will be required.
9. The program of poverty alleviation demands a special focus on vulnerable groups and the need to establish linkages with the private sector and NGOs in addressing their needs. The improvement of the health status of these groups is of high priority.
10. The intensification of the EPI Program with special focus on the elimination of rubella and control and prevention of STDs, with special emphasis on HIV/AIDS within high-risk communities, such as tourist areas, is of vital importance. The gains in dental health and other areas will continue to be promoted.
11. Problems which have developed in the areas of Health Facilities Maintenance and transportation management will be largely addressed by training.
12. It is also necessary to manage the organization's priorities more efficiently. The head office is to be restructured. Some services and facilities are to be

privatized. These include the Cassava Piece Health Clinic and a wing of the National Chest Hospital. Proposals have also been made to privatize the National Public Health Lab and the Portmore Health Center. The role of regulatory councils must be reviewed.

13. Poor environmental conditions continue to undermine the health status of some communities. However, it is evident that members of the communities also need to take responsibility for some of the poor environmental conditions such as reforestation, air pollution and flooding caused from disposal of solid waste in drains, resulting in turn to the proliferation of vectors. Attempts to address the issue of sewerage in some urban areas have been made through the implementation of EEC funded projects implemented by PAHO to effect proper sewerage systems in some inner city communities. No sewerage systems exist in rural areas and environmental conditions continue to be of major concern.

14. In addition to the problems of potable water and the deterioration of air quality in the major urban population centers, waste water management poses significant problems for national development and health protection. The coverage is low and about 50% of the population use pit latrines.

15. The national industrial policy and the decisions taken at the Rio Conference regarding Agenda 21 have stimulated and guided national decisions on workers health, the institutional framework for environmental health management including food safety and the establishment of a national environmental agency.

16. Health manpower continued to be affected by the downturn in the economy. Government's inability to remunerate health professionals at a higher rate led to attrition. This negatively affected the delivery of health care services. High vacancy continues to exist.

### ***National Priorities for PAHO's Technical Cooperation***

17. Pursuit of programs and strategies to secure improvements in environmental quality and promote

improvements in health and human welfare with particular focus on the monitoring of water management, excreta disposal, vector control, marine pollution and workers health. Development and implementation of programs designed to promote healthy lifestyles, including prevention of violence and in general responsible healthy behavior. Research initiatives for financing health care. Expansion and improvement of the quality of family planning services counseling and general services in collaboration with the National Family Planning Board, to facilitate the achievement of the National Population Policy target. Promote policies and activities which would promote the incorporation of women's needs into program planning and raise 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 through the following:- To strengthen capacity and capability of the Health Sector to Reform, the Organization, Management, Financing and delivery of Health Services. Disaster Preparedness with emphasis on disaster planning and simulation exercises. Maternal and Child Health with emphasis on reduction of maternal mortality to under 10 per 10,000 live births. Reduction of perinatal mortality and the elimination of poliomyelitis and measles. Oral health with emphasis on public education and monitoring of Salt Fluoridation Project. Emphasis on the integration of mental health into primary care services. Public education and nutrition surveillance geared at improving nutritional status and prevention of chronic diseases targeting mainly diabetes and hypertension. Veterinary Public Health - emphasis on food borne disease surveillance. Environmental Health - with emphasis on improvement of drinking water quality, reduction of air pollution. Improvement of environments in relation to occupational/workers health. Enhancement of excreta/sewerage/solid wastes disposal. Involvement of Non-governmental Organizations, in health and epidemiological surveillance particularly with respect to STDs, HIV, dengue, hepatitis B, typhoid, food borne diseases, tuberculosis, Hansen's diseases and cholera. Strengthening the capabilities of MOH for the human resources development manpower planning, training capacity of tertiary institutions, and program planning. Increase in the managerial capabilities and efficiency of the Representation in order to enhance delivery of technical cooperation.

## *Technical Cooperation Strategy*

18. The technical cooperation strategy will focus on support of the Health Reform Program in order to set the basis for institutional strengthening of the Central Ministry and Regional Health Authorities, together with the application of the health promotion approach to address lifestyle related diseases and the promotion of the Healthy Parish Initiative.

19. Strategies will also be directed towards vulnerable groups, women, children and adolescents. Additionally, in support of health and tourism, environmental strategies, related to water, waste water, solid waste and food protection will be addressed.

20. In relation to institutional strengthening, the main functional approaches will be: Development of policies, plans and norms; Training; -Direct technical cooperation.

21. With respect to addressing issues of lifestyle related diseases and thrust for health promotion, the first approach will be directed to research as it relates to behavior risk factors, training in order to provide health personnel with new skills, direct technical cooperation and dissemination of information to support promotional campaigns.

22. With respect to environmental protection and control, the functional approaches will be directed towards development of policies and norms in support of strengthening legislation, the establishment of safety standards for water, solid wastes and stack emissions.

23. The training of personnel and research aimed at the establishment of policies and the development of programs for sustainable development in this area.

24. In programs which will address the needs of vulnerable groups, the functional approaches will be through direct technical cooperation, research and training of other partners in support of the needs of these groups.

25. Therefore, the areas to be addressed under technical cooperation will be the following:

26. A continuation of a technical cooperation strategy in line with the Ministry's mission, which is "to promote the physical, mental and social well-being and enhanced quality of life of the Jamaican people by empowering individuals and communities and ensuring access to adequate health care through the provision of cost-effective, promotive, preventive, curative and rehabilitative services in partnership with other stakeholders". The goals defined by the country are in compliance with agreed goals and strategies.

27. Special attention will continue to be paid to the following areas. Providing support for:

28. Strengthening management and general administration of the Ministry of Health.

29. The implementation of a proper information system at all levels of the Ministry.

30. Improvement of the monitoring and evaluation process of the health sector's policies and plans.

31. Development of broad policy for financing health care.

32. Development of a healthy lifestyle program with specific reference to predominant diseases such as hypertension, diabetes and cancer and promoting individual responsibility for health with special emphasis on adolescent health/reproductive health, mental health/substance abuse, STD/AIDS, disaster preparedness and reduction of intentional injuries.

33. Development of surveillance systems for identification, prevention and control of chronic diseases.

34. Integration of mental health services into all health programs.

35. Promote intersectoral collaboration to supply potable water on a 24 hour basis, proper disposal of solid waste excreta, medical waste, protection of the environment and the monitoring of food hygiene, as well as the adequacy of occupational health standards.

36. Provision of adequate diagnostic, curative and rehabilitative services.

37. The Healthy Parish Initiative.
38. The application of the epidemiology approach to the prevention and control of violence.
39. The quality assurance program.
40. Human resource development with special reference to education of health manpower in support of decentralization and availability of nursing tutors.
41. Development of a sustainable biomedical equipment maintenance program.
42. A gender-based approach in the analysis and development of programs.
43. Disaster mitigation.
44. Development of appropriate legislation in respect of environmental protection and development and in the modernization of health service delivery regarding public health, mental health and nurse practitioners.
45. Completion of the installation of the WASAMS water quality monitoring network.
46. Development of a framework for monitoring the implementation of the National Solid Waste Plan.
47. Completion of exercise to develop stack emission standards locally.
48. Expansion of Italian supported Vector Control Program to other parishes.
49. Assist in the establishment of a Food Borne Disease Surveillance System.
50. Development of a National Policy on Worker's health.
51. Vaccination against immunizable diseases with emphasis on Rubella.
52. Levels of collaboration will be accomplished with regional, national and international institutions such as CFNI, UTECH, UWI, and IDB, with the purpose of implementing relevant programs, specifically in the case of human resource development in the case of UTECH and UWI and strengthening health care services, in areas including infrastructure, in the case of IDB, and nutrition, in the case of CFNI.

53. The functional approaches which will be used include direct technical assistance, training, research, dissemination of information, development of policies, plans and norms and mobilization of resources.

### ***Objectives for PAHO's Technical Cooperation***

- To improve the knowledge and capacity of the personnel in the ECD and Inspection Services of the Ministry of Health and the Regional Health Authorities in the exercise of Planning, Programming and monitoring of water quality, solid waste, sewage and excreta disposal and workers' health.
- Strengthen the capacity of the Ministry of Health with respect to the control and prevention of communicable diseases, including those prevented by immunization.
- To provide knowledge, skills and techniques to improve quality, and accreditation, financial sustainability, effectiveness, efficiency, equity and access to health care services.
- Comprehensive food protection and priority zoonosis program developed, reviewed and implemented in collaboration with relevant Government agencies and NGO.
- Strengthening the capabilities of the Ministry of Health to improve the health of families and empower them to be responsible for their own health.
- Reeducation of morbidity and mortality due to chronic non-communicable diseases.
- Promote Mental Health wellness and improve the delivery of Mental Health Services.

### ***Expected Results***

54. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

55. *Cooperation networks, alliances.* To organize a regional workshop for the Region of the Americas, with Headquarter's support on oral health, with emphasis on the Salt Fluoridation Program; formation of intra and inter-sectoral linkages for

mental health; with community meetings for the support of Healthy Lifestyle program for the elderly.

*56. Surveillance and information systems.*

Appropriate low cost technologies for vector control and water disinfection systems at parish water supplies to protect human health and enhance environmental quality; TCC project on dengue surveillance and GIS; improval of capacity for food borne diseases surveillance; for the management of chronic non-communicable diseases; monitoring of sealants and salt fluoridation for the prevention of dental caries; quality assurance standards, policies and procedures implemented in hospitals.

*57. Standards and guidelines.*

For care of mothers and young children; intersectoral mechanism and educational material for Healthy School concept; policy legislation guidelines for food protection program; for management of chronic diseases and cervical cancer screening; mental health component included in Family and Community Health programs and the curricula of pre-school, primary and secondary schools; substance abuse prevention and control component included in national mental health plan.

*58. Research and evaluation studies.*

Of economic and financial characteristics of health system; sectoral analysis on water and sanitation; of indoor and ambient air quality; of current quality and extent of blood banking services by the end of 2000; on behavioral factor for prevalence of lifestyle related illnesses; roles and responsibilities of members of the Mental Health Team re-defined (implementation initiated in at least two regions).

*59. Plans, projects and policies.*

For collecting, analyzing, retrieving and utilizing environmental health data and information for use in planning, program development, monitoring and evaluation; strategies for the control of emerging and re-emerging diseases; new techniques and the development of networks for regional surveillance; plan for eye care services; dissemination of information on emergency infections; strategies for the control of emerging and re-emerging diseases; strategies for the integration of primary and secondary care; dissemination of Adolescent Health

policy; procedures for the certification for Jamaica to be free of bovine TB, rabies, and the control of leptospirosis and to maintain foot and mouth diseases and rabies free status; dental health strategies for disabled sports personnel and school children; for early detection and prevention of mental health disorders in children and adolescents.

*60. Methods, models and technologies.*

In the use of management and evaluation tools for monitoring environmental quality and waste systems; to monitor and upgrade legislation norms and standards; skills, knowledge, techniques and capacity to assess the impact of wastes and to complete environmental impact assessments (EIA); improvement of parish water supplies systems; improvement of knowledge, communication skills, planning and management capabilities of Environmental Officer; to strengthen immunization systems and surveillance capacity of laboratories; to control diarrheal diseases through breastfeeding; to improve technical capacities in Management, Public Health and Environmental Health; to strengthen capacity of Nursing Schools; to upgrade training capacity of Bureau of Women's Affairs; to improve regions' management of both Information Systems and community mental health (and the human resource capabilities of the latter); to develop and upgrade Mental Health legislation.

*61. Training programs.*

In monitoring air quality; in management disciplines; for the revision of Medical Sciences curriculum; for Parish and Registrar General in vital statistics and registration; for Medical Records personnel; for TCC with Panama in the area of decentralization and integration of health services; for adolescent health personnel; for Environmental Health Officers in HACCP methodology; on juvenile diabetes; for staff of Dental schools.

*62. Promotional campaigns and advocacy.*

Of parish water supplies systems monitoring network; of the environmental component in health; of National participation in World Environmental Day, United Nations Water Day and Inter American Water Day; of health care service models emphasizing wellness and prevention; of Mental Health wellness and destigmatization of mental illness; supporting essential National Health research.

63. *Direct support.* Of data collection and analysis capacity in coordination with the Registrar General's Department; to central office through technical assistance; for the prevention of intentional and

unintentional injuries; of substance abuse prevention programs in selected populations, including children and young adults.

<b>JAMAICA PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health In Human Development	1,203,500	1,254,800	20,000	20,000
Health Systems And Services Development	980,200	862,700	161,800	27,000
Health Promotion And Protection	175,500	118,500	0	0
Environmental Protection And Development	369,000	389,100	1,924,500	192,000
Disease Prevention And Control	427,400	577,500	73,300	0
<b>Total</b>	<b>3,155,600</b>	<b>3,202,600</b>	<b>2,179,600</b>	<b>239,000</b>

# MEXICO

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## *Health Situation*

1. Mexico has been maintaining its growth and promoting economic stability since the 1995 crisis, when the gross domestic product (GDP) fell by 6.2%, the peso was devalued slightly more than 50%, and domestic demand declined by 14%. The country's population currently exceeds 90 million, and a growth rate of 1.85% was estimated for 1997. Life expectancy at birth reached 73.3 years, and a slow but steady annual increase is anticipated. Population projections indicate that the proportion of children under 15 years of age will continue to decline (34.7% in 1996), while the number of people over the age of 65 (4.4% in 1996) will increase. Although rather high levels of poverty persist, the aim of the government is to contain and reduce its prevalence. According to a 1997 report, poverty is the prevailing condition in rural areas, where it is acute among almost 60% of the population. In the states of Oaxaca, Chiapas, and Guerrero, populated largely by indigenous groups, over 40% of households live in poverty. Dwellings with household water connections and sewerage services have increased in recent years (87.5% and 74.9% in 1995, respectively), and current projections point to a gradual increase in access to these services, mainly for the rural population, through the installation of public hydrants and federal and state investment in impoverished areas.

2. Total mortality (4.6 per 1,000 population in 1996), infant mortality (16.9 per 1,000 live births in 1996), and maternal mortality (4.8 in 1996) have exhibited a downward trend in recent decades. Commitments for action to benefit children for the year 2000 are aimed at continuing this downward trend. The leading causes of death among the general population at the national level are heart disease, malignant neoplasms, accidents, and cerebrovascular disease, although in some relatively less developed countries acute respiratory infections and diarrheal disease figure among the 10 leading causes of death. The principal causes of death in children under 1 year of age, such as perinatal disorders, birth defects, pneumonia, influenza, and nutritional deficiencies, have not varied in the last decade. In children aged 1-4 and 5-14, accidents are the leading cause of death. It has been verified that the general mortality trends

noted above conceal differences among various population groups, as less favorable health situations have been documented among women, the rural population, the poor, and areas with large indigenous populations.

3. Vaccination rates are high, reaching 89.6% completion in 1997 in children under 1 year of age and 96.8% in children aged 1-4. The government maintains a firm commitment to sustaining these levels and to improving them in rural areas. Diarrheal diseases, including cholera, have increased in recent years (3,653 per 100,000 population in 1993 and 5,842 in 1995), while mortality from this cause in the general population fell by more than half in the same period (10.5 in 1995); it has also diminished steadily in children under 5 (with a 69.4% variation between 1990 and 1996, while in 1996 alone the reduction was 38.4%). The incidence of acute respiratory infections doubled between 1991 and 1996 (29,009 cases per 100,000), while mortality from pneumonia and influenza diminished among the general population (22.1 in 1996). It also declined steadily in children under 5 (variation of -36.5% between 1990 and 1996), reaching 73.5 in 1996. According to the Secretariat of Health, chronic non-communicable diseases are increasing, and data from the last national survey conducted in 1993 revealed prevalences of 23.6% for hypertension, 7.2% for diabetes mellitus, and 8.9% for hypercholesterolemia in people over 20 years of age. AIDS is a growing problem, as the rate of incidence rose from 3.7 to 4.8 between 1991 and 1995 and is increasing among heterosexuals. Malaria is endemic, although the number of people with the disease has fallen by more than half between 1992 and 1996 (18.6 versus 6.8 cases per 100,000 population, respectively). The dengue situation is similar, with 20,056 classical and 884 hemorrhagic cases reported in 1996. Other vector-borne diseases whose incidence increased in 1996 were onchocerciasis (25,889 cases), leishmaniasis (1,025 cases), and scorpion bites (108,359 cases).

4. In response to the most serious health problems in the country, the Secretariat of Health devised 11 disease prevention and control programs for the period 1997-2000, for which it will invest both Mexican and international cooperation resources in reproductive health; child health, adult health, and

health of the elderly; vector-borne diseases; zoonoses; microbacteriosis; cholera; epidemiological emergencies and disasters; HIV/AIDS and other sexually transmitted diseases; addictions; and oral health, each provided with precise work components and impact targets for the states and the country as a whole. As an adjunct it has programmed two lines of work to be implemented for each program--health promotion and research in health services--and three support mechanisms: epidemiological surveillance, through a national system to monitor all events of interest and the response of the system to their appearance; statistical information to record and systematize data from all public service institutions; and comprehensive supervision for developing and evaluating program implementation at the intermediate and local levels of the health system.

5. The Secretariat of Health and the Mexican Social Security Institute (IMSS) are implementing the strategies of the Program for Health Sector Reform, 1995-2000--that is, the program for the expansion of coverage through the delivery of a basic package of health services provided by the Secretariat of Health; in 1997 this package covered more than 6 million people in rural areas out of a target population of 10 million. It is also developing a nutrition, health, and education program for the population living in extreme poverty. IMSS expanded its beneficiary population base with a family insurance plan that aims at incorporating 350,000 families between 1998 and 2000. PAHO is providing cooperation to help the health authorities to share international experiences in the dissemination of information on other reform processes under way in the Americas and in offering recommendations to improve efficiency in the evaluation of service expansion in the states.

6. The decentralization initiated in 1997 by the Secretariat of Health is being consolidated. The state health services institutes are autonomous in their decision-making with regard to financing and the delivery of services. In the years to come IMSS plans to increase the autonomy of the 139 medical areas and the third-level hospitals. These processes require administrative development of the state and local health entities for the exercise of their new functions. Planning is under way for a program to train and develop state managers for the year 2000 in which PAHO is currently cooperating with the National Health Council in identifying needs and formulating training proposals. It will proceed with development of the training activities over the next two years.

7. A vigorous "Healthy Municipios" movement is under way to develop health initiatives on the part of the municipal leadership. This movement includes 860 municipios (35% of the total), whose growth is encouraged by the Secretariat of Health and by their integration into the national and state networks of municipios desirous of promoting health and whose development is expected to increase further in the coming years. Programs for health education and mass communication are under way that will integrate the efforts of various sectors; these efforts include partnerships with private enterprise, which will continue to be strengthened.

8. Health expenditure as a percentage of GDP has grown in recent years, reaching 6.1% in 1994. Of the total, 49% is contributed by households, 29% by employers, and 22% by the Federal Government. The largest public investment in health was for curative care, which represented 68% of the budget, while only 7% was spent on prevention. It is difficult to forecast the contribution of the government budget to health in the coming years given the present economic situation, although it has been officially stated that at the very least the same levels of disbursement for the social sector will be maintained and, insofar as possible, increase if national income growth so permits.

9. IMSS is the largest health services provider in the country, and it is expected to continue as such for many years; it is followed by the Secretariat of Health, the Social Security and Services Institute for Government Employees (ISSTE), and the rest of the social security institutes. General speaking, 50% of the nation's population is affiliated with the social security system, a percentage that is expected to increase in the coming years with the introduction of new social security modalities. Private insurance covers only 3% of the population. In the years to come the population served by private medicine will increase, promoted by the transfer of contributions and the subrogation of services, a practice IMSS plans to regulate by 1998.

10. Among the major development projects in health with external financing are: (1) the expansion of service coverage to the uninsured, financed by the World Bank and implemented by the Secretariat of Health, disbursing US\$ 320 million between 1996 and 2001; and (2) the modernization of IMSS, also financed by with the World Bank in 1998 in the

amount of US\$ 700 million, to be implemented by 2000.

### ***National Priorities for PAHO's Technical Cooperation***

11. Reduce the indexes of morbidity, mortality, and case-fatality from current communicable and non-communicable diseases or those that have a national or regional impact. Improve the health status of the population and facilitate interventions in the determinants of the health/disease process through initiatives to promote health and community participation. Reduce the environmental risks for health. Support the strategic guidelines for health sector reform, with emphasis on expanding health services coverage and decentralization of the Secretariat of Health. Prevent and control zoonotic, exotic, and reemerging animal diseases. Improve quality assurance for food, the monitoring of risk factors for consumers, and the factors that pose obstacles to national and international trade. Support the training and development of the human resources that work in health. Develop the information system for the planning, monitoring, and evaluation of health programs and health services. Intensify the Comprehensive Reproductive Health and Family Planning Program. Reduce inequities in health as an expression of social development, with emphasis on women, vulnerable groups, and indigenous peoples.

### ***Technical Cooperation Strategy***

12. The PAHO/WHO technical cooperation strategy will be based, on one hand, on guidelines of the Ninth General Program of Work of WHO for 1996-2001 and the Strategic and Programmatic Orientations of PASB, 1999-2002; and on the other, on the requests for technical cooperation received from the national health authorities in recent years and on the sectoral problems and guidelines for action indicated in the Program for Health Sector Reform, 1995-2000. PAHO cooperation will provide particular support to government initiatives to achieve greater equity in health through the expansion of service coverage by the Secretariat of Health and IMSS; the rechanneling of resources from the federal to the state and municipal levels for the institutions supplying health services; improvement of the quality and efficiency of the health sector,

including support for deregulation and administrative simplification; and finally, decisive cooperation in the planning, development, and evaluation of measures to prevent disease and promote health.

13. Although the Secretariat of Health will remain the principal interlocutor in PAHO/WHO technical cooperation, collaboration with other institutions will also be maintained, particularly social security institutes (IMSS and ISSSTE), SAGAR, universities and centers for advanced education, as well as selected non-governmental organizations. Support for interinstitutional and intersectoral work will be promoted at both the federal and state level through PAHO cooperation projects and activities in the country. PAHO/WHO cooperation for the newly decentralized states is expected to increase in coordination with the National Health Council, in keeping with PAHO cooperation priorities.

14. Given the characteristics of Mexico's health services and programs and their degree of development, the mobilization of Mexican experts and technicians will be encouraged to provide cooperation to other countries in the Region. This should be accompanied by technology transfer and the sharing of Mexico's scientific experience to support regional actions promoted by PAHO. The areas identified as most developed for this purpose are the regulation and operation of services networks; epidemiological surveillance; communicable disease control programs, particularly for vector-borne and vaccine-preventable diseases; and the development of strategies and partnerships for health promotion.

15. The dissemination of technical information and support for issues related to health promotion and mass communication will also provide substantial elements for the technical cooperation strategy, as will those related to intensifying human resources development at all administrative levels of the health system.

16. Within the framework of the PAHO/WHO Representative Office and the Organization's regional programs, interprogram projects and activities will be organized in strategic areas, such as health situation analysis, healthy municipios, the promotion of research, women's health, adolescence, and indigenous populations.

## ***Objectives for PAHO's Technical Cooperation***

- Increase Mexico's capacity for environmental management associated with the protection of human health.
- Increase the adoption and use of health promotion strategies, methodologies, and actions within the institutions of the health sector and other related sectors.
- Increase the sharing of experiences through the execution of sanitary programs with countries in the Region.
- Strengthen the capacity of the federal and state health authorities for health services development as part of the reform process.
- Endemic zoonoses will be subject to control programs in priority areas, and warning and immediate response systems will be operating in the health and agriculture sectors to attend to any epidemiological emergence of these kinds of diseases.
- Prevent, control, and reduce foodborne diseases and avoid rejection of food exports for reasons of sanitary quality.
- Intervene in high risk factors associated with the appearance and spread of diseases and bring about a quantitative and qualitative increase in intra- and intersectoral coordination, as well as international coordination.
- Develop institutional capacity by improving administrative management in the education and training of human resources, within the framework of sectoral reform and decentralization.
- Contribute to an improvement in the knowledge of health workers, strengthening scientific and technological capacity in institutional health service providers and trainers of human resources.
- Implement all the components of the Comprehensive Reproductive Health and Family Planning Program.
- Generate greater sensitivity and motivation with regard to the health and socioeconomic conditions of women and their differences, as well as of indigenous peoples.
- Strengthen the national capacity to analyze health profiles and formulate sectoral policies using the criterion of equity.

## ***Expected Results***

17. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

18. *Cooperation networks, alliances.* In health between Mexico and the countries of Latin American, particularly the Central American countries, as part of the Tuxtla mechanism; among the responsible national institutions for disaster preparedness, prevention, and mitigation; for interinstitutional, intersectoral, and international collaboration in diagnosis, training, information exchange, and technology transfer linked with the prevention and control of zoonoses; for the participation of Mexico in the Inter-American Network of Food Analysis Laboratories (INFAL) and strengthening of the National Laboratory Network; for the dissemination and utilization of scientific and technical health information, with emphasis on health and education; and among institutions in Mexico and with other countries in the Americas for the development and evaluation of sectoral policies.

19. *Surveillance and information systems.* On foodborne diseases as part of the SUIVE and of the Regional Information System on Foodborne Diseases (SIRVE-FBD); to improve the coverage, capacity, and quality of the reference, diagnostic, and analytical services of the National Network of Diagnostic and Public Health Laboratories through the Virtual Health Library in Latin America and the Caribbean.

20. *Standards and guidelines.* To promote health, within the framework of national environmental management for disaster mitigation in health sector institutions and educational centers to ensure the sanitary quality of food; and for the accreditation of schools.

21. *Research and evaluation studies.* On health sector reform strategies and the networks of services; on the reproductive health of adolescents; to strengthen information systems and the surveillance of zoonoses; on the TAES strategy to evaluate its coverage and effectiveness and to consolidate the elimination of leprosy as a public health problem; to strengthen the managerial capacity of the vector

control program; to secure greater knowledge of health differences in the human development of women in Mexico, as well as of experiences in other countries of the Region; and in sectoral analyses and health profiles.

22. *Plans, projects and policies.* For expanding coverage of basic sanitation and improving water quality; on surveillance and information on the management of chemical substances, hazardous waste, and air quality; to develop and consolidate the value of health promotion as a policy, strategy, and methodology for attaining higher levels of health through advocacy, training, and action projects; for the development of a multisectoral program on healthy aging, assigning priority to health promotion methodologies; to control diseases in the border states; for coverage and quality of the health services; to strengthen epidemiological surveillance of endemic, emerging, and reemerging communicable diseases, consolidating the Unified Information System (SUIVE) at the state and local level; to expand vaccination series and evaluate boosters; to contribute to the development of surveillance and information systems directed toward health managers.

23. *Methods, models and technologies.* For the prevention of chronic non-communicable diseases; for prevention projects using the public health approach to unintentional injuries, chronic diseases, cancer, and cardiovascular disease and to ensure oral health; in the areas of inputs, laboratories, and equipment to improve performance and information; for the adaptation, implementation, and dissemination of new forms of verification and health surveillance consistent with the reform program, encompassing the local levels (*municipios* and

jurisdictions) and the organized community; for implementation of the Program on Integrated Management of Childhood Illness with regard to vaccination, prevention, and treatment of acute diarrheal diseases (ADD), acute respiratory diseases (ARI), and malnutrition; to improve the quality and efficiency of human resources in health; to improve the training of health resources in conjunction with the WHO Collaborating Centers; and for reproductive health services for adolescents.

24. *Training programs.* In the field of Workers' Health; for the regulation and management of the health services; and to contribute to improvement of the quality of reproductive health care in secondary-level hospitals.

25. *Promotional campaigns and advocacy.* To promote the integrated approach to adolescent care through prioritization of the approaches to health promotion: Participation of adolescents, formal education and communication, advocacy, and projects for action; to promote mental health and healthy lifestyles and prevent the use of tobacco, alcohol, illegal drugs, and violent behavior; for food security, nutritional surveillance, and formal and informal education; for mass communication and advocacy by UNAIDS-CONASIDA; to increase sensitivity and knowledge about the social situation that affects the indigenous peoples, particularly in health.

26. *Direct support.* To encourage the generation and dissemination of knowledge and the sharing of experiences with regard to human resources for the managers of educational institutions and the health services, through the development of surveillance and information systems; and to health programs for women and indigenous peoples.

<b>MEXICO</b>				
<b>PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health in Human Development	2,466,300	2,423,900	393,900	35,000
Health Systems and Services Development	1,057,100	1,145,100	0	0
Health Promotion and Protection	968,600	971,400	5,000	0
Environmental Protection and Development	537,600	523,300	90,800	0
Disease Prevention and Control	889,800	855,700	194,600	0
<b>Total</b>	<b>5,919,400</b>	<b>5,919,400</b>	<b>684,300</b>	<b>35,000</b>



# NETHERLAND ANTILLES

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## *Health Situation*

1. The Netherland Antilles is comprised of five islands: Curaçao, Bonaire, Saba, St. Eustatius, and St. Maarten. Although they have been autonomous since 1954, these islands are still part of the Kingdom of the Netherlands. The Netherland Antilles has a total area of 800 km<sup>2</sup>. Its total population (1995) is 207,333 inhabitants, with a population density of 259 inhabitants per km<sup>2</sup> and a population growth (1995) of 2.5%. Dutch is the official language and is used in both education and the civil service. Papiamentu is the dialect spoken in Curaçao and Bonaire, while English is spoken in St. Maarten, Saba, and St. Eustatius. Both Papiamentu and English are used in Parliament and the communications media.

2. Curaçao, the largest of the Dutch islands in the Caribbean, whose capital is Willemstad, is also the seat of the Central Government. The island measures 62 km in length, with a total area of 444 km<sup>2</sup>. Curaçao has a population of 152,448 inhabitants (1995), representing 73% of the population of the Netherland Antilles. It has a population density of 341 inhabitants/km<sup>2</sup>. Population growth on the island in 1995 was 1.3%.

3. Services are the main economic activity, with tourism predominating. Other sectors of economic activity are the petroleum industry, manufacturing, and construction.

4. The inflation rate reported for 1994 was 4%.

5. There was a slight increase in the crude death rate between 1986 and 1993, from 5.31 per 1,000 individuals in 1986 to 7.10 per 1,000 in 1993. This can be explained by demographic change, seen in the standardized mortality rates, which ranged from 4.71 per 1,000 individuals in 1986 to 5.46 per 1,000 in 1993. The standardized mortality rate in men is 1.5 times higher than in women.

6. The infant mortality rate dropped from 17.8 per 1,000 live births in 1986 to 11 per 1,000 live births in 1993.

7. The leading causes of death in the first year of life (1991-1993) are perinatal causes, 64.5%, and birth defects, 23%. Infectious diseases account for 6.6% of infant mortality.

8. Dengue has been a health problem in Curaçao since it became endemic in 1973. A surveillance system is in place, and vector control measures are being carried out. In 1995, 555 cases were reported, double the number for 1993.

9. In January 1997, after the measles outbreak in Guadeloupe, surveillance on the island was intensified; as of May 1997, 14 suspected cases had been reported, 10 of which were ruled out.

10. From 1985 to 1996, the cumulative number of people infected with AIDS in the Netherland Antilles (Curaçao and St. Maarten) was 815; 466 of whom were men and 349 of whom were women, with the majority in the 25-44 age group. In Curaçao AIDS constitutes one of the leading causes of death in the 25-44 age group, accounting for 14% of deaths from 1991 to 1993. There are no official data for the other islands of the Netherland Antilles. Transmission of the infection is heightened by the migratory patterns of this population group.

11. Mortality from external causes (accidents and poisoning) has exhibited a rising trend, especially among males.

12. The Government is interested in promoting the development, analysis, and implementation of projects directed to advancing health sector reform and the financial management of the sector.

13. Health problems common to all the islands: Problems linked to the environment (water supply, refuse disposal, environmental pollution); Drug and alcohol abuse; Teenage pregnancy; Sexually transmitted diseases and HIV/AIDS; Vector-borne diseases; Inadequate food security.

14. Management problems common to all the islands: Poor management of the health services, resulting in irrational use of resources and high expenditures in terms of the outcomes observed; Drain of human resources from the public sector to other sectors.

15. Problems specific to some islands: Landslides on the Island of Saba; Basic sanitation in St. Maarten.

16. Specific problems with a national impact: Low vaccination coverage in St. Maarten; Inadequate hospital budget in St. Maarten; Emergency medical care (serious, acute, cases of multiple trauma).

At the national level

17. Health promotion and mass communication in health; Monitoring and surveillance of the health of people and the environment; Supply management system for drugs and equipment in emergencies and disasters; Accreditation and certification of health facilities and human resources; Policies and the National Plan for HIV/AIDS Control.

At the island level

St. Maarten

18. Development of the Expanded Program on Immunization, EPI.

19. Improved care for the population 0 to 19 years of age.

20. Support for the program on emergency preparedness and disaster relief.

21. Development of a program for health education, health promotion, and mass communication.

22. Establishment of a perinatal information system.

23. Development of a vector-borne disease control program, especially for *Aedes aegypti*.

24. Establishment of a Management Information System, MIS, to promote the development of a program for quality assurance and accreditation of the health services.

Bonaire

25. Development of a program to guarantee food security.

26. Development of an oral health program and introduction of methodologies for the fluoridation of water and salt for human consumption.

27. Development of a health program for the elderly and other adults, with emphasis on the prevention, treatment, and control of chronic diseases.

28. Creation of a Management Information System to promote the development of a program for quality assurance and accreditation of the health services.

St. Eustatius and Saba

29. Development of a vector-borne disease control program, in particular for *Aedes aegypti*.

30. Establishment of a Management Information system.

31. Promotion of the development of a program for quality assurance and accreditation of health services.

At the national level

32. Health promotion and mass communication in health; System for Monitoring and Surveillance of the Health of People and the Environment; Supply management system for drugs and equipment in emergencies and disasters; Accreditation and certification of health facilities and human resources; Policies and the National Plan for HIV/AIDS Control.

At the island level

St. Maarten

33. Expanded Program on Immunization, EPI; Program for care of the population aged 0 to 19; Program for emergency preparedness and disaster relief; Program for health education, health promotion, and mass communication; Perinatal information system; Control program for vector-borne diseases, especially *Aedes aegypti*; Management Information System to promote the development of a program for quality assurance and accreditation of health services.

Bonaire

34. Program to guarantee food safety; Oral health program and introduction of methodologies for the fluoridation of water and salt for human consumption; Health of the elderly and other adults, with emphasis on prevention; Prevention and control of chronic diseases; Management Information System; Quality assurance and accreditation of health services.

St. Eustatius

35. Vector-borne disease control, in particular for *Aedes aegypti*; Management Information System; Quality assurance and accreditation of health services.

Aruba

36. Aruba, located in the Caribbean some 15 miles off the northern coast of Venezuela, has an area of 188 km<sup>2</sup>. It is divided into eight regions: Noord/Tanki Leendert, Oranjestad-Oeste, Oranjestad Este, Paradera, Santa Cruz, Savaneta, San Nicolás-Norte, and San Nicolás-Sur.

37. Dutch is the official language and Papiamentu the national language. English and Spanish are compulsory subjects at the primary level.

38. Aruba is an autonomous entity of the Kingdom of the Netherlands. Services are the principal economic activity, with tourism predominating. The oil refinery has been reopened. Between 1991 and 1994, the population of Aruba grew by 20%. The estimated population for 1995 was 83,652 inhabitants; population growth for that year was

4.1%. Some 6.6% of the population is over the age of 65.

39. In 1995, the crude death rate was 6 per 1,000 population. Life expectancy at birth is 77.1 for women and 71.1 for men.

40. The five leading causes of death are: diseases of the circulatory system, neoplasms, diseases of the endocrine system, external causes, and diseases of the respiratory system. For 1993, 25.6% of mortality was attributable to ill-defined causes.

41. In 1995, Aruba was struck by an epidemic of dengue, with 87 suspected cases reported. Serotype 2 was isolated, with serological confirmation of 51.7%.

42. Work is under way to consolidate vaccination coverage data.

43. Up to 1996, 25 cases of AIDS had been reported. Some 50% of the serotype-positives were found in immigrants requesting work permits, most of whom have returned to their home country.

44. The health survey conducted in 1990 found hypertension and diabetes to be the most prevalent diseases in the adult population. Ischemic heart disease constitutes the leading cause of death.

45. Anatomicopathological studies point to a high percentage (92%) of breast carcinomas diagnosed in an invasive state, which means that early diagnosis of this disease should be made a priority.

46. The Government has already made a commitment to reorganize public health, properly distribute financial resources, improve information and communication on health promotion and disease prevention, and upgrade the quality of medical and paramedical care.

47. With regard to the reorganization of public health, the priorities are to revise the current legislation, implement the general insurance law,

reduce and control medical expenditures, step up health promotion and education, and introduce an inspection system for the public health services.

### ***National Priorities for PAHO's Technical Cooperation***

48. To improve the health conditions of the population of the Netherland Antilles through support for the formulation of health policies, the development of information systems and improvement of the health services, the strengthening of the promotion and protection of health and the environment, and the control of damages. To improve the health conditions of the population of Aruba through support for the formulation of health policies, the development of information systems and improvement of the health services, the strengthening of the promotion and protection of health and the environment, and the control of damages.

### ***Technical Cooperation Strategy***

49. Since 1994, meetings have been held between the directors of the Netherland Antilles health departments and the Netherland Antilles Public Health Director and Ministry of Health. Organization of these meetings is the responsibility of the Secretariat through the PAHO/WHO Representative Office in Venezuela. At these meetings technical cooperation needs are discussed, PAHO cooperation for meeting these identified needs is defined, and the exchange of experts and/or information on experiences between the islands is programmed, with training needs based on the development of the programs and their priority in each of the five islands, in coordination with the Ministry of Health.

50. Technical cooperation with the Netherland Antilles and Aruba will be strengthened, as will the leadership that by the Ministry of Health and Environment of the Netherland Antilles and Aruba must assume in inspecting and supervising the

quality of public health in the islands. Technical cooperation will be channeled according to national priorities through policies and plans to optimize health expenditure and improve the quality of services through accreditation and analysis of sectoral financing and health expenditure.

51. Emphasis will be placed on health surveillance systems and on research and human resources development to support decision-making that will reduce disparities in health, disease and death, giving priority to health promotion and to the prevention of the most serious health problems.

52. Working relations with the English-speaking Caribbean and CAREC will be strengthened. Resources will be mobilized among the islands and between them and Venezuela, depending on the experience with each of the programs and/or services between the countries, and support will be provided for participation by the Netherland Antilles and Aruba in Andean and Caribbean subregional initiatives.

### ***Objectives for PAHO's Technical Cooperation***

- To consolidate the development of services and strategic and priority programs aimed at the population and the environment through efficient, effective, and equitable health services networks with the participation of all social actors.

### ***Expected Results***

53. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

54. *Surveillance and information systems.* For epidemiological and environmental surveillance through development of the unit of epidemiology and of morbidity and mortality registers.

55. *Standards and guidelines.* For the accreditation and certification of health services for the population.

cancer, and diabetes, and for communicable disease prevention and control with emphasis on AIDS and dengue.

56. *Plans, projects and policies.* For the supply of drugs and equipment for emergencies and disasters (SUMA), for comprehensive care of the population and the environment in St. Maarten, Bonaire, St. Eustatius, and Saba in order to implement early diagnosis, noncommunicable disease prevention and control, with emphasis on cardiovascular diseases,

57. *Methods, models and technologies.* To improve the quality of care in the health services and optimize expenditures on health.

58. *Promotional campaigns and advocacy.* For the promotion of health, education, and mass communication in health.

<b>NETHERLAND ANTILLES PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health in Human Development	41,400	78,200	0	0
Health Systems and Services Development	53,000	41,600	0	0
Health Promotion and Protection	26,400	27,800	0	0
Environmental Protection and Development	39,800	42,200	0	0
Disease Prevention and Control	49,800	20,600	0	0
<b>Total</b>	<b>210,400</b>	<b>210,400</b>	<b>0</b>	<b>0</b>



# NICARAGUA

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## *Health Situation*

1. Nicaragua is faced with a complex epidemiological situation, characterized by communicable and noncommunicable diseases, environmental risks, and high vulnerability of specific population groups. This health profile is marked chiefly by a high prevalence of acute respiratory infections, intestinal infectious diseases, disorders originating in the perinatal period, and diseases of the circulatory system. Of all the population growth variables, the reduction in mortality has had the greatest impact on the size and age structure of the population. The country's age distribution poses a challenge, since it has become a basic referent for the design of policies and self-sustainable development programs in the immediate future. The reduction in mortality in Nicaragua is associated with the incorporation of the worldwide advances in medicine, the availability of basic medical services (primary health care), basic sanitation for the population, and a high rate of participation by the population and civil society organizations.

2. In April 1995, after a period of 24 years, the national census was conducted. The final data revealed a national population of 4,357,099, with a growth rate between censuses of about 3.5%, up from 2.5% in 1971, one of highest in Latin America. The estimated population for 1998 is 4,824,945, with a male/female ratio of approximately 97/100. In 1950 almost 65% of the population resided in rural areas; at the present time, however, that proportion has declined to slightly less than 46%. The percentage of children under 15 years of age rose from 43% in 1950 to 45% in 1995, and the dependency ratio--that is, the proportion of dependent persons (<15 and >65 years) per 100 population 15-64 years of age--rose from 86 in 1950 to 94 in 1995. Internal migration, for the most part, flows toward the urban areas, especially to departmental and municipal centers in the central and northern parts of the country.

3. Nicaragua's population is not evenly distributed; it is largely concentrated in the Pacific region, which, accounting for only 15.3% of the national territory, is home to 61.5% of the total population (with

prevalences of poverty ranging from 5% to 24%) and 76.4% of the urban population. The central region, with 33.9% of the national territory, has 32.6% of the total population, with poverty ranging from 15% to 35% in a mostly rural population. The Atlantic region, which represents 50.9% of the national territory, has only 5.9% of the total population, with poverty ranging from 35% to 45%.

4. The birth rate between 1990 and 1995 was 40 per 1,000 population, with a total fertility rate of 4.5 children per woman. The crude death rate was 6.8 per 1,000. Life expectancy at birth was estimated at 66.7 years, 68.5 years for women and 64.8 years for men. Life expectancy at birth is increasing, rising from 48.5 years in between 1960 and 1965 to 66.7 years between 1990 and 1995. It has been estimated that life expectancy at birth in rural areas is some 10 years less than in urban areas.

5. It is estimated that the infant mortality rate fell from 151 per 1,000 between 1950 and 1955 to 49 per 1,000 between 1995 and 2000 (58 per 1,000 for 1995). The 1995 census results, coupled with recent surveys, vital statistics, and Ministry of Health estimates, point to the following situation in the integrated local health systems (SILAIS): high levels of fertility and high levels of infant mortality above the national rate in Jinotega, Matagalpa, Madriz, and Río San Juan; high levels of fertility and medium levels of infant mortality at roughly the national rate in Chontales, RAAN, and Nueva Segovia; medium levels of fertility and medium to low levels of infant mortality in Chinandega, Carazo, Grenada, and Rivas; and low levels of fertility and low levels of infant mortality below the national rate in Managua, León, Masaya, and Estelí.

6. Slightly more than 20% of all deaths recorded in 1995 were from communicable diseases. The principal causes were perinatal disorders, acute diarrheal diseases, and acute respiratory infections, which are together responsible for 80% of all deaths in children under 1 year of age.

7. Maternal mortality is high, estimated in 1996 at 155 per 100,000 live births (110 per 100,000 live births in 1995), mainly attributable to the high reproductive risk characteristic of Nicaraguan women, which is manifested in a high number of

births per woman and in a high fertility rate. The SILAIS with the highest levels of maternal mortality are Matagalpa, Jinotega, and RAAN.

8. The most frequent reportable diseases are acute diarrheal diseases, acute respiratory infections, gonococcal infection, pulmonary tuberculosis, viral hepatitis, and syphilis.

9. Acute diarrheal diseases, acute respiratory infections, and malnutrition persist as the leading causes of death in children aged 1-4.

10. Vaccine-preventable diseases have exhibited a rapid decline in recent years due to increased vaccination coverage. Nicaragua certified the eradication of polio in 1994. No deaths from measles have been recorded for four years, and the incidence of neonatal tetanus (NNT) is 1 case per year.

11. A downward trend in malaria can be observed (from 70,235 cases in 1995 to 51,858 in 1997). The SILAIS with the highest case incidence are Managua, León, and Chinandega.

12. Between 1994 and 1996 a total of 2,005 cases of three forms of leishmaniasis were notified; 1,071 cases were notified in 1997, predominantly in the cutaneous form, known as mountain leprosy, which has mainly affected the SILAIS in RAAS, RAAN, Río San Juan, Chontales, Jinotega, Matagalpa, and Nueva Segovia.

13. In 1993 there was an outbreak of dengue hemorrhagic fever, and in 1994 the circulation of dengue serotype 3 was verified, which denotes a significant increase in this disease among the causes of morbidity and mortality (19,260 cases of dengue in 1995, 2,794 in 1996, and 3,021 in 1997). Endoepidemic dengue is concentrated principally in the SILAIS in Managua, RAAN, RAAS, Chontales, and León.

14. Cholera cases have declined since 1995 (from 8,111 cases in 1995 to 1,813 in 1997), but a high case-fatality rate has been maintained. The most affected SILAIS are Madriz, Nueva Segovia, Jinotega, and RAAN.

15. The number of AIDS patients and HIV carriers has been increasing, and the prognosis is that it will continue to do so even more rapidly (157 cases between 1987 and 1997). The most affected SILAIS are Managua, Chinandega, León, and Rivas.

16. In 1995 an outbreak of leptospirosis occurred (1,904 suspected cases), prompting the mobilization of the country and resulting in an overburdening of the health services.

17. In recent years there has been a significant increase in noncommunicable diseases, mainly diabetes mellitus, the cardiovascular disease, malignant tumors, and hypertension (with an overall increase of 4% per year, accounting for approximately 35% of all deaths in the country).

18. An increase in cases of social, family, and sexual violence has been observed throughout the country. According to national police data, there was a 16.1% increase in homicides between 1996 and 1997. In that period, suicides and sexual crimes increased by 51.4% and 15.2%, respectively, with a consequent impact on the health services and a rise in morbidity and mortality. With respect to homicides and suicides, the incidence was greater among men, and in sexual crimes women were the most affected.

19. The greatest problem connected with occupational risks in Nicaragua is pesticide exposure and/or poisoning; 50% of all poisonings are attributable to occupational causes, reflected in an acute poisoning rate of 58 per 100,000 population in 1996.

20. A study conducted in 1994 revealed that 74.8% of households are living in some degree of poverty and that 43.6% are in the category of extreme poverty--that is, those that lack from two to four basic needs. In urban areas poverty prevails in 65% of households, and in rural areas, in 87%.

21. The gross domestic product (GDP) recently pointed to development and an improvement in the economy. There is a large fiscal deficit that is covered by donations and international cooperation.

22. The cost of a market basket of 53 products at the end 1997 was approximately C\$ 1,384.44, indicating an increase of 11.72% over the figures for 1996. The average nominal wage for the same period was C\$ 958.84, less than the cost of the market basket.

23. The illiteracy rate is 30%, and an estimated 70% of schoolchildren repeat a grade or drop out of school between the first and fourth grade, and only 23 out of every 100 complete their schooling.

24. According to a national survey on micronutrient deficiencies conducted in 1993, the national average caloric intake of children was only 88.9% of the recommended daily allowance. It may therefore be concluded that almost one out of every three children suffers from vitamin A deficiency and iron-deficiency anemia; two out of every three preschool children suffer from, or are at risk for, vitamin A deficiency; and one out of every three adult women suffers from anemia, caused mainly by deficient consumption and absorption of iron.

25. High morbidity rates (especially from infectious diseases such as diarrhea and acute respiratory infections) also contribute to the prevalence of high levels of micronutrient deficiencies in Nicaraguan children.

26. The per capita food intake and its contribution of calories and daily protein have declined in recent years to an average of 80% of the recommended daily allowance. The population living in extreme poverty consumes barely 45% of its needs.

27. There are an estimated 621,926 dwellings in Nicaragua, 46.6% of which receive drinking water supplied by the Nicaraguan Institute of Water Supply and Sewerage Systems (INAA), 21.5% from excavated wells, 12.7% from rivers and ponds, 15.5% from public hydrants, and, 3.9%, occasionally, from tank trucks.

28. Coverage by drinking-water supply systems is insufficient, and in 1996 it was estimated that this is the norm for 55% of the national population, a situation that is more dramatic in rural areas, where it is estimated at 30%.

29. Twenty sanitary sewerage systems cover 31.5% of the urban population. For the most part, waste is discharged directly into lakes and rivers without any kind of pretreatment. Only 16% of the rural population has adequate sanitary excreta disposal.

30. Only 69 of the 145 municipios have regular solid waste collection systems, which account for 35% of the solid waste generated. Final disposal takes place in open dumps, and no treatment, recovery, or recycling methods are applied.

31. Most industrial wastewater is not treated prior to final disposal and this, combined with the

uncontrolled use of pesticides, is causing serious damage to ecosystems.

32. The Ministry of Health is the main provider of health services. It is estimated that the private sector serves 4% of the population and that the social security system covers another 5%. With the exception of some remote areas, the service coverage of the Ministry of Health is adequate; geographical access is acceptable in urban areas but not in rural areas, where service coverage is inadequate.

33. The Ministry of Health has three main sources of financing: taxes (29.4%), credit (25.8%), and donations (49.35%). Analysis of the ratio of health expenditure to GDP and public spending shows that in 1995 the health sector received 6.6% of GDP, representing 16.2% of public spending.

34. Health expenditure in 1996 was 13.2% of GDP, reflecting a per capita outlay of C\$ 658.74. With regard to financing, the public sector contributes 41.5%, the private sector 40.83%, and international cooperation 17.66%, indicating a reduction compared to previous years.

35. Distribution of the expenditure was as follows: 26.01% for health promotion and disease prevention, 6.11% for administration, and 67.88% for curative care, 42.02% of which was for hospital care. Only 3% of the total expenditure was earmarked for investments.

36. In the context of State reform, the principal institutions in the health sector (the Ministry of Health, the INSS, the private sector, the Military Health Service, and the various training institutions) are reexamining their strategies with a view to finding better responses to the health problems of the population.

37. The Ministry of Health has promoted changes based on the public health approach and decentralization of its intermediate structures--the integrated local health systems--although further change is still needed at all levels.

38. The social security system has undertaken the financing and regulation of the 32 medical insurance companies from which it purchases a basic package of services for its 110,269 active beneficiaries. The private sector is gradually increasing its participation

through the organization of medical insurance companies to provide health services plans.

39. The Ministry of Health provides health services to almost 90% of the Nicaraguan population. In recent years its most important achievements have been the extension of coverage in primary health care, the control of vaccine-preventable diseases, and the reduction of infant mortality from diarrhea. However, the country is confronting emerging diseases and an increase in chronic diseases and deaths from accidents, which are among the leading causes of death. This situation, which intensifies and diversifies health needs without a corresponding expansion and availability of the resources necessary for improving the health sector's response capacity, makes it necessary to confront these problems and introduce changes or reforms with an approach that will make it possible to implement new organizational modalities.

40. The major challenges the Ministry of Health must tackle in order to fulfill its mission and advance in institutional reform are: incorporation of new organizational and management modalities; implementation of new financing alternatives; modernization of the hospitals; protection of investments in infrastructure and equipment; design and provision of a basic package of essential services; determination of priority territorial and risk groups; promotion of health and prevention of disease; efficiency in the utilization of resources; and improvement of management control systems.

41. The national health policy (1997-2002) is aimed at providing organizational, financial, and managerial responses for reform of the health system through: modernization of the health sector; strengthening of the Ministry of Health; strengthening of hospital care; new public health strategies; and reform of social security.

### ***National Priorities for PAHO's Technical Cooperation***

42. To reduce morbidity and mortality from vaccine-preventable, communicable, and non-communicable diseases. To improve the living conditions of the population through the promotion of healthy environments, with the participation of different sectors at the national and local level. To improve the quality of life through health promotion and

development activities, formulating sectoral and intersectoral policies and projects at the local and national level. To strengthen the reform of the health sector in order to increase the equity of its benefits, the efficiency of its management, and the effectiveness of its services, so as to satisfy the health needs of the population.

### ***Technical Cooperation Strategy***

43. The representation will accompany actively the process of health sector reform, initiated by the ministry of health of Nicaragua.

44. The support for the steering role of the Ministry of Health on the one hand and to the decentralization of responsibilities to the Integrated Local Health Systems (SILAIS) and municipios coherently and coordinated will continue to be an important objective for cooperation. In this regard it is expected that PAHO/WHO continues to be co-responsible for the implementation of the PROSILAIS project in 6 SILAIS of the country, among others.

45. The health situation analysis, the selection of priority problems, and the determination of priorities will constitute a frame of reference (as well as the SPOs) to define the expected results and pertinent activities for the program of cooperation, considering that the regular funds of the organization should constitute the articulating axis of said cooperation, strengthened by extra budgetary, national, subregional and/or regional projects which will be available during the biennium.

46. The identified priority problems that will be addressed are: Steering role of the sector; Deficient organization and low coverage of health services; Inadequate financing; Morbidity and mortality due to hygienic-sanitary conditions; deficient and insufficient coverage of basic services; Elevated incidence of communicable diseases; High rates of maternal and child morbidity and mortality; and chronic malnutrition.

47. In addition to a close collaboration with the central level of the Ministry of Health and a strengthening of the SILAIS, PAHO will collaborate with public or nongovernmental entities especially those which form the inter-institutional commission support to the health sector, those which participate in the national health council and governing boards

of SILAIS, and those which are members of specific initiatives. For example, the local team of the initiative "Managua Healthy Municipio" or the organisms that support the national health and environment plan. At the local level there will be collaboration with the municipios and local health commissions.

48. It is also expected to achieve the strengthening and a development of national cooperating centers on the basis of the successful experience with UNAN-León.

49. Inter-agency coordination will have particular importance due to the large number of projects of international cooperation, distributed in all the national territory. Different efforts of interagency coordination will be actively supported, especially with the most important cooperation agencies in the sector in Nicaragua, such as the World Bank, Sweden, AID through the committees of monitoring to the sector reform, of local development projects and EPI, among others. Moreover initiatives and common activities will be included with other agencies of the United Nations system on the basis of the successful previous experience with UNICEF.

50. The four technical cooperation projects and the technical staff of the Country office will be articulated in two major areas: health policies and systems, disease prevention and control. The projects that are executed at the local level, as PROSILAIS, will constitute an opportunity for comprehensive cooperation and inter-programmatic of the Country office at the local level.

51. The delivery of cooperation is based on the technical assistance provided by the team of the Country office, with the support of the regional programs, or outside experts when required.

52. The mobilization of external resources (especially extra-budgetary funds) continues to be a need in view for the situation of Nicaragua, in particular in the social sector. Much of the operational execution of the activities will be carried out at the local level and under the direct responsibility of national institutions (Ministry of Health, SILAIS, municipios, other entities of government, Universities and NGOs). The strengthening of the managerial local level capacity will continue to be strengthened.

## ***Objectives for PAHO's Technical Cooperation***

- To strengthen the national capacity to take comprehensive, intersectoral, and sustainable action for the prevention, control, elimination, and eradication of communicable, noncommunicable, and vaccine-preventable diseases.
- To reduce morbidity and mortality associated with poor sanitary conditions and the irrational use of pesticides, by strengthening the capacity for environmental management at the national and local level.
- To strengthen and consolidate the capacity of the State and civil society to plan and evaluate sectoral and intersectoral processes that foster the development of health and the promotion of healthy behaviors and lifestyles.
- To consolidate the steering role in the health sector and define the role of each of its agents, structuring their coordination and participation in order to increase services and benefits coverage with quality and sustainability.

## ***Expected Results***

53. During the 2000-2001 biennium PAHO is committed to developing, jointly with the country, the following expected results:

54. *Cooperation networks, alliances.* Between the Ministry of Health, other government institutions, private enterprise, and civil society for disease prevention and health promotion, with emphasis on the local level.

55. *Surveillance and information systems.* In order to respond to epidemics and acute pesticide poisoning in a timely fashion at the local level.

56. *Standards and guidelines.* For incorporating the gender approach in cooperation activities and in comprehensive patient care models. For the management, financing, regulation, and articulation of the sector.

57. *Plans, projects and policies.* For reducing maternal mortality in priority SILAIS and for sanitary surveillance of drugs. For immunization services with quality and equity for the control, elimination, and eradication of vaccine-preventable diseases. Comprehensive plans for the prevention and control of communicable and non-communicable diseases in the priority SILAIS. For providing basic water and sanitation services and monitoring environmental health risk factors. For food and nutritional security. For decentralization, with efficiency, equity, and effectiveness in the context of sectoral modernization.

58. *Methods, models and technologies.* For health promotion experiences, expanding their application

to priority SILAIS. For comprehensive care focusing on disease prevention, health promotion, and basic packages of service that respond to the needs of the various social groups. For an alternative and self-sustainable supply of essential drugs.

59. *Training programs.* For human health resources that respond to the needs of the health sector within the reform process.

60. *Direct support.* In activities identified and designated high priority within the framework of the Health of the Indigenous Peoples Initiative.

<b>NICARAGUA PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health in Human Development	1,203,000	1,155,100	2,380,200	28,000
Health Systems and Services Development	780,100	672,000	4,240,600	3,910,000
Health Promotion and Protection	160,000	193,400	17,000	15,000
Environmental Protection and Development	200,000	198,500	578,000	405,000
Disease Prevention and Control	500,000	737,100	2,079,400	920,000
<b>Total</b>	<b>2,843,100</b>	<b>2,956,100</b>	<b>9,295,200</b>	<b>5,278,000</b>

# NORTHERN CARIBBEAN

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## *Health Situation*

### Bermuda

1. Bermuda continues to benefit from a sound economy and its health status also continues to be of a high standard.
2. The incidence of STDs, particularly HIV/AIDS, has been a matter of concern. The leading causes of death continue to be heart disease, cerebrovascular disease, AIDS, accidents and violence, pneumonia, diabetes, renal disease and chronic liver disease.
3. Road traffic accidents are a major cause of morbidity and mortality, although the occurrence of these is on the decline. In an effort to lower the accident rate, safety campaigns are being launched and alcohol analyzers have been introduced.
4. 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.
5. Drinking water is gathered from individual roof catchment water collection and storage systems - other sources of water are the Government-controlled fresh water reservoirs and hotel desalination plants.
6. Individual household cesspits, septic tanks and aeration plants are the main types of excreta disposal systems. Pollution control regulations are under review.
7. Collection and disposal of solid wastes are carried out by the Public Works Department.
8. Nutrition education programs are at present being implemented in primary and secondary schools. A preventive dental care program provides fluoride treatment for children.
9. Health services are considered adequate, available and accessible to the entire population. Hospital insurance is compulsory for all employed persons. Costs are borne equally by employers and employees. Health care is provided by the Government and the private sector. Population

groups eligible for special attention include mothers, infants, school-age children and the elderly. School children receive free treatment, and hospitalization of persons over age 65 is 75 to 100% subsidized.

10. A primary health care information system has been implemented to enhance management of data in primary health care.

11. Efforts have been intensified in the area of health promotion, particularly in the "Healthy Schools Initiative", through which health indices have been developed to improve the health status in schools.

12. After identifying areas of need, the Government initiated a program to provide services for elderly and evaluated the public schools program.

### Cayman Islands

13. The Cayman Islands continue to experience a sound economy in addition to high standards in its health status.

14. The leading causes of death are circulatory system diseases, malignancy, accidents, poisoning and respiratory system diseases. The exact prevalence of diabetes and hypertension is not known, but it has been estimated that 1 out of every 4 adults who visit clinics has either one or both of these conditions. In 1994 there were 150 deaths in Grand Cayman and Cayman Islands, of whom 25 were visitors.

15. The overall number of accidents occurring in the country is not known. It is estimated that most are due to road traffic accidents, many of which are alcohol related.

16. Alcohol and drug abuse have been increasingly perceived as related factors in mental health cases.

17. 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.

18. In the area of environmental health, a collection and disposal of solid waste system is in operation. Sewage treatment plants for large-scale

establishments and septic tanks for similar units are the methods used for excreta disposal.

19. Sanitary conditions and water quality in restaurants and other food handling establishments are routinely monitored. Animals slaughtered for local consumption are examined ante-post-mortem.

20. In the areas of maternal and child health, the Government carries out a rigorous immunization program offering EPI, Oral Polio, MMR and Haemophilus Influenza B Vaccines. Health education on immunization is given at pre and post-natal clinics, as well as through the media.

21. Efforts have been intensified in the area of health promotion, particularly in the "Healthy Schools initiative", through which health indices have been developed to improve the health status in schools.

22. PAHO/WHO has collaborated with the Governments of the Cayman Islands and Bermuda to address the aforementioned problems, especially in the areas of development of human resources, in order to expand health care delivery.

23. The Government of the Cayman Islands also gave special attention to health manpower development, and consequently sought PAHO's technical assistance mainly in this area.

24. Alternative methods of financing the health care delivery are now being considered by the Cayman Islands. These range from direct payment by the patient or a national health insurance plan to a combination of both. Presently, the Government has embarked upon strategic planning for health services as well as drug abuse prevention and rehabilitation in the Cayman Islands.

25. In the Cayman Islands, the health care system is expanding and a new hospital is being built to improve delivery of secondary and some tertiary care services. The Government has increased the cadre of health workers more than 60% and hence it is expected that the demands for technical cooperation will increase.

26. This, therefore, raises the issue of resources allocated to the Cayman Islands for technical cooperation purposes.

27. In the area of health promotion, they have intensified their work, especially in the area of the Healthy Schools Program. The Ministry is now seriously focusing on the issues of tourism/health, and hence has requested support for the next biennium in the area of food safety and quality assurance. HACCP and hotel surveillance are important areas related to food safety, to which consideration has been given.

### ***National Priorities for PAHO's Technical Cooperation***

28. Pursuit of programs and strategies to enhance health care delivery with emphasis on human resource development. Promoting better environmental health services for the population. Enhancement of water supply systems for the benefit of households. Promotion of healthy lifestyles through social communication strategies for the benefit of the public.

### ***Technical Cooperation Strategy***

29. The Technical Cooperation Strategy achieved will be aimed at the following:

30. Cayman - Strengthening the capabilities of the Department of Health in the delivery of health care services.

31. Bermuda - Strengthening the management and support services for enhanced delivery of health care services.

32. In order to accomplish strengthening of these services, health manpower development is considered a priority area for both the Bermudian and Caymanian Governments. Requests for technical assistance lie mainly in this area. This is provided through support for fellowships, training in the form of workshops and participation in overseas meetings, and conferences.

33. Other functional approaches used to a lesser extent are: information dissemination; development of policies, plans and norms; direct technical cooperation; and mobilization of resources and research.

### ***Objectives for PAHO's Technical Cooperation***

- To strengthen the capacity of the Health Services to manage its human, physical and financial resources effectively and therefore encourage high standards on the delivery of health care.

### ***Expected Results***

34. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

35. *Standards and guidelines.* For water quality of swimming pools and for quality assurance program for health services.

36. *Plans, projects and policies.* To develop: educational material for healthy lifestyles, 2) a palliative care program in the Cayman Islands, and 3) a workers' health plan.

37. *Methods, models and technologies.* To improve managerial skills of health workers.

<b>NORTHERN CARIBBEAN PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health Systems and Services Development	95,300	95,300	0	0
<b>Total</b>	<b>95,300</b>	<b>95,300</b>	<b>0</b>	<b>0</b>



# PANAMA

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## *Health Situation*

1. Within the framework of the modernization and reform process, the central mission of public health policy is to contribute toward increasing the sustainable human development of the entire Panamanian population. This development is reflected in the positive indicators of comprehensive health, that is to say, at the population and environmental level. Improving these indicators requires the modernization of all health sector entities. To this end no effort should be spared, so that each institution in the sector can overhaul its technical, administrative, and financial management to attain the capabilities needed for the process.

2. In order to strengthen and sustain the reform and modernization process, institutional capacity and legal authority must be enhanced to enable the Ministry of Health (MINSa) to exercise its steering role. The five dimensions of this are: sectoral management, sectoral regulation, development of the essential functions of public health, sectoral financing, insurance, and service delivery.

3. Panama is preparing to take over the Canal Zone on 31 December 1999. The administration of this territory will require control over and attention to factors that are potentially harmful to the population and the environment.

4. Likewise, integration poses challenges for the expansion of the health sector. The process involves multisectoral objectives such as the consolidation of democracy, sustainable development, free trade, and progress toward equity. Furthermore, free trade can affect the availability, cost, and quality of the many health inputs and services for the population.

5. The technical cooperation of the Organization during the biennium 2000-2001 will be geared toward strengthening the sector's institutional capacity, as reflected in the human resources, materials, and technology needed for the consolidation and sustainability of the reform process and the modernization of Panama's current system. There will also be cooperation in other priorities established by the country.

6. At the start of the current administration in September 1994, the government designed a program of public policies for development. This program is spearheading a series of reforms for the "promotion of sustainable, broad-based economic growth, through efficiency and higher productivity" and "significant reductions in both poverty and extreme poverty."

7. Poverty has been identified as one of the principal social problems of the country. Unequal income distribution is considered a major cause of poverty, along with deficient infrastructure. For 1995, the GDP was estimated at US\$7,144 billion, yielding a per capita GDP of US\$2,746. The national average conceals major inequalities and enormous social gaps which translate into the poverty indicators.

8. In 1997 Panama's Gross Domestic Product (GDP) grew by 4.4% in 1982 prices. Overall economic performance is characterized by activities linked with the external sector, such as trade in the Colón Free Zone, port activities, and tourism; there are also activities related to the domestic economy, including manufacturing and construction. The livestock sector was particularly affected by El Niño, exhibiting negative growth rates.

9. According to the recent Social Report 1997, the growth in social expenditure has paralleled the performance of the economy and now accounts for approximately 20.6% of GDP. This places Panama among the Latin American countries that channel the highest percentage of their resources toward social objectives.

10. Panama's population was estimated at 2,718,686 inhabitants in 1997, 47.4% of whom reside in the Province of Panama. The annual average population growth rate was 1.6%, almost a third of the growth rate of the economy.

11. Panama's territory covers 75,517 km<sup>2</sup>. It is divided into 9 provinces, 67 districts or municipios, 4 indigenous regions, and 511 mayoral districts.

12. The population is made up of several groups: the Hispanic-indigenous group, the racially mixed majority; the Afro-colonial group, descended from

African slaves brought during the colonial era; the Afro-West Indian group, descended from West Indian workers; and indigenous groups, which represent 8.3% of the total population of the country and are divided into five groups: Kuna, Embera-Wounana, Ngobe Bugle, Bokotas, and Teribes.

13. The health administration division consists of 13 health regions. The Province of Panama is divided into four regions. The remaining regions correspond to each of the eight provinces, plus one territory.

14. The National Health System (SNS) is currently made up of a network of institutions that directly and indirectly provides community, public, and private services. This System, in turn, is part of a broader social network, comprised of public and private entities, such as local governments and diverse organizations of civil society, which generate the various processes for the social production of health.

15. In 1996, the public health sector had 718 facilities with varying degrees of complexity for the provision of health care to the population: 671 (93.4%) were classified as primary care facilities; 40 (5.6%) were at the secondary level; and 7 (1%) belonged to the tertiary level of care.

16. The health services coverage of MINSA is directed toward marginal areas and the indigenous communities, where it is responsible for the bulk of the coverage.

17. MINSA provides comprehensive care through a variety of programs for health promotion, disease prevention, and general care; its funding comes from the State. The Social Security Fund (CSS) covers approximately 56% of the population. Its facilities are primarily urban, and services are provided through the maternity and disease program. Funding comes from worker-employer payroll deductions. The private sector offers treatment and recovery services, which are financed by private insurance or directly by the patient.

18. There were 63,401 live births in the Republic of Panama in 1996, a crude birth rate of 23.7 per 1,000 population. A detailed analysis of the year's birth rates reveals a decline from 1995 in four of the nine provinces; only one province, Colón, with figures higher than the national rate (29.8 per 1,000 population). The remaining provinces did not record statistically significant variations.

19. With regard to professional care during deliveries, 89.9% of all births were attended by a health professional.

20. Life expectancy been on a rising trend in recent years. In 1996 it was estimated at 73.7 years. The national average conceals certain inequalities, since the averages for metropolitan Panama and the central provinces exceed the national average. The opposite is true in poor and isolated indigenous areas, where life expectancies are below the national average.

21. The infant mortality rate was 22.6 per 1,000 live births in 1996, with a downward trend since 1991, when the rate was 26.6 per 1,000 live births. There are major disparities in infant mortality within the country, with rates ranging from 14.8 to 46.4 per 1,000 live births.

22. The crude death rate for 1996 was 5.2 per 1,000 population. The leading causes of death were accidents, suicides, homicides, and other acts of violence, followed by malignant neoplasms, cerebrovascular disease, and acute myocardial infarction. In 1996, 90.9% of deaths were medically certified; the figure for urban areas was 99.4%.

23. According to Ministry of Health statistics, 8.9% of newborns had low birthweight in 1994. In that same year, Panama conducted the Survey on the Prevalence of Malnutrition in children under 5. The survey found that moderate weight-for-age deficits were found in 4.2% and severe deficits in 1.0%. Within the same age cohort, 5.2% were identified as having a moderate height-for-age deficit, with 3.4% classified as severely deficient.

24. The incidence of pulmonary tuberculosis was 43.6 per 100,000 population in 1997, an increase over 1990, when the rate was 33.0 per 100,000 population. The province of Bocas del Toro is the region with the highest rates. In 1997 this province also experienced an outbreak of bovine tuberculosis, caused by *M. bovis*. The high prevalence rates in livestock in that province (cattle: 7% of reactors to the simple caudal tuberculin test in 1997, and 5% in 1998, with nearly 17% of herds infected; buffalo: 1 herd with test reaction in approximately 17% of the animals), combined with the habitual consumption of unpasteurized milk products, may be what is increasing the incidence of *M. bovis* TB in area residents.

25. With regard to AIDS, 300,000 seropositives were estimated for 1997. That year 1,654 cumulative cases were reported, with a rising trend. This is a public health problem, particularly in the health regions of the metropolitan area, San Miguelito, Colón, and Western Panama.

26. In 1997 there were 2,628 cases of classical dengue, a rate of 96.7 per 100,000 population. No cases of dengue hemorrhagic fever have been reported since 1995.

27. The country recorded its last two cases of poliomyelitis in 1972, and its last cases of diphtheria in 1981. Since 1985 the annual incidence of neonatal tetanus has been 6 or 7 cases per year, with a marked reduction in 1995 and 1997, when only one case was reported. No cases of neonatal tetanus were reported in 1996. Cases of measles have not been reported since 1995; the international evaluation of the epidemiological surveillance system for measles showed no evidence of circulation of the measles virus in the country.

28. The last case of canine rabies in Panama was recorded in 1973. Since then, all human cases registered have been related exclusively to attacks by vampire bats.

29. The historical data on foodborne diseases (FBD) suggested low rates in the country, but better data collection and analysis of specific information indicated that the situation is otherwise, making an official effort at control necessary.

### ***National Priorities for PAHO's Technical Cooperation***

30. To continue to develop and strengthen the steering role of the National Health System. To optimize the existing resources of the National Health System for the delivery of comprehensive social health services. To foster the concept of health as a human right through comprehensive health promotion and protection at the social, family, and individual level. To develop the Epidemiological Surveillance System of Population and Environmental Health. To develop and strengthen the standardization, control, and regulation in the area of water and sanitation, and to improve the surveillance and information systems on coverage of water quality and the general situation with regard to basic

sanitation. To modernize the administrative and logistical support systems for technical cooperation, with the object of guaranteeing attainment of the expected results and complying with the mandates of the Governing Bodies.

### ***Technical Cooperation Strategy***

31. MINSA has established the national health priorities to be observed in order to meet the objectives of the National Health System. PAHO/WHO, together with the Ministry of Health, has defined the priorities for which PAHO/WHO technical cooperation is being requested.

32. For this purpose, the team at the PAHO/WHO Representative Office in Panama, in coordination with the national authorities, has developed a set of projects that constitutes the biennial technical cooperation program for 2000-2001. Below is a brief description of the strategy for implementing the technical cooperation projects:

33. The project on strengthening the steering role and health legislation gears its activities towards strengthening sectoral capacity, at the institutional and human resources level. In institutional terms, it will improve the capacity to formulate plans, policies, and strategies; it will help develop the organization's analytical capacity, and its operational capacity to redefine functions. The formulation and/or modification of laws and regulations should also be promoted, in order to give the Ministry of Health the legal authority it needs to exercise its steering role.

34. Human resources are a basic and indispensable element of the reform and modernization process. Regional and local capacity will continue to be strengthened, in such a way as to build the decentralization process on a core of human resources capable of assuming new functions and facing challenges efficiently and effectively.

35. The Health Services modernization project emphasizes the development of systems for management and regulation that contribute to the accreditation of the network of services; the development and implementation of policies, plans and programs related to sectoral reform; and the adaptation of the new model of care in the regions

through direct technical assistance and the dissemination of scientific and technical information.

36. The cooperation strategy in the Health Promotion project is characterized by activities to strengthen the institutional steering role through the development of policies, plans, and programs for the promotion of healthy lifestyles (with multisectoral participation), with a view to protecting the health of the population and the environment. In particular, it will aim at building institutional and community capacity through direct technical assistance, and at training for local management of services, within the framework of the new health care model.

37. The project on Disease Prevention and Control promotes interventions for the prevention and control of zoonoses, as well as food protection, consistent with lines of action suggested by PAHO. Particular importance will be assigned to the strategy of cooperation in activities that will help to eradicate vaccine-preventable and other diseases, such as bovine tuberculosis. Likewise, the epidemiological surveillance system for the early detection of exotic diseases will be strengthened, with special attention to foot-and-mouth disease and to emerging and reemerging diseases.

38. The basis of the cooperation strategy for the project on Water and Sanitation is the strengthening of national capacity in surveillance, control, and regulation of the environmental risk factors that affect health. It includes creation of the conditions necessary to advance the primary environmental strategy, which presupposes environmental protection and promotion in the local arena, with the full participation of civil society.

39. Additionally, the project on Occupational and Environmental Aspects of Exposure to Pesticides in the Central American Isthmus (PLAGSALUD) incorporates cooperation strategies within the framework of a bottom-up approach. This type of approach is more concretely expressed in the decentralization of the health sector and in comprehensive health initiatives at the local level. Putting this approach into practice and disseminating its use is closely linked with training activities in the services, community education, the mobilization of resources, and direct technical cooperation. It creates linkage with other sectors to achieve an integrated, multisectoral approach to the problems associated with pesticides.

## *Objectives for PAHO's Technical Cooperation*

- The Ministry of Health exercises the steering role in the health sector.
- To help to improve the quality and efficiency of public health services through consolidation of the new health care model within the framework of sectoral reform and modernization.
- To increase social participation in the promotion and delivery of social health services at the national and local levels.
- To strengthen the normative, monitoring, and regulatory capacity of the Ministry of Health in the area of water and sanitation.
- To strengthen the national and local capacity to monitor and respond to changing problems caused by pesticide use.

## *Expected Results*

40. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

41. *Surveillance and information systems.* For registry and pharmacological surveillance of essential drugs; for pesticides; for the regulation and assessment of health technologies in public sector services; for water and sanitation and management information for the development and evaluation of management commitments.

42. *Standards and guidelines.* Review and updating of health standards and legislation. Proposal of standards, regulations, and other legal instruments related to water and sanitation.

43. *Research and evaluation studies.* On exercise of the steering role by the Ministry of Health; for diagnosis of the use of the gender approach in undergraduate professional training curricula; for execution of the 1998-2002 National Food and Nutritional Security Plan; for water and sanitation; on adaptive water and sanitation technologies at the rural level; on environmental management at the marginal rural or urban level; on health problems related to pesticides; and on policies and standards related to communicating for health.

44. *Plans, projects and policies.* For disseminating scientific and technical information; for managing

human resources in the health sector; on the topic of gender; for the accreditation and standardization of services at the national and regional level; for establishing networks for intra- and intersectoral coordination and partnerships; for the integration of a sexual and reproductive health program; for legal instruments that incorporate health and environment criteria in the area of pesticide problems, and for health promotion at the national and local level.

45. *Methods, models and technologies.* For comprehensive attention to domestic violence, with multisectoral participation, and attention to it in the health regions.

46. *Training programs.* For developing a new management model; for analysis and utilization of information on health promotion; on select water and sanitation topics; for services to workers in the health

sector and other institutions; on management tools for evaluating the quality of care; for community education at the local level and on various aspects related to pesticides.

47. *Promotional campaigns and advocacy.* At local level, with community participation.

48. *Direct support.* To strengthen the capacity of the Assistant Director's Office for Environmental Health in the application of primary environmental care (PEC) concepts. To the Assistant Director's Office for Environmental Health in developing activities that will reduce health hazards in industrial processes. To intersectoral local and interinstitutional committees in order to coordinate and participate in the development of strategies for epidemiological monitoring of pesticides.

<b>PANAMA PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health in Human Development	884,700	945,500	75,300	45,000
Health Systems and Services Development	876,900	818,000	29,600	0
Health Promotion and Protection	0	0	41,000	15,000
Environmental Protection and Development	284,100	271,000	495,300	355,000
Disease Prevention and Control	167,000	219,100	96,300	0
<b>Total</b>	<b>2,212,700</b>	<b>2,253,600</b>	<b>737,500</b>	<b>415,000</b>



# PARAGUAY

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## *Health Situation*

1. Paraguay has accumulated deficits in the areas of poverty eradication, the delivery of social services, and social equity. Its traditional social policy has been dissociated from a comprehensive vision of economic and social development, resulting in the inability to generate income and meet the basic needs of society's most disadvantaged groups.

2. Social indicators show clear inequities and deficiencies regarding the coverage and quality of social services. Moreover, there are persistent shortcomings in the distribution and efficiency of government spending.

3. Thus, while the national average of households with at least one unmet basic need is 64%, it is 33% in Asunción, and 93% in the Alto Paraguay Department. The country's reported infant mortality rate is 21.0 per 1,000 live births, ranging from 16.0 in the Central Department to 61.5 per 1,000 live births in Alto Paraguay. Much the same can be observed with respect to maternal mortality, which is on average 123.0 per 100,000 live births, ranging from 59.7 in Asunción to 1,538 per 100,000 live births in Alto Paraguay.

4. In regard to the distribution of resources, Paraguay's average number of inhabitants per physician is 2,026, ranging from 385 in Asunción to 13,308 inhabitants per physician in the Canendiyu Department. With respect to the number of hospital beds per 1,000 population, the national average is 1.5, ranging from 7.5 in the Boquerón Department to 0.68 beds per 1,000 in the Caaguazú Department.

5. On average, 50% of all live births occur in an institutional setting. This percentage, however, ranges from 76% in the Cordillera Department to 13% in Alto Paraguay.

6. The 1996 household survey reveals that only 30% of the population has some type of health insurance. The Ministry of Public Health and Social Welfare concedes that 30% of the population does not have regular access to health services. Moreover, there continue to be disparities in the allocation of resources and access to health care between rural and

urban areas and among the neighborhoods of the major cities. This is especially true of Asunción.

7. This problem is being addressed in a strategic social development plan focusing on two main approaches: 1) expanding economic opportunities for the population, especially those living in poverty; and 2) providing social services designed to increase productive capacity and meet basic needs such as education, health, nutrition, and housing.

8. In terms of effectiveness and quality, the regulatory power of the Ministry of Public Health and Social Welfare is weak. To date it has not been possible to establish programs for professional or institutional accreditation. Likewise, there are few precedents regarding treatment protocols, auditing procedures, and regulations for the registry, monitoring, and quality control of drugs. Furthermore, there are no entities for technology assessment and no system in place for conducting periodic user satisfaction surveys.

9. Some studies are available on institutions and programs in maternal and child health, conducted between 1993 and 1995. Although these studies reveal low levels of dissatisfaction, they point to problems of inadequate treatment, limited communication with users, excessive waiting periods, and inadequate preparation of health workers.

10. The establishment of the National Health Authority and the National Medical Bureau under Law 1032/96 is measure aimed at compensating for these deficiencies.

11. Problems identified by the sector study with respect to efficiency have been associated with the following factors: a) deficiencies in the planning, regulation, and evaluation of resources; b) lack of an integrated information system; c) limited interinstitutional cooperation in the sector; d) lack of intra- and intersectoral coordination mechanisms; e) serious operational limitations in the referral and basic-referral system; f) geographical inequities in the distribution of resources, infrastructure, equipment, and maintenance; g) inadequate performance of hospitals, h) lack of a national drug

formulary; i) absence of permanent mechanisms for analyzing productivity and costs among service providers; and j) insufficient budgetary allocations for hospitals and clinics to meet their operating expenses.

12. A two-part strategy has been developed to overcome system inefficiencies. The first component establishes a national referral and back-referral system by region, while the second evaluates the efficiency of each hospital in relation to its level of complexity, functionally adjusting the supply of services and coordinating operations among the hospitals of the Ministry of Public Health and Social Welfare and the Welfare Bureau (IPS).

13. With regard to sustainability, the sectoral study estimated a total national expenditure of 7.4% of the gross domestic product (GDP). Broken down, this figure reveals private sector expenditures of 4.8 % of GDP for 1996, while public sector expenditures amounted to 2.59%. These figures signal a problem of insufficient public sector resources.

14. The establishment of the National Health Fund under Law 1032/96 constitutes the main strategy for ensuring the sustainability of the national health system.

15. Historical and other reasons have had the effect of limiting social and community participation in health matters. The creation of regional health councils has provided a forum for inhabitants and local organizations to voice their demands and participate in the search for solutions. The strategy of choice in this regard aims at strengthening the regional health councils at the national, regional, and local levels, in order to ensure participation of both beneficiaries and service providers in the areas of planning, execution and evaluation. Thus, by encouraging participation, the slogan: "Health, the Responsibility of All," can become reality.

### ***National Priorities for PAHO's Technical Cooperation***

16. Institutional Development of the National Health Council, the Ministry of Health, the Health Authority, the National Medical Directorate, the National Institute of Health, and the National Sanitation Service. Identification and implementation of the Comprehensive Health Financing Policies and

Plan; and development of National Health Insurance. Monitoring and evaluation of the proposals for health reform; and administrative and financial decentralization of the public health sector. A national policy is in place that regulates environmental protection and financial investments in the water and sanitation sector and organizes this sector. Support for the health sector in the eradication of measles and neonatal tetanus, Chagas' disease, urban rabies, and leprosy; and in the control of AIDS, tuberculosis, dengue, and malaria through development of the comprehensive health surveillance system and strengthening of the Expanded Program on Immunization. Support for activities to link the guidelines for healthy municipios, communities, and schools comprehensively with the decentralization and social participation promoted by health sector reform; and monitoring and evaluation of the comprehensive care plans for children and adolescents, and of reproductive health, food and nutrition, and environmental health.

### ***Technical Cooperation Strategy***

17. Technical cooperation will concentrate on supporting two processes of momentous political and epidemiological importance. The first involves implementing structural changes in the organization and financing of the health and environmental sectors, while the second aims at meeting global and regional objectives and commitments in the area of health, especially those associated with controlling the epidemiological potential in Paraguay.

18. With a view to ensuring that our technical cooperation conforms to the requirements laid out in the two aforementioned processes, our Organization will adjust its strategic priorities for the period 1999–2002. Adjustments in this regard will reflect the new global health policy as well as the health priorities defined by the new Government of the Republic for the period 1998–2003.

19. Our work will be based on: a) interagency coordination; b) the interprogrammatic activities of our Representative Office; c) supporting the institutions responsible for national health policy--the National Health Council and the Cabinet of the Ministry of Public Health and Social Welfare; d) facilitating regional integration processes, especially MERCOSUR; and e) decentralizing our technical cooperation to promote health reform in the health

and environment sectors, assigning the departmental and municipal levels the highest priority in this regard.

20. In light of the aforementioned, technical cooperation will be oriented primarily toward processes that facilitate the attainment of health objectives and mobilize resources in an equitable manner. This can be accomplished by utilizing our prestige and capacity to serve as a catalyst for mobilizing health resources. We can also work locally to internalize and assist in the decentralization process, as a means of providing access to health services for all.

21. National priorities requiring PAHO technical cooperation encompass three major areas or processes: reform of the health and environmental sectors; disease prevention and control; and health promotion.

22. Technical cooperation priorities in health sector reform are: To promote institutional strengthening of the National Health Bureau of the Ministry of Public Health and Social Welfare (steering role), the National Health Authority, the National Medical Bureau, the National Health Institute, and the National Health Service. To formulate and implement health policy and a comprehensive health financing plan, and to establish a national health insurance plan. To monitor and evaluate the postulates of the Health Reform. To promote administrative and financial decentralization of the public health sector by implementing agreements for areas of management responsibility (local health plans, cost and productivity analysis, and basic indicators--situation rooms). To formulate and implement a national water supply and excreta disposal plan within the framework of reforms of this subsector.

23. Technical cooperation priorities in the area of disease control are: To provide support to the health sector in the eradication of measles and neonatal tetanus, Chagas' disease, urban rabies, and leprosy; assisting in the control of AIDS, tuberculosis, dengue, and malaria through the development of a comprehensive health monitoring system; and strengthening the "Expanded Program on Immunization" (EPI).

24. Technical cooperation priorities in the area of health sector reform are: To support measures conducive to implementing municipal and community proposals and improving health conditions in schools; and, in keeping with the postulates of health sector reform, the implementation of these proposals should be made integrally through decentralization and social participation. To monitor and evaluate comprehensive plans promoting child and adolescent health, reproductive health, food protection, improved nutrition, and environmental health.

### ***Objectives for PAHO's Technical Cooperation***

- Public health services will be functioning in a decentralized manner with broad social and community participation.
- The steering role of the MSPBS and the National Health Council will have been strengthened within the framework of decentralization and health sector reform.
- Health situation analysis at the national level will be implemented with criteria of equity and efficiency, and programs will be executed for the elimination and control of the principal diseases that affect the population.
- The capacity of the country to control risks will have increased with health promotion interventions in plans, programs, and projects aimed at the formulation and implementation of healthy public policies.
- The National Environmental Health System will have been set up through policies, plans, and projects that guarantee sustainable human development in Paraguay.

### ***Expected Results***

25. During the biennium 2000-2001 PAHO is committed to developing jointly with the country:

26. *Cooperation networks, alliances.* Diagnostic laboratories and blood banks to strengthen reference and improve the quality of the services.

27. *Surveillance and information systems.* On environmental information.

28. *Standards and guidelines.* For the organization of services and improvement of the quality of care in the principal health regions.

29. *Research and evaluation studies.* On national health promotion experiences versus recovery and rehabilitation activities, with emphasis on cost-effectiveness.

30. *Plans, projects and policies.* The national health plan and guidelines for its financing; human resources development; and technology and research; the elimination of *T. infestans* and interruption of transfusion-transmitted *T. cruzi*, the elimination of leprosy, and implementation of the DOTS and IMCI strategies; the elimination of measles and neonatal tetanus, the maintenance of polio eradication, and the inclusion hepatitis b, *Haemophilus influenzae*, and yellow fever vaccines; control of malaria, the struggle against *Aedes aegypti*, and control of leishmaniasis and other vector-borne diseases. Elimination of urban canine rabies and other zoonoses that threaten public stages of the life cycle, with emphasis on integrated activities to include

nutrition, mental health, and the prevention of tobacco, alcohol, and drug use; water and sanitation and the promotion of healthy environments and behaviors.

31. *Methods, models and technologies.* For monitoring and evaluating health sector reform and assessing its equity, efficiency, and quality.

32. *Training programs.* To improve the management and the performance of human resources in the context of health reform; the development of a health surveillance system integrated into a network of information systems and health services, with the active participation of the central laboratory and the organized community; dissemination and implementation of interventions to promote health in cities, communities, and healthy schools.

33. *Direct support.* To strengthen institutional capacity for the management and prevention of environmental risks.

<b>PARAGUAY PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health in Human Development	818,200	915,300	0	0
Health Systems and Services Development	838,700	763,500	47,100	0
Health Promotion and Protection	62,000	55,600	163,000	0
Environmental Protection and Development	364,300	337,200	123,300	0
Disease Prevention and Control	517,000	742,200	69,000	0
<b>Total</b>	<b>2,600,200</b>	<b>2,813,800</b>	<b>402,400</b>	<b>0</b>

# PERU

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## *Health Situation*

1. The population of the Republic of Peru, as of 30 June 1998, was estimated at 24,800,768, 34.9% of which are children under the age of 15 (exhibiting a downward trend), and 4.5% are 65 years or older (exhibiting an upward trend). Life expectancy at birth for 1995-2000 is estimated at 68.3 years (70.9 for women and 65.9 for men). The birth, fertility, and growth rates of the population declined to 24.9 births per 1,000 population, 3.0 children per woman, and 1.73%, respectively. Recent years have witnessed a steady migration from the countryside to the cities. Thus, in 1996, 71.5% of the population resided in urban areas and 28.5% in rural areas. Metropolitan Lima alone has 6.9 million people, 29% of the total population of Peru, and 44% of the country's total urban population.

2. The crude death rate for 1995-2000 is estimated at 6.4 per 1,000 population. The infant mortality rate was 43 per 1,000 live births in 1996. This latter figure has decreased by 50% over the past 20 years, chiefly due to improved control of diarrheal and vaccine-preventable diseases and acute respiratory infections.

3. However, large disparities still persist among the different regions of the country. The lowest mortality rates are found in the departments of Lima and Arequipa and the highest in Huancavelica and Apurimac. These differences reflect the gaps between socioeconomic groups.

4. Underreporting of deaths, estimated at 39.5%, is a major problem in the mortality statistics; furthermore, only 74.2% of the deaths recorded are certified by a physician (1995). Acute respiratory infections remain the leading cause of mortality. The number of deaths from neoplasms, cardiovascular problems, and violence has increased from year to year. Disorders of the neonatal period, acute respiratory infections, and acute diarrheal disease account for 68% of deaths in children under 1 year.

Furthermore, ARI, ADD, and nutritional deficiencies were responsible for 52% of the deaths in children between the ages of 1 and 4 years of age; all of these, as it is well known, can be treated with simple, effective and low-cost interventions.

5. With regard to morbidity, communicable diseases are still a national priority, reflected by their inclusion in the health policy goals for 1995-2000.

6. Despite an improvement in the coverage of the National Tuberculosis Control Program, and in the effectiveness and efficiency of treatment, the annual incidence rate for pulmonary tuberculosis with positive bacilloscopy was 112 cases per 100,000 population, a 30% reduction over 1993. The detection of cases with positive bacilloscopy has increased seven-fold; the efficacy of the treatment is 92%; and the dropout rate has declined considerably, from 50% in 1990 to 3.5% in 1997.

7. The cumulative number of AIDS cases up to March 1998 was 7,199, with the majority (75%) concentrated in Lima. The most common form of transmission continues to be sexual. Over the past four years, however, there has been a notable marked increase in vertical transmission. The number of heterosexual men and women who contract the disease is increasing, with a higher incidence in coastal and urban areas; furthermore, other sexually transmitted diseases (STD) are still not under effective control.

8. In 1997, 180,338 cases of malaria were recorded (annual incidence rate: 740 per 100,000), 52,718 of which were *P. falciparum* (annual incidence rate: 216.5 per 100,000). A steady increase of falciparum malaria over the past 4 years has been evident. Between 1994 and 1997 diagnoses by thick blood film have increased six-fold, the dropout rate has fallen, and free treatment has been maintained.

9. Classical dengue has been found in 9 of the 32 health subregions; 1,357 cases (annual incidence rate: 5.57 per 100,000) were reported. No cases of dengue hemorrhagic fever have been recorded, although the risk of occurrence remains high.

10. Yellow fever remains endemic in 12 watersheds in the central mountainous zones and jungle areas. An outbreak occurred in 1995, with 498 cases and a 38% case-fatality rate. Intensification of prevention activities and inclusion of the yellow fever vaccine in the Expanded Program on Immunization that same year have helped to reduce the caseload. As of December 1997, 44 cases were recorded, with a 45.95% case-fatality.

11. The incidence of vaccine-preventable disease declined during 1994-1997. Both current and programmed actions make it possible to assume that this trend will continue through 2000-2001.

12. There has been a steady reduction in the plague, following the 1994 epidemic in the departments of Cajamarca, Piura, Lambayeque, and La Libertad, where 1,122 cases were reported, with 51 deaths. For 1997, 46 cases were reported, with 3 deaths. Rabies has followed a similar pattern. The persistence of zoonoses with a public health impact, such as caprine brucellosis, distomatosis, cysticercosis, and hydatidosis, should also be noted.

13. Bartonellosis progressively increased from 1985 to 1997; it occurs in four departments of the northern area of the country, with an estimated exposed population of 1,687,236.

14. Chagas' disease occurs in six departments of the southern area of the country. In 1996 24,170 cases of infection were recorded in these endemic areas.

15. Cholera exhibited a downward trend between 1994 and 1997, especially along the coast. Outbreaks have occurred, however, among rural populations in mountainous and jungle areas, with high case-fatality rates. During the closing weeks of 1997 there was an increase in cases attributable to El Niño.

16. El Niño is a cyclical climatological event accompanied by rising temperatures and torrential rains, with serious consequences such as the destruction of dwellings, crops, and the services infrastructure, leading to the displacement of

populations to refugee areas that are characterized by overcrowding, food and water shortages, and inadequate excreta disposal, all of which foster the transmission of diseases. It is estimated that El Niño 1997-1998 left more than 300,000 victims in its wake. Its latest recurrence--which was very intense--was in 1983, when Peru had no areas of cholera, dengue, or falciparum malaria transmission.

17. Areas affected by El Niño experienced outbreaks of acute respiratory infections, skin diseases, conjunctivitis, and diarrheal diseases. Of these, cholera had the strongest impact on health. As of 16 May 1998, 32,622 cases had been reported, far more than had been recorded during all of 1996 and 1997. This cholera epidemic has spread to various rural communities of Peru, some of which have had case-fatality rates of more than 5.

18. Among the vector-borne diseases, both malaria and dengue have increased, particularly in the weeks following the rainy season, since the new pools of water that collect foster the spread of the vector. Ecological changes wrought by El Niño can expand the transmission areas of vector-borne diseases. As of 16 May 1998, 25,175 cases of falciparum malaria were reported, together with 623 cases of dengue and a major outbreak of yellow fever, with 111 cases and 30 deaths in the province of La Convención, Cuzco.

19. There is a post-El Niño effect that leads to an increase in agricultural production and, consequently, a larger rodent population; this, in turn, favors the transmission of bubonic plague in the rural areas of the northern part of the country. Fortunately, the incidence of this disease has remained low since the last epidemic in 1994.

20. With regard to reproductive health, 67.3% of pregnant women receive prenatal check-ups only, and just 49.6% of deliveries are attended in the health services. This contributes to the fact that average maternal mortality is 265 deaths per 100,000 live births, 15% of which are in young pregnant women. Furthermore, approximately 20% of deaths are attributable to abortion. Chronic malnutrition in children under 5 is approximately 26%; the anemia

rate is estimated at 53% for children under 5, and the rate for women of reproductive age is estimated at 50%. Vitamin A deficiency for these groups is 38% and 15%, respectively.

21. Non-communicable diseases have been receiving growing attention. Recent studies of populations in Piura, Chiclayo, and Lima have revealed a 4.2%-7.5% prevalence of diabetes mellitus, a 15% and 33.8% prevalence of hypertension, and a 14%-42% prevalence of hypercholesterolemia. The incidence and mortality rates for cervical cancer observed in Lima and Trujillo confirm that this is a major public health problem.

22. National policies aimed at social sector reform, the privatization of public enterprises, the liberalization of trade, and the promotion of foreign investment have yielded favorable macroeconomic results, reactivating the economy, stimulating economic growth, and checking inflation. As in other countries of the Region, however, these effects have not trickled down to the household economy. An estimated 20% of the total population lives in extreme poverty, and in 53.9% of Peruvian homes at least one basic need goes unmet, according to data from the 1993 Census. Underemployment remains a fundamental problem, affecting the majority of the economically active population. Other such problems are violence fostered by the precarious living conditions, questions about the institutional performance of the State (judiciary and services), and the translation of terrorist violence into crime.

23. Three fundamental aspects of the health situation should be pointed out: a) a substantial improvement in the traditional indicators of the standard of living, as well as in the social gaps with respect to the same indicators; b) demographic and social changes that modify lifestyles and the basic health indicators, requiring the adoption of new indicators to evaluate capacity in people's performance (in education, health, labor) and to evaluate basic services, including public safety; and, c) state reform and the health reform proposals premised on the need to increase competitiveness.

24. With regard to environmental conditions, in some regions of the country the degradation of water

resources has become critical. This is largely due to industrial pollution, particularly from metallurgical operations, and to household and agrochemical waste. Air quality has been affected by the environmental degradation of some parts of the country, such as Metropolitan Lima, and the industrial areas of other cities, such as Chimbote, Ilo, and Cerro de Pasco. The leading causes for this degradation are industrial development without proper pollution control or prevention measures, and an increase in motor vehicles, many of which are in poor condition. Several areas of the country have had environmental quality problems with the soil, due partly to mine tailings and partly to indiscriminate waste disposal in unauthorized areas.

25. At the national level, there are many limitations to the coverage and delivery of water supply services. Only 8% of the water supply is continuous. According to the ENAHO-IV95, 47.4% of the national population has sewerage services, and 21.95% has latrines. An estimated 70% of the population is covered by municipal solid waste collection, but only Lima has adequate final disposal via sanitary landfill. The country lacks adequate systems for the treatment of hospital waste; incineration is very limited and inefficient, and there are no secure landfills to deposit hazardous waste of this type.

26. Some basic achievements should nonetheless be pointed out: increases water and sanitation coverage, progress with environmental policies, and the implementation of programs for quality improvement in each sector.

27. Between 1994 and 1997, as part of the effort to combat poverty, the sanitary infrastructure and the basic health services were expanded considerably. Much of the credit goes to the Basic Health for All program.

28. The National Censuses of Health Sector Infrastructure and Resources, conducted in 1992 and 1996, reveal that the number of health facilities grew by 63% and that the average availability of physicians at the national level increased from 7.6 to

9.8 per 10,000 population; the availability of nurses grew from 5.2 to 6.2, of midwives from 1.2 to 2.1, and of dentists from 0.7 to 1.1 per 10,000 population.

29. Nevertheless, there is still a need for improved planning, as well as continuing education for human resources and their equitable distribution. The poorest departments with the highest proportion of indigenous population, such as Huancavelica, Apurimac, and Cajamarca, have only 3 physicians per 10,000 population. In the least disadvantaged areas, such as Arequipa and Lima, the figures are 15 and 19 per 10,000, respectively.

30. The national average for hospital beds is 1.8 per 1,000 population; but the figure varies from 0.8 to 3.0, to the detriment of the poorest areas; furthermore, approximately 40% of all hospital beds are in areas with a high degree of seismic vulnerability. Observable progress has been made in the operational definition of health services networks, but problems still linger in terms of organization, planning, operation, logistical support, evaluation, supervision, and quality control, which hinder the accreditation process. In order to increase productivity and quality, self-management is being promoted among the public hospitals of the health sector, as well as the signing of administrative agreements between the Ministry of Health and the health regions for the management and/or purchase of services in local networks. The regulatory mechanisms, pricing mechanisms for services, and treatment protocols to ensure a minimum quality of care all remain to be spelled out.

31. The usage rates and effectiveness of health services also need improvement; only 32.5% of the population covered by the Ministry of Health and 36.5% of the beneficiaries of the IPSS utilize the services. Respectively, these average 2.3 and 4.3 medical consultations per person seen each year. This situation is worse at the national level, where the 1995 average was barely 0.7 consultations per year, ranging from 0.4 for Huancavelica to 3.0 for El Callao. The network of rehabilitation services has been strengthened, but there are still deficiencies in the coding and registry of disabilities, which impedes an accurate estimate of the morbidity burden.

32. At the level of specific services, there is a caries-prevention program involving the topical application of fluorine and the fluoridation of salt for human consumption; the services are still insufficient for serving 95% of children under 14 with caries, 85% of those with periodontal disease, and 75% of those with malocclusion. Eye care is targeted mainly to schoolchildren and adolescents. Early detection of blindness and refraction defects nevertheless reaches only 20% of the at-risk population, and 10% of persons with cataracts have the problem surgically corrected each year. Mental health care is not integrated into the general health services system, nor has an adequate effort been made to promote such integration. Psychiatric care continues to be provided primarily in psychiatric hospitals.

33. The PACFARM program has significantly improved the availability and accessibility of drugs in the primary care facilities of the Ministry of Health, but problems related to quality persist, largely due to noncompliance with good manufacturing practices, contraband, and unauthorized production. New health legislation permits a high degree of flexibility in sanitary registry, which might facilitate the inappropriate use of drugs.

34. The political and legal framework for health sector reform--whose purpose is to improve access to essential health services, with equity and basic quality--is set forth in the National Health Policies for 1995-2000, the Social Security Law (updated in 1996), and the General Health Law (enacted in 1997).

### ***National Priorities for PAHO's Technical Cooperation***

35. To promote and strengthen the surveillance of public health and the capacity to analyze the health situation at both the central level and in the health bureaus; To support the health sector reform process with respect to the steering role of the Ministry of Health; the management of public health services; the formulation of models of care that respond to the new social realities; and the decentralization of resources to guarantee access to health care with quality and equity; To promote and support public policies and

legal initiatives that promote health, healthy lifestyles, community participation, multisectoral coordination and consensus building, the sharing of experiences, the mobilization of resources, health promotion and protection, research, and the acquisition of financing; To promote coordination and technical cooperation among countries, facilitating the exchange of information and technology to strengthen and integrate health programs and public health surveillance.

### ***Technical Cooperation Strategy***

36. The quadrennial Joint Evaluation of the Technical Cooperation of PAHO/WHO for 1994-1997 has facilitated a careful analysis of the country's health situation; it has helped to understand the main factors influencing health, identify problems, and obtain a more thorough understanding of the main achievements to date.

37. Using this document as a reference point, particularly the general and specific recommendations produced by the dialogue between the government officials responsible for the management and implementation of the health programs and the Organization's consultants, the following technical cooperation strategies have been defined:

38. Surveillance and analysis of the health situation to permit a thorough, comprehensive understanding of the problem at the national level, by geopolitical region, and, especially, at the local levels of health services delivery, and the implementation of pertinent public health actions.

39. Promotion of the active participation of all sectors of government and civil society, together with the community, in the identification of problems and conditions that affect health and well being. To this end, it is necessary to develop and maintain the opportunities and consensus-building channels needed to maximize the use of resources and efforts needed to resolve the problems thus identified.

40. Strengthened public information, with national coverage, so that society can actively participate in

the formulation of national policies conducive to improving access to health care for the entire population, with equity, and to controlling and eliminating the chief threats to health and the environment, including: the principal communicable, chronic, and degenerative diseases; injuries; violence; and health problems resulting from undesirable lifestyles.

41. Continued support for the various state agencies in reorganizing the health services in order to achieve good quality care at both the individual and collective levels.

42. Safe maternity, with a reduction in the high maternal mortality and abortion rates, for which specific strategies should be designed and implemented that take into account exceptional, social, and cultural conditions that need to be corrected to achieve adequate, more patient-friendly care.

43. Development of the most depressed regions and marginalized populations by the various economic and social sectors of the government, with emphasis on indigenous communities, to ensure that they have greater access to drinking water, sanitation, good nutrition, and healthy housing.

44. Assistance in creating a culture of prevention and self-care to respond to the natural, meteorological, and social mobilization phenomena that cyclically occur in the country and that influence the risk of sickness or death for the population.

### ***Objectives for PAHO's Technical Cooperation***

- To improve intercountry integration through the formulation of plans of action in border areas and with other countries.
- To develop national capabilities for health management within the process State and sectoral reform.

- To consolidate the organization and operation of service networks, as a means of offering comprehensive individual and collective health activities guided by the principles of universality, equity, quality, and efficiency.
- To develop the national capacity for health promotion and protection from the standpoint of human development.
- To develop the national capacity for public health surveillance to implement effective prevention and control measures.
- To develop local health surveillance and the response capacity in every district in the country, in order to protect its population, prevent epidemics, and comply with international commitments for elimination.
- To develop the national capacity for health and environmental surveillance and for improving the quality of public health services in order to implement effective prevention and control measures.

## ***Expected Results***

45. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

46. *Cooperation networks, alliances.* Between countries with a common border for surveillance and control of diseases, environmental damage and risks; interinstitutional and community networks for the surveillance, prevention, and control of priority diseases; and alliances with NGO's and the private sector that make it possible to keep vaccination coverage above 95%.

47. *Surveillance and information systems.* For the registry, evaluation of quality, and epidemiological surveillance of drugs; on maternal and perinatal deaths; on public health at the national level for decision-making at different levels; sanitary and environmental information on water, soil, air, and food, as well as the use of hazardous chemical substances and the quality of housing, for the prevention and control of environmental risks.

48. *Standards and guidelines.* For adopting the gender approach in the health plan; for ocular health, mental health, oral health, community-based

rehabilitation, and control of chronic health problems; for the control of priority diseases, for quality control of water and sanitation services, solid waste management, and chemical safety and air quality systems.

49. *Research and evaluation studies.* On demand, financing flows, costs, cost-benefit analysis, and payment mechanisms; on hospital accreditation and vulnerability in all the regional and national referral hospitals; on interfamily violence, drug abuse, and traffic accidents. Operational studies for decision-making on prioritizing resources, the introduction of new vaccines, improving the quality of care, and evaluating the progress of the program.

50. *Plans, projects and policies.* For the analysis of health and public health surveillance; intersectoral health promotion projects; operational, epidemiological, and evaluation policies on priority diseases; and for incorporating new vaccines and maintaining the public nature of the vaccines.

51. *Methods, models and technologies.* For health and environment; for public health surveillance and health analysis, with emphasis on measuring inequities; comprehensive health models for individual and collective care in health services networks, prioritizing activities in primary health care; models for operating systems and logistical support for health services networks; models for education and communicating for health; at the health laboratories; and for monitoring workers' health to prevent and control occupational health risks.

52. *Training programs.* For implementing new models and guidelines in health systems; for the personnel of the training units of the departmental health bureaus; on the formulation, development, and evaluation of continuing education plans; for the personnel of the departments in the proper use of drugs; on food and nutrition, with emphasis on micronutrients; for journalists in the mass media to get information out to the public on self-care, health promotion, and healthy lifestyles; for the prevention, control, and surveillance of priority diseases; and for mass communication.

53. *Direct support.* For the preparation and monitoring of processes, plans, and budgets, by expected result, in the central, departmental, and

local areas; for the formulation of policies and operating plans for the strategic resources of the

Ministry of Health; and for the formulation of health regulations to increase coverage.

<b>PERU PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health in Human Development	2,535,200	2,663,600	877,400	683,500
Health Systems and Services Development	1,342,500	1,179,100	122,300	45,000
Health Promotion and Protection	788,200	824,400	20,300	20,000
Environmental Protection and Development	518,600	560,000	5,000	2,700
Disease Prevention and Control	607,100	653,900	95,500	2,800
<b>Total</b>	<b>5,791,600</b>	<b>5,881,000</b>	<b>1,120,500</b>	<b>754,000</b>



# PUERTO RICO

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## *Health Situation*

1. The social transformation that Puerto Rico has undergone in the past 50 years has resulted in a significant increase in longevity and life expectancy. This pattern is expected to continue; by the year 2030, it is estimated that some 15% of the population will belong to the 65+ age group. This and other trends, such as the transition from a rural agricultural society to an urban industrial one, have meant changes in morbidity and mortality. The epidemiological profile has changed and with it, the incidence of tropical diseases, cardiovascular diseases, diabetes, and cancer. Alcohol and tobacco consumption are high, the population does not get enough physical exercise, its diet is excessively high in fats and proteins, and a growing proportion uses illegal drugs. In the late 1980s and early 1990s, it became increasingly clear that access to a wide range of health services provided directly by the State at government facilities was more theory than practice for the population with the least resources. The reality was that this large segment of the populace received care inferior to that received by those with access to private insurance.

2. In order to achieve equity and access to high-quality health care, especially among the uninsured, Puerto Rico is implementing a profound restructuring of the health sector, within the framework of an effective decentralization toward the local level. The basic goal of the reform is to put a halt to the rapid rise in costs and ensure that all of the island's inhabitants obtain quality health care at a reasonable cost.

3. Privatization of the health system continues to advance, making adjustments along the way. In regions where the process has been implemented, government facilities for health services delivery have been privatized. One or more insurance companies have been contracted per region through a competitive bidding process; these companies are committed to organizing the local health resources interested in serving the uninsured population into managed care centers that the full range of services characteristic of such centers. The Health Department, with the collaboration of the Health

Insurance Administration (ASES), is ensuring that the insurance companies and private service providers comply with the guidelines laid down by the government for services to the uninsured. The coverage outlined in such guidelines should include all services necessary to maintain a good level of physical and mental health among the population--that is, outpatient, physician, hospital, laboratory, dental and pharmacy services. In 1997, Puerto Rico entered the second phase of the sectoral reform, with the goal of developing an integrated health system.

4. Two aspects of the transformation processes distinguish Puerto Rico from other countries of the Region of the Americas. The first is related to the fact that the Puerto Rican reform is very much home-grown, the product of its own reflection, self-knowledge, political will, and geopolitical and economic position in a federal and international context. The second has to do with the active role played today by the nonprofit and for-profit private sector in the administration and delivery of public health services, which demonstrates that social equity can be achieved with the broad participation of this sector, provided that the State shifts from the role of service provider to regulator. The State retains and strengthens its absolute responsibility for the health of the population but delegates the administration of that responsibility to private organizations.

5. The basic principles of this second phase of the sectoral reform remain the following: To eliminate duality and discrimination in medical care; to guarantee access to quality health services for the entire population; to increase the efficiency and productivity of the health system through competitive mechanisms; to increase the quality of health services; and especially, to redefine the Government's health intervention strategy, gearing it toward regulation and control of the personal health care component and toward health promotion and disease prevention.

## *National Priorities for PAHO's Technical Cooperation*

6. The priorities for PAHO's technical cooperation in Puerto Rico, at its different levels, consist in

carrying out joint activities in the areas of healthy municipios, "CARMEN" programs, wellness centers, environmental primary health, bioethics, geographic information system for epidemiological surveillance, and violence.

### ***Technical Cooperation Strategy***

7. Technical cooperation between PAHO and Puerto Rico consists of strengthening those fields of public health in which the strategic inputs of the Organization are used to advance or accelerate health sector reform, emphasizing disease prevention and health promotion. The dissemination of technical and scientific information, the generation of policies and plans, research, and direct technical cooperation constitute the functional approaches that generally characterize this strategy.

### ***Objectives for PAHO's Technical Cooperation***

- To support Puerto Rico in the dissemination and refining of the health sector reform, with emphasis on the health promotion and prevention of the disease.

### ***Expected Results***

8. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

9. *Direct support.* In the present stage of the process of sector reform, that emphasizes the health promotion, and to support Puerto Rico in its technical relationship with others Member States of the Organization.

<b>PUERTO RICO PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health in Human Development	0	38,300	0	0
Health Systems and Services Development	199,000	197,500	0	0
<b>Total</b>	<b>199,000</b>	<b>235,800</b>	<b>0</b>	<b>0</b>

# SAINT KITTS AND NEVIS

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## *Health Situation*

1. St. Kitts and Nevis is a Federation of two islands with a Federal Parliament in St. Kitts and fairly autonomous local government in Nevis, with a local assembly. In 1997 the Nevis Administration officially announced its intention to secede. Efforts of the Caribbean Community to encourage more and not less integration failed, and Nevis is proceeding towards a referendum as called for in the Constitution.
2. The mid-year estimated population of St. Kitts and Nevis in 1995 was 43,530, with 35,510 population in St. Kitts and 8,020 in Nevis, and an almost equal proportion of males and females. These figures show a slight increase over that of the 1991 census, when the population was 40,618, having declined from 43,291 in 1981. Such decline was thought due to net emigration, which continued to 1994. Of the entire population, 31% are under 15 years of age, with 9.4% aged 65 years and over.
3. CDB reports that the prospects for economic performance look good. Agriculture remains the major currency of the economy. Sugar production increased by 52%, and this was largely responsible for the 3% growth in GDP in 1997, which was an outstanding year of performance for the industry. Non-sugar crops production is also increasing, notwithstanding mild decline in exports in 1997 due to the discovery of the pink mealy bug in St. Kitts. Even with the expected decline in production in 1998 due to lower than normal rainfall, agriculture will remain important in the medium level. Tourism is expected to be boosted by an increase in cruise ships at the recently completed port and the opening of large hotels belonging to successful all-inclusive chains. Manufacturing is expected to be marked by growth in the electronic sector. Strong marketing strategies will be needed to overcome competition from Trinidad and Tobago in the food and beverage sector. Unemployment in St. Kitts and Nevis is among the lowest in the Caribbean. A labor force survey in 1994 confirmed a rate of 4.3%. In addition, St. Kitts places high priority on education as reflected in the fact that 89.2% of one 5-19 year age group attend school in 1994 without the legal requirement for compulsory participation.
4. However, there remains a significant challenge to encourage local production of food. This is going to be more difficult as the service sector grows.
5. Life expectancy (1994) for males is 67.4 years, and for females 70.4 years, having risen from 65 and 70, respectively, in 1991. The crude death rate has shown a decline (9.3) in 1995 from 1994 when it was 9.7. Infant mortality is relatively constant at 20/year with neonatal deaths accounting for 75% (15). The major causes of admissions to the hospitals for infants in St. Kitts and Nevis have been acute respiratory infections (ARI) and gastroenteritis.
6. For children 1-4 years, gastroenteritis, acute respiratory infections and trauma are the most common causes of hospital admission. The high incidence of gastroenteritis may be associated with the use of untreated drinking water in the rural areas. There were three maternal deaths in the four-year period from 1992-1995 - only in 1994 was there no death. Maternal morbidity and mortality continue to be low. Data on injuries, poisoning and external causes treated at the Casualty and Emergency department reveal that there has been an increase. The number of registered mental health patients has steadily increased from 1992 (249) to 1995 (300), with the improvement of the Psychiatric/Mental Health Service. The main causes of death for all ages and both sexes remained the same in 1995. These were ranked as heart and cerebrovascular diseases, accidents, neoplasm and pneumonia.
7. Environmental Health: The environment continues to be an area of concern, due to the lack of treatment of the rural water system and excreta disposal in rocky terrain, where difficulty is experienced in constructing pit latrines. The open drains in Basseterre contribute to the pollution of seawater, which could contribute to adverse effects

on the tourism industry, fishing, and health of the population. Food safety in all eating establishments and among itinerant vendors is cause for health services involvement. The integrated approach to vector control is limited and the need for expansion from the pilot to other areas is seen as a priority by the Ministry of Health.

8. **Health Promotion and Disease Prevention:** The integration of health promotion strategies in chronic non-communicable diseases and communicable disease programs has been delayed due to the lack of training of personnel in health promotion. The need for development of these programs is a priority, following which mechanisms for evaluation should be included. Attempts to integrate STD/HIV/AIDS programs into health services have not been very successful due to the fact that contact tracing is not always enforced. Medium term planning should be addressed. Surveillance systems for chronic non-communicable and communicable diseases should be in place for monitoring and program planning. The mental health program remains directed towards community based services applying a team approach. This has been hampered due to the lack of appropriate trained personnel to strengthen the team. Services for adolescents are minimal and the need for developing these services has been recognized. In the area of perinatal care, local and overseas training of health personnel has been identified as a necessity to provide the type of support needed to reduce the incidence of perinatal mortality.

9. **Health Sector Reform:** With the thrust of health sector reform, the need for strengthening the managerial capacity at all levels is needed in areas such as information systems, planning and management. The health service is in the process of reorganization at the Central, Secondary and Primary levels to make services more accessible and to improve the quality of care rendered. The rebuilding of the Joseph N France Hospital in St. Kitts and upgrading the Alexandria Hospital in Nevis with assistance of the EU has been making very slow progress and should have been completed by 2000. In 1996 Dallonsie University Medical Center and the Government of St Kitts finalized arrangements to have access via teleradiological linkages to consultant radiological services.

## *National Priorities for PAHO's Technical Cooperation*

10. To improve the health status of the population. Promotion of personal, family and community responsibilities the adoption of health lifestyles. Human resource development, staff development, manpower training. Efficient utilization of staff, performance appraisal induction/orientation. Health sector development and reform. Organization restructuring - policy development (for reformed hospital structure), legislative reform, health care financing - designing National health insurance scheme. Physical infrastructure upgrade - planning health facilities, increased capacity in building and equipment maintenance. Quality assurance. Environmental health including water quality, food safety, vector control and waste disposal. Health information - development of hospital and national information systems, management systems. New services development program planning and evaluation, strengthen capacity in essential national health research, adolescent health.

## *Technical Cooperation Strategy*

11. Over the biennium 2000 - 2001, technical cooperation of PAHO CPC will be delivered through three projects Environmental Health, Health Promotion, and Health Sector Reform. Delivery will occur at both bilateral and subregional levels, will seek to enhance complementarity including that of CCH II. This program of work calls for collaboration of all the PAHO units and PAHO CPC. Collaboration with regional institutions, other agencies and community-based organizations will also be pursued. Emphasis will be on building capacity and in particular in ensuring sustainability at both the ministry and local institutions (school of Nursing) as well as regional institutions (e.g. UWI's HEU, CEHI etc.) with whom we collaborate in delivering direct technical assistance.

12. All functional approaches: resource mobilization; training; development of policies, plans

and norms; dissemination of information; direct technical assistance; and research Will be used in the delivery process, with the training of personnel remaining the single most frequently employed functional approach.

13. Priority areas of the CCH II initiative, which still needs to be ratified, are consistent with the areas of this plan of action, and therefore no change is anticipated following the introduction of the CCH II.

14. The strategic approaches to be used in the execution of technical cooperation over the period will include: capacity building through in-country training as a means of increasing the number of skilled personnel and through consultants working with nationals over the medium term.

15. Promotion of multi-sectoral action, particularly for health and tourism activities and health promotion projects.

16. Increased use of TCC to bring relevant experiences of other Caribbean countries to St Kitts and Nevis, in order to share the experience in the implementation of a national health needs assessment.

17. The following strategies will be used in the execution of technical cooperation:

#### Project SCN-01 Environmental Health

18. Promoting the updating of standards and regulations governing the quality of environmental services and products, e.g. waste management.

19. Fostering programs for health promotion and disease prevention in occupational health (including revising legislation).

20. Developing regulatory and technical mechanisms for the improvement of water supply systems.

21. Promoting food protection along lines of action suggested by PASB, e.g. food safety monitoring.

#### Project SCN-02 Health Promotion

22. The reorientation of services with health promotion and disease prevention criteria that improve the quality and comprehensiveness of the interventions and strengthen the operational capability of the services.

23. Promoting the adoption of healthy lifestyles and risk prevention by out of school youth.

#### Project SCN-03 Health Sector Reform

24. Promoting and supporting the development of human resources.

25. Strengthening and developing programs for the planning, operation, maintenance and renovation of the physical and technology infrastructure of the health sector, including disaster-related activities. Strengthening institutional capacity in the sector for the development and implementation of information systems for programs and services, e.g. human resource development, including the provision of hardware and software.

27. Activities in each project area will be contributing towards human resources training and education.

### ***Objectives for PAHO's Technical Cooperation***

- Cleaner and safer environment sustained.
- Positive lifestyles adopted.
- Ministry of Health will be able to demonstrate more effective and efficient management of health projects.

***Expected Results***

28. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

29. *Research and evaluation studies.* Of environmental health program and that of disaster mitigation, preparedness and response.

30. *Plans, projects and policies.* For implementing health promotion strategies in selected priority areas.

31. *Methods, models and technologies.* To improve the application of health promotion strategies in the environmental health program and that of the management of health services.

32. *Training programs.* To increase human resource development capacity in the Ministry and for environmental protection.

<b>SAINT KITTS AND NEVIS PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health Systems and Services Development	91,400	82,900	0	0
Health Promotion and Protection	40,800	0	0	0
Environmental Protection and Development	30,900	33,700	0	0
Disease Prevention and Control	0	81,100	0	0
<b>Total</b>	<b>163,100</b>	<b>197,700</b>	<b>0</b>	<b>0</b>

# SAINT LUCIA

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## *Health Situation*

1. In 1996, the mid-year population of Saint Lucia was estimated at 147,179, showing an increase of 11,204 over the 1991 Population Census figure of 135,975. The average growth rate was estimated at 1.6%, an increase of 2,000 to 2,500 additional individuals per year. The percentage of the population under 15 years decreased from 44% (1970) to 34% (1996), while those aged 65 years and above accounted for 6% of the population. The dependency ratio dropped from 1.2 in 1970 to 0.68 in 1996.

2. Saint Lucia's economy is agricultural-based, with successful diversification into the tourism sector. In 1997, Saint Lucia's banana industry suffered because of the continued departure of farmers from the industry and the severe dry season. This situation is to be compounded to in the future by the loss of potential markets in Europe as a result of the WTO ruling. Thus, mixed economic prospects are possible in the medium term because of the expected continued growth in visitor arrivals, especially from cruise ships.

3. Following elections in April 1997, Dr. Kenny Anthony, member of the Saint Lucia Labor Party, became the new Prime Minister, interrupting the 30-year rule of Sir John Compton's United Worker's Party.

4. Life expectancy at birth for females and males was estimated in 1995 at 73.3 and 67.5 years, respectively.

5. Crude death rates have leveled off (1986-1995), ranging from 6.0 to 6.8 deaths per 1000 population per year, with rates of 7.3 (males) and 6.0 (females) per 1000.

6. The three leading causes of death for children 0-5 years are conditions originating in the perinatal period (52%), congenital abnormalities (13%), and accidents and adverse effects (7%). In the 15-44 age group the principle causes of death are accidents and adverse effects, malignant neoplasms, heart disease

and external causes, while in the 45 to 64 years old population, leading causes are malignant neoplasm, cerebrovascular diseases, diabetes mellitus and heart disease. Among the 65 years old and over, the main causes of death are heart diseases, cerebrovascular diseases, malignant neoplasms, diabetes mellitus and hypertensive diseases. Chronic non-communicable diseases remain a problem. Plans and programs implementing health promotion strategies would decrease the degree of morbidity and disabilities resulting from these diseases.

7. Other health concerns, which are not reflected in the high mortality rates, are obesity, substance abuse, HIV/STD/AIDS and violence. In 1991, Population Census recorded 67% of the population as being disabled, 46% of whom were in the working age group, with 9% under 15 years of age. Locomotor disabilities accounted for 47% and visual impairment for 24%. Although physiotherapy services are available, the coverage by rehabilitation services and other social welfare provisions remains very limited.

8. The decline of fertility over the past decades is reflected consistently in the decrease in the crude birth rate from 36 live births per 1000 persons in 1986 to 23 in 1996, and reduction of the general fertility rate from 135 live births per 100 women in the child bearing age in 1986 to 91 in 1996. Between 1989 and 1996 data suggest that fertility dropped more among younger women (15 to 24 years) than among the older groups. The proportion of women less than 20 years of age giving birth has fallen from 22% in 1990 to 17% in 1996. The total fertility rate decreased from 3.8 children per women in 1980 to 2.5 children per women in 1996.

9. The disposal of fecal waste into the sea and on land and wastewater disposal in areas with a high water table have contributed to pollution. The treatment and distribution of water from the Roseau dam needs to be improved and the actual incidence of schistosomiasis needs to be established.

10. Solid Waste Management in Castries and its environs is managed by a body created by the Government, with privatization of the collection

system. Landfill management has received funding from GTZ, and CEHI continues to execute this project.

11. The need to improve monitoring and surveillance systems for insect vector control and food safety is critical for the prevention of vectorborne and foodborne diseases in this tourist economy.

12. Health services are available and accessible and are provided by a network of health centers and referral hospitals. To improve management of health services, a management structure that reflects decentralization of authority and normative function at the central level, the capacity to manage at the middle level, coordination of manpower training and strengthening of the health planning process need to be undertaken.

13. The main focus of the Ministry of Health is reforming the health sector in order to improve the quality of health services delivered to the population. The third phase of the EU funded rehabilitation of Victoria hospital will begin during the 1998/99 biennium. The Ministry will also be receiving assistance from the Cuban government to improve psychiatric services.

14. The Ministry of Health is engaging in health sector reform with a view to implementing a National Health Insurance Scheme and to decentralize the authority for the hospital. Emphasis is being placed on community participation in the process. Strong leadership will have to be complemented by management and accountability in both the community services and the hospital services. The new roles of the Ministry of Health will need to be defined.

### ***National Priorities for PAHO's Technical Cooperation***

15. Integration of Health and Human Services to deliver holistic services to families. Better quality and more efficient health services available to all. Promoting a family friendly environment. Health sector reform. Strengthen capacity in Health Promotion. Improve technical and strengthen managerial capacity of staff (team approach to

Planning Management). Financing health system to identify new sources of funding. Environmental issues - waste disposal and water pollution. Improve health information system. Mental Health Women's Health, minimize the impact of STDs, cervical cancer screening. Revitalization of HIV/STD Program. Improve capacity to address child abuse. Programs for promotion of health and prevention of disease/disability to decrease violence; Road safety; Prostate cancer; Diabetes and high blood pressure; Support services for the disabled; Reproductive health.

### ***Technical Cooperation Strategy***

16. Over the biennium 2000 - 2001, the technical cooperation of PAHO CPC will be delivered through three projects: Environmental Health, Health Promotion and Disease Prevention, and Health Systems and Services. Delivery will take place at both the bilateral and subregional levels and will seek to enhance complementarity, including that of CCH II. This work program calls for collaboration of all PAHO units and PAHO CPC. Collaboration with regional institutions, other agencies and community-based organizations will also be pursued. Emphasis will be placed on building capacity and in particular on ensuring sustainability at both the ministry and local institutions, as well as regional institutions (e.g. CEHI) with whom we interact in delivering direct technical assistance.

17. All functional approaches: resource mobilization, training, development of policies, plans and norms; dissemination of information; direct technical assistance and research, will be instrumental in delivery of services, with the training of personnel remaining the single most frequently employed functional approach.

18. The priority areas of the yet to be ratified CCH II initiative are in tone with the areas of this work plan; therefore, no change is anticipated following the introduction of the CCH II.

19. The strategic approaches to be used in the execution of technical cooperation over the period will include: a) capacity building through in-country training to increase the number of skilled personnel and through the use of consultants to work with

nationals over the medium term; b) promotion and facilitation of multi-sectoral action, particularly for health and tourism activities and health promotion projects; and c) increased use of TCC to bring relevant experiences of other Caribbean countries to Saint Lucia and share the experience of its efforts in implementing a biomedical equipment maintenance program child abuse and violence prevention and control programs.

20. The following strategies will be used in the execution of technical cooperation:

**Project SAL-01 Environmental Health**

21. Promoting institutional strengthening and, thus, the regulatory and organizational capacity of the environmental health sector by: developing the standards and regulations governing the quality of waste disposal and minimization; designing and implementing a water surveillance plan promoting food protection along lines of action suggested by PASB.

**Project SAL-02 Health Promotion and Disease Prevention**

22. Supporting the reorientation of services with health promotion and disease prevention criteria to improve the quality and comprehensiveness of the interventions, and to strengthen the operational capability by: evaluating protocols /plans (HIV/STD; adolescent health); assessment of needs for clients of diabetes and hypertension services; training of professionals in violence prevention strategies; social marketing of these strategies

**Project SAL-03 Health Systems and Services Development**

23. Continuing to develop the capacity to analyze the organization and operation of the sector to redefine the role of the central government in organizing and managing public health and personal

health services, within the context of decentralization.

24. Strengthening national capabilities for planning and managing. Regulating human resources through the development of a human resource policy and resource mobilization for training.

### ***Objectives for PAHO's Technical Cooperation***

- Quality of delivery of environmental health services improved.
- Improved quality of family life.
- Implementation Plan for approved HSR policy in progress

### ***Expected Results***

25. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

26. *Surveillance and information systems.* For monitoring water quality.

27. *Standards and guidelines.* To improve liquid and solid waste management.

28. *Research and evaluation studies.* To improve management of selected health programs.

29. *Plans, projects and policies.* To establish quality assurance program and to improve response of health services to violence.

30. *Methods, models and technologies.* To support the HSR process and to improve food safety program.

31. *Direct support.* To develop component of manpower plan and to train manpower.

**SAINT LUCIA  
PROPOSED BUDGET ALLOCATION**

Appropriation Level	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Health Systems and Services Development	116,800	114,800	0	0
Health Promotion and Protection	38,500	33,200	0	0
Environmental Protection and Development	35,000	40,700	0	0
Disease Prevention and Control	0	9,000	0	0
<b>Total</b>	<b>190,300</b>	<b>197,700</b>	<b>0</b>	<b>0</b>

# SAINT VINCENT AND THE GRENADINES

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## *Health Situation*

1. The estimated population of St. Vincent and the Grenadines in 1996 was 111,165, reflecting an increase of 4,716 persons above the 1991 census of 106,499. The population is young, with 37% falling below 15 years of age and 7% aged 65 years and over, that is on a 42% dependency ratio. A female heads 34% of all households.
2. Over the period '92 - '95, GPD grew at 3.5%, that is, half the rate experienced over the previous five-year period. This slow growth reflects the economic importance of the banana industry, which suffered as a result of severe external market conditions and the drought. The Poverty Assessment Report (1996) revealed that 35% of all households (42% of the population) were classified as poor, while 31% of households (36% of the population) were indigent (unable to meet their dietary demands). The percentage of indigents was higher among female headed households (34%), 28% in male headed households and 39% in rural households.
3. Total fertility is approximately 2.8. The crude birth rate was 24 in 1995, with a relatively stable crude death rate of 6.5/1000 inhabitants and a rate of natural increase of 14/1000.
4. With just about 2500 live births annually, the infant mortality rate (IMR) fluctuates from year to year. Using a five year rolling average, the IMR appears to have fallen from 21.3 to 17.6 over the period '90-'94 to '92 -'96. There is a 60% occurrence of infant deaths in the perinatal period.
5. Circulatory diseases comprise the category accounting for the largest proportion (39%) of deaths from known causes, followed by cancers and deaths from external causes.
6. Diabetes mellitus and/or hypertension accounted for one in five consultations at the government run clinics. One out of ten consultations was related to hypertension, whereas 4% of them were due to both hypertension and diabetes.
7. Teenage fertility has remained relatively constant during this decade, with one in five births taking place among mothers younger than 20 years of age.
8. Immunization has been very close to 100% for several years. About 6% of children can be classified as being undernourished (mainly in the mild category).
9. The Government has sought mechanisms to recover the costs of health care delivery. After successfully revising the fees for services at the Kingstown General Hospital, the Government has mandated the National Insurance Board to explore the introduction of a National Health Insurance Program, the definitive studies for which should be completed during the 1998-99 biennium.
10. In addressing health needs, the Government has identified the following priority areas: development of a draft strategic plan; obtaining meaningful morbidity data for chronic diseases; reducing birth rate, including adolescent fertility; environmental health concerns, not only health of the population, but also economic development, especially as it relates to tourism; revitalizing mental health issues, such as providing drug abuse services, which include intersectoral restructuring of community MH and incorporation into the social skills package for schools; linking health of the elderly with other needs to generate national interest and seek consensus; oral health - high incidence of oral/dental problems; nutrition services - how to educate the population and encourage awareness with respect to chronic diseases and antenatal care; widening the focus of health education mass media to use the health promotion approach; consolidating the health information system for sustainability and use in the planning process; through ECDS, strengthen pharmaceutical services and address the high expenditure on pharmaceuticals; more efficient and effective services of higher quality through MOH health reform; infrastructure development (at a cost of \$10M) will include construction of 5 new health centers, completion of the KGH Phase III, Kingstown district clinic, central medical stores and environmental health complex, Rose Hall clinic and Mental Health Center.

## ***National Priorities for PAHO's Technical Cooperation***

11. Improvement of health status and quality of life of the population. Improve efficiency and effectiveness of the Reform of Ministry of Health, intersectorally restructure community health, improve management of pharmaceutical services and revise health legislation. Analysis of human resource development/manpower. Comprehensive chronic disease management using the health promotion approach. Environmental health including: water quality, solid and liquid waste management, vector control, occupational health. Maternal and Child Health/Family Planning. Apply quality improvement concept to all institutions. Improve health information to inform decision-making. Use of health promotion approach, broaden the focus of health education beyond the use of mass media, incorporation of social skills in FLE program of schools. Mental health including drug abuse - development of Mental Health policy. Health of the elderly. Dental health. Nutrition services, food protection. Management of litigation issues. Resource mobilization for infrastructure development.

### ***Technical Cooperation Strategy***

12. Over the 2000 - 2001 biennium, technical cooperation from PAHO CPC will be delivered through three projects: Environmental Health, Health Promotion and Protection, and Health Systems Development. Delivery will occur at both bilateral and subregional levels, and will seek to enhance complementarity, including that of CCH II. This program of action calls for collaboration of all PAHO units and PAHO CPC. Collaboration with regional institutions, other agencies and community-based organizations will also be pursued. Emphasis will be placed on building capacity and in particular on ensuring sustainability at both the ministry and local institutions (school of nursing), as well as regional institutions (e.g. CEHI), with which we collaborate in delivering direct technical assistance.

13. All functional approaches: mobilization of resources; training; development of policies, plans and norms; dissemination of information; direct

technical assistance; and research will be used in the delivery process, with the training of personnel remaining the single most frequently employed functional approach.

14. The development of guidelines, standards and policies feature heavily in the program of cooperation, reflecting the concern of nationals to improve quality of the services delivered. Evaluations and research activities are also in demand owing to the wish of ensuring effectiveness.

15. Priority areas of the CCH II initiative, which is yet to be ratified, are consistent with the areas of this plan of action, and therefore no change is anticipated following the introduction of the CCH II.

16. The strategic approaches to be used in the execution of technical cooperation over the period will include: capacity building through in-country training as a means of increasing the number of skilled personnel, and through the work of consultants with nationals over the medium term; promotion of multi-sectoral action, particularly for health and tourism activities and health promotion projects; increased use of TCC to bring relevant experiences of other Caribbean countries to St. Vincent and the Grenadines, in order to share their pioneering experience in the implementation of a computerized patient classification system; national health insurance plan quality improvement program.

17. The strategies to be used in the execution of technical cooperation are as listed below.

18. Environmental protection and development strategies: Promoting the updating of standards and regulations - waste management; Fostering programs for health promotion and disease prevention in occupational health (including revision of legislation); developing regulatory and technical mechanisms for improved water supply systems; Promoting food protection along the lines suggested by PASB, e.g. food safety monitoring.

19. Health promotion and disease prevention strategies: reorienting services with health promotion and disease prevention criteria that improve the quality and comprehensiveness of the interventions and strengthen the operational capability of the diabetes and hypertension services; expanding the

adoption of healthy lifestyles and risk prevention to other sectors.

20. Health systems and services development strategies: Promoting and supporting the development of national quality assurance programs for health services; Strengthening and developing programs for the planning, operation, maintenance and renovation of the physical and technology infrastructure of the health sector; Strengthening institutional capacity in the sector for the development and implementation of information systems for programs and services.

21. Activities in each project area will contribute towards human resources training and education.

### ***Objectives for PAHO's Technical Cooperation***

- To improve environmental health conditions.
- To reduce mortality and morbidity due to selected conditions.
- To improve management and delivery of health services.

### ***Expected Results***

22. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

23. *Cooperation networks, alliances.* For expansion of IVC programs.

24. *Surveillance and information systems.* To monitor food safety and to strengthen water quality program.

25. *Standards and guidelines.* To regulate private health care facilities and services and to manage Occupational Health program.

26. *Research and evaluation studies.* To evaluate and improve perinatal service and bio-medical equipment maintenance program.

27. *Plans, projects and policies.* To improve adolescent care, for resource mobilization designed to assess contraceptive use, for the development and operation of HIS plan and to propose infrastructure development to support the health sector strategy plan.

28. *Methods, models and technologies.* To implement quality improvement program and to improve pharmaceutical management.

29. *Training programs.* For personnel in Occupational Health.

30. *Direct support.* For training to regulate private health care facilities and services, for Healthy Lifestyles approach, for improving national diabetes and hypertension program and for Human Resource development in Mental Health Program.

<b>SAINT VINCENT AND THE GRENADINES PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health Systems and Services Development	114,000	110,800	0	0
Health Promotion and Protection	34,400	42,400	0	0
Environmental Protection and Development	38,000	44,500	0	0
<b>Total</b>	<b>186,400</b>	<b>197,700</b>	<b>0</b>	<b>0</b>



# SURINAME

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## *Health Situation*

1. Suriname is located on the northeast of South America. Mountainous rain forests cover about 80% of the country. Most of the people live in the flat coastal area. Suriname has an area of 63,037 square miles and a population of about 425,000 as of 31 December 1996. Two-thirds live in or near Paramaribo, the capital, largest city and main port, with a population of 200,000.
2. The Netherlands ruled the country during most of the period from 1667 until 1975, when Suriname gained its independence. The official language is Dutch. In addition, Sarnami, Javanese, Chinese and Saranian are also spoken.
3. The population is composed of many ethnic backgrounds. Hindustanis, who are descendants of people from India, make up more than a third of the population; Creoles with mixed European and Black African ancestry make up about another third of the population. The rest of the population are Indonesians, Japanese, Chinese, Lebanese and Europeans. Each ethnic group has kept its own culture, religion and language. The annual growth rate was 1.9% in 1990, and 1.8% in 1991.
4. During the last four years the economic situation has shown signs of improvement. However, a recent IMF/IDB report points out that continuing the current financial and monetary policies will be disastrous for Suriname. These policies will lead to increasing budget deficits, a rise in foreign loans and deflation of foreign currency.
5. Crude mortality rates have remained fairly constant in the past decade. The crude mortality rate was 6.9 per 1,000 in 1990. Roughly one-third of the medically certified mortality is attributed to heart disease, vascular disease, and diabetes mellitus.
6. Major causes of infant mortality are premature births and obstetric complications. Malnutrition is increasing according to surveillance figures of the B.O.G. Among children 1-4 years of age the leading causes of death are diarrheal disease, acute respiratory infections and accidents.
7. Malaria is endemic in the interior and thousands of people are being infected. Major malaria epidemic continues to develop along the Suriname-river, and it remains the major public health problem for Suriname. Incidents of leprosy have been declining, but there are still a few trouble spots in the interior. Leptospiroses and dengue remain important infectious diseases.
8. Suriname has entered the stage of reconstruction, which is characterized by three processes: 1) The democratization of politics and government resulting in free elections for national and local governing bodies in May 1991; 2) The peace process, resulting in the Peace Treaty of August 1992, bringing a formal end to the war in the interior; and 3) The structural adjustment of the economy.
9. Inflation was 25% in 1991 and much higher (46%) in 1992 and estimated at 125% in 1993; 0.6% in 1995 and 0.8% in 1996, as detailed by ABS, but started to increase steadily again.

10. The exchange rate was stable, but now shows some disturbing fluctuations.

11. In the health sector, external aid continues to ease the shortages of essential drugs and some medical supplies. The problem of skilled personnel leaving hospitals and public health institutions persists as a major problem. Managing health institutions is a real challenge and is still a serious issue to be solved, although improvement in the primary Health Care is being accomplished.

12. The national development strategy of Suriname remains based on the principles of democracy, national dependence and social justice. Decentralization of the governmental systems and participation of local communities in regional government has been deemed specifically important in the strategy for national development. This program has been put in effect in some districts. In defense of the principles of equity and universality, the provision of essential basic health care services in poor urban neighborhoods, rural areas and in the interior, continue to be very important. Strengthening of local health care facilities has top priorities. Expansion of the State Health Insurance Plan for civil servants, in order to include the majority of the population, especially workers and the poor, is an indispensable element of this strategy. All health care programs are developing efforts aimed at special risk groups such as the elderly, the urban poor, rural populations, tribal communities in the interior, women and children. The development of an occupational health program supports the national goal of increased productivity. The anti-malaria campaign has also economic significance.

13. Participation of local communities in the planning and implementation of health care programs through the establishment of district health councils and the organization of district health committees to formulate district health plans is the object of increasing attention.

14. Through increased cooperation with the Ministry of Agriculture, Social Affairs, Regional Development and Natural Resources, and other organizations,

MOH will support efforts to improve the living standards of the population.

15. Health education programs will be strengthened through cooperation with the Ministry of Education and the media.

16. Environmental protection will be another major area for intersectoral cooperation.

17. Cost reduction, increasing cost-benefit ratios and rationalization of health care programs are cornerstones of the strategies of the MOH. Measures related to budgeting (especially for hospitals) are highlights in this area.

18. In order to achieve coordination of the different policies within the health sector and those in other sectors, the manpower capability of the MOH and other institutions in the health care system must be strengthened against continuous erosion by "brain drain", as qualified personnel are joining the private sector or leaving the country.

19. Steps must be taken to: prevent further weakening of the health care system; stop the "brain drain" of trained health workers; replace lost personnel and train new health personnel; improve management, efficiency, cost control and intersectoral coordination in the health care system.

20. The government has highlighted the following priorities in its work plan: More emphasis on primary health care; the provision of essential health care to all inhabitants of Suriname, especially to marginalized populations, and enforcement of social justice; Continuation of the policy of decentralization of services and privatization of governmental institutions; cooperation and specialization among hospitals; Stimulation of health care at home and in the community, consequently discouraging unnecessary referral to costlier levels of care; Cost control measures related to subsidies and tariffs; development of legislation in support of cost control measures; Development of community participation and intersectoral cooperation are crucial, especially

in the areas of food and nutrition, drinking water supplies, sanitary facilities, solid waste and education; Strengthening of preventive services, such as immunization programs, and integration of preventive and curative services; Strengthening of health information systems and epidemiological surveillance as a means to provide policy workers with information on health situation and trends; Development of training programs for health workers so as to increase their capabilities for implementation of primary health care strategies.

### ***National Priorities for PAHO's Technical Cooperation***

21. Establish a National information system. Prevent transmission of vector-borne diseases and food-borne diseases. Improve environmental health management, with an emphasis on potable water, basic sanitation, pollution control, occupational health, vector control and occupational health and safety. Promote healthy settings programs, starting by public markets and schools. Prevent and mitigate natural and man-made disasters. Provide basic health care services to the population based on principles of equity, accessibility and community participation. Provide adequate manpower for the health care system. Reduce morbidity rates. Strengthen cooperation between Suriname and neighboring countries and others in the region. Contribute to the reduction of nutritional problem in vulnerable segments of the populations. Reduce maternal and perinatal mortality. Control of malaria on the basis of PAHO Mission recommendation. Increase the coverage of immunization activities. Improvement of Public Health Administration.

### ***Technical Cooperation Strategy***

22. A major element of the national health strategy is strengthening the Ministry of Health as the central coordinating body in the national health care system, while at the same time decentralizing services to private and semi-private institutions.

23. Activities will continue to bridge the gap between theory versus practice in primary health care by focusing on the strengthening of local health systems by defining the role of the intramural sector in PHC, in addition to improving coordination of health planning at the regional and the national levels, and continue with the integration of BOG, RGD, Medical Mission, COVAB and other institutions in the planning process aimed at the formulation of the BPB, APB and PTC plans embodied in the technical cooperation with PAHO.

24. Establishment and reinforcement of cooperation links geared towards the development of clinics for children aged five and under and the Child Development Bureau, the school health program for development of day care centers, the nutrition program and EPI will be pursued.

25. Crucial elements in this improved cooperation are the joint activities aimed at improving health information systems and supervision "in the field". Review of standards, especially operational standards for day care centers, and for perinatal care, is an integral part of these activities. Conduct surveys to clarify aspects of the population sector under age five, women and school children.

26. The use of pesticides and other chemicals, especially the dumping of mercury lead to pollution of rivers, swamp areas and thus poses a threat to people's health in the interior, as well as endangers fishstocks and wildlife.

27. Activities will continue to be planned with the goal of establishing effective information systems and networks and strengthening prevention, control and treatment services. These activities include control of infectious diseases such as sexually transmitted diseases, tuberculosis, and other vector-borne diseases such as malaria, leptospirosis, filariasis, leishmaniasis, dengue, etc. Leprosy control is also an integral part of the program. Also included are non-communicable diseases such as hypertension, diabetes and cancer. Malaria is transmitted only in the interior, but it constitutes a real health problem that must be controlled. Yellow fever is no longer a

priority public health problem, yet the present fear of dengue makes control of *Aedes aegypti* a must.

28. PAHO will also continue assisting in its support of activities which will be concerned with the maintenance of adequate and acceptable levels of health care services through immunization, control of diarrheal diseases and acute respiratory infections, nutrition, perinatology, and by early detection and treatment of developmental disorders through the Bureau of Child Development (MOB), the clinics for children under five years of age and the school health program.

29. PAHO will continue to cooperate in the development of policies, plans and norms for the MCH program as a whole and particularly for those priority component areas. Particular emphasis will be given to increase the EPI coverage levels.

30. Since diarrheal diseases, including shigellosis, as well as respiratory infections, are major problems, PAHO will continue to cooperate to train physicians, nurses and other health workers throughout the country. Mobilization of resources will be aimed at securing financing for the future development of the MCH program. These activities will continue to have a priority in the 2000 – 2001 biennium.

31. PAHO will make extra efforts to assist in resource mobilization activities which facilitate the participation of university students and staff, professionals and local leaders; increase the level of financial support from outside the country; information dissemination activities focusing on the use of the mass media to raise public awareness on critical health issues, and seminars to conform local, political, religious, and professional leaders; training activities to improve the technical and administrative capacities of supervisory and operations personnel in the health sector; activities involving the development of norms, plans and policies will entail providing assistance in the preparation of legislation and regulations and the decentralization process; studying the use and distribution of trained health professionals, standardizing data gathering and processing procedures. Attention will be placed both

on the consolidation of commitments already being made by other sources, both nationally and internationally. In all of the above program areas particular attention will be assigned to promotion of technical cooperation among countries.

### ***Objectives for PAHO's Technical Cooperation***

- To establish an effective and efficient managerial and administrative support mechanism, for the delivery of technical cooperation activities as well as explore other sources of funds, within the general framework of the strategic and
- To develop formal systems for the cooperation between Suriname, Jamaica, Belize, Guyana, French Guyana, Curacao, Aruba and other regional countries.
- To ensure adequate provision of vaccine, needles and syringes along with the adequate facilities for proper storage and distribution and other safe disposal after use.
- To develop national capacities in management of environment, improvement of drinking water and basic sanitation, and prevention/mitigation of disasters.
- To strengthen development of human resources in all field critical for the sufficient functioning of health services.
- To adjust and consolidate the national disease notification and information (NDNI) system.
- To improve the diagnostic acumen of public and private animal health workers.
- To increase the diagnostic capacity of the veterinary laboratory in Paramaribo.
- To institutionalize the minimum disease monitoring system necessary to protect the interest of farmers and consumers.
- To improve the ability of animal health workers to respond to epidemic and endemic diseases.
- To provide basic preventive and curative services to the population of the coastal area, with special emphasis on underserved population and based on the principles of equity and universality.
- To improve delivery and utilization of pre-, peri-, and post-natal health care services with focus on the under-fives.

- To develop the national nutrition program.
- To strengthen the knowledge, management, prevention and control of communicable and non-communicable diseases (NCD).
- To train staff from NGO's, Government Clinics and Public Health facilities in conducting of AIDS awareness campaigns for the counseling and offering of psych-social support to HIV+ and AIDS patients through workshops.

## *Expected Results*

32. During the 2000-2001, PAHO is committed to developing, jointly with the country, the following expected results:

33. *Cooperation networks, alliances.* Between the Suriname Nurses Association and the Caribbean Nursing Association, amongst all national entities intervening in the Environment Sector; with RGD, BOG, Medical Mission and PAHO for program planning and implementation of EPI; between Suriname, Guyana and French Guyana (including the exchange of information systems).

34. *Surveillance and information systems.* Of drinking water and recreational water quality.

35. *Standards and guidelines.* For the restructuring of the national drinking water sector; on administrative systems and procedures; of EPI diseases surveillance system; of the quality of EPI; on feasibility of the utilization of vaccine; of a considerable number of probable causes of polio and measles; of the Bachelor of Science training program; of the midwifery training program and the school meal program, and for salt imported for human consumption to be fortified with iodine.

36. *Research and evaluation studies.* Of environmental pollution from heavy metals, such as mercury and lead.

37. *Plans, projects and policies.* For a better cervical cancer diagnostic screening at specialized institutions, for the participation of head nurses and unit managers in the design and implementation of COVAB training programs, for an iron supplementation program, in solid waste management, and for an occupational health and safety national action plan.

38. *Methods, models and technologies.* To review the curriculum for nursing, for nutritional data collection (from under five clinics), analysis and feedback (at BOG).

39. *Training programs.* Of key-persons, health workers and teachers in local communities, to develop a network of health educators at the local level, for human resources responsible for Veterinary Laboratory procedures, to improve staff qualifications on selected non-communicable disease, for administrative systems and procedures, for meat/poultry inspection, for veterinary services, for meat technology and hygiene in the private sector, and for national physiotherapists.

40. *Promotional campaigns and advocacy.* Of Healthy Settings (schools, public markets, etc.) program.

41. *Direct support.* In the control of malaria in migrating and border area population, on EPI in border area population, and for regional cooperative links in the area of human resource development and training.

**SURINAME  
PROPOSED BUDGET ALLOCATION**

Appropriation Level	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Health in Human Development	717,300	737,300	0	0
Health Systems and Services Development	112,000	106,000	674,000	0
Health Promotion and Protection	32,300	58,600	0	0
Environmental Protection and Development	336,600	344,600	0	0
Disease Prevention and Control	159,000	110,700	14,400	2,500
<b>Total</b>	<b>1,357,200</b>	<b>1,357,200</b>	<b>688,400</b>	<b>2,500</b>

# TRINIDAD AND TOBAGO

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## *Health Situation*

1. The 1990 census reported a population of 1,238,800. The average annual growth rate was 1.1 percent over the period 1980-1995 and is projected to remain relatively unchanged between 1995 and 2000. The slowing of the population growth rate is partly due to declines in the total fertility rate (2.4 per 1000) and crude birth rate (19.7 per 1000 in 1990 and 15.8 per 1000 in 1995), combined with a stable crude death rate (6.7 per 1000 in 1990 and 7.1 per 1000 in 1995), and the stabilizing of the substantial out-migration between 1980 and 1990 (estimated at 131,918).

2. The age-sex structure has been moving from the broad-based developing country population pyramid of 1960 to a more transitional constrictive shaped population pyramid, with 30 percent of the population still under 15 years of age, and 6 percent over 65. By 2010, the over-65 population is expected to increase to 7.5 percent of the total population.

3. The life expectancy at birth continues to improve, and in 1990 it was 72.7 for females and 69.3 for males. However, much of the gain in life expectancy at birth has been in the under - 15 age group, with less than a year gain at age 65 between 1980 and 1990.

4. Mortality causes in 1994 are ranked as follows: diseases of the circulatory system (39.7%); tumors (13.4%); diabetes (12.5%); communicable diseases (12.5%); external causes (7.3%); and certain conditions originating in the perinatal period (1.9%).

5. Mortality data since the 1960s have indicated the importance of lifestyle related diseases. Two major studies in the 1970s (i.e. the St. James Cardiovascular Study and the Plymouth Bethesda Study) quantified the risk factors and identified the attendant target

groups. In 1990, a KAP study on chronic diseases indicated that tobacco, alcohol, exercise and nutrition were the factors that needed most attention.

6. Food available to the population is sufficient to meet its basic needs, with an excess of energy (30%), protein (60%) and fat (50%). A National Nutrition Policy is being formulated with a focus on the prevention of non-communicable diseases. The Trinidad and Tobago Association of Dietitians and Nutritionists has issued guidelines on healthy eating.

7. The National Health Survey (1995) indicated that although a majority of adults know that regular physical activity is good for their health, less than 20 percent meet the criteria of 30 minutes of regular exercise 3 times weekly.

8. Since 1997, the Ministry of Sports has been working on a plan to promote physical activity in the community. There has also been a noticeable increase in the number of both commercial and NGO-sponsored physical activity events.

9. As is well known, PAHO (TRT) has undertaken an annual 5K Fun Run/Walkathon as a health promotion initiative for the past seven (7) years. This event has been a resounding success and is included in the annual calendar of Trinidad and Tobago's road running events.

10. Domestic violence continues to make headlines in the media on a regular basis, but it is difficult to quantify it. Fourteen percent of males 15 years and over reported sustaining an injury in the past year, as well as 7 percent of females. Male injury was maximal at age 15-24 and declined in older age groups, while injury rates in females increased with age. Mortality rates indicate an increase in intentional injury and a decline in accidents.

11. The Ministry of Health has now stated that injury prevention is one of its priorities, and in this

regard there have been improvements in the Accident and Emergency departments, CPR and triage training for health workers who man these areas. Suicide is the second leading cause of injury related deaths and is a major problem in the 15-24 age group. Insecticide ingestion is the most commonly used method and measures to control the availability, storage and distribution of these toxic chemicals need to be brought to the forefront.

12. The Government has placed crime reduction as one of its main priorities. Further steps have been taken to revise the legislative framework, modernize the judicial system and increase the coverage of protective services.

13. PAHO has also provided assistance, under its HSS project, by funding training in trauma, health promotion programs in schools dealing with gender awareness, conflict resolution and life skills.

14. Thirteen percent of males age 15-24 and 30% of all males over 15 (NHS 1995) report that they have smoked 100 or more cigarettes in their lifetime. Prevalence was highest (37.6%) in the 35-44 age group and declined in older age groups.

15. It is worth noting that smoking prevalence was significantly higher in households reporting low per capita incomes and among less well educated respondents. The Ministry of Health now has a non-smoking policy aimed at making all publicly-funded health institutions smoke-free, discouraging its organizations from using funds obtained from tobacco companies for sponsoring health events and informing all prospective employees when they apply for jobs that the Ministry of Health and its associates have a no-smoking policy. PAHO in collaboration with the NADAPP, the Cancer Society, the Ministry of Health and other agencies, promotes awareness of tobacco use on World No Tobacco Day.

16. Although there are a number of regulations pertaining to alcohol control, they are not effectively enforced. Some education and health promotion

takes place in schools, work places and amid the community, but it is far from adequate. The breathalyzer is now being tested and hopefully this will signal a more effective approach to alcohol control.

17. A significant proportion of the population of Trinidad and Tobago does not have access to mental health services despite efforts to distribute the services. There are five major problem areas in mental health: psychiatric emergencies; longstanding psychiatric conditions; ambulatory services at secondary levels and in-patients at acute care hospitals; psychiatric and emotional problems of high-risk groups; and lack of promotion of mental wellness.

18. A PAHO-supported Mental Health Plan is currently being devised. It stresses a complete systematic approach for integrating mental health into primary care with an adequate referral system and partial decentralization of services.

19. Surveillance of mosquito borne diseases was stepped up in 1996-1997, particularly as it applies to the control of dengue and dengue hemorrhage fever. Emphasis has been placed on community-based interventions rather than insecticide control. At the request of the GOTT, PAHO brought in an expert on Dengue from Cuba in early 1998 to provide guidance and direction in the control of Dengue and Dengue Hemorrhage Fever.

20. Immunization programs are well organized and continue to have consistently high rates of success and coverage.

21. Communicable diseases are still a major cause of death and morbidity in Trinidad and Tobago, causing 12.5% of deaths. They are the second most frequent causes of admission to acute-stay hospitals (8%).

22. The AIDS epidemic continues to cause premature death among sexually active males and

females and the children of HIV positive mothers (71.7% and 7.2%, respectively, of total AIDS deaths in 1983-1995). The pattern of this disease in Trinidad is that of heterosexual transmission (51.9% of cases in 1983-1995).

23. Incidence rates are still rising (from 14.0% in 1990 to 27.2% in 1995), as well as the laboratory reported HIV, and this trend is expected to continue. PAHO has continued to provide direct assistance to the National AIDS Program through its HST project and has complemented this with other measures adopted through the UNAIDS consortium.

24. The major institutional inhibitions to foster progress in the formulation and implementation of national health policies and strategies over the past three (3) decades have been identified as: the centralized nature of decision making in the Ministry of Health; the rigid financial and personnel regulations within the public health sector; the absence of the organizational capacity, in terms of skills and systems, in the central Ministry of Health for this role.

25. Significant progress has been made towards removing these constraints by the Government of Trinidad and Tobago (GOTT), which is embarking on a Health Sector Reform Program in 1995 funded by the InterAmerican Development Bank.

26. PAHO has played a significant role over the past four (4) years in strengthening the managerial capabilities of the national counterparts to tackle the HSRP under the IDB Loan Agreement.

27. The Government of Trinidad and Tobago has made consistent efforts to develop national environmental health strategies, but these have been constrained by the fact that responsibility for the myriad of different activities is spread across many different Government Ministries and Agencies with no lead agency empowered to manage.

28. In pursuit of its stated commitment to safeguarding the environment, the Government created a Statutory Body - the Environmental Management Authority (EMA), which is responsible for the coordination of the activities of the several agencies directly concerned with the preservation of the environment.

29. It is to be noted that PAHO supported several workshops and consultancies which resulted in the establishment of a National Commission for Health, Environment and Development.

30. The deteriorating state of the physical infrastructure, including equipment, is of particular concern to the Ministry of Health and the Regional Health Authorities. This is attributed to the lack of ongoing preventive and routine maintenance systems. In order to address the issue of the sustainability of investment in physical infrastructure, a National Health Service Plan was developed, which is one of the major outputs of the Health Sector Reform Program funded by the InterAmerican Development Bank.

31. With PAHO's support, the Ministry of Health has developed national policies aimed at the provision of safe and effective drugs.

32. As a middle income country, Trinidad and Tobago does not qualify for major donor assistance. Major assistance comes from PAHO, UNDP and, in 1995, from the IDB, namely the financing of the Health Sector Reform Program.

33. Over the last two decades, Trinidad and Tobago has made substantial progress in controlling communicable diseases and reducing infant mortality. The country is now undergoing demographic and epidemiological transitions, which in turn has resulted in a shift in the major causes of morbidity and mortality towards chronic conditions and non-communicable diseases, including diabetes, hypertension, and cancer.

34. While the gains to date have resulted in improved health status, the sustainability of these successes may be at risk, since the system is unable to respond in a timely and cost effective manner to the changing needs of the population.

35. Accordingly, the Government of Trinidad and Tobago has embarked on Phase I of a comprehensive Health Sector Reform Program (funded by an IDB loan), in which the key objectives are: strengthening policy-making, planning and management capacity of the health sector; separating the provision of services from financing the regulatory responsibilities; shifting public expenditure and influencing the re-direction of private expenditure to high priority problems and cost effective solutions; establishing new administrative and employment structures which encourage accountability, increased autonomy and appropriate incentives to improve productivity and efficiency; and reducing preventable morbidity and mortality through promotion of lifestyle changes and other social interventions.

36. The new program strategies are: reform of the Ministry of Health in order to make it a policy, planning, sponsorship and regulatory body; devolution of service delivery and management of five (5) regional health authorities; development of a human resources strategy; rationalization of health services and infrastructure to focus on cost-effective and high priority interventions; emphasizing preventive and promotive services and strengthening primary care; and development of a comprehensive financing strategy for the health sector.

### ***National Priorities for PAHO's Technical Cooperation***

37. Healthy lifestyles and behaviors adopted by the population of Trinidad and Tobago. Surveillance systems developed to inform appropriate development of health services. Health Sector Reform program is operationalized and implemented. Support for the development and implementation of management systems at Central and Regional levels

which include financial, information, human resource, quality assurance and accreditation. Support for the implementation of the National Health Services Plan to include: strengthening of the referral system within primary care and between primary and hospital services and the strengthening of the support services including diagnostic and pharmacy services. Incidence of non-communicable diseases and vaccine preventable diseases reduced. Support activities aimed at extending water and sanitation services to vulnerable groups addressing problems associated with intermittent water supplies, poor sewage disposal and alleviation of air, water and soil pollution in critical areas. Support provided for the development of health sector agencies and intersectoral partners to assess and control environmental health risks. To establish national capacity in food borne disease surveillance and control. To improve reproductive health, health of the population of Trinidad and Tobago. Health public policy developed nationally which promote poverty alleviation and health of the population. Identification and mobilization of government and non-governmental resources at national and international levels to assist in the delivery of quality health services and the more efficient use of resources. To realize the decentralization of the health services and to reach an agreement on administrative linkages between the RHAs and Central Ministry of Health.

### ***Technical Cooperation Strategy***

38. It is envisaged that at the beginning of the new millennium, delivery of environmental health services will become the shared responsibility of the regional health authorities and the local government. In order to ensure good quality and equitable coverage, the development of norms and procedures in the provision of these services is essential.

39. Review of existing services, development of procedural manuals and surveillance systems, adoption of national standards and regulations, as well as training of public health officers, are all activities that will assist in the smooth process of decentralization of environmental health services from the Ministry of Health to the Regional Health

Authorities and the Regional Corporations of Local Government.

40. Community involvement is an important resource of primary environmental health care and primary public health care, particularly in the areas of water and sanitation and vector control. Promotional campaigns improve public awareness and empower communities to become involved in improving their own health conditions.

41. Support will be provided in the areas of strengthening and sustaining programs in EPI, disease surveillance and in promoting integrated care of chronic diseases. The focus will also include improvement of quality of care and provider client communication.

42. Technical cooperation will be delivered through the enhancement of staff skills in communication as well as clinical management, dissemination of information, and development of policies and plans in the development and revision of protocols.

43. Support will be directed towards strengthening the capacity of the Ministry of Health and Regional Health Authorities to lead the intersectoral process in the promotion of healthy lifestyles utilizing the strategies outlined in the Caribbean Charter of Health Promotion. In addition, the promotion of "healthy communities" will be the main strategy for promoting community involvement and intersectoral collaboration in promoting wellness.

44. Technical cooperation will be delivered through the enhancement of the skills of health personnel, thereby enabling them to lead initiatives in health promotion, dissemination of information, and direct cooperation in supporting projects in regional health authorities, local government and communities.

45. Technical cooperation will focus on assisting the Ministry of Health in strengthening its participation in policy development and policy setting across

various sectors. In addition, the project will also assist the Ministry of Health in leading the intersectoral process and developing projects and plans with other Ministries, with particular reference to the social sector Ministries such as the Ministry of Social and Community Development and the Ministry of Culture and Women's Affairs.

46. Support will be provided for development of an integrated surveillance system to support health situation analysis at both regional and national levels. Technical cooperation will be delivered through development of plans and procedures for such a system, as well as strengthening the capacity of human resources in use of the system.

47. Support will be provided to monitor and evaluate quality of care in reproductive health services as well as to increase community participation in planning and improving services. In addition, support will be provided to enhance the skills of staff in clinical management, as well as in counseling in the area of adolescent and reproductive health.

48. Technical cooperation will support the development of human resources and basic systems to facilitate the operationalization of the Health Sector Reform Program. A major strategy will be to support the development of procedures and guidelines, as well as training of operational managers in the use of these regulatory instruments, to enable RHAs to carry out their mandate of service provision. Strengthening the capacity to provide appropriate education of health professionals, in keeping with the objectives of health sector reform, is also a major direction, to be accomplished through various studies and reviews as well as through the Fellowship program.

### ***Objectives for PAHO's Technical Cooperation***

- The capacity of nationals developed in food borne disease surveillance and control with particular emphasis on veterinary public health.

- The capacity of the government and non-government sectors and communities to undertake disease prevention and control programs strengthened.
- To strengthen the capacity of national agencies and communities to carry out their responsibilities to improve the state of health and well-being of the population at the national and local levels.
- To strengthen the capacity of the public sector, NGO's and other agencies to incorporate elements for improving health and addressing issues of gender and equity in their development plans.
- To strengthen the capacity of the health sector to provide quality services in reproductive health.
- To develop the human and institutional capacity so as to assess and control health risks associated with environmental hazards and to promote improvements in water and sanitation.
- To strengthen the surveillance and control of vector borne diseases.
- To increase the capacity of MOH and RHAs for the collection, analysis, interpretation, and dissemination of health information for control of disease.
- To strengthen human resources and basic systems development to support operationalization of Health Sector Reform program.
- To strengthen the managerial capabilities of the Representation's internal operations with a view to improve the level and scope of their technical cooperation program.
- To improve the teaching curricula at the College of Health Sciences (NIHERST/TRT) and the Natuur Technisch Instituut Middelbare Beroepsopleidingen(NATIN-MBO/SUR) to meet CARICOM and EU criteria.

## ***Expected Results***

49. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

50. *Surveillance and information systems.* For Veterinary Public Health, for environmental health

and occupational health and safety, and for chronic diseases.

51. *Standards and guidelines.* In National food safety, to support effective implementation of the disease prevention and control project, to strengthen the vaccine control programs, which promote greater intersectoral collaboration in development of social sector plans which impact on health, of WHO adapted to develop national standards and guidelines, for public health and clinical management of STDs, for procedures and standards in National Food Safety, to detail surveillance system plan, for patient referral system, to improve the quality of care for diabetes and hypertension, and for health technology assessment system developed to support health sector reform program.

52. *Research and evaluation studies.* To support cancer control programs, of performance of health personnel regarding compliance with communicable disease control guidelines, of results of Strategic Plan for Nursing 1995-1999, of health situation and health professions' curricula, and of methodologies for health promotion initiatives in schools and communities.

53. *Plans, projects and policies.* Incorporating the strategies outlined in the Caribbean Charter on Health Promotion, to improve the health of adolescents, for development of an accreditation/certification system for water/waste water plant operators, for Healthy Spaces project, for the treatment and disposal of animal wastes, for community participation in vector control, for port health vector control training, for operationalization of surveillance system, and to support implementation of National Oral Health Policy and National Drug Policy.

54. *Methods, models and technologies.* To strengthen the vaccine control programs.

55. *Training programs.* For RHA's in food safety, to undertake effective vaccine control programs, to

undertake chronic disease control programs and several communications and community mobilization tasks and policy development, analysis and quality work in reproductive health, on integrated vector control for all RHAs, on environmental health, in management skills in RHAs to support implementation of HSRP, in technical skills to support Health Sector Reform program objectives, and in Disaster Preparedness and Response.

56. *Promotional campaigns and advocacy.* To advance the concept of healthy lifestyles in school settings with an emphasis on violence reduction and conflict resolution, of mental health and wellness plans in all RHAs, of the importance of interaction between the sexes, health and development, and of environmental health protection.

57. *Direct support.* To strengthen healthy settings approach in health promotion.

<b>TRINIDAD AND TOBAGO PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health in Human Development	947,900	952,200	0	0
Health Systems and Services Development	813,400	810,200	0	0
Health Promotion and Protection	29,000	27,300	0	0
Environmental Protection and Development	348,300	351,100	0	0
Disease Prevention and Control	101,100	108,900	0	0
<b>Total</b>	<b>2,239,700</b>	<b>2,249,700</b>	<b>0</b>	<b>0</b>



# TURKS AND CAICOS ISLANDS

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## *Health Situation*

1. The Turks and Caicos Islands is a 417 square kilometer multi-island territory of approximately 40 islands and cays located at the end of the Bahamas chain. It comprises eight main islands, six of which are inhabited by the majority of the population, which resides on two main islands. At the time of the 1990 census, of 12,350 persons present on the island, 11,465 were residents. Of those residents, 7,901 (69%) were classified as native to the islands. Grand Turk, the administrative center, had a population of 3,691 whereas Providenciales, the business center, had 4,821. The 1996 population has been estimated to be somewhere around 19,000-22,000 by the Statistical Unit, and around 14,500 by UNDP. It is estimated to have grown at a faster rate between 1990-1996 than it did between 1980-1990 (4.46% per annum), much of this because of immigration influx. Due to economic and political problems in Haiti, there has been a considerable flow of nationals from Haiti to the TCI, which create an added burden for the health services.

2. Major development continues to take place in Providentials with the fastest growing population, and therefore great attention is being paid to the improvement of the range and quality of services on that island.

3. Because of the limited expertise and technology available in the country, Government expenditure on overseas medical treatment and hospitalization is quite high.

4. Following elections in 1995, Health Services is now the jurisdiction of the Ministry of Health, Education, Youth and Sport, the Permanent Secretary (Health Services) being given responsibility for health issues. As a result of the Health Sector Adjustment Project the management structure of Health Services was revamped to make allowance for the position of a Health Service Manager who would be responsible for the administrative aspects, traditionally the domain of the Chief Medical Officer, leaving the CMO to concentrate on clinical and technical public health matters. Since then there have been two different persons in that position, thus disrupting continuity. Other changes included the

creation of the position of Primary Health Care Manager. These positions came about through redesignation and reallocation of duties.

5. The Health Service comprises a 36 bed hospital on Grand Turk, the newly commissioned secondary care facility Myrtle Rigby Health Complex (12 beds), in Providentials, and 10 clinics scattered throughout the islands. There have been expressions of dissatisfaction with the quality of care provided at the main hospital and in response a Nursing Policy Manual has been developed and is now being used.

6. There are a large number of ex-patriot staff within the Health services mainly from the Caribbean. There are no national doctors and in nursing, the largest number of health care workers, almost 50% are ex-patriot. Similar situations exist in the support services and environmental health sectors. Therefore, the number one priority is human resource development, and PAHO has been asked to support this endeavor.

7. The islands have limited natural resources, little vegetation and restricted agricultural potential, hence the increasing importance of tourism. Expansion of the tourism sector places increasing pressure on the fragile natural environment and threatens the islands sustainable development prospects. These factors call into question the ability of the country to maintain its current 5% average annual economic growth. UNDP is to help the government in the creation of a national integrated development plan that will put into place procedures for determining the islands' priorities to this end for a 10-year period. The plan will emphasize a multi-sectoral approach addressing in particular development needs in the areas of health, population, education, tourism and economic and social development.

8. Health sector reform is still a current issue with the Ministry of Health, but at this time it is not clear in which direction the services will go. However, there are certain underlying issues which must be addressed regardless of the health services design.

9. There is no organized health information system and raw data has to be analyzed from the death registry maintained by the Public Health Department, and from the records at Grand Turk Hospital in order

to obtain the health situation profile. Technical support is badly needed for the development of a Health Information Unit. Although assistance has been previously provided through the Health Services Adjustment Project, PAHO has been requested to provide further assistance.

10. Over the past two decades, particularly in the past 5 years, mortality trends indicate an overall increase in number of deaths. Deaths increased from 67 to 89 between 1993-1995 and reached 70 in 1996. (Rates cannot be calculated in the absence of a known population base.) In 1996, 24 (32%) of the deaths were recorded as due to Cardio-pulmonary arrest or were unstated. This year has therefore been omitted from the analysis of causes of death. The largest number of deaths occur in the 65 year and over age group with more than 50% in the 45 year and over age group.

11. From 1994-1995, the most commonly recorded causes of death were cardiovascular disease (19%), cerebrovascular disease and AIDS (14%), accidents and violence (11%) and cancer (8%). In the (20-44) age group out of 35 deaths, the most common causes were AIDS (46%), cardiovascular disease (20%) and accidents and violence (9%), conditions which are largely preventable by lifestyle changes. Since 1994, a Health Promotion Committee has been established to devise and implement strategies to deal with this situation. There is a need for continuing efforts and PAHO will be providing support.

12. In terms of AIDS deaths, between 1993-1996 there has been a downward trend from 12 to 7. This may reflect an actual improvement in the situation or the fact that expatriates are returning to their homeland to die. Since 1995 ODA assistance to the AIDS program was discontinued and currently it has not been included in the UNAIDS program. Activities are therefore totally funded through the national budget. This raises some concern as to whether it can be sustained at the previous level.

13. Very few deaths occur during childhood and adolescence. During the three year period only 2 deaths were recorded in the (1-4) age group, and 4 in the (15-19) age group, all due to accidents and violence.

14. Except for 1994, when there was a decline, there has been a steady increase in births during 1993-1996 (311-336). Total infant deaths have also been increasing from 2 in 1992 to 9 in 1996. The infant

mortality rate for 1991 was 11.9%, while during 1994-1996 it was 24.6 per 1000 live births with a stillbirth rate of 19.29 per 1000 live births. Some 60.9% of infant deaths took place during the perinatal period. The Government has responded by concentrating on upgrading the skills of midwives, and will have to continue doing this, (because of the high mobility of the expatriate staff), until adequate numbers of nationals have been trained. PAHO is to cooperate in this effort.

15. Over the last two decades, there has been a reduction in the crude birth rate from 33.3 per 1000 population in 1990 to 18.6 in 1995. In spite of this decline, the pregnancy rate has been on the increase, particularly among teens. Hospital admissions in 1996 show abortions as one of the leading causes for admission.

16. In 1996 there were 224 deliveries registered at Grand Turk Hospital, of which 153 (68%) were recorded as normal and an additional 51 (23%) were by cesarean section. The reason for this level of LSCS is unclear. The majority of births (41%) were among women in the 20-29 age group, with 20% being among women 30-39 and 10% among women under 20 years of age. Of these women giving birth one was a teenager under 15 years old and two were teenagers between 15-19.

17. No analysis is available on the causes of hospital admissions or reasons for ambulatory care services. It is imperative that some system of health information collection and analysis be instituted as soon as possible so as to be able to plan for improvement in health status in the Turks and Caicos, as well as to evaluate the process.

18. Although the degree of food borne diseases is not known, there is great concern because of the intermittent outbreaks and the rapidly growing tourism sector. The need for stricter attention to food safety is therefore obvious. Cooperation has been provided in the past for improvement in food handling practices, and this is expected to continue.

19. Given the importance of tourism for the TCI economy, environmental protection for sustainable development is imperative. This growing sector has impelled demand on the supply of water and wastewater services. Additionally, pressure for development in the coastal zone has raised concerns about pollution. PAHO will continue to cooperate with the national authorities in this area.

## ***National Priorities for PAHO's Technical Cooperation***

20. Develop and build capacity of human resources at all levels aimed at preparing nationals to assume full responsibility for the functioning of Health Services. Build capacity in the design, planning, implementation and evaluation of projects. Maintenance of the fragile natural environment in the face of rapid expansion of the tourism plant capacity, to ensure sustainable development. Replacement/upgrading of the physical plant of the Grand Turk hospital. Strengthening of processes and systems for improving professional and service standards. Control of lifestyle and nutrition related chronic non-communicable diseases with emphasis on mental health, drug abuse and obesity. Evaluation of health promotion program with a view to strengthening that program. Improved food and nutritional status of the population. Control of communicable diseases with special attention to HIV/AIDS and food borne illnesses/food safety. Further development of the health information system, with particular attention to communicable and chronic non-communicable diseases. Continued strengthening of disaster preparedness capabilities. Environmental conditions have improved and associated health risks are reduced.

### ***Technical Cooperation Strategy***

21. PAHO's technical cooperation will be delivered through two projects - Health Services Development and Environmental Protection and Development. Each project will be the responsibility of a specific technical officer. In the case of a multidisciplinary project, a different officer may be given responsibility for specific expected results in the project.

22. Most of the technical cooperation will be devoted to training, both at the local and international level. The areas in which training will be provided have not yet been disclosed, but will include at least disease surveillance, disaster management, and nutrition. TCI will curriculum development and preparation of training materials.

23. Direct technical cooperation will be provided in the areas of disaster mitigation and management, environmental protection and health promotion. Norms and policies will be developed for the

operation of the health information system and the community of the hospital and in nutritional aspects of chronic diseases.

24. A significant portion of program evaluation will be carried out to set the pace for the next biennium.

25. Information dissemination will be the basis for health promotion, but will also be used in promoting regional cooperation in PAHO priority areas and initiatives.

## ***Objectives for PAHO's Technical Cooperation***

- To put in place the systems and adequately trained human resources to ensure good quality clinical and community services.
- To strengthen national capacity to control, regulate, monitor and protect natural resources and manmade environments.

### ***Expected Results***

26. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

27. *Surveillance and information systems.* For selected health programs.

28. *Standards and guidelines.* For diet and exercise adapted for use in the country.

29. *Research and evaluation studies.* On food protection/safety program in the hotel industry; on health education; and to determine nutrition status of school population.

30. *Plans, projects and policies.* For the commissioning of the new Grand Turk hospital; and for national drinking water quality monitoring.

31. *Training programs.* In the areas identified as crucial to the proper functioning of the health services; for improving disaster preparedness in selected family islands; in water quality and wastewater plant monitoring; and in monitoring management of hazardous waste.

**TURKS AND CAICOS ISLANDS  
PROPOSED BUDGET ALLOCATION**

Appropriation Level	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Health in Human Development	10,100	4,900	0	0
Health Systems and Services Development	31,000	54,000	0	0
Health Promotion and Protection	23,100	4,600	0	0
Environmental Protection and Development	11,900	12,600	0	0
<b>Total</b>	<b>76,100</b>	<b>76,100</b>	<b>0</b>	<b>0</b>

# UNITED STATES OF AMERICA

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## *Health Situation*

1. The health situation of United States residents has improved in the last 10 years. Between 1990 and 1995, overall life expectancy at birth increased from 75.4 years to 75.8 years. By 1995, a person who had reached the age of 60 years could expect to live an average of 21.1 more years, for a total of 81.1 years. A person reaching the age of 65 could expect to live an average of 17.4 more years, to 82.4 years. The resident population of the United States totaled 263 million in 1995, a 6% increase over the 1990 population. Between 1990 and 1995, the population 75-84 years of age grew by 11% to 11 million, and the population 85 years and older grew by 20% to 3.6 million. The black population increased by 8%, to 33 million, and the Hispanic population increased by 20%, to 27 million. The Asian and Pacific Islander population grew by 24%, reaching 9 million persons.

2. Growth has been much faster among racial/ethnic minority populations than the majority non-Hispanic white population over the past two decades, a trend that is expected to continue for at least the next 30 years. It is projected that the black population will increase 35% from 1990 to the year 2020, while the population of other minority groups (mostly Asians and Pacific Islanders, but also American Indian/Alaskan Natives) will more than double. The Hispanic population is expected to rise by 84%. The projected increase in the non-Hispanic white population during this period is only 11%.

3. While chronic disease conditions are the leading causes of death for both minority and non-minority persons over 45 years of age, minority populations (Blacks, Hispanics, Native Americans, and Asian American/Pacific Islanders) incur a disproportionate share of death, illness, disability, and adverse health conditions. Commonly used health indicators such as life expectancy at birth and infant mortality rates show continued widening of the health gap between minority and majority populations. Poverty is a major contributing factor to the disparities in health status. An estimated 36 million people were living in poverty in 1995. The national poverty rate was 13.8% in 1995, compared with 15.1% in 1993. The

poverty rate among blacks, the largest minority group, was 29.3% -- nearly triple the rate among the white population. Nonetheless, the Department of Health and Human Services has committed itself to the elimination of disparities in health.

4. National health expenditures in 1995 were US\$988.5 billion, up from US\$937.1 billion in 1994. Growth in health spending in 1995 was slightly higher than the 5.1% increase registered in 1994, while spending rose by US\$156 per person from US\$3,465 in 1994. Growth in the nation's health care spending decelerated steadily from annual double-digit and near double-digit increases in the 1980s and early 1990s to 6.9% in 1993. The growth rates for 1994 and 1995 are the lowest in more than 30 years. National health expenditures represented 13.6% of the gross domestic product in 1995.

5. The health care system in the United States relies heavily on the provision of payment for medical care through private insurance. Private insurance provided by employers or purchased individually covers about three-quarters of the population; 14% of the population has no medical coverage at all.

6. Medicare and Medicaid funded about 36% of all spending for personal health care in 1995 and accounted for 80.9% of the public share of health care financing. These two programs financed 47% of hospital care and about 26-29% of physician services. Medicare, created in 1965, was designed to protect people 65 and older from the high costs of medical care. In 1972, it was expanded to cover other populations such as disabled workers and people with end-stage renal disease. Unlike other federal health programs, Medicare is not financed solely from the general revenue. In 1995, 85.4% of the hospital insurance portion of the program came from a 1.45% payroll tax levied on both employers and employees. The Supplemental Medical Insurance portion of Medicare that covers physician services is financed through monthly premiums paid by the 35.7 million beneficiaries.

7. Spending has grown faster for Medicare than the private sector, primarily because the private sector has garnered greater savings from managed care.

Medicare must base its managed care payments on a formula related to Medicare free-for-service costs. Therefore, under current law, Medicare may not benefit from discounts and other factors that generate savings for the private sector. This is a primary reason why private sector spending grew at a rate of 2.9% in 1995 while public sector spending grew by 8.7% in that year.

8. Managed care is characterized by its emphasis on preventive care, elimination of unnecessary services, negotiated price discounts, and smaller copayments and deductibles. More than half of the U.S. population was enrolled in managed care in 1995. There are increasing signs that managed care customers, long accustomed to third party/fee-for-service arrangements, are not happy with restrictions placed upon them by managed care companies. This has resulted in dozens of legislative initiatives being introduced at the state and federal levels to define basic rights of patients under managed care.

9. Medicaid, also initiated in 1965, is a combined state-federal program intended to provide services to the poor. The federal government determines broad eligibility guidelines and mandatory services. Individual states have the option of expanding the basic coverage package by offering additional services. In 1995, Medicaid provided services to 36.3 million people and had actual expenditures of US\$328.9 billion.

10. Medicaid expenditures are mostly institutional, with 39.1% spent on hospital care and 27.2% spent on nursing home care. It is the largest third-party payer of long-term care expenditures, and financed 46.5% of nursing home care in 1995. One-fourth of program benefits went to poor Medicaid recipients, while the blind and disabled, who account for only one-third of the Medicaid population, used three-fourths of the benefits.

11. The most comprehensive U.S. policy to improve health and prevent adverse health conditions is called Healthy People 2000. The central goal is to increase the number of people who live long, healthy, and disability-free lives. The second goal of the plan calls for the elimination of disparities in health among population groups. The third goal of the strategy is to achieve access to clinical preventive services for all people.

12. As overall coordinator of Healthy People 2000, the Office of Disease Prevention and Health Promotion, a program office in the Department of Health and Human Services, works with Public Health Service agencies, other federal agencies and departments, and members of the Healthy People consortium. The Consortium consists of 345 national membership organizations representing professional, voluntary, and corporate interests and 271 state agencies that collaborate to support the prevention agenda and achieve the year 2000 goals. The Consortium members have worked on revising and adding to the year 2000 objectives and many have participated in periodic progress reviews chaired by the Assistant Secretary for Health.

13. In 1994, the Public Health Service undertook a midcourse review of the Healthy People 2000 objectives. The resulting review document showed that of the 300 objectives, 50% were moving toward the target, 18% were moving away from the target, 3% showed no change, and 29% had insufficient data to measure progress. As of 1997, 44 states, the District of Columbia, and Guam had published Healthy People 2000 plans of their own. By 1993, 70% of local health departments were using Healthy People objectives.

14. At the 1996 meeting of the Healthy People Consortium, at which PAHO was represented, the foundation was laid for the third generation of these objectives, Healthy People 2010, which will be released in January 2000. Consortium members and federal, state, and local agencies are collaborating to develop a set of objectives that will reflect current prevention science and the most important health promotion and disease prevention issues. Healthy People 2010 is the United States response to the World Health Organization's renewing the Health for All strategy.

15. Global public health issues have an increasing effect on the health of the population of the United States. Trends such as emerging and reemerging infectious diseases, food and pharmaceutical harmonization, global disease surveillance mechanisms, and the increasing importance of chronic diseases all are serious concerns. The United States is an active participant in multilateral and bilateral efforts to address the growing importance of these issues.

16. There is ongoing international collaboration on several fronts. Programs under the supervision of the Office of International Refugee Health, Department of Health and Human Services, include: the Health Committee of the Gore-Chernomyrdin Binational Commission; the promotion of enhanced cooperation with Mexico, with special emphasis on the border; the U.S./Mexico Binational Commission; the development of a new program with USAID in Egypt, focusing on health policy and decision-making; support for the Gore-Mbeki Commission, a bilateral agreement with South Africa; cooperation with Israel, the Netherlands, Japan, and China on health policy and related issues; provisions of departmental support for regional and global programs with PAHO, UNAIDS, UNICEF, and WHO; and ongoing cooperation with the Office of Refugee Resettlement and USAID on refugee health issues and emergency response capacity.

### ***National Priorities for PAHO's Technical Cooperation***

17. To collaborate with U.S. federal, state, and local government, and private and public partners in strengthening partnerships along the U.S.-Mexico border. To work with U.S. and Mexican authorities to develop effective linkages in priority health issues. To cooperate with U.S. government agencies in addressing global health issues, and fostering interchanges for policy dialogue in areas such as: emerging infectious diseases, tobacco, promotion of healthy lifestyles and behaviors, assuring a healthy start for children, increase awareness among U.S. public opinion about global health concerns and their impact on the U.S., as well as monitoring and follow up on the Miami Summit of the Americas, among others.

### ***Technical Cooperation Strategy***

18. The global technical cooperation strategy with the United States of America focuses on using the funds, as well as technical and logistical expertise of the Organization to address and support priority areas identified by the U.S. Assistant Secretary for Health for regional and global health. A major interest in this strategy will continue to be health issues and problems along the U.S.-Mexico border.

### ***Objectives for PAHO's Technical Cooperation***

- Foster U.S. participation (with an accent on equity and Pan-Americanism) in global and regional health issues, including the U.S.-Mexico border.

### ***Expected Results***

19. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

20. *Cooperation networks, alliances.* Between U.S. agencies and national agencies of other Member States of PAHO, to augment on-going cooperation and/or provide on-site technical expertise.

21. *Plans, projects and policies.* To address health concerns along the U.S.-Mexico Border on issues where PAHO's input can play a technical and brokering role.

22. *Direct support.* Of the U.S./Mexico/PAHO Joint Border Strategy with emphasis on meeting its epidemiological surveillance needs.

**UNITED STATES OF AMERICA  
PROPOSED BUDGET ALLOCATION**

Appropriation Level	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Health Systems and Services Development	396,400	396,400	0	0
<b>Total</b>	<b>396,400</b>	<b>396,400</b>	<b>0</b>	<b>0</b>

# URUGUAY

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## *Health Situation*

1. Uruguay is a representative democracy with fully operational executive, legislative, and judicial branches. A politically stable country, it has a coalition government with a majority vote in both houses of the legislature and an economic framework strongly linked to MERCOSUR.

2. The priorities for 1998 set forth in the government's agenda are as follows: modifying the legal statutes of public enterprises to adapt them to the law governing private enterprise, passing a law on collective bargaining and union authority, and modifying the structure of the agency that controls private social security.

3. In 1997 the GDP of Uruguay rose 6.3% over that of the previous year (total GDP of US\$18,956 million as of September 1997), with a per capita GDP of US\$5,918.

4. In 1997 the inflation rate was 15.16%. Inflation has fallen gradually since 1991. Although Uruguay has the highest inflation of the MERCOSUR countries and their regional partners, this decline is considered satisfactory. The regional and international situation is expected to heighten deflationary pressures. Projections put inflation at around 9.0% by the end of 1998.

5. The budget deficit in the public sector for 1997 was 1.6% of GDP (US\$312 million as of September 1997). Most of this deficit can be attributed to the cost of reforming the social security system and the State bureaucracy; 24.0% of total government expenditure in 1996 consisted of transfers to social security (4.9% of GDP).

6. Urban unemployment was 11.5% at the end of 1997.

7. Health expenditure was equivalent to the total GDP for 1995, roughly US\$ 564 per capita.

8. Uruguay has a total population of 3,164,000, with an annual population growth of 0.6%, an urban population of almost 91.0%, and a population 65 years and older of 12.8% (National Census, 1996).

9. Regarding health conditions, a comparison of morbidity and mortality indicators in the different departments, including Montevideo, leads to the conclusion that Uruguay enjoys equitable levels of health.

10. Mortality rates by age and sex show a declining trend in children under 5, persons between 45 and 65, and persons 65 years and older. This has led to an increase in the population 65 years and older, making life expectancy at birth 73.3 years (77.4 years for women and 69.3 years for men).

11. The infant mortality rate was 16.5 per 1,000 in 1997.

12. Cardiovascular diseases were the leading cause of death in 1996, accounting for 38.5% of deaths from known causes; 98.0% of those deaths were recorded in people 45 years of age and older.

13. Malignant neoplasms ranked second in total deaths in 1996, accounting for 24.8% of deaths from known causes.

14. In 1996, accidents and violence were the third leading cause of death in the country, at 6.9%.

15. For several years there have been no cases of the following infectious and parasitic diseases: human rabies; poliomyelitis; diphtheria; neonatal tetanus; and cholera, the latter of which did not spread to Uruguay during the recent epidemic. As for communicable diseases, there was a substantial reduction in diarrheal diseases and cases and deaths from vaccine-preventable diseases. The Expanded Program on Immunization (EPI) was broadened to include compulsory vaccination coverage for Hib (*Haemophilus*) and meningococcal meningitis; this has reduced the incidence and case-fatality of meningitis.

16. Regarding AIDS, the growth rate has slowed, with 50 cases per million inhabitants annually. There were no cases of malaria, dengue, plague, schistosomiasis, or yellow fever in Uruguay. *Aedes aegypti* was eradicated in 1958, following an intense national campaign. However, between February and March 1997, *Aedes aegypti* larvae were found in the country.

17. Uruguay was declared free of foot-and-mouth disease following the vaccination campaign of March 1993. With respect to Chagas' disease, in September 1997 an international mission evaluated the activities of the Control Program and certified that vector-borne or natural transmission of the disease had been interrupted.

18. In 1994, the prevalence of smoking in urban Uruguay was 22.0% in the population over 15 years of age (male/female ratio: 2.2:1).

19. In 1996, 82.2% of private dwellings had drinking water supply through indoor connections, and 79.5% of homes had private plumbing that provide immediate sewerage disposal.

20. In Uruguay, 34.0% of the population receives health care through the Ministry of Public Health (MPH-ASSE), 47.0% through nonprofit private health institutions (collective health care institutions - CHCI), (National Census, 1996). The remaining 19.0% receives care through other public hospitals such as the teaching hospital (*Hospital de Clínicas*) and the hospitals of the armed forces health services, the Social Welfare Bank, and the Municipal Government of Montevideo. Vaccination coverage was 99.0% for BCG; 88.0% for DPT and polio; and 84.0% for measles, mumps, and rubella (Coorte 1995). There are roughly 10,000 hospital beds for acute cases throughout the country, 42.0% of which belong to the MPH-ASSE, 14.0% to other public institutions, 26.0% to the CHCIs, and 13.0% to other private institutions.

21. The Uruguayan government has been placing greater emphasis on activities in diverse social sectors, with strong financial backing from IDB and World Bank loans directed to the reform of public education, upgrading of the public health sector, and an increase in the percentage of dwellings with sanitation and drinking water, as well as work in the legal field, the strengthening of microenterprises, and social security.

### ***National Priorities for PAHO's Technical Cooperation***

22. To develop methodologies and models for programs and interventions in health promotion; To undertake national action to improve the environment and reduce environmental risks to the health of the

population; To reduce infant mortality; To strengthen the decentralization/ deconcentration of the health services of the Ministry of Public Health/State Health Service Administration; To prevent emerging and reemerging diseases; To develop a primary health care strategy and strengthen local health systems; To define and implement health policies aimed at reducing inequality and inequity; To establish health policies that target disadvantaged population groups; To increase the quality of health care.

### ***Technical Cooperation Strategy***

23. At the heart of the technical cooperation provided to Uruguay is the coordination with the Ministry of Public Health through the General Bureau of Health and international cooperation. The programming (BPB and PTS) is developed jointly by PAHO and the Ministry, bearing in mind national health priorities, the programs for which health authorities are responsible, and the SPO 2000-2001.

24. Another aspect is related to activities with other government agencies working in fields related to health. In this area, intersectoral coordination is an important mechanism for technical cooperation; in general, the MPH participates in all the initiatives, since it must exercise a leadership role and/or a presence in areas such as food protection, the quality of medical care, sanitation, etc.

25. Strengthening the intersectoral network will further PAHO's efforts, through the presence of the Office of Planning and Budget of the Office of the President (OPP), the Health Services Organization (OSE), the Ministry of Livestock, Agriculture and Fisheries (MAGP), the University, the School of Medicine, NGOs, and other institutions.

26. It is important to maintain excellent relations with the administrative secretariats of MERCOSUR, INCOSUR, and LAIA, given the importance of these subregional groups in the context of health.

27. The presence and participation of the country's Departments was defined at the joint evaluation meeting. Acting through the departmental health offices, they are considered an instrument for decentralizing technical cooperation, making it possible for the benefits of that cooperation to reach the people. For the purposes of this strategy, the

healthy municipios and communities policy will remain a priority in the proposed activities, particularly health promotion.

28. PAHO involvement in the activities of the State Health Services Administration (ASSE) should be intensified, particularly in the decentralization of medical care, giving priority to the training of health workers.

29. With regard to disease prevention and/or control, aspects such as maintaining active epidemiological surveillance will allow for early detection of situations requiring speedy intervention.

30. A steady drop in infant mortality implies active supervision of the various aspects of comprehensive care for children and mothers through universal application of IMCI.

### ***Objectives for PAHO's Technical Cooperation***

- To promote the formulation of policies, plans, programs, standards, and instruments for health promotion and the adoption of healthy public policies.
- To carry out national activities in diverse fields of sanitation and environmental quality control.
- To reduce morbidity and mortality from the principal diseases through interventions for disease prevention and health promotion.
- To achieve greater equity and efficiency in activities geared toward promoting and improving the health of the population.
- To create the conditions for administrative, political and technical management that permit proper implementation of the different technical cooperation projects, as well as monitoring and evaluation, based on the national health priorities and the Strategic and Programmatic Orientations.
- To improve the equity, effectiveness, and efficiency of the health activities of the public and private health sectors.

### ***Expected Results***

31. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

32. *Cooperation networks, alliances.* With the public, private, and philanthropic sectors for health promotion.

33. *Standards and guidelines.* For the creation of a Public Health Institute; for operation of the national network of healthy municipios; for environmental quality and quality health care.

34. *Plans, projects, and policies.* Directed to improving the annual activities of the specific programs, attempting to measure and evaluate their real impact.

35. *Methods, models, and technologies.* For the prevention and reduction of non-communicable diseases.

36. *Training programs.* For primary health workers on the promotion of healthy lifestyles; in various disciplines and procedures, sufficient to produce changes in the effectiveness and efficiency of the activities; continuing medical education.

37. *Promotional campaigns and advocacy.* Organized jointly with the allied institutions of the public, private, and philanthropic sectors.

38. *Direct support.* To obtain the gradual technical, organizational, and economic development of the solid waste sector; to expand drinking water and sanitation coverage and maintain the quality of services; to bring about improvements in other areas of environmental sanitation; for specific control programs, with emphasis on measles eradication, and their intra- and extrasectoral coordination; to increase subregional coordination in the Southern Cone, in INCOSUR and MERCOSUR.

<b>URUGUAY PROPOSED BUDGET ALLOCATION</b>				
Appropriation Level	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Health in Human Development	1,115,100	1,172,000	0	0
Health Systems and Services Development	81,000	69,500	0	0
Health Promotion and Protection	440,500	429,700	0	0
Environmental Protection and Development	112,000	105,200	191,000	0
Disease Prevention and Control	91,000	89,200	80,000	0
<b>Total</b>	<b>1,839,600</b>	<b>1,865,600</b>	<b>271,000</b>	<b>0</b>

# VENEZUELA

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## *Health Situation*

1. The Republic of Venezuela has a land area of 916,445 km<sup>2</sup> made up of 22 states, a Federal District, and federal dependencies. The states and the Federal District are divided into 293 municipios, which, in turn, are subdivided into 928 capital parishes. The estimated population in 1998 was 22,777,000, with a growth rate of 2.0% for the period 1995-2000.

2. Regionally, approximately 52% of the population is distributed along the northern coast, 23% in the center of the country, and 24% in the border area. Socioeconomic conditions vary in each of these regions, manifesting themselves in a variety of health profiles. The population is basically urban; in 1996 only 14% lived in rural areas, and the remaining 86.0% in urban areas.

3. An economic crisis arose in the early 1990s (Adjustment Programs of 1989), in which a limited concept of policies and the sequence in which the proposed reforms were adopted proved insufficient to reduce inflation, thereby increasing poverty and diminishing the possibilities for sustained economic growth. Public spending was consequently reduced, leading to the reemergence of deficits, a growing dependence on oil revenues, increased debt, and repeated currency devaluations.

4. In 1995 Venezuela announced a series of measures in the *Agenda Venezuela*, whose prime purpose was to reduce inflation by recovering macroeconomic stability and economic growth.

5. The *Agenda Venezuela* proposes a plan of financial, monetary, and foreign exchange measures, aimed mainly at reducing inflation, restructuring and strengthening the financial system, organizing a new social security system, instituting a massive transfer of resources toward the most vulnerable sectors, and promoting structural transformation of the economy and the legal framework.

6. To achieve these objectives programs have been organized for macroeconomic stabilization, institutional reforms, social services, and the restructuring of production. For the purposes of

social strategy, a close association between economic and social policy is assumed.

7. The period 1993-1996 was characterized by State reform in the direction of decentralization, particularly with regard to the health sector. Social reform involves a struggle against the extreme poverty that prevails and the search for alternatives to address the social gaps that have become increasingly acute.

8. Classification of the unmet basic needs in income groups I to V in the country leads to the conclusion that the majority of the population is found in groups II and III; nevertheless, 82% of the population in group V, with the worst living conditions, is found in the border region, 5% in the northern coastal region, and 12% in the central region.

9. Venezuela's epidemiological picture is reflected in its mortality profile, largely attributable to communicable diseases, among them intestinal infectious diseases and acute respiratory infections, external causes (accidents and a growing number of homicides), cardiovascular disease (especially ischemic heart disease), and neoplasms (chiefly stomach, lung, cervical, and breast cancer).

10. Infant mortality began to decline in 1988, as exemplified in the 20.5-23.5 deaths per 1,000 live births recorded in the 5-year period 1992-1996. The rate reported for 1996 was 22.0. This mortality rate, however, conceals the significant disparities among the states in the country. Maternal mortality is stable. For 1996 a figure of 6.6 per 10,000 live births was registered, varying from one state to another.

11. Two major epidemics of dengue and Venezuela equine encephalitis were reported in 1995. In 1996, cholera reappeared, resulting in 168 cases and 9 deaths. In 1997, 2,289 cases were reported, with an incidence of 11.2 per 100,000 population. The case-fatality rate was 2.3%, with 59 deaths. In 1998, only 13 cases were reported. In epidemiological week 42 of 1997, another epidemic cycle of dengue appeared, with a total of 33,717 cases.

12. Intestinal and acute respiratory infections persist as major causes of illness, and the epidemiological

situation of tuberculosis, malaria, dengue, AIDS, and rabies requires special attention. Significant progress has been made in the prevention and control of vaccine-preventable diseases, among them measles, diphtheria, and neonatal tetanus; nevertheless, the activities of the immunization program must be strengthened in order to maintain and/or improve the successes already achieved in this area.

13. Both curative and preventive health services are available in Venezuela. However, factors such as the response capacity of the health facilities, together with others of a cultural and economic nature associated with demand patterns, make it necessary for these services to become more accessible to the Venezuelan population, especially those with fewer resources.

14. Health sector reform is inspired by the State's guarantee of health to the Venezuelan people. Health reform consequently takes into account: a) strengthening of the steering role exercised through the political, normative, and control regulations applied in the health system, as well as the coordination and supervision of these policies in the states; b) decentralization of operations and services; and c) institutional restructuring and strengthening.

15. In carrying out the reform process, the Ministry of Health and Social Welfare (MSAS) enjoys the financial support of the multilateral banking institutions through the "Health Sector Reform Program" (MSAS and World Bank), "Project for Modernizing and Strengthening the Health Sector" (MSAS-IDB), and the "Project for the Control of Endemic Diseases" (Sectoral Office of the Director of Malariology and Environmental Sanitation, the Biomedicine Institute, and the World Bank).

16. Technical and financial cooperation needs have been identified in this context.

17. National Health Priorities: Health sector reform. Strengthening and modernization of the health sector; Strengthening of comprehensive maternal, child, and adolescent health care; Improvement of the quality, coverage, efficiency, effectiveness, and timelines of care provided by the health services, with emphasis on the strengthening of primary health care; Institutional organization of public health programs to elicit responses from the health services for comprehensive care of the population. Strengthening of health management and health care in border

areas, among scattered rural populations, and in marginalized urban areas; Communicable disease prevention and control, with emphasis on dengue, malaria, and cholera; Community organization and participation, emphasizing health promotion; Environmental protection and development; Improvement of the nutritional status of vulnerable groups.

18. National Priorities for Technical Cooperation in Health: Health sector reform; Decentralization of the health services; New management and financing models; Institutional restructuring and strengthening; Support for vulnerable groups and health emergencies; Technical cooperation with other countries; Strengthening of national groups of expert; Coordination of international cooperation in health; Adaptation of the current legal framework.

### *National Priorities for PAHO's Technical Cooperation*

19. To improve the health conditions of the Venezuelan population through support for the formulation of health policies and the implementation of the reform process, strengthening of the steering role of the Ministry of Health and Social Welfare, the development of information systems, and the improvement of health services. To improve the health conditions of the Venezuelan people through activities in health promotion and protection; in comprehensive care for mothers, children, and adolescents; and in the prevention and control of non-communicable diseases. To improve the health conditions of the Venezuelan people both through the prevention and control of communicable diseases and environmental protection and development, prioritizing border areas, scattered rural populations, and marginal urban areas.

### *Technical Cooperation Strategy*

20. PAHO's cooperation was a response to the national priorities for technical cooperation identified in conjunction with the national health authorities. They take shape in three projects corresponding to the Strategic and Programmatic Orientations, as follows:

21. "Health in Human Development and Health Systems and Services Development."

22. "Health Promotion and Protection, and Prevention of Non-communicable Diseases."

23. "Communicable Disease Prevention and Control and Environmental Health."

24. These projects include activities in technical cooperation among countries, as well as others corresponding to the projects and agreements for the execution of World Bank funds. There is also a project for the development and operation of the Representative Office (VEN/CPS).

25. The cooperation strategy will promote primary health care and renewal of the Strategy of Health for All in the Twenty-first Century, a work project of our Representative Office and the Ministry of Health and Social Welfare.

26. The technical staff of the Representative Office has been integrated into three technical areas, with the object of providing a better technical cooperation response, described in the three projects referred to above and, in turn, facilitating integrated and interprogram work.

27. Work with the PAHO Technical Centers, other Representative Offices, and PAHO Headquarters will also be encouraged. Resources will be mobilized through extrabudgetary projects and intersectoral and interagency activities.

28. PAHO/MSAS joint programming of technical cooperation and its periodic evaluation will be strengthened.

### ***Objectives for PAHO's Technical Cooperation***

- To consolidate the health sector reform process and strengthen the steering role of the Ministry of Health and Social Welfare, in order to ensure the timely delivery of comprehensive services to the people, through efficient, effective, and equitable health services networks.

- To develop and implement a model of care that gives special attention to activities for health promotion and protection, recognizing human development and health as a social and individual good, promoting healthy lifestyles, broad social participation, and the incorporation of the health services in activities for health promotion and the prevention of non-communicable diseases.
- To improve training in the Ministry of Health and Social Welfare for carrying out activities for the prevention and control of communicable diseases and improving the capacity for detecting and controlling health risks linked to the environment.

### ***Expected Results***

29. During the 2000-2001 biennium, PAHO is committed to developing, jointly with the country, the following expected results:

30. *Cooperation networks, alliances.* For health services, by level of complexity, in order to facilitate the delivery of comprehensive health services for the population under conditions of efficiency, effectiveness, and equity.

31. *Surveillance and information systems.* For the management, monitoring, and evaluation of comprehensive activities in maternal and child and adolescent health, with emphasis on health promotion; for the determining conditions, trends, and priorities in health, incorporating the gender approach and health ethics.

32. *Plans, projects, and policies.* For the prevention and control of the prevalent zoonoses with the greatest impact in the country; that lend feasibility and viability to the sectoral reform process and to the exercise of the steering role by the Ministry of Health and Social Welfare; for comprehensive health promotion and protection geared toward the creation of healthy lifestyles; comprehensive projects for the prevention and control of communicable diseases; for the formulation and application of drug policies.

33. *Methods, models, and technologies.* For comprehensive, intersectoral, and participatory

mental health care, for the prevention and control of accidents and acts of violence; for integrated management of childhood illness (IMCI); intersectoral food and nutrition models.

34. *Training programs.* For integral human resources development in keeping with the demands of the sectoral reform process.

<b>VENEZUELA</b>				
<b>PROPOSED BUDGET ALLOCATION</b>				
<b>Appropriation Level</b>	<b>Regular Budget</b>		<b>Other Sources</b>	
	<b>1998-1999</b>	<b>2000-2001</b>	<b>1998-1999</b>	<b>2000-2001</b>
Health in Human Development	1,606,700	2,429,000	700	700
Health Systems and Services Development	1,097,100	1,129,700	1,946,200	0
Health Promotion and Protection	316,800	449,200	0	0
Environmental Protection and Development	176,400	118,500	0	0
Disease Prevention and Control	726,800	560,900	1,970,100	10,000
<b>Total</b>	<b>3,923,800</b>	<b>4,687,300</b>	<b>3,917,000</b>	<b>10,700</b>

# FIELD OFFICE: UNITED STATES/MEXICO BORDER

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## *Health Situation*

1. During the 1992-1994 period, the United States and Mexico had an estimated average annual population of 346,112,484 inhabitants (257,717,175 and 88,395,309, respectively). The average annual population of the 10 border states of the two countries was 69,202,664 inhabitants: 54,777,223 in the states of California, Arizona, New Mexico, and Texas; 14,425,441 in the states of Baja California, Sonora, Chihuahua, Coahuila, Nuevo León, and Tamaulipas. The inhabitants of these states represented 21.2% of the total U.S. population and 16.3% of the Mexican population.
2. The average annual population of the U.S.-Mexico Border, made up of 25 U.S. counties and 37 Mexican municipios, was 10,930,646 inhabitants. Of these, 85% (9,291,049) correspond to what are known as "sister communities." The U.S. counties that form part of the sister communities constituted 59.4% of that population. Of the total population in the border states, 13.4% can be found in the sister communities (10% of the population of the border states on the U.S. side and 26.1% on the Mexican side).
3. The gender distribution in the sister communities was similar in the two countries, with a slightly higher percentage of females in the population (50.3% versus 49.7%). The age distribution differed with respect to the percentage of the population represented by children under 15 and adults over 64 years of age. On the U.S. side, children under 15 accounted for 24.5% of the population and adults over 64, 11%. On the Mexican side, the figures were 33.2% and 3.4%, respectively. This indicates a predominance of young people in the population on the Mexican side and of the elderly on the U.S. side.
4. The age distribution on either side of the border tends to differ from the general age distribution of its respective country and be more like that of the neighboring country. In the United States, the proportion of children under 15 is 21.9% and that of adults over 64, 12.7%. In Mexico, the proportion of children under 15 is 36.9% and that of adults over 64, 4%.
5. Annual Population Growth. During the period 1992-1994 population growth on the Mexican side was 3.1%, while on the U.S. side it was 2.4%. This was higher than the overall growth in the respective countries (Mexico: 1.9%; United States: 1.2%). Population growth was higher on the Mexican side.
6. Fertility. On the Mexican side the fertility rate per 1,000 women aged 15 to 44 was higher than the rate for the U.S. side (109.2 versus 89.8).
7. Birth Rate. The crude birth rate on the Mexican side was 28.5 per 1,000 and on the U.S. side, 20.9 per 1,000.
8. Mortality. The annual number of deaths during the period 1992-1994 in the sister municipios and counties along the border was 55,534, with a crude rate of 597.7 per 100,000 population. On the Mexican side this corresponded to 18,285 deaths, with a crude rate of 485.5 and a masculinity ratio of 1.5. On the U.S. side, 37,249 deaths were registered, which comes to a crude death rate of 674.2, with a masculinity ratio of 1.2. A comparison of mortality on both sides of the border through age-adjusted ratios indicates a 1.45 times greater risk of death (or 45% greater) on the Mexican side.
9. Deaths in children under 1 year of age account for 3.7% of the total deaths registered on the Mexican side, while on the U.S. side the percentage is only 0.63%. In contrast, the proportion of deaths in adults over 64 years of age is considerably lower in some municipios than that observed in the U.S. counties (e.g., the municipios of Tijuana, 34.7%; Juárez, 39.8%; and Reynosa, 40.6%, compared with

the counties of San Diego, 71.6%; El Paso, 64.9%; and Hidalgo 68%).

10. First among the significant causes of death from diseases of the circulatory system is ischemic heart disease (with a rate of 99.4 per 100,000 population), followed by pulmonary and other heart disease (a rate of 43.1), and cerebrovascular disease (a rate of 36.2).

11. In the category of mortality from malignant neoplasms, the highest rate is from tumors of the trachea, bronchus, and lung (a rate of 28.2), followed by other tumors of the digestive organs and peritoneum (a rate of 14.1); tumors of the lymphatic tissue and hematopoietic organs occupy third place (a rate of 11.6). First among external causes are motor vehicle accidents (a rate of 15.5), followed by homicides with legal intervention and operations of war (a rate of 12.2), with suicide and self-inflicted injuries in third place (a rate of 9.1).

12. Among deaths from communicable diseases, acute respiratory infections show the highest rate (22.7), followed by AIDS (a rate of 10.1) and other infectious and parasitic diseases (8.1). Under the perinatal category, hypoxia, asphyxia, and disorders of the fetus or newborn (a rate of 8.1), together with obstetric complications (a rate of 1.4) are the most significant. Finally, among the rest the relevant rates are for diabetes mellitus (a rate of 27.9), chronic obstructive pulmonary disease (a rate of 25.7), and cirrhosis and other chronic liver diseases (a rate of 14.4).

13. Mortality by Age Group. In the infant population on the U.S. side, the leading causes of mortality are perinatal conditions, followed by birth defects, sudden infant death syndrome, accidents, and pneumonia and influenza. On the Mexican side, perinatal and birth defects also occupy first and second place, followed by pneumonia and influenza and infectious intestinal diseases. In the preschool population, in the United States the leading causes were accidents, birth defects, and malignant neoplasms; on the Mexican side they were accidents, pneumonia and influenza, and infectious intestinal diseases. For the reproductive ages, Mexico reported

accidents, malignant neoplasms, and cardiovascular disease. The U.S. counties registered the same three causes, however with accidents in third place. In the population over 65, the countries share heart disease and malignant neoplasms as the leading causes, but after that diabetes becomes significant on the Mexican side and cerebrovascular disease on the U.S. side.

14. Health Problems. In this regard, the agreement reached by the heads of the health departments of the 10 border states in February 1998 should be considered. A series of public health problems was given priority, based on several criteria (frequency, extent in the border region, epidemic capacity, severity, and capacity for prevention and control), thereby enabling the countries to address them jointly. These problems are: a) Tuberculosis; b) Substance abuse; c) Vaccine-preventable diseases (immunization), epidemiological surveillance; d) STD and AIDS; e) Women's health (cervical and breast cancer; reproductive health); f) Environmental health; g) Access to health services; h) Regional communicable diseases (such as dengue); i) Food safety; j) Diabetes mellitus.

15. It is also important to mention certain infectious diseases such as hepatitis (A, B, C, E), classical dengue, dengue hemorrhagic fever, and other exanthematous febrile diseases (rubella, measles) that will be subject to binational surveillance through sentinel sites. In addition, chronic diseases (e.g. cardiovascular disease, cancer, cirrhosis), occupational health problems (particularly among maquiladora workers), and injuries (intentional and unintentional) significantly affect the border population.

16. Since morbidity primarily affects the most disadvantaged segments of the population, it will be necessary to focus efforts on the groups with inadequate access to a diverse range of services, including health services, on both sides of the border. In order to address the problems technically and operationally, the heads of the state health departments propose the creation or adaptation of structures, with the participation of a variety of public and private institutions. They also propose strengthening the public health laboratory infrastructure to support epidemiological surveillance and environmental health.

## ***National Priorities for PAHO's Technical Cooperation***

17. Serve as a conduit for information dissemination for the U.S./Mexico Border on health (including environmental health) issues, data (e.g. health profiles), networks and activities. Promote and support sister cities relationships, including coordination, joint planning, and implementation of program/projects in that context. Promote partnerships, including resource mobilization efforts (monetary and non-monetary) among the public and private sector, e.g., foundations, local community groups, State and/or local health officials and/or universities on both sides of the border. Provide the Secretariat function for the U.S./Mexico Border Health Association (USMBHA) and its subcomponents. This would include strengthening the efforts of the USMBHA's Binational Health Councils. Facilitate an ongoing process for development of priorities for border health. Promote appropriate regional approaches to problems and issues.

## ***Technical Cooperation Strategy***

18. Since it began operations in 1942, the Field Office of the Pan American Health Organization in El Paso, Texas, has played an important role in supporting Mexico and the United States at the federal, state, and local levels, as well as other institutions, in their collective efforts to improve health in the border area. Within this context, the Field Office provides essential support for the United States-Mexico Border Health Association and helps to achieve goals for the countries through the Association.

19. It is known for a fact that problems in the border area have become more complex in recent years, as a result of population and industrial growth, environmental pollution, and human exposure to a growing number of hazards. Moreover, the expectations not only of the people in the area, but governments at all levels on their behalf, have grown.

20. Purpose. This strategy includes agreed upon strategic approaches, which are serving the two countries and PAHO well. However, it also articulates a broader set of principles to help guide the work of the Field Office. The strategy will also help those who look to the Field Office for guidance and technical cooperation to better understand how it can best be of assistance to them.

21. Scope of Relationships. Federal and state governments, including but not limited to, health and environmental agencies. Local health departments, including counties and cities. Universities. Non-governmental organizations. Foundations and other entities.

22. Over-arching goal. The broad goal of the Field Office is to improve health in the U.S./Mexico border area, particularly through capacity building through better communications, coordination, and technical guidance.

23. Objectives. Based upon the broad goal stated above, the Field Office will focus its technical cooperation and resources on the following objectives.

24. To serve as a vehicle for disseminating information for the U.S./Mexico Border on health issues (including environmental health), statistics (e.g. health profiles), networks, and activities.

25. To foster and support relations between sister cities, including coordination, joint planning, and program/project implementation within that context.

26. To promote partnerships, including resource mobilization efforts (monetary and nonmonetary) among the public and private sector, e.g., foundations, local community groups, state and/or local health officials, and/or universities on both sides of the border.

27. To serve as Secretariat for the U.S./Mexico Border Health Association (USMBHA) and its subcomponents. This would include support for the efforts of the USMBHA's Binational Health Councils.

28. To facilitate an ongoing process to establish priorities for border health.

29. To promote appropriate regional approaches to problems and issues.

30. Organizational/Management principles. The Field Office will work to strengthen its role as USMBHA Secretariat, targeting its organizational infrastructure and strengthening its binational mechanisms.

31. The Field Office will enhance its role as a facilitator, coordinator, catalyst, and communications network for U.S./Mexico efforts.

32. To this end it will apply the various functional approaches in technical cooperation, concentrating on policy development, information dissemination, and resource mobilization.

### ***Objectives for PAHO's Technical Cooperation***

- To strengthen the technical, administrative and logistical capacity of the El Paso Field Office in support of its technical cooperation program in the U.S./Mexico border area.
- Proactively seek partnerships among the public and private sector, foundations, local community groups, and State and/or local health officials to mobilize resources (monetary and non-

monetary) which could be utilized to address border health problems.

- To improve the organizational infrastructure and binational mechanisms of the USMBHA to achieve its potential as a viable membership association and border health resource.

### ***Expected Results***

33. During the biennium 2000-2001, PAHO is committed to developing, jointly with the country, the following expected results:

34. *Cooperation networks, alliances.* Along the US/Mexico border.

35. *Research and evaluation studies.* To improve border health through technically reputable and financially manageable publications: Newsletter, Journal of Border Health and web page.

36. *Plans, projects and policies.* To improve the capacity of border institutions to better compete in funding environments and to improve the effectiveness and efficiency of the USMBHA to achieve financial self-sufficiency and increase its membership.

37. *Training programs.* For strengthening governance mechanism of USMBHA.

38. *Promotional campaigns and advocacy.* Of border public health and healthy borders issues and advocate their inclusion in ongoing dialogue among existing and new partnerships of the U.S./Mexico border.

39. *Direct support.* Of a network of interconnected systems of institutions, programs and individuals working toward improvement of border health through the execution of annual meetings of superior technical quality and for the El Paso Field Office and USMBHA activities (in an administrative and managerial capacity).

**FIELD OFFICE: UNITED STATES/MEXICO BORDER  
PROPOSED BUDGET ALLOCATION**

Appropriation Level	Regular Budget		Other Sources	
	1998-1999	2000-2001	1998-1999	2000-2001
Health in Human Development	1,219,400	1,219,400	0	0
Health Promotion and Protection	0	0	99,100	0
Environmental Protection and Development	0	0	20,000	0
Disease Prevention and Control	0	0	184,400	0
<b>Total</b>	<b>1,219,400</b>	<b>1,219,400</b>	<b>303,500</b>	<b>0</b>



**V. BUDGET TABLE:  
COUNTRIES**

V. BUDGET TABLE:  
COUNTRIES

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COUNTRY TOTAL

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b> =====	<b>43,476,200</b>	<b>42.2</b>	<b>47,370,300</b>	<b>44.5</b>
GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT	293,800	0.3	288,400	0.3
PUBLIC INFORMATION	INF 293,800	0.3	288,400	0.3
PUBLIC POLICY AND HEALTH	2,785,700	2.7	3,030,800	2.8
HEALTH IN SOCIOECONOMIC DEVELOPMENT	HSD 2,418,000	2.3	2,740,800	2.6
WOMEN, HEALTH AND DEVELOPMENT	WHD 367,700	0.4	290,000	0.3
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	31,099,100	30.2	34,545,500	32.4
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 30,603,700	29.7	34,015,500	32.0
HEALTH PLANNING	HPL 270,000	0.3	333,800	0.3
EMERGENCY AND HUMANITARIAN ACTION	EHA 225,400	0.2	196,200	0.2
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS	5,592,900	5.4	6,029,000	5.7
HEALTH SITUATION AND TREND ASSESSMENT	HST 4,757,100	4.6	5,251,600	4.9
HEALTH AND BIOMEDICAL INFORMATION	HBI 835,800	0.8	777,400	0.7
TECHNICAL COOPERATION AMONG COUNTRIES	TCC 3,704,700	3.6	3,476,600	3.3
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b> =====	<b>26,315,900</b>	<b>25.5</b>	<b>24,883,100</b>	<b>23.4</b>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	20,601,400	20.0	19,303,500	18.1
UNIVERSAL ACCESS TO HEALTH CARE	UAH 20,512,800	19.9	19,054,700	17.9
HEALTH SYSTEMS RESEARCH	HSR 15,000	.*	134,200	0.1
TRADITIONAL MEDICINE AND INDIGENOUS HEALTH	TRM 20,000	.*	53,400	0.1
DISABILITY PREVENTION AND REHABILITATION	DPR 5,000	-	36,600	.*
ORAL HEALTH	ORH 48,600	.*	24,600	.*
HUMAN RESOURCES FOR HEALTH	HRH 4,799,000	4.7	4,335,800	4.1
ESSENTIAL DRUGS	EDV 786,100	0.8	881,600	0.8
QUALITY OF CARE AND HEALTH TECHNOLOGY	129,400	0.1	362,200	0.3
QUALITY OF CARE AND HEALTH TECHNOLOGY ASSESSMENT	QAC 129,400	0.1	312,600	0.3
QUALITY, SAFETY & EFFICACY OF DRUGS & BIOLOGICALS	DSE 0	-	49,600	.*

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COUNTRY TOTAL  
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PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>4. HEALTH PROMOTION AND PROTECTION</b> =====	<b>9,921,200</b>	<b>9.6</b>	<b>10,113,700</b>	<b>9.5</b>
<b>FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES</b> -----	<b>4,609,600</b>	<b>4.5</b>	<b>4,655,900</b>	<b>4.4</b>
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 4,515,800	4.4	4,511,700	4.2
ADOLESCENT HEALTH	ADH 68,800	0.1	69,900	0.1
HEALTH OF THE ELDERLY	HEE 25,000	.*	74,300	0.1
<b>HEALTHY LIFESTYLES AND MENTAL HEALTH</b> -----	<b>4,049,800</b>	<b>3.9</b>	<b>4,217,800</b>	<b>4.0</b>
HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED 2,440,500	2.4	2,418,500	2.3
PREVENTION AND CONTROL OF SUBSTANCE ABUSE	ADT 70,000	0.1	290,700	0.3
MENTAL HEALTH	MNH 0	-	3,000	-
SETTINGS FOR HEALTH PROMOTION	STP 1,539,300	1.5	1,503,600	1.4
PROTECTION FROM VIOLENCE	PRV 0	-	2,000	-
<b>NUTRITION, FOOD SECURITY AND SAFETY</b> -----	<b>1,261,800</b>	<b>1.2</b>	<b>1,240,000</b>	<b>1.2</b>
FOOD AND NUTRITION	NUT 463,900	0.5	498,800	0.5
FOOD SAFETY	FOS 797,900	0.8	741,200	0.7
<b>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</b> =====	<b>10,668,100</b>	<b>10.4</b>	<b>10,719,500</b>	<b>10.1</b>
<b>ENVIRONMENTAL HEALTH</b> -----	<b>10,668,100</b>	<b>10.4</b>	<b>10,719,500</b>	<b>10.1</b>
WATER SUPPLY AND SANITATION	CWS 8,943,500	8.7	8,641,000	8.1
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA 1,688,600	1.6	1,907,200	1.8
MANAGEMENT OF SOLID WASTE AND HOUSING HYGIENE	MWH 16,000	.*	156,500	0.1
WORKERS' HEALTH	OCH 20,000	.*	14,800	.*
<b>6. DISEASE PREVENTION AND CONTROL</b> =====	<b>12,686,600</b>	<b>12.3</b>	<b>13,376,500</b>	<b>12.6</b>
<b>CONTROL OF COMMUNICABLE DISEASE</b> -----	<b>8,713,400</b>	<b>8.5</b>	<b>8,834,400</b>	<b>8.3</b>
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID 1,481,100	1.4	1,534,600	1.4
ACUTE RESPIRATORY INFECTIONS	ARI 62,000	0.1	56,800	0.1
DIARRHEAL DISEASES	CDI 10,000	-	9,900	-
AIDS	GPA 234,000	0.2	309,400	0.3
SEXUALLY TRANSMITTED DISEASES	STD 24,000	.*	3,000	-
TUBERCULOSIS	TUB 30,000	.*	84,000	0.1
MALARIA AND OTHER TROPICAL DISEASES	CTD 410,500	0.4	569,800	0.5
OTHER COMMUNICABLE DISEASES	OCD 6,461,800	6.3	6,266,900	5.9

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COUNTRY TOTAL  
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PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
CONTROL OF NONCOMMUNICABLE DISEASES	2,455,400	2.4	2,802,700	2.6
CANCER	24,000	.*	13,600	.*
CARDIOVASCULAR DISEASES	15,000	.*	9,900	-
OTHER NONCOMMUNICABLE DISEASES	2,416,400	2.3	2,779,200	2.6
VETERINARY PUBLIC HEALTH	1,517,800	1.5	1,739,400	1.6
FOOT-AND-MOUTH DISEASE	55,200	0.1	0	-
ZONOSIS	1,462,600	1.4	1,739,400	1.6
=====	=====	=====	=====	=====
GRAND TOTAL	103,068,000	100.0	106,463,100	100.0
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\* INDICATES LESS THAN .05 PERCENT

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COUNTRY TOTAL  
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PROGRAM BUDGET - EXTRABUDGETARY FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b> =====	<b>14,565,200</b>	<b>16.3</b>	<b>2,045,800</b>	<b>6.6</b>
GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT	11,500	.*	0	-
EXTERNAL COORDINATION	11,500	.*	0	-
PUBLIC POLICY AND HEALTH	1,816,400	2.0	353,000	1.1
WOMEN, HEALTH AND DEVELOPMENT	1,816,400	2.0	353,000	1.1
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	12,632,500	14.2	1,692,800	5.4
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	1,804,800	2.0	997,700	3.2
HEALTH PLANNING	286,000	0.3	0	-
EMERGENCY AND HUMANITARIAN ACTION	10,541,700	11.8	695,100	2.2
TECHNICAL COOPERATION AMONG COUNTRIES	104,800	0.1	0	-
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b> =====	<b>42,066,700</b>	<b>47.2</b>	<b>12,938,700</b>	<b>41.5</b>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	29,796,000	33.4	8,007,500	25.7
UNIVERSAL ACCESS TO HEALTH CARE	29,561,000	33.1	7,982,500	25.6
HEALTH SYSTEMS RESEARCH	25,000	.*	0	-
DISABILITY PREVENTION AND REHABILITATION	65,200	0.1	0	-
ORAL HEALTH	144,800	0.2	25,000	0.1
HUMAN RESOURCES FOR HEALTH	3,275,000	3.7	0	-
ESSENTIAL DRUGS	8,748,700	9.8	4,916,200	15.7
QUALITY OF CARE AND HEALTH TECHNOLOGY	247,000	0.3	15,000	.*
CLINICAL, LABORATORY AND IMAGING TECHNOLOGY	247,000	0.3	15,000	.*

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COUNTRY TOTAL  
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PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<u>4. HEALTH PROMOTION AND PROTECTION</u>	<u>2,213,100</u>	<u>2.5</u>	<u>732,100</u>	<u>2.3</u>
<u>FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES</u>	<u>1,166,500</u>	<u>1.3</u>	<u>600</u>	<u>-</u>
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 1,166,500	1.3	600	-
<u>HEALTHY LIFESTYLES AND MENTAL HEALTH</u>	<u>848,900</u>	<u>1.0</u>	<u>670,000</u>	<u>2.1</u>
HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED 690,100	0.8	650,000	2.1
PREVENTION AND CONTROL OF SUBSTANCE ABUSE	ADT 103,800	0.1	20,000	0.1
MENTAL HEALTH	MNH 55,000	0.1	0	-
<u>NUTRITION, FOOD SECURITY AND SAFETY</u>	<u>197,700</u>	<u>0.2</u>	<u>61,500</u>	<u>0.2</u>
FOOD AND NUTRITION	NUT 180,700	0.2	46,500	0.1
FOOD SAFETY	FOS 17,000	.*	15,000	.*
<u>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</u>	<u>13,933,800</u>	<u>15.6</u>	<u>7,834,700</u>	<u>25.1</u>
<u>ENVIRONMENTAL HEALTH</u>	<u>13,933,800</u>	<u>15.6</u>	<u>7,834,700</u>	<u>25.1</u>
WATER SUPPLY AND SANITATION	CWS 8,113,000	9.1	4,194,700	13.4
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA 5,452,800	6.1	3,290,000	10.5
MANAGEMENT OF SOLID WASTE AND HOUSING HYGIENE	MWH 368,000	0.4	350,000	1.1
<u>6. DISEASE PREVENTION AND CONTROL</u>	<u>16,421,800</u>	<u>18.4</u>	<u>7,663,300</u>	<u>24.6</u>
<u>CONTROL OF COMMUNICABLE DISEASE</u>	<u>15,489,500</u>	<u>17.4</u>	<u>7,563,300</u>	<u>24.2</u>
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID 3,984,100	4.5	1,800,000	5.8
DIARRHEAL DISEASES	CDD 281,000	0.3	23,300	0.1
AIDS	GPA 2,667,500	3.0	1,319,000	4.2
TUBERCULOSIS	TUB 54,500	0.1	0	-
MALARIA AND OTHER TROPICAL DISEASES	CTD 7,698,700	8.6	4,400,500	14.1
OTHER COMMUNICABLE DISEASES	OCD 205,900	0.2	10,000	.*
LEPROSY	LEP 597,800	0.7	10,500	.*
<u>CONTROL OF NONCOMMUNICABLE DISEASES</u>	<u>288,700</u>	<u>0.3</u>	<u>0</u>	<u>-</u>
CANCER	CAN 15,300	.*	0	-
OTHER NONCOMMUNICABLE DISEASES	NCD 273,400	0.3	0	-

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COUNTRY TOTAL  
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PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
VETERINARY PUBLIC HEALTH	643,600	0.7	100,000	0.3
FOOT-AND-MOUTH DISEASE	FMD 530,300	0.6	100,000	0.3
ZOOZOSIS	ZNS 113,300	0.1	0	-
=====	=====	=====	=====	=====
GRAND TOTAL	89,200,600	100.0	31,214,600	100.0
=====	=====	=====	=====	=====

\* INDICATES LESS THAN .05 PERCENT

ANTIGUA AND BARBUDA

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b>	<b>106,000</b>	<b>58.0</b>	<b>99,300</b>	<b>50.2</b>	
----- ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	106,000	58.0	99,300	50.2	
----- UNIVERSAL ACCESS TO HEALTH CARE	UAH	106,000	58.0	99,300	50.2
<b>4. HEALTH PROMOTION AND PROTECTION</b>	<b>0</b>	<b>-</b>	<b>45,500</b>	<b>23.0</b>	
----- HEALTHY LIFESTYLES AND MENTAL HEALTH	0	-	45,500	23.0	
----- HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED	0	-	45,500	23.0
<b>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</b>	<b>38,700</b>	<b>21.2</b>	<b>0</b>	<b>-</b>	
----- ENVIRONMENTAL HEALTH	38,700	21.2	0	-	
----- WATER SUPPLY AND SANITATION	CWS	38,700	21.2	0	-
<b>6. DISEASE PREVENTION AND CONTROL</b>	<b>38,000</b>	<b>20.8</b>	<b>52,900</b>	<b>26.8</b>	
----- CONTROL OF COMMUNICABLE DISEASE	0	-	16,200	8.2	
----- AIDS	GPA	0	-	16,200	8.2
----- CONTROL OF NONCOMMUNICABLE DISEASES	38,000	20.8	36,700	18.6	
----- OTHER NONCOMMUNICABLE DISEASES	NCD	38,000	20.8	36,700	18.6
=====	=====	=====	=====	=====	
GRAND TOTAL	182,700	100.0	197,700	100.0	
=====	=====	=====	=====	=====	

ARGENTINA

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
2. HEALTH IN HUMAN DEVELOPMENT =====	3,082,000	54.2	2,991,600	52.4	
PUBLIC POLICY AND HEALTH -----	126,000	2.2	551,700	9.7	
HEALTH IN SOCIOECONOMIC DEVELOPMENT	HSD	126,000	2.2	551,700	9.7
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT. -----	2,617,100	46.0	1,949,100	34.2	
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS	2,617,100	46.0	1,949,100	34.2
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS -----	173,300	3.0	337,500	5.9	
HEALTH SITUATION AND TREND ASSESSMENT	HST	173,300	3.0	337,500	5.9
TECHNICAL COOPERATION AMONG COUNTRIES -----	TCC	165,600	2.9	153,300	2.7
3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT =====	1,615,600	28.4	1,853,000	32.5	
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC -----	656,300	11.5	815,900	14.3	
UNIVERSAL ACCESS TO HEALTH CARE	UAH	656,300	11.5	815,900	14.3
HUMAN RESOURCES FOR HEALTH -----	HRH	860,300	15.1	838,600	14.7
QUALITY OF CARE AND HEALTH TECHNOLOGY -----	99,000	1.7	198,500	3.5	
QUALITY OF CARE AND HEALTH TECHNOLOGY ASSESSMENT	QAC	99,000	1.7	198,500	3.5
4. HEALTH PROMOTION AND PROTECTION =====	193,400	3.4	0	-	
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES -----	74,300	1.3	0	-	
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH	74,300	1.3	0	-
HEALTHY LIFESTYLES AND MENTAL HEALTH -----	119,100	2.1	0	-	
SETTINGS FOR HEALTH PROMOTION	STP	119,100	2.1	0	-

ARGENTINA

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

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT =====	573,700	10.1	562,200	9.9
ENVIRONMENTAL HEALTH -----	573,700	10.1	562,200	9.9
WATER SUPPLY AND SANITATION	CWS 573,700	10.1	562,200	9.9
6. DISEASE PREVENTION AND CONTROL =====	222,800	3.9	297,700	5.2
CONTROL OF COMMUNICABLE DISEASE -----	148,500	2.6	261,000	4.6
OTHER COMMUNICABLE DISEASES	OCD 148,500	2.6	261,000	4.6
CONTROL OF NONCOMMUNICABLE DISEASES -----	74,300	1.3	36,700	0.6
OTHER NONCOMMUNICABLE DISEASES	NCD 74,300	1.3	36,700	0.6
=====	=====	=====	=====	=====
GRAND TOTAL =====	5,687,500	100.0	5,704,500	100.0

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 ARGENTINA  
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PROGRAM BUDGET - EXTRABUDGETARY FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
2. <u>HEALTH IN HUMAN DEVELOPMENT</u>	163,600	59.7	165,000	100.0
<u>NATIONAL HEALTH POLICIES &amp; PROG. DEVELOP. &amp; MGMT.</u>	163,600	59.7	165,000	100.0
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 163,600	59.7	165,000	100.0
4. <u>HEALTH PROMOTION AND PROTECTION</u>	30,000	11.0	0	-
<u>HEALTHY LIFESTYLES AND MENTAL HEALTH</u>	30,000	11.0	0	-
MENTAL HEALTH	MNH 30,000	11.0	0	-
6. <u>DISEASE PREVENTION AND CONTROL</u>	80,300	29.3	0	-
<u>CONTROL OF COMMUNICABLE DISEASE</u>	80,300	29.3	0	-
AIDS	GPA 80,300	29.3	0	-
<u>GRAND TOTAL</u>	273,900	100.0	165,000	100.0

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BAHAMAS

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b> =====	<b>640,000</b>	<b>53.2</b>	<b>731,000</b>	<b>57.0</b>
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT. -----	507,700	42.2	616,500	48.0
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.      CPS	507,700	42.2	616,500	48.0
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS -----	34,500	2.9	23,900	1.9
HEALTH SITUATION AND TREND ASSESSMENT                      HST	34,500	2.9	23,900	1.9
TECHNICAL COOPERATION AMONG COUNTRIES                    TCC	97,800	8.1	90,600	7.1
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b> =====	<b>128,400</b>	<b>10.7</b>	<b>113,500</b>	<b>8.8</b>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC -----	128,400	10.7	113,500	8.8
UNIVERSAL ACCESS TO HEALTH CARE                            UAH	128,400	10.7	76,900	6.0
DISABILITY PREVENTION AND REHABILITATION                   DPR	0	-	36,600	2.9
<b>4. HEALTH PROMOTION AND PROTECTION</b> =====	<b>94,200</b>	<b>7.8</b>	<b>71,900</b>	<b>5.6</b>
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES -----	50,000	4.2	48,600	3.8
WOMEN AND CHILD HEALTH AND FAMILY PLANNING                WCH	30,500	2.5	5,500	0.4
ADOLESCENT HEALTH    ADH	19,500	1.6	33,200	2.6
HEALTH OF THE ELDERLY    HEE	0	-	9,900	0.8
HEALTHY LIFESTYLES AND MENTAL HEALTH -----	7,500	0.6	17,800	1.4
HEALTH EDUCATION AND SOCIAL COMMUNICATION                 HED	7,500	0.6	17,800	1.4
NUTRITION, FOOD SECURITY AND SAFETY -----	36,700	3.1	5,500	0.4
FOOD AND NUTRITION    NUT	11,500	1.0	5,500	0.4
FOOD SAFETY   FOS	25,200	2.1	0	-

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 BAHAMAS  
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PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT =====	295,000	24.5	336,800	26.2	
ENVIRONMENTAL HEALTH -----	295,000	24.5	336,800	26.2	
WATER SUPPLY AND SANITATION	CWS	279,000	23.2	325,100	25.3
MANAGEMENT OF SOLID WASTE AND HOUSING HYGIENE	MWH	16,000	1.3	11,700	0.9
6. DISEASE PREVENTION AND CONTROL =====	45,600	3.8	30,300	2.4	
CONTROL OF COMMUNICABLE DISEASE -----	22,600	1.9	25,800	2.0	
OTHER COMMUNICABLE DISEASES	OCD	22,600	1.9	25,800	2.0
CONTROL OF NONCOMMUNICABLE DISEASES -----	23,000	1.9	4,500	0.4	
OTHER NONCOMMUNICABLE DISEASES	NCD	23,000	1.9	4,500	0.4
=====	=====	=====	=====	=====	
GRAND TOTAL =====	1,203,200	100.0	1,283,500	100.0	

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BARBADOS

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
2. HEALTH IN HUMAN DEVELOPMENT	195,000	24.3	213,200	26.6
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	195,000	24.3	213,200	26.6
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 195,000	24.3	213,200	26.6
3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT	360,000	44.9	309,100	38.6
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	360,000	44.9	309,100	38.6
UNIVERSAL ACCESS TO HEALTH CARE	UAH 360,000	44.9	309,100	38.6
4. HEALTH PROMOTION AND PROTECTION	166,900	20.8	176,100	22.0
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	58,900	7.4	95,200	11.9
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 58,900	7.4	95,200	11.9
HEALTHY LIFESTYLES AND MENTAL HEALTH	108,000	13.5	80,900	10.1
HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED 108,000	13.5	80,900	10.1
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT	79,000	9.9	96,200	12.0
ENVIRONMENTAL HEALTH	79,000	9.9	96,200	12.0
WATER SUPPLY AND SANITATION	CWS 79,000	9.9	96,200	12.0
6. DISEASE PREVENTION AND CONTROL	0	-	6,300	0.8
CONTROL OF COMMUNICABLE DISEASE	0	-	6,300	0.8
AIDS	GPA 0	-	6,300	0.8
GRAND TOTAL	800,900	100.0	800,900	100.0

BELIZE

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<u>2. HEALTH IN HUMAN DEVELOPMENT</u>	<u>933,100</u>	<u>81.4</u>	<u>973,400</u>	<u>84.8</u>
PUBLIC POLICY AND HEALTH	272,700	23.8	266,400	23.2
HEALTH IN SOCIOECONOMIC DEVELOPMENT	HSD 241,700	21.1	245,200	21.4
WOMEN, HEALTH AND DEVELOPMENT	WHD 31,000	2.7	21,200	1.8
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	516,900	45.1	578,700	50.4
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 516,900	45.1	578,700	50.4 <sup>o</sup>
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS	28,000	2.4	21,300	1.9
HEALTH SITUATION AND TREND ASSESSMENT	HST 15,000	1.3	7,500	0.7
HEALTH AND BIOMEDICAL INFORMATION	HBI 13,000	1.1	13,800	1.2
TECHNICAL COOPERATION AMONG COUNTRIES	TCC 115,500	10.1	107,000	9.3
<u>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</u>	<u>24,500</u>	<u>2.1</u>	<u>17,900</u>	<u>1.6</u>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	24,500	2.1	7,500	0.7
UNIVERSAL ACCESS TO HEALTH CARE	UAH 24,500	2.1	7,500	0.7
HUMAN RESOURCES FOR HEALTH	HRH 0	-	10,400	0.9
<u>4. HEALTH PROMOTION AND PROTECTION</u>	<u>149,500</u>	<u>13.0</u>	<u>123,900</u>	<u>10.8</u>
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	47,000	4.1	7,500	0.7
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 47,000	4.1	7,500	0.7
HEALTHY LIFESTYLES AND MENTAL HEALTH	84,500	7.4	99,200	8.6
SETTINGS FOR HEALTH PROMOTION	STP 84,500	7.4	99,200	8.6



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 BELIZE  
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PROGRAM BUDGET - EXTRABUDGETARY FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
2. HEALTH IN HUMAN DEVELOPMENT =====	100,000	19.4	30,000	17.6
PUBLIC POLICY AND HEALTH -----	59,900	11.6	30,000	17.6
WOMEN, HEALTH AND DEVELOPMENT WHD	59,900	11.6	30,000	17.6
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT. -----	36,500	7.1	0	-
EMERGENCY AND HUMANITARIAN ACTION EHA	36,500	7.1	0	-
TECHNICAL COOPERATION AMONG COUNTRIES -----	3,600	0.7	0	-
3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT =====	42,000	8.2	0	-
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC -----	36,300	7.1	0	-
ORAL HEALTH ORH	36,300	7.1	0	-
HUMAN RESOURCES FOR HEALTH -----	5,700	1.1	0	-
4. HEALTH PROMOTION AND PROTECTION =====	82,300	16.0	0	-
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES -----	57,900	11.3	0	-
WOMEN AND CHILD HEALTH AND FAMILY PLANNING WCH	57,900	11.3	0	-
HEALTHY LIFESTYLES AND MENTAL HEALTH -----	24,400	4.7	0	-
MENTAL HEALTH MNH	24,400	4.7	0	-
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT =====	210,900	41.0	140,000	82.4
ENVIRONMENTAL HEALTH -----	210,900	41.0	140,000	82.4
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT ERA	210,900	41.0	140,000	82.4

BELIZE

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
6. DISEASE PREVENTION AND CONTROL =====	79,100	15.4	0	-
CONTROL OF COMMUNICABLE DISEASE -----	79,100	15.4	0	-
AIDS	77,400	15.0	0	-
MALARIA AND OTHER TROPICAL DISEASES	1,700	0.3	0	-
=====	=====	=====	=====	=====
GRAND TOTAL	514,300	100.0	170,000	100.0
=====	=====	=====	=====	=====



BOLIVIA

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

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
6. DISEASE PREVENTION AND CONTROL =====	1,032,000	22.2	984,500	21.1
CONTROL OF COMMUNICABLE DISEASE -----	742,000	15.9	696,600	14.9
OTHER COMMUNICABLE DISEASES            OCD	742,000	15.9	696,600	14.9
CONTROL OF NONCOMMUNICABLE DISEASES -----	290,000	6.2	287,900	6.2
OTHER NONCOMMUNICABLE DISEASES        NCD	290,000	6.2	287,900	6.2
=====	=====	=====	=====	=====
GRAND TOTAL =====	4,656,900	100.0	4,675,700	100.0

BOLIVIA

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b>	<b>299,300</b>	<b>6.3</b>	<b>5,000</b>	<b>0.6</b>
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PUBLIC POLICY AND HEALTH	240,800	5.0	0	-
-----	-----	-----	-----	-----
WOMEN, HEALTH AND DEVELOPMENT	WHD 240,800	5.0	0	-
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	58,500	1.2	5,000	0.6
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DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 4,700	0.1	5,000	0.6
HEALTH PLANNING	HPL 53,800	1.1	0	-
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b>	<b>2,868,300</b>	<b>60.1</b>	<b>654,200</b>	<b>81.9</b>
-----	-----	-----	-----	-----
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	915,500	19.2	645,000	80.7
-----	-----	-----	-----	-----
UNIVERSAL ACCESS TO HEALTH CARE	UAH 827,200	17.3	620,000	77.6
DISABILITY PREVENTION AND REHABILITATION	DPR 36,500	0.8	0	-
ORAL HEALTH	ORH 51,800	1.1	25,000	3.1
ESSENTIAL DRUGS	EDV 1,952,800	40.9	9,200	1.2
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<b>4. HEALTH PROMOTION AND PROTECTION</b>	<b>81,900</b>	<b>1.7</b>	<b>10,000</b>	<b>1.3</b>
-----	-----	-----	-----	-----
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	70,600	1.5	0	-
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WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 70,600	1.5	0	-
NUTRITION, FOOD SECURITY AND SAFETY	11,300	0.2	10,000	1.3
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FOOD AND NUTRITION	NUT 11,300	0.2	10,000	1.3
<b>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</b>	<b>1,265,200</b>	<b>26.5</b>	<b>20,000</b>	<b>2.5</b>
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ENVIRONMENTAL HEALTH	1,265,200	26.5	20,000	2.5
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WATER SUPPLY AND SANITATION	CWS 1,265,200	26.5	20,000	2.5

BOLIVIA

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
6. DISEASE PREVENTION AND CONTROL =====	255,700	5.4	110,000	13.8
CONTROL OF COMMUNICABLE DISEASE -----	114,400	2.4	10,000	1.3
DIARRHEAL DISEASES	CDD 19,000	0.4	10,000	1.3
AIDS	GPA 94,300	2.0	0	-
TUBERCULOSIS	TUB 1,100	.*	0	-
CONTROL OF NONCOMMUNICABLE DISEASES -----	15,000	0.3	0	-
OTHER NONCOMMUNICABLE DISEASES	NCD 15,000	0.3	0	-
VETERINARY PUBLIC HEALTH -----	126,300	2.6	100,000	12.5
FOOT-AND-MOUTH DISEASE	FMD 126,300	2.6	100,000	12.5
=====	=====	=====	=====	=====
GRAND TOTAL =====	4,770,400	100.0	799,200	100.0

\* INDICATES LESS THAN .05 PERCENT

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 BRAZIL  
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PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<u>2. HEALTH IN HUMAN DEVELOPMENT</u>	<u>4,775,600</u>	<u>44.7</u>	<u>4,903,500</u>	<u>45.9</u>
GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT	223,800	2.1	211,000	2.0
PUBLIC INFORMATION	INF 223,800	2.1	211,000	2.0
PUBLIC POLICY AND HEALTH	750,800	7.0	581,000	5.4
HEALTH IN SOCIOECONOMIC DEVELOPMENT	HSD 675,800	6.3	581,000	5.4
WOMEN, HEALTH AND DEVELOPMENT	WHD 75,000	0.7	0	-
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	3,632,000	34.0	3,955,000	37.0
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 3,537,000	33.1	3,800,000	35.6
HEALTH PLANNING	HPL 50,000	0.5	112,500	1.1
EMERGENCY AND HUMANITARIAN ACTION	EHA 45,000	0.4	42,500	0.4
TECHNICAL COOPERATION AMONG COUNTRIES	TCC 169,000	1.6	156,500	1.5
<u>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</u>	<u>1,645,000</u>	<u>15.4</u>	<u>1,575,300</u>	<u>14.7</u>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	744,200	7.0	718,400	6.7
UNIVERSAL ACCESS TO HEALTH CARE	UAH 744,200	7.0	718,400	6.7
HUMAN RESOURCES FOR HEALTH	HRH 430,000	4.0	405,400	3.8
ESSENTIAL DRUGS	EDV 470,800	4.4	451,500	4.2
<u>4. HEALTH PROMOTION AND PROTECTION</u>	<u>1,539,500</u>	<u>14.4</u>	<u>1,558,200</u>	<u>14.6</u>
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	899,000	8.4	940,800	8.8
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 899,000	8.4	940,800	8.8

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 BRAZIL

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
NUTRITION, FOOD SECURITY AND SAFETY	640,500	6.0	617,400	5.8	
FOOD AND NUTRITION	NUT	171,000	1.6	161,400	1.5
FOOD SAFETY	FOS	469,500	4.4	456,000	4.3
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT	627,500	5.9	605,400	5.7	
ENVIRONMENTAL HEALTH	627,500	5.9	605,400	5.7	
WATER SUPPLY AND SANITATION	CWS	513,500	4.8	498,200	4.7
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA	114,000	1.1	107,200	1.0
6. DISEASE PREVENTION AND CONTROL	2,098,200	19.6	2,043,400	19.1	
CONTROL OF COMMUNICABLE DISEASE	1,628,200	15.2	1,600,200	15.0	
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID	605,800	5.7	614,200	5.7
ACUTE RESPIRATORY INFECTIONS	ARI	57,000	0.5	53,800	0.5
OTHER COMMUNICABLE DISEASES	OCD	965,400	9.0	932,200	8.7
CONTROL OF NONCOMMUNICABLE DISEASES	254,000	2.4	239,500	2.2	
OTHER NONCOMMUNICABLE DISEASES	NCD	254,000	2.4	239,500	2.2
VETERINARY PUBLIC HEALTH	216,000	2.0	203,700	1.9	
ZOOONOSIS	ZNS	216,000	2.0	203,700	1.9
=====	=====	=====	=====	=====	
GRAND TOTAL	10,685,800	100.0	10,685,800	100.0	
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 BRAZIL  
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PROGRAM BUDGET - EXTRABUDGETARY FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
2. HEALTH IN HUMAN DEVELOPMENT =====	349,800	1.9	0	-
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT. -----	349,800	1.9	0	-
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS. CPS	349,800	1.9	0	-
3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT =====	11,707,600	62.2	600,000	12.0
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC -----	10,090,700	53.6	100,000	2.0
UNIVERSAL ACCESS TO HEALTH CARE UAH	10,090,700	53.6	100,000	2.0
HUMAN RESOURCES FOR HEALTH -----	808,700	4.3	0	-
ESSENTIAL DRUGS -----	808,200	4.3	500,000	10.0
EDV	808,200	4.3	500,000	10.0
4. HEALTH PROMOTION AND PROTECTION =====	106,500	0.6	0	-
NUTRITION, FOOD SECURITY AND SAFETY -----	106,500	0.6	0	-
FOOD AND NUTRITION NUT	106,500	0.6	0	-
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT =====	29,500	0.2	0	-
ENVIRONMENTAL HEALTH -----	29,500	0.2	0	-
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT ERA	29,500	0.2	0	-

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 BRAZIL  
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PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
6. DISEASE PREVENTION AND CONTROL =====	6,641,800	35.3	4,408,500	88.0	
CONTROL OF COMMUNICABLE DISEASE -----	6,641,800	35.3	4,408,500	88.0	
MALARIA AND OTHER TROPICAL DISEASES	CTD	6,046,700	32.1	4,400,500	87.9
LEPROSY	LEP	595,100	3.2	8,000	0.2
=====	=====	=====	=====	=====	
GRAND TOTAL	18,835,200	100.0	5,008,500	100.0	
=====	=====	=====	=====	=====	

\* INDICATES LESS THAN .05 PERCENT

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CANADA

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
2. HEALTH IN HUMAN DEVELOPMENT =====	0	-	57,500	6.4	
TECHNICAL COOPERATION AMONG COUNTRIES -----	TCC	0	-	57,500	6.4
3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT =====	847,800	100.0	841,300	93.6	
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC -----	847,800	100.0	841,300	93.6	
UNIVERSAL ACCESS TO HEALTH CARE -----	UAH	847,800	100.0	841,300	93.6
=====	=====	=====	=====	=====	
GRAND TOTAL =====	847,800	100.0	898,800	100.0	
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 CARIBBEAN  
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PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<u>2. HEALTH IN HUMAN DEVELOPMENT</u>	<u>2,790,000</u>	<u>41.2</u>	<u>2,812,700</u>	<u>40.1</u>
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	2,358,600	34.8	2,461,400	35.1
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 2,358,600	34.8	2,461,400	35.1
TECHNICAL COOPERATION AMONG COUNTRIES	TCC 431,400	6.4	351,300	5.0
<u>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</u>	<u>1,620,100</u>	<u>23.9</u>	<u>1,604,400</u>	<u>22.9</u>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	1,293,600	19.1	1,340,100	19.1
UNIVERSAL ACCESS TO HEALTH CARE	UAH 1,293,600	19.1	1,340,100	19.1
HUMAN RESOURCES FOR HEALTH	HRH 326,500	4.8	264,300	3.8
<u>4. HEALTH PROMOTION AND PROTECTION</u>	<u>979,800</u>	<u>14.5</u>	<u>1,254,400</u>	<u>17.9</u>
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	381,800	5.6	422,100	6.0
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 344,500	5.1	422,100	6.0
ADOLESCENT HEALTH	ADH 37,300	0.6	0	-
HEALTHY LIFESTYLES AND MENTAL HEALTH	598,000	8.8	832,300	11.9
HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED 598,000	8.8	632,300	9.0
PREVENTION AND CONTROL OF SUBSTANCE ABUSE	ADT 0	-	200,000	2.9
<u>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</u>	<u>472,600</u>	<u>7.0</u>	<u>486,600</u>	<u>6.9</u>
ENVIRONMENTAL HEALTH	472,600	7.0	486,600	6.9
WATER SUPPLY AND SANITATION	CWS 472,600	7.0	486,600	6.9

CARIBBEAN

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

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
6. DISEASE PREVENTION AND CONTROL	906,600	13.4	850,500	12.1
CONTROL OF COMMUNICABLE DISEASE	256,500	3.8	264,300	3.8
MALARIA AND OTHER TROPICAL DISEASES	CTD 256,500	3.8	264,300	3.8
CONTROL OF NONCOMMUNICABLE DISEASES	393,600	5.8	321,900	4.6
OTHER NONCOMMUNICABLE DISEASES	NCD 393,600	5.8	321,900	4.6
VETERINARY PUBLIC HEALTH	256,500	3.8	264,300	3.8
ZOOZOSIS	ZNS 256,500	3.8	264,300	3.8
GRAND TOTAL	6,769,100	100.0	7,008,600	100.0

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 CARIBBEAN  
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PROGRAM BUDGET - EXTRABUDGETARY FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<u>2. HEALTH IN HUMAN DEVELOPMENT</u>	<u>2,051,200</u>	<u>73.0</u>	<u>445,000</u>	<u>74.8</u>
PUBLIC POLICY AND HEALTH	5,400	0.2	0	-
WOMEN, HEALTH AND DEVELOPMENT	5,400	0.2	0	-
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	2,045,800	72.9	445,000	74.8
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS. EMERGENCY AND HUMANITARIAN ACTION	235,400 1,810,400	8.4 64.5	0 445,000	- 74.8
<u>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</u>	<u>32,000</u>	<u>1.1</u>	<u>0</u>	<u>-</u>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	32,000	1.1	0	-
UNIVERSAL ACCESS TO HEALTH CARE	3,400	0.1	0	-
DISABILITY PREVENTION AND REHABILITATION	28,600	1.0	0	-
<u>4. HEALTH PROMOTION AND PROTECTION</u>	<u>238,000</u>	<u>8.5</u>	<u>0</u>	<u>-</u>
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	237,400	8.5	0	-
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	237,400	8.5	0	-
HEALTHY LIFESTYLES AND MENTAL HEALTH	600	.*	0	-
MENTAL HEALTH	600	.*	0	-
<u>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</u>	<u>388,600</u>	<u>13.8</u>	<u>150,000</u>	<u>25.2</u>
ENVIRONMENTAL HEALTH	388,600	13.8	150,000	25.2
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	388,600	13.8	150,000	25.2

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 CARIBBEAN

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
6. DISEASE PREVENTION AND CONTROL =====	98,200	3.5	0	-	
CONTROL OF COMMUNICABLE DISEASE -----	82,900	3.0	0	-	
MALARIA AND OTHER TROPICAL DISEASES	CTD	82,900	3.0	0	-
CONTROL OF NONCOMMUNICABLE DISEASES -----	15,300	0.5	0	-	
CANCER	CAN	15,300	0.5	0	-
=====	=====	=====	=====	=====	
GRAND TOTAL	2,808,000	100.0	595,000	100.0	
=====	=====	=====	=====	=====	

\* INDICATES LESS THAN .05 PERCENT

CHILE

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b>	<b>1,168,600</b>	<b>44.6</b>	<b>1,256,400</b>	<b>47.9</b>
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	967,600	36.9	1,072,200	40.9
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 967,600	36.9	1,072,200	40.9
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS	114,700	4.4	104,200	4.0
HEALTH SITUATION AND TREND ASSESSMENT	HST 69,300	2.6	104,200	4.0
HEALTH AND BIOMEDICAL INFORMATION	HBI 45,400	1.7	0	-
TECHNICAL COOPERATION AMONG COUNTRIES	TCC 86,300	3.3	80,000	3.1
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b>	<b>1,114,200</b>	<b>42.5</b>	<b>767,500</b>	<b>29.3</b>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	965,300	36.8	680,200	26.0
UNIVERSAL ACCESS TO HEALTH CARE	UAH 965,300	36.8	680,200	26.0
HUMAN RESOURCES FOR HEALTH	HRH 148,900	5.7	87,300	3.3
<b>4. HEALTH PROMOTION AND PROTECTION</b>	<b>40,800</b>	<b>1.6</b>	<b>195,500</b>	<b>7.5</b>
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	40,800	1.6	0	-
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 40,800	1.6	0	-
HEALTHY LIFESTYLES AND MENTAL HEALTH	0	-	195,500	7.5
SETTINGS FOR HEALTH PROMOTION	STP 0	-	195,500	7.5

CHILE

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

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT =====	132,700	5.1	165,800	6.3
ENVIRONMENTAL HEALTH -----	132,700	5.1	165,800	6.3
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT ERA	132,700	5.1	165,800	6.3
6. DISEASE PREVENTION AND CONTROL =====	164,200	6.3	235,300	9.0
CONTROL OF COMMUNICABLE DISEASE -----	68,000	2.6	112,300	4.3
AIDS OTHER COMMUNICABLE DISEASES GPA OCD	0	-	19,000	0.7
OTHER COMMUNICABLE DISEASES OCD	68,000	2.6	93,300	3.6
CONTROL OF NONCOMMUNICABLE DISEASES -----	96,200	3.7	123,000	4.7
OTHER NONCOMMUNICABLE DISEASES NCD	96,200	3.7	123,000	4.7
=====	=====	=====	=====	=====
GRAND TOTAL =====	2,620,500	100.0	2,620,500	100.0

CHILE

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
2. HEALTH IN HUMAN DEVELOPMENT	138,400	55.7	0	-	
=====	=====	=====	=====	=====	
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	138,400	55.7	0	-	
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DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS	127,000	51.1	0	-
EMERGENCY AND HUMANITARIAN ACTION	EHA	11,400	4.6	0	-
3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT	13,900	5.6	0	-	
=====	=====	=====	=====	=====	
HUMAN RESOURCES FOR HEALTH	HRH	13,900	5.6	0	-
-----	-----	-----	-----	-----	
6. DISEASE PREVENTION AND CONTROL	96,200	38.7	0	-	
=====	=====	=====	=====	=====	
CONTROL OF COMMUNICABLE DISEASE	84,400	34.0	0	-	
-----	-----	-----	-----	-----	
AIDS	GPA	84,400	34.0	0	-
CONTROL OF NONCOMMUNICABLE DISEASES		11,800	4.7	0	-
-----	-----	-----	-----	-----	
OTHER NONCOMMUNICABLE DISEASES	NCD	11,800	4.7	0	-
=====	=====	=====	=====	=====	
GRAND TOTAL		248,500	100.0	0	0.0
=====	=====	=====	=====	=====	

COLOMBIA

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<u>2. HEALTH IN HUMAN DEVELOPMENT</u>	<u>1,877,200</u>	<u>40.6</u>	<u>1,922,300</u>	<u>41.6</u>
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	1,339,800	29.0	1,420,700	30.7
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS. EMERGENCY AND HUMANITARIAN ACTION	CPS 1,294,400 EHA 45,400	28.0 1.0	1,374,700 46,000	29.7 1.0
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS	411,800	8.9	385,300	8.3
HEALTH SITUATION AND TREND ASSESSMENT	HST 411,800	8.9	385,300	8.3
TECHNICAL COOPERATION AMONG COUNTRIES	TCC 125,600	2.7	116,300	2.5
<u>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</u>	<u>884,500</u>	<u>19.1</u>	<u>860,900</u>	<u>18.6</u>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	613,200	13.3	588,000	12.7
UNIVERSAL ACCESS TO HEALTH CARE	UAH 613,200	13.3	588,000	12.7
HUMAN RESOURCES FOR HEALTH	HRH 225,900	4.9	226,900	4.9
ESSENTIAL DRUGS	EDV 45,400	1.0	46,000	1.0
<u>4. HEALTH PROMOTION AND PROTECTION</u>	<u>417,300</u>	<u>9.0</u>	<u>145,800</u>	<u>3.2</u>
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	145,900	3.2	145,800	3.2
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 145,900	3.2	145,800	3.2
HEALTHY LIFESTYLES AND MENTAL HEALTH	271,400	5.9	0	-
SETTINGS FOR HEALTH PROMOTION	STP 271,400	5.9	0	-

COLOMBIA

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

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT =====	511,100	11.1	497,500	10.8
ENVIRONMENTAL HEALTH -----	511,100	11.1	497,500	10.8
WATER SUPPLY AND SANITATION	CWS 511,100	11.1	497,500	10.8
6. DISEASE PREVENTION AND CONTROL =====	932,100	20.2	1,195,700	25.9
CONTROL OF COMMUNICABLE DISEASE -----	437,000	9.5	470,100	10.2
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID 225,900	4.9	256,600	5.6
OTHER COMMUNICABLE DISEASES	OCD 211,100	4.6	213,500	4.6
CONTROL OF NONCOMMUNICABLE DISEASES -----	319,200	6.9	547,300	11.8
OTHER NONCOMMUNICABLE DISEASES	NCD 319,200	6.9	547,300	11.8
VETERINARY PUBLIC HEALTH -----	175,900	3.8	178,300	3.9
ZOOZOSIS	ZNS 175,900	3.8	178,300	3.9
=====				
GRAND TOTAL =====	4,622,200	100.0	4,622,200	100.0

COLOMBIA

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<u>2. HEALTH IN HUMAN DEVELOPMENT</u>	<u>611,200</u>	<u>31.1</u>	<u>0</u>	<u>-</u>
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	611,200	31.1	0	-
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS. EMERGENCY AND HUMANITARIAN ACTION	CPS 2,900 EHA 608,300	0.1 30.9	0 0	- -
<u>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</u>	<u>384,100</u>	<u>19.5</u>	<u>0</u>	<u>-</u>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	303,900	15.4	0	-
UNIVERSAL ACCESS TO HEALTH CARE	UAH 303,900	15.4	0	-
ESSENTIAL DRUGS	EDV 80,200	4.1	0	-
<u>4. HEALTH PROMOTION AND PROTECTION</u>	<u>8,000</u>	<u>0.4</u>	<u>0</u>	<u>-</u>
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	8,000	0.4	0	-
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 8,000	0.4	0	-
<u>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</u>	<u>622,400</u>	<u>31.6</u>	<u>0</u>	<u>-</u>
ENVIRONMENTAL HEALTH	622,400	31.6	0	-
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA 622,400	31.6	0	-
<u>6. DISEASE PREVENTION AND CONTROL</u>	<u>341,600</u>	<u>17.4</u>	<u>14,000</u>	<u>100.0</u>
CONTROL OF COMMUNICABLE DISEASE	57,500	2.9	14,000	100.0
DIARRHEAL DISEASES	CDD 27,300	1.4	5,000	35.7
AIDS	GPA 9,300	0.5	9,000	64.3
OTHER COMMUNICABLE DISEASES	OCD 20,900	1.1	0	-

COLOMBIA

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
CONTROL OF NONCOMMUNICABLE DISEASES	196,600	10.0	0	-
OTHER NONCOMMUNICABLE DISEASES	NCD 196,600	10.0	0	-
VETERINARY PUBLIC HEALTH	87,500	4.4	0	-
ZOOZOSIS	ZNS 87,500	4.4	0	-
===== GRAND TOTAL =====	1,967,300	100.0	14,000	100.0

COSTA RICA

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
<b>2. HEALTH IN HUMAN DEVELOPMENT</b>	<b>1,446,300</b>	<b>47.7</b>	<b>1,644,200</b>	<b>54.3</b>	
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PUBLIC POLICY AND HEALTH	0	-	133,100	4.4	
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HEALTH IN SOCIOECONOMIC DEVELOPMENT	HSD	0	133,100	4.4	
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.		1,058,700	35.0	1,038,100	34.3
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DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS	1,058,700	35.0	1,038,100	34.3
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS		287,400	9.5	380,200	12.6
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HEALTH SITUATION AND TREND ASSESSMENT	HST	287,400	9.5	380,200	12.6
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	100,200	3.3	92,800	3.1
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<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b>	<b>694,800</b>	<b>22.9</b>	<b>471,500</b>	<b>15.6</b>	
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ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC		639,800	21.1	368,200	12.2
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UNIVERSAL ACCESS TO HEALTH CARE	UAH	639,800	21.1	368,200	12.2
HUMAN RESOURCES FOR HEALTH	HRH	55,000	1.8	0	-
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QUALITY OF CARE AND HEALTH TECHNOLOGY		0	-	103,300	3.4
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QUALITY OF CARE AND HEALTH TECHNOLOGY ASSESSMENT	QAC	0	-	103,300	3.4
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<b>4. HEALTH PROMOTION AND PROTECTION</b>	<b>328,600</b>	<b>10.8</b>	<b>470,400</b>	<b>15.5</b>	
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FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES		328,600	10.8	235,200	7.8
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WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH	328,600	10.8	235,200	7.8
HEALTHY LIFESTYLES AND MENTAL HEALTH		0	-	235,200	7.8
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SETTINGS FOR HEALTH PROMOTION	STP	0	-	235,200	7.8

COSTA RICA

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

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT	327,400	10.8	400,600	13.2
ENVIRONMENTAL HEALTH	327,400	10.8	400,600	13.2
WATER SUPPLY AND SANITATION	CWS 85,000	2.8	0	-
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA 242,400	8.0	400,600	13.2
6. DISEASE PREVENTION AND CONTROL	232,000	7.7	42,400	1.4
CONTROL OF COMMUNICABLE DISEASE	105,000	3.5	42,400	1.4
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID 31,000	1.0	16,600	0.5
OTHER COMMUNICABLE DISEASES	OCD 74,000	2.4	25,800	0.9
CONTROL OF NONCOMMUNICABLE DISEASES	105,000	3.5	0	-
OTHER NONCOMMUNICABLE DISEASES	NCD 105,000	3.5	0	-
VETERINARY PUBLIC HEALTH	22,000	0.7	0	-
ZOOZOSIS	ZNS 22,000	0.7	0	-
GRAND TOTAL	3,029,100	100.0	3,029,100	100.0

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COSTA RICA

PROGRAM BUDGET - EXTRABUDGETARY FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
2. <u>HEALTH IN HUMAN DEVELOPMENT</u>	952,400	11.6	140,100	2.6	
<u>PUBLIC POLICY AND HEALTH</u>	301,800	3.7	140,000	2.6	
WOMEN, HEALTH AND DEVELOPMENT	WHD	301,800	3.7	140,000	2.6
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.		626,600	7.6	100	-
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS. EMERGENCY AND HUMANITARIAN ACTION	CPS EHA	98,000 528,600	1.2 6.4	0 100	- -
TECHNICAL COOPERATION AMONG COUNTRIES	TCC	24,000	0.3	0	-
3. <u>HEALTH SYSTEMS AND SERVICES DEVELOPMENT</u>	1,752,600	21.3	600,000	11.0	
<u>ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC</u>	1,504,600	18.3	600,000	11.0	
UNIVERSAL ACCESS TO HEALTH CARE	UAH	1,504,600	18.3	600,000	11.0
HUMAN RESOURCES FOR HEALTH	HRH	248,000	3.0	0	-
4. <u>HEALTH PROMOTION AND PROTECTION</u>	29,600	0.4	20,000	0.4	
<u>HEALTHY LIFESTYLES AND MENTAL HEALTH</u>	29,600	0.4	20,000	0.4	
PREVENTION AND CONTROL OF SUBSTANCE ABUSE	ADT	29,600	0.4	20,000	0.4
5. <u>ENVIRONMENTAL PROTECTION AND DEVELOPMENT</u>	5,460,800	66.5	4,710,000	86.1	
<u>ENVIRONMENTAL HEALTH</u>	5,460,800	66.5	4,710,000	86.1	
WATER SUPPLY AND SANITATION	CWS	4,467,800	54.4	4,000,000	73.1
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA	993,000	12.1	710,000	13.0

COSTA RICA

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)

PAHD PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
6. DISEASE PREVENTION AND CONTROL =====	14,700	0.2	0	-
CONTROL OF COMMUNICABLE DISEASE -----	14,700	0.2	0	-
MALARIA AND OTHER TROPICAL DISEASES	CTD 14,700	0.2	0	-
=====	=====	=====	=====	=====
GRAND TOTAL	8,210,100	100.0	5,470,100	100.0
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CUBA

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
2. HEALTH IN HUMAN DEVELOPMENT =====	942,700	36.9	1,034,500	39.5
----- PUBLIC POLICY AND HEALTH -----	0	-	75,600	2.9
HEALTH IN SOCIOECONOMIC DEVELOPMENT	0	-	75,600	2.9
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT. -----	626,800	24.5	665,700	25.4
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS. EMERGENCY AND HUMANITARIAN ACTION	606,800 20,000	23.7 0.8	633,200 32,500	24.2 1.2
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS -----	150,000	5.9	139,600	5.3
HEALTH SITUATION AND TREND ASSESSMENT HEALTH AND BIOMEDICAL INFORMATION	90,000 60,000	3.5 2.3	89,900 49,700	3.4 1.9
TECHNICAL COOPERATION AMONG COUNTRIES -----	165,900	6.5	153,600	5.9
3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT =====	1,381,800	54.0	1,231,800	47.0
----- ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC -----	844,300	33.0	738,400	28.2
UNIVERSAL ACCESS TO HEALTH CARE HEALTH SYSTEMS RESEARCH	829,300 15,000	32.4 0.6	604,200 134,200	23.1 5.1
HUMAN RESOURCES FOR HEALTH -----	507,500	19.8	493,400	18.8
ESSENTIAL DRUGS -----	30,000	1.2	0	-
4. HEALTH PROMOTION AND PROTECTION =====	100,000	3.9	223,200	8.5
----- FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES -----	0	-	99,300	3.8
WOMEN AND CHILD HEALTH AND FAMILY PLANNING ADOLESCENT HEALTH HEALTH OF THE ELDERLY	0 0 0	- - -	29,800 29,800 39,700	1.1 1.1 1.5

CUBA

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

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
HEALTHY LIFESTYLES AND MENTAL HEALTH	80,000	3.1	123,900	4.7	
HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED	0	-	29,800	1.1
SETTINGS FOR HEALTH PROMOTION	STP	80,000	3.1	94,100	3.6
NUTRITION, FOOD SECURITY AND SAFETY		20,000	0.8	0	-
FOOD AND NUTRITION	NUT	20,000	0.8	0	-
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT		50,000	2.0	44,400	1.7
ENVIRONMENTAL HEALTH		50,000	2.0	44,400	1.7
WATER SUPPLY AND SANITATION	CWS	50,000	2.0	0	-
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA	0	-	14,800	0.6
MANAGEMENT OF SOLID WASTE AND HOUSING HYGIENE	MWH	0	-	14,800	0.6
WORKERS' HEALTH	OCH	0	-	14,800	0.6
6. DISEASE PREVENTION AND CONTROL		82,500	3.2	86,100	3.3
CONTROL OF COMMUNICABLE DISEASE		51,500	2.0	0	-
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID	27,500	1.1	0	-
SEXUALLY TRANSMITTED DISEASES	STD	24,000	0.9	0	-
CONTROL OF NONCOMMUNICABLE DISEASES		31,000	1.2	46,400	1.8
CANCER	CAN	16,000	0.6	0	-
CARDIOVASCULAR DISEASES	CVD	15,000	0.6	0	-
OTHER NONCOMMUNICABLE DISEASES	NCD	0	-	46,400	1.8
VETERINARY PUBLIC HEALTH		0	-	39,700	1.5
ZOONOSIS	ZNS	0	-	39,700	1.5
GRAND TOTAL		2,557,000	100.0	2,620,000	100.0

CUBA

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b>	<b>273,500</b>	<b>39.6</b>	<b>169,000</b>	<b>32.6</b>
=====	=====	=====	=====	=====
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	273,500	39.6	169,000	32.6
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DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 9,200	1.3	9,000	1.7
HEALTH PLANNING	HPL 79,100	11.4	0	-
EMERGENCY AND HUMANITARIAN ACTION	EHA 185,200	26.8	160,000	30.8
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b>	<b>50,000</b>	<b>7.2</b>	<b>0</b>	<b>-</b>
=====	=====	=====	=====	=====
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	25,000	3.6	0	-
-----	-----	-----	-----	-----
HEALTH SYSTEMS RESEARCH	HSR 25,000	3.6	0	-
ESSENTIAL DRUGS	EDV 25,000	3.6	0	-
-----	-----	-----	-----	-----
<b>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</b>	<b>368,000</b>	<b>53.2</b>	<b>350,000</b>	<b>67.4</b>
=====	=====	=====	=====	=====
ENVIRONMENTAL HEALTH	368,000	53.2	350,000	67.4
-----	-----	-----	-----	-----
MANAGEMENT OF SOLID WASTE AND HOUSING HYGIENE	MWH 368,000	53.2	350,000	67.4
=====	=====	=====	=====	=====
<b>GRAND TOTAL</b>	<b>691,500</b>	<b>100.0</b>	<b>519,000</b>	<b>100.0</b>
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DOMINICA

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT =====	221,000	72.6	159,900	52.5	
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC -----	221,000	72.6	159,900	52.5	
UNIVERSAL ACCESS TO HEALTH CARE	UAH	221,000	72.6	159,900	52.5
4. HEALTH PROMOTION AND PROTECTION =====	41,500	13.6	72,100	23.7	
HEALTHY LIFESTYLES AND MENTAL HEALTH -----	41,500	13.6	72,100	23.7	
HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED	41,500	13.6	72,100	23.7
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT =====	42,000	13.8	72,500	23.8	
ENVIRONMENTAL HEALTH -----	42,000	13.8	72,500	23.8	
WATER SUPPLY AND SANITATION	CWS	42,000	13.8	72,500	23.8
=====	=====	=====	=====	=====	
GRAND TOTAL =====	304,500	100.0	304,500	100.0	

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DOMINICAN REPUBLIC

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<u>2. HEALTH IN HUMAN DEVELOPMENT</u>	<u>1,742,200</u>	<u>51.6</u>	<u>1,764,600</u>	<u>51.7</u>
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	975,500	28.9	1,030,100	30.2
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 975,500	28.9	1,030,100	30.2
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS	659,500	19.5	635,300	18.6
HEALTH SITUATION AND TREND ASSESSMENT	HST 539,500	16.0	526,100	15.4
HEALTH AND BIOMEDICAL INFORMATION	HBI 120,000	3.6	109,200	3.2
TECHNICAL COOPERATION AMONG COUNTRIES	TCC 107,200	3.2	99,200	2.9
<u>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</u>	<u>823,800</u>	<u>24.4</u>	<u>853,500</u>	<u>25.0</u>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	673,800	19.9	853,500	25.0
UNIVERSAL ACCESS TO HEALTH CARE	UAH 673,800	19.9	853,500	25.0
HUMAN RESOURCES FOR HEALTH	HRH 150,000	4.4	0	-
<u>4. HEALTH PROMOTION AND PROTECTION</u>	<u>270,000</u>	<u>8.0</u>	<u>248,500</u>	<u>7.3</u>
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	270,000	8.0	248,500	7.3
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 270,000	8.0	248,500	7.3
<u>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</u>	<u>469,500</u>	<u>13.9</u>	<u>497,400</u>	<u>14.6</u>
ENVIRONMENTAL HEALTH	469,500	13.9	497,400	14.6
WATER SUPPLY AND SANITATION	CWS 469,500	13.9	497,400	14.6

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 DOMINICAN REPUBLIC

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
6. DISEASE PREVENTION AND CONTROL =====	72,000	2.1	49,600	1.5	
CONTROL OF COMMUNICABLE DISEASE -----	72,000	2.1	49,600	1.5	
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID	72,000	2.1	49,600	1.5
=====	=====	=====	=====	=====	
GRAND TOTAL =====	3,377,500	100.0	3,413,600	100.0	

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**DOMINICAN REPUBLIC**  
**PROGRAM BUDGET - EXTRABUDGETARY FUNDS**  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b> =====	943,500	86.3	0	-
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT. -----	943,500	86.3	0	-
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS. EMERGENCY AND HUMANITARIAN ACTION	CPS 1,200 EHA 942,300	0.1 86.2	0 0	- -
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b> =====	54,200	5.0	0	-
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC -----	1,400	0.1	0	-
ORAL HEALTH	ORH 1,400	0.1	0	-
HUMAN RESOURCES FOR HEALTH -----	HRH 29,400	2.7	0	-
ESSENTIAL DRUGS -----	EDV 23,400	2.1	0	-
<b>6. DISEASE PREVENTION AND CONTROL</b> =====	96,000	8.8	1,000	100.0
CONTROL OF COMMUNICABLE DISEASE -----	96,000	8.8	1,000	100.0
DIARRHEAL DISEASES	CDD 1,000	0.1	1,000	100.0
AIDS	GPA 95,000	8.7	0	-
=====	=====	=====	=====	=====
<b>GRAND TOTAL</b> =====	1,093,700	100.0	1,000	100.0

EASTERN CARIBBEAN

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT	155,500	57.0	124,700	45.7	
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	155,500	57.0	124,700	45.7	
UNIVERSAL ACCESS TO HEALTH CARE	UAH	155,500	57.0	124,700	45.7
4. HEALTH PROMOTION AND PROTECTION	71,000	26.0	0	-	
HEALTHY LIFESTYLES AND MENTAL HEALTH	71,000	26.0	0	-	
HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED	71,000	26.0	0	-
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT	46,400	17.0	60,000	22.0	
ENVIRONMENTAL HEALTH	46,400	17.0	60,000	22.0	
WATER SUPPLY AND SANITATION	CWS	46,400	17.0	60,000	22.0
6. DISEASE PREVENTION AND CONTROL	0	-	88,200	32.3	
CONTROL OF COMMUNICABLE DISEASE	0	-	2,300	0.8	
AIDS	GPA	0	2,300	0.8	
CONTROL OF NONCOMMUNICABLE DISEASES	0	-	85,900	31.5	
OTHER NONCOMMUNICABLE DISEASES	NCD	0	85,900	31.5	
GRAND TOTAL	272,900	100.0	272,900	100.0	

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EASTERN CARIBBEAN

PROGRAM BUDGET - EXTRABUDGETARY FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT =====	1,800	2.4	1,500	100.0	
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC -----	1,800	2.4	1,500	100.0	
UNIVERSAL ACCESS TO HEALTH CARE	UAH	1,800	2.4	1,500	100.0
6. DISEASE PREVENTION AND CONTROL =====	72,500	97.6	0	-	
CONTROL OF COMMUNICABLE DISEASE -----	72,500	97.6	0	-	
AIDS	GPA	72,500	97.6	0	-
=====	=====	=====	=====	=====	
GRAND TOTAL	74,300	100.0	1,500	100.0	
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PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<u>2. HEALTH IN HUMAN DEVELOPMENT</u>	<u>1,370,200</u>	<u>38.7</u>	<u>1,629,000</u>	<u>46.0</u>
PUBLIC POLICY AND HEALTH	245,200	6.9	216,300	6.1
HEALTH IN SOCIOECONOMIC DEVELOPMENT	HSD 245,200	6.9	216,300	6.1
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	701,400	19.8	1,006,700	28.4
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 701,400	19.8	1,006,700	28.4
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS	315,900	8.9	306,400	8.7
HEALTH SITUATION AND TREND ASSESSMENT	HST 315,900	8.9	306,400	8.7
TECHNICAL COOPERATION AMONG COUNTRIES	TCC 107,700	3.0	99,600	2.8
<u>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</u>	<u>887,200</u>	<u>25.1</u>	<u>734,900</u>	<u>20.8</u>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	806,600	22.8	649,600	18.4
UNIVERSAL ACCESS TO HEALTH CARE	UAH 806,600	22.8	649,600	18.4
HUMAN RESOURCES FOR HEALTH	HRH 80,600	2.3	85,300	2.4
<u>4. HEALTH PROMOTION AND PROTECTION</u>	<u>249,300</u>	<u>7.0</u>	<u>202,900</u>	<u>5.7</u>
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	99,000	2.8	40,800	1.2
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 99,000	2.8	40,800	1.2
HEALTHY LIFESTYLES AND MENTAL HEALTH	78,300	2.2	118,400	3.3
HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED 78,300	2.2	118,400	3.3
NUTRITION, FOOD SECURITY AND SAFETY	72,000	2.0	43,700	1.2
FOOD AND NUTRITION	NUT 72,000	2.0	43,700	1.2

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PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT =====	542,200	15.3	502,100	14.2
ENVIRONMENTAL HEALTH -----	542,200	15.3	502,100	14.2
WATER SUPPLY AND SANITATION	CWS 542,200	15.3	502,100	14.2
6. DISEASE PREVENTION AND CONTROL =====	489,700	13.8	469,700	13.3
CONTROL OF COMMUNICABLE DISEASE -----	461,700	13.0	425,400	12.0
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID 64,000	1.8	70,300	2.0
OTHER COMMUNICABLE DISEASES	OCD 397,700	11.2	355,100	10.0
CONTROL OF NONCOMMUNICABLE DISEASES -----	28,000	0.8	44,300	1.3
OTHER NONCOMMUNICABLE DISEASES	NCD 28,000	0.8	44,300	1.3
=====	=====	=====	=====	=====
GRAND TOTAL =====	3,538,600	100.0	3,538,600	100.0

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PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT =====	146,300	4.6	0	-	
ENVIRONMENTAL HEALTH -----	146,300	4.6	0	-	
WATER SUPPLY AND SANITATION	CWS	136,500	4.3	0	-
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA	9,800	0.3	0	-
6. DISEASE PREVENTION AND CONTROL =====	193,400	6.1	4,200	0.3	
CONTROL OF COMMUNICABLE DISEASE -----	167,600	5.3	4,200	0.3	
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID	163,300	5.1	0	-
DIARRHEAL DISEASES	CDD	4,300	0.1	4,200	0.3
VETERINARY PUBLIC HEALTH -----	25,800	0.8	0	-	
ZOOZOSIS	ZNS	25,800	0.8	0	-
=====	=====	=====	=====	=====	
GRAND TOTAL =====	3,173,600	100.0	1,383,300	100.0	

\* INDICATES LESS THAN .05 PERCENT

EL SALVADOR

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b>	<b>1,209,800</b>	<b>42.0</b>	<b>1,242,600</b>	<b>41.6</b>
PUBLIC POLICY AND HEALTH	25,000	0.9	34,700	1.2
WOMEN, HEALTH AND DEVELOPMENT	25,000	0.9	34,700	1.2
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	1,021,600	35.5	1,053,300	35.2
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	1,021,600	35.5	1,053,300	35.2
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS	53,000	1.8	52,700	1.8
HEALTH SITUATION AND TREND ASSESSMENT	53,000	1.8	52,700	1.8
TECHNICAL COOPERATION AMONG COUNTRIES	110,200	3.8	101,900	3.4
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b>	<b>813,000</b>	<b>28.2</b>	<b>828,400</b>	<b>27.7</b>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	751,000	26.1	766,800	25.7
UNIVERSAL ACCESS TO HEALTH CARE	751,000	26.1	766,800	25.7
HUMAN RESOURCES FOR HEALTH	62,000	2.2	61,600	2.1
<b>4. HEALTH PROMOTION AND PROTECTION</b>	<b>44,000</b>	<b>1.5</b>	<b>33,700</b>	<b>1.1</b>
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	44,000	1.5	33,700	1.1
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	44,000	1.5	33,700	1.1
<b>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</b>	<b>405,100</b>	<b>14.1</b>	<b>435,100</b>	<b>14.6</b>
ENVIRONMENTAL HEALTH	405,100	14.1	435,100	14.6
WATER SUPPLY AND SANITATION	405,100	14.1	435,100	14.6

EL SALVADOR

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

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
6. DISEASE PREVENTION AND CONTROL	408,900	14.2	449,000	15.0
CONTROL OF COMMUNICABLE DISEASE	330,500	11.5	371,100	12.4
OTHER COMMUNICABLE DISEASES	OCD 330,500	11.5	371,100	12.4
CONTROL OF NONCOMMUNICABLE DISEASES	52,600	1.8	52,200	1.7
OTHER NONCOMMUNICABLE DISEASES	NCD 52,600	1.8	52,200	1.7
VETERINARY PUBLIC HEALTH	25,800	0.9	25,700	0.9
ZOOZOSIS	ZNS 25,800	0.9	25,700	0.9
GRAND TOTAL	2,880,800	100.0	2,988,800	100.0

EL SALVADOR

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b>	<b>384,900</b>	<b>8.9</b>	<b>35,000</b>	<b>5.5</b>
PUBLIC POLICY AND HEALTH	96,900	2.2	35,000	5.5
WOMEN, HEALTH AND DEVELOPMENT	WHD 96,900	2.2	35,000	5.5
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	272,400	6.3	0	-
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 17,700	0.4	0	-
EMERGENCY AND HUMANITARIAN ACTION	EHA 254,700	5.9	0	-
TECHNICAL COOPERATION AMONG COUNTRIES	TCC 15,600	0.4	0	-
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b>	<b>3,225,700</b>	<b>74.3</b>	<b>0</b>	<b>-</b>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	3,208,700	73.9	0	-
UNIVERSAL ACCESS TO HEALTH CARE	UAH 3,208,700	73.9	0	-
HUMAN RESOURCES FOR HEALTH	HRH 17,000	0.4	0	-
<b>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</b>	<b>605,000</b>	<b>13.9</b>	<b>480,000</b>	<b>75.6</b>
ENVIRONMENTAL HEALTH	605,000	13.9	480,000	75.6
WATER SUPPLY AND SANITATION	CWS 4,800	0.1	0	-
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA 600,200	13.8	480,000	75.6
<b>6. DISEASE PREVENTION AND CONTROL</b>	<b>125,100</b>	<b>2.9</b>	<b>120,000</b>	<b>18.9</b>
CONTROL OF COMMUNICABLE DISEASE	125,100	2.9	120,000	18.9
AIDS	GPA 125,100	2.9	120,000	18.9
<b>GRAND TOTAL</b>	<b>4,340,700</b>	<b>100.0</b>	<b>635,000</b>	<b>100.0</b>

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PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT	170,000	100.0	170,000	100.0
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	170,000	100.0	170,000	100.0
UNIVERSAL ACCESS TO HEALTH CARE	UAH 170,000	100.0	170,000	100.0
GRAND TOTAL	170,000	100.0	170,000	100.0

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PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT =====	83,600	50.3	87,000	44.0	
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC -----	83,600	50.3	87,000	44.0	
UNIVERSAL ACCESS TO HEALTH CARE	UAH	83,600	50.3	87,000	44.0
4. HEALTH PROMOTION AND PROTECTION =====	34,000	20.5	39,700	20.1	
HEALTHY LIFESTYLES AND MENTAL HEALTH -----	34,000	20.5	39,700	20.1	
HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED	34,000	20.5	39,700	20.1
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT =====	38,000	22.9	38,300	19.4	
ENVIRONMENTAL HEALTH -----	38,000	22.9	38,300	19.4	
WATER SUPPLY AND SANITATION	CWS	38,000	22.9	38,300	19.4
6. DISEASE PREVENTION AND CONTROL =====	10,500	6.3	32,700	16.5	
CONTROL OF COMMUNICABLE DISEASE -----	0	-	32,700	16.5	
AIDS	GPA	0	-	32,700	16.5
CONTROL OF NONCOMMUNICABLE DISEASES -----	10,500	6.3	0	-	
OTHER NONCOMMUNICABLE DISEASES	NCD	10,500	6.3	0	-
=====	=====	=====	=====	=====	
GRAND TOTAL	166,100	100.0	197,700	100.0	
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PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b> =====	<b>2,035,500</b>	<b>46.5</b>	<b>2,083,000</b>	<b>47.1</b>
<b>PUBLIC POLICY AND HEALTH</b> -----	<b>71,900</b>	<b>1.6</b>	<b>71,400</b>	<b>1.6</b>
<b>WOMEN, HEALTH AND DEVELOPMENT</b> WHD	71,900	1.6	71,400	1.6
<b>NATIONAL HEALTH POLICIES &amp; PROG. DEVELOP. &amp; MGMT.</b> -----	<b>1,281,500</b>	<b>29.3</b>	<b>1,338,600</b>	<b>30.3</b>
<b>DEVELOPMENT, MANAGEMENT &amp; COORD. OF COUNTRY PROGS.</b> CPS	1,261,500	28.8	1,318,900	29.8
<b>EMERGENCY AND HUMANITARIAN ACTION</b> EHA	20,000	0.5	19,700	0.4
<b>BIOMEDICAL AND HEALTH INFORMATION AND TRENDS</b> -----	<b>534,100</b>	<b>12.2</b>	<b>536,100</b>	<b>12.1</b>
<b>HEALTH SITUATION AND TREND ASSESSMENT</b> HST	381,200	8.7	384,400	8.7
<b>HEALTH AND BIOMEDICAL INFORMATION</b> HBI	152,900	3.5	151,700	3.4
<b>TECHNICAL COOPERATION AMONG COUNTRIES</b> -----	<b>148,000</b>	<b>3.4</b>	<b>136,900</b>	<b>3.1</b>
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b> =====	<b>818,800</b>	<b>18.7</b>	<b>818,500</b>	<b>18.5</b>
<b>ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC</b> -----	<b>627,000</b>	<b>14.3</b>	<b>628,200</b>	<b>14.2</b>
<b>UNIVERSAL ACCESS TO HEALTH CARE</b> UAH	627,000	14.3	628,200	14.2
<b>HUMAN RESOURCES FOR HEALTH</b> -----	<b>95,900</b>	<b>2.2</b>	<b>95,100</b>	<b>2.2</b>
<b>ESSENTIAL DRUGS</b> EDV	95,900	2.2	95,200	2.2
<b>4. HEALTH PROMOTION AND PROTECTION</b> =====	<b>259,800</b>	<b>5.9</b>	<b>258,100</b>	<b>5.8</b>
<b>FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES</b> -----	<b>187,900</b>	<b>4.3</b>	<b>186,500</b>	<b>4.2</b>
<b>WOMEN AND CHILD HEALTH AND FAMILY PLANNING</b> WCH	187,900	4.3	186,500	4.2

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PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
NUTRITION, FOOD SECURITY AND SAFETY	71,900	1.6	71,600	1.6
FOOD SAFETY	FOS 71,900	1.6	71,600	1.6
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT	577,700	13.2	579,300	13.1
ENVIRONMENTAL HEALTH	577,700	13.2	579,300	13.1
WATER SUPPLY AND SANITATION	CWS 457,800	10.5	460,400	10.4
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA 119,900	2.7	118,900	2.7
6. DISEASE PREVENTION AND CONTROL	683,400	15.6	684,200	15.5
CONTROL OF COMMUNICABLE DISEASE	606,800	13.9	608,200	13.8
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID 47,800	1.1	47,500	1.1
OTHER COMMUNICABLE DISEASES	OCD 559,000	12.8	560,700	12.7
CONTROL OF NONCOMMUNICABLE DISEASES	28,800	0.7	28,500	0.6
OTHER NONCOMMUNICABLE DISEASES	NCD 28,800	0.7	28,500	0.6
VETERINARY PUBLIC HEALTH	47,800	1.1	47,500	1.1
ZOOZOSIS	ZNS 47,800	1.1	47,500	1.1
GRAND TOTAL	4,375,200	100.0	4,423,100	100.0

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PROGRAM BUDGET - EXTRABUDGETARY FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<u>2. HEALTH IN HUMAN DEVELOPMENT</u>	<u>895,900</u>	<u>10.3</u>	<u>43,500</u>	<u>2.3</u>
PUBLIC POLICY AND HEALTH	404,300	4.6	35,000	1.8
WOMEN, HEALTH AND DEVELOPMENT	WHD 404,300	4.6	35,000	1.8
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	458,000	5.3	8,500	0.4
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 8,800	0.1	8,500	0.4
HEALTH PLANNING	HPL 153,100	1.8	0	-
EMERGENCY AND HUMANITARIAN ACTION	EHA 296,100	3.4	0	-
TECHNICAL COOPERATION AMONG COUNTRIES	TCC 33,600	0.4	0	-
<u>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</u>	<u>5,270,000</u>	<u>60.6</u>	<u>1,075,000</u>	<u>55.7</u>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	5,221,300	60.0	1,075,000	55.7
UNIVERSAL ACCESS TO HEALTH CARE	UAH 5,221,300	60.0	1,075,000	55.7
HUMAN RESOURCES FOR HEALTH	HRH 23,500	0.3	0	-
ESSENTIAL DRUGS	EDV 25,200	0.3	0	-
<u>4. HEALTH PROMOTION AND PROTECTION</u>	<u>300,000</u>	<u>3.4</u>	<u>0</u>	<u>-</u>
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	300,000	3.4	0	-
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 300,000	3.4	0	-

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PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT =====	718,800	8.3	560,000	29.0
ENVIRONMENTAL HEALTH -----	718,800	8.3	560,000	29.0
WATER SUPPLY AND SANITATION	CWS 2,800	.*	0	-
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA 716,000	8.2	560,000	29.0
6. DISEASE PREVENTION AND CONTROL =====	1,515,000	17.4	250,000	13.0
CONTROL OF COMMUNICABLE DISEASE -----	1,515,000	17.4	250,000	13.0
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID 1,164,200	13.4	0	-
DIARRHEAL DISEASES	CDD 1,500	.*	0	-
AIDS	GPA 330,700	3.8	250,000	13.0
MALARIA AND OTHER TROPICAL DISEASES	CTD 18,600	0.2	0	-
=====	=====	=====	=====	=====
GRAND TOTAL	8,699,700	100.0	1,928,500	100.0
=====	=====	=====	=====	=====

\* INDICATES LESS THAN .05 PERCENT

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PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b>	<b>709,600</b>	<b>39.9</b>	<b>833,200</b>	<b>46.6</b>
<b>PUBLIC POLICY AND HEALTH</b>	<b>5,000</b>	<b>0.3</b>	<b>22,800</b>	<b>1.3</b>
HEALTH IN SOCIOECONOMIC DEVELOPMENT	HSD 0	-	22,800	1.3
WOMEN, HEALTH AND DEVELOPMENT	WHD 5,000	0.3	0	-
<b>NATIONAL HEALTH POLICIES &amp; PROG. DEVELOP. &amp; MGMT.</b>	<b>587,300</b>	<b>33.0</b>	<b>694,900</b>	<b>38.8</b>
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 587,300	33.0	646,400	36.1
HEALTH PLANNING	HPL 0	-	27,700	1.5
EMERGENCY AND HUMANITARIAN ACTION	EHA 0	-	20,800	1.2
<b>BIOMEDICAL AND HEALTH INFORMATION AND TRENDS</b>	<b>0</b>	<b>-</b>	<b>6,900</b>	<b>0.4</b>
HEALTH SITUATION AND TREND ASSESSMENT	HST 0	-	6,900	0.4
<b>TECHNICAL COOPERATION AMONG COUNTRIES</b>	<b>117,300</b>	<b>6.6</b>	<b>108,600</b>	<b>6.1</b>
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b>	<b>435,000</b>	<b>24.4</b>	<b>365,600</b>	<b>20.4</b>
<b>ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC</b>	<b>341,000</b>	<b>19.2</b>	<b>272,400</b>	<b>15.2</b>
UNIVERSAL ACCESS TO HEALTH CARE	UAH 336,000	18.9	244,600	13.7
TRADITIONAL MEDICINE AND INDIGENOUS HEALTH	TRM 0	-	27,800	1.6
DISABILITY PREVENTION AND REHABILITATION	DPR 5,000	0.3	0	-
<b>HUMAN RESOURCES FOR HEALTH</b>	<b>65,000</b>	<b>3.7</b>	<b>82,400</b>	<b>4.6</b>
<b>QUALITY OF CARE AND HEALTH TECHNOLOGY</b>	<b>29,000</b>	<b>1.6</b>	<b>10,800</b>	<b>0.6</b>
QUALITY OF CARE AND HEALTH TECHNOLOGY ASSESSMENT	QAC 29,000	1.6	10,800	0.6
<b>4. HEALTH PROMOTION AND PROTECTION</b>	<b>129,000</b>	<b>7.3</b>	<b>115,200</b>	<b>6.4</b>
<b>FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES</b>	<b>38,000</b>	<b>2.1</b>	<b>26,300</b>	<b>1.5</b>
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 26,000	1.5	14,500	0.8
ADOLESCENT HEALTH	ADH 12,000	0.7	6,900	0.4
HEALTH OF THE ELDERLY	HEE 0	-	4,900	0.3

GUYANA

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

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
HEALTHY LIFESTYLES AND MENTAL HEALTH	50,000	2.8	54,200	3.0	
HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED	46,000	2.6	17,900	1.0
MENTAL HEALTH	MNH	0	-	3,000	0.2
SETTINGS FOR HEALTH PROMOTION	STP	4,000	0.2	31,300	1.7
PROTECTION FROM VIOLENCE	PRV	0	-	2,000	0.1
NUTRITION, FOOD SECURITY AND SAFETY		41,000	2.3	34,700	1.9
FOOD AND NUTRITION	NUT	26,000	1.5	30,800	1.7
FOOD SAFETY	FOS	15,000	0.8	3,900	0.2
<b>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</b>		<b>342,000</b>	<b>19.2</b>	<b>339,500</b>	<b>19.0</b>
ENVIRONMENTAL HEALTH		342,000	19.2	339,500	19.0
WATER SUPPLY AND SANITATION	CWS	342,000	19.2	328,700	18.4
MANAGEMENT OF SOLID WASTE AND HOUSING HYGIENE	MWH	0	-	10,800	0.6
<b>6. DISEASE PREVENTION AND CONTROL</b>		<b>163,600</b>	<b>9.2</b>	<b>135,700</b>	<b>7.6</b>
CONTROL OF COMMUNICABLE DISEASE		134,000	7.5	103,200	5.8
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID	45,000	2.5	25,800	1.4
ACUTE RESPIRATORY INFECTIONS	ARI	5,000	0.3	3,000	0.2
DIARRHEAL DISEASES	CDD	10,000	0.6	9,900	0.6
AIDS	GPA	20,000	1.1	6,000	0.3
SEXUALLY TRANSMITTED DISEASES	STD	0	-	3,000	0.2
TUBERCULOSIS	TUB	30,000	1.7	36,800	2.1
MALARIA AND OTHER TROPICAL DISEASES	CTD	0	-	11,800	0.7
OTHER COMMUNICABLE DISEASES	OCD	24,000	1.3	6,900	0.4
CONTROL OF NONCOMMUNICABLE DISEASES		21,000	1.2	32,500	1.8
CANCER	CAN	8,000	0.4	13,600	0.8
CARDIOVASCULAR DISEASES	CVD	0	-	9,900	0.6
OTHER NONCOMMUNICABLE DISEASES	NCD	13,000	0.7	9,000	0.5
VETERINARY PUBLIC HEALTH		8,600	0.5	0	-
ZOOZOSIS	ZNS	8,600	0.5	0	-
<b>GRAND TOTAL</b>		<b>1,779,200</b>	<b>100.0</b>	<b>1,789,200</b>	<b>100.0</b>

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PROGRAM BUDGET - EXTRABUDGETARY FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b> =====	90,300	57.9	4,000	100.0	
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC -----	4,100	2.6	4,000	100.0	
UNIVERSAL ACCESS TO HEALTH CARE	UAH	4,100	2.6	4,000	100.0
HUMAN RESOURCES FOR HEALTH -----	HRH	86,200	55.3	0	-
<b>6. DISEASE PREVENTION AND CONTROL</b> =====	65,600	42.1	0	-	
CONTROL OF COMMUNICABLE DISEASE -----	65,600	42.1	0	-	
AIDS	GPA	65,600	42.1	0	-
=====	=====	=====	=====	=====	
<b>GRAND TOTAL</b> =====	155,900	100.0	4,000	100.0	

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HAITI

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b>	<b>1,974,800</b>	<b>43.3</b>	<b>2,292,100</b>	<b>50.1</b>
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	783,900	17.2	1,085,900	23.7
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS. EMERGENCY AND HUMANITARIAN ACTION	CPS EHA 783,900 0	17.2 -	1,056,100 29,800	23.1 0.7
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS	986,500	21.6	1,017,200	22.2
HEALTH SITUATION AND TREND ASSESSMENT	HST 986,500	21.6	1,017,200	22.2
TECHNICAL COOPERATION AMONG COUNTRIES	TCC 204,400	4.5	189,000	4.1
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b>	<b>620,100</b>	<b>13.6</b>	<b>607,100</b>	<b>13.3</b>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	555,100	12.2	487,900	10.7
UNIVERSAL ACCESS TO HEALTH CARE	UAH 555,100	12.2	487,900	10.7
ESSENTIAL DRUGS	EDV 65,000	1.4	69,600	1.5
QUALITY OF CARE AND HEALTH TECHNOLOGY	0	-	49,600	1.1
QUALITY, SAFETY & EFFICACY OF DRUGS & BIOLOGICALS	DSE 0	-	49,600	1.1
<b>4. HEALTH PROMOTION AND PROTECTION</b>	<b>953,500</b>	<b>20.9</b>	<b>693,500</b>	<b>15.2</b>
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	653,500	14.3	693,500	15.2
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 653,500	14.3	693,500	15.2
HEALTHY LIFESTYLES AND MENTAL HEALTH	300,000	6.6	0	-
SETTINGS FOR HEALTH PROMOTION	STP 300,000	6.6	0	-

HAITI

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

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT	700,700	15.4	655,600	14.3
ENVIRONMENTAL HEALTH	700,700	15.4	655,600	14.3
WATER SUPPLY AND SANITATION	CWS 700,700	15.4	424,200	9.3
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA 0	-	112,200	2.5
MANAGEMENT OF SOLID WASTE AND HOUSING HYGIENE	MWH 0	-	119,200	2.6
6. DISEASE PREVENTION AND CONTROL	314,000	6.9	324,800	7.1
CONTROL OF COMMUNICABLE DISEASE	314,000	6.9	324,800	7.1
AIDS	GPA 214,000	4.7	134,800	2.9
MALARIA AND OTHER TROPICAL DISEASES	CTD 100,000	2.2	190,000	4.2
GRAND TOTAL	4,563,100	100.0	4,573,100	100.0

HAITI

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b>	<b>1,100,500</b>	<b>15.2</b>	<b>91,000</b>	<b>1.7</b>
GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT	11,500	0.2	0	-
EXTERNAL COORDINATION	ECO 11,500	0.2	0	-
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	1,089,000	15.0	91,000	1.7
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS. EMERGENCY AND HUMANITARIAN ACTION	CPS 92,400 EHA 996,600	1.3 13.8	91,000 0	1.7 -
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b>	<b>5,022,500</b>	<b>69.4</b>	<b>4,400,000</b>	<b>80.1</b>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	200	-	0	-
UNIVERSAL ACCESS TO HEALTH CARE	UAH 200	-	0	-
HUMAN RESOURCES FOR HEALTH	HRH 5,800	0.1	0	-
ESSENTIAL DRUGS	EDV 5,008,800	69.2	4,400,000	80.1
QUALITY OF CARE AND HEALTH TECHNOLOGY	7,700	0.1	0	-
CLINICAL, LABORATORY AND IMAGING TECHNOLOGY	CLT 7,700	0.1	0	-
<b>4. HEALTH PROMOTION AND PROTECTION</b>	<b>281,900</b>	<b>3.9</b>	<b>0</b>	<b>-</b>
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	281,900	3.9	0	-
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 281,900	3.9	0	-

HAITI

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
6. DISEASE PREVENTION AND CONTROL	834,300	11.5	1,000,000	18.2
CONTROL OF COMMUNICABLE DISEASE	834,300	11.5	1,000,000	18.2
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	828,900	11.5	1,000,000	18.2
TUBERCULOSIS	5,400	0.1	0	-
GRAND TOTAL	7,239,200	100.0	5,491,000	100.0

HONDURAS

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b>	<b>1,553,600</b>	<b>45.3</b>	<b>1,483,100</b>	<b>42.6</b>
<b>PUBLIC POLICY AND HEALTH</b>	<b>280,000</b>	<b>8.2</b>	<b>143,800</b>	<b>4.1</b>
HEALTH IN SOCIOECONOMIC DEVELOPMENT	HSD 280,000	8.2	89,300	2.6
WOMEN, HEALTH AND DEVELOPMENT	WHD 0	-	54,500	1.6
<b>NATIONAL HEALTH POLICIES &amp; PROG. DEVELOP. &amp; MGMT.</b>	<b>856,300</b>	<b>25.0</b>	<b>918,200</b>	<b>26.4</b>
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 856,300	25.0	918,200	26.4
<b>BIOMEDICAL AND HEALTH INFORMATION AND TRENDS</b>	<b>319,700</b>	<b>9.3</b>	<b>330,700</b>	<b>9.5</b>
HEALTH SITUATION AND TREND ASSESSMENT	HST 248,500	7.2	259,500	7.4
HEALTH AND BIOMEDICAL INFORMATION	HBI 71,200	2.1	71,200	2.0
<b>TECHNICAL COOPERATION AMONG COUNTRIES</b>	<b>97,600</b>	<b>2.8</b>	<b>90,400</b>	<b>2.6</b>
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b>	<b>528,500</b>	<b>15.4</b>	<b>572,100</b>	<b>16.4</b>
<b>ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC</b>	<b>528,500</b>	<b>15.4</b>	<b>443,100</b>	<b>12.7</b>
UNIVERSAL ACCESS TO HEALTH CARE	UAH 528,500	15.4	443,100	12.7
<b>HUMAN RESOURCES FOR HEALTH</b>	<b>0</b>	<b>-</b>	<b>79,400</b>	<b>2.3</b>
ESSENTIAL DRUGS	EDV 0	-	49,600	1.4
<b>4. HEALTH PROMOTION AND PROTECTION</b>	<b>283,000</b>	<b>8.2</b>	<b>352,400</b>	<b>10.1</b>
<b>HEALTHY LIFESTYLES AND MENTAL HEALTH</b>	<b>283,000</b>	<b>8.2</b>	<b>253,100</b>	<b>7.3</b>
HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED 283,000	8.2	253,100	7.3

HONDURAS

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

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
NUTRITION, FOOD SECURITY AND SAFETY	0	-	99,300	2.9
FOOD AND NUTRITION	0	-	99,300	2.9
NUT	0	-	99,300	2.9
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT	533,500	15.5	527,400	15.1
ENVIRONMENTAL HEALTH	533,500	15.5	527,400	15.1
WATER SUPPLY AND SANITATION	533,500	15.5	527,400	15.1
CWS	533,500	15.5	527,400	15.1
6. DISEASE PREVENTION AND CONTROL	532,500	15.5	548,600	15.7
CONTROL OF COMMUNICABLE DISEASE	532,500	15.5	548,600	15.7
OTHER COMMUNICABLE DISEASES	532,500	15.5	548,600	15.7
OCD	532,500	15.5	548,600	15.7
GRAND TOTAL	3,431,100	100.0	3,483,600	100.0

HONDURAS

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<u>2. HEALTH IN HUMAN DEVELOPMENT</u>	<u>2,082,700</u>	<u>32.0</u>	<u>40,000</u>	<u>1.7</u>
PUBLIC POLICY AND HEALTH	79,000	1.2	40,000	1.7
WOMEN, HEALTH AND DEVELOPMENT	WRD 79,000	1.2	40,000	1.7
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	1,986,800	30.5	0	-
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS. EMERGENCY AND HUMANITARIAN ACTION	CPS 68,300 EHA 1,918,500	1.0 29.5	0 0	- -
TECHNICAL COOPERATION AMONG COUNTRIES	TCC 16,900	0.3	0	-
<u>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</u>	<u>2,676,500</u>	<u>41.1</u>	<u>965,000</u>	<u>42.0</u>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	2,597,300	39.9	965,000	42.0
UNIVERSAL ACCESS TO HEALTH CARE	UAH 2,594,900	39.9	965,000	42.0
ORAL HEALTH	ORH 2,400	*	0	-
HUMAN RESOURCES FOR HEALTH	HRH 5,700	0.1	0	-
ESSENTIAL DRUGS	EDV 73,500	1.1	0	-
<u>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</u>	<u>690,400</u>	<u>10.6</u>	<u>470,000</u>	<u>20.5</u>
ENVIRONMENTAL HEALTH	690,400	10.6	470,000	20.5
WATER SUPPLY AND SANITATION	CWS 4,700	0.1	0	-
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA 685,700	10.5	470,000	20.5

HONDURAS

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
6. DISEASE PREVENTION AND CONTROL =====	1,055,300	16.2	820,300	35.7
CONTROL OF COMMUNICABLE DISEASE -----	1,055,300	16.2	820,300	35.7
DIARRHEAL DISEASES	CDD 114,900	1.8	300	.*
AIDS	GPA 940,200	14.5	820,000	35.7
MALARIA AND OTHER TROPICAL DISEASES	CTD 200	-	0	-
=====	=====	=====	=====	=====
GRAND TOTAL	6,504,900	100.0	2,295,300	100.0
=====	=====	=====	=====	=====

\* INDICATES LESS THAN .05 PERCENT

JAMAICA

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b>	<b>1,203,500</b>	<b>38.1</b>	<b>1,254,800</b>	<b>39.2</b>
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	987,200	31.3	1,040,800	32.5
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 987,200	31.3	1,040,800	32.5
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS	96,500	3.1	103,200	3.2
HEALTH SITUATION AND TREND ASSESSMENT	HST 96,500	3.1	103,200	3.2
TECHNICAL COOPERATION AMONG COUNTRIES	TCC 119,800	3.8	110,800	3.5
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b>	<b>980,200</b>	<b>31.1</b>	<b>862,700</b>	<b>26.9</b>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	752,200	23.8	862,700	26.9
UNIVERSAL ACCESS TO HEALTH CARE	UAH 752,200	23.8	862,700	26.9
HUMAN RESOURCES FOR HEALTH	HRH 228,000	7.2	0	-
<b>4. HEALTH PROMOTION AND PROTECTION</b>	<b>175,500</b>	<b>5.6</b>	<b>118,500</b>	<b>3.7</b>
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	90,000	2.9	47,300	1.5
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 90,000	2.9	47,300	1.5
NUTRITION, FOOD SECURITY AND SAFETY	85,500	2.7	71,200	2.2
FOOD SAFETY	FOS 85,500	2.7	71,200	2.2
<b>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</b>	<b>369,000</b>	<b>11.7</b>	<b>389,100</b>	<b>12.1</b>
ENVIRONMENTAL HEALTH	369,000	11.7	389,100	12.1
WATER SUPPLY AND SANITATION	CWS 369,000	11.7	389,100	12.1

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 JAMAICA

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
6. <u>DISEASE PREVENTION AND CONTROL</u>	427,400	13.5	577,500	18.0
<u>CONTROL OF COMMUNICABLE DISEASE</u>	110,700	3.5	153,100	4.8
OTHER COMMUNICABLE DISEASES	OCD 110,700	3.5	153,100	4.8
<u>CONTROL OF NONCOMMUNICABLE DISEASES</u>	316,700	10.0	424,400	13.3
OTHER NONCOMMUNICABLE DISEASES	NCD 316,700	10.0	424,400	13.3
<u>GRAND TOTAL</u>	<u>3,155,600</u>	<u>100.0</u>	<u>3,202,600</u>	<u>100.0</u>

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MEXICO

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b>	<b>2,466,300</b>	<b>41.7</b>	<b>2,423,900</b>	<b>40.9</b>
GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT	70,000	1.2	77,400	1.3
PUBLIC INFORMATION	INF 70,000	1.2	77,400	1.3
PUBLIC POLICY AND HEALTH	59,300	1.0	60,000	1.0
WOMEN, HEALTH AND DEVELOPMENT	WHD 59,300	1.0	60,000	1.0
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	1,941,800	32.8	1,914,400	32.3
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 1,626,800	27.5	1,720,800	29.1
HEALTH PLANNING	HPL 220,000	3.7	193,600	3.3
EMERGENCY AND HUMANITARIAN ACTION	EHA 95,000	1.6	0	-
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS	239,800	4.1	228,200	3.9
HEALTH SITUATION AND TREND ASSESSMENT	HST 239,800	4.1	228,200	3.9
TECHNICAL COOPERATION AMONG COUNTRIES	TCC 155,400	2.6	143,900	2.4
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b>	<b>1,057,100</b>	<b>17.9</b>	<b>1,145,100</b>	<b>19.3</b>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	673,000	11.4	771,600	13.0
UNIVERSAL ACCESS TO HEALTH CARE	UAH 653,000	11.0	746,000	12.6
TRADITIONAL MEDICINE AND INDIGENOUS HEALTH	TRM 20,000	0.3	25,600	0.4
HUMAN RESOURCES FOR HEALTH	HRH 384,100	6.5	373,500	6.3
<b>4. HEALTH PROMOTION AND PROTECTION</b>	<b>968,600</b>	<b>16.4</b>	<b>971,400</b>	<b>16.4</b>
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	424,800	7.2	404,300	6.8
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 399,800	6.8	384,500	6.5
HEALTH OF THE ELDERLY	HEE 25,000	0.4	19,800	0.3

MEXICO

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

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
HEALTHY LIFESTYLES AND MENTAL HEALTH	419,800	7.1	428,100	7.2	
HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED	110,000	1.9	109,200	1.8
PREVENTION AND CONTROL OF SUBSTANCE ABUSE	ADT	70,000	1.2	90,700	1.5
SETTINGS FOR HEALTH PROMOTION	STP	239,800	4.1	228,200	3.9
NUTRITION, FOOD SECURITY AND SAFETY		124,000	2.1	139,000	2.3
FOOD AND NUTRITION	NUT	30,000	0.5	29,800	0.5
FOOD SAFETY	FOS	94,000	1.6	109,200	1.8
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT		537,600	9.1	523,300	8.8
ENVIRONMENTAL HEALTH		537,600	9.1	523,300	8.8
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA	517,600	8.7	523,300	8.8
WORKERS' HEALTH	OCH	20,000	0.3	0	-
6. DISEASE PREVENTION AND CONTROL		889,800	15.0	855,700	14.5
CONTROL OF COMMUNICABLE DISEASE		480,000	8.1	449,000	7.6
OTHER COMMUNICABLE DISEASES	OCD	480,000	8.1	449,000	7.6
CONTROL OF NONCOMMUNICABLE DISEASES		70,000	1.2	54,500	0.9
OTHER NONCOMMUNICABLE DISEASES	NCD	70,000	1.2	54,500	0.9
VETERINARY PUBLIC HEALTH		339,800	5.7	352,200	5.9
ZOOZOSIS	ZNS	339,800	5.7	352,200	5.9
GRAND TOTAL		5,919,400	100.0	5,919,400	100.0

MEXICO

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b>	<b>393,900</b>	<b>57.6</b>	<b>35,000</b>	<b>100.0</b>
PUBLIC POLICY AND HEALTH	30,100	4.4	0	-
WOMEN, HEALTH AND DEVELOPMENT	30,100	4.4	0	-
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	363,800	53.2	35,000	100.0
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	36,500	5.3	35,000	100.0
EMERGENCY AND HUMANITARIAN ACTION	327,300	47.8	0	-
<b>4. HEALTH PROMOTION AND PROTECTION</b>	<b>5,000</b>	<b>0.7</b>	<b>0</b>	<b>-</b>
HEALTHY LIFESTYLES AND MENTAL HEALTH	5,000	0.7	0	-
HEALTH EDUCATION AND SOCIAL COMMUNICATION	5,000	0.7	0	-
<b>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</b>	<b>90,800</b>	<b>13.3</b>	<b>0</b>	<b>-</b>
ENVIRONMENTAL HEALTH	90,800	13.3	0	-
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	90,800	13.3	0	-
<b>6. DISEASE PREVENTION AND CONTROL</b>	<b>194,600</b>	<b>28.4</b>	<b>0</b>	<b>-</b>
CONTROL OF COMMUNICABLE DISEASE	194,600	28.4	0	-
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	96,100	14.0	0	-
AIDS	98,500	14.4	0	-
<b>GRAND TOTAL</b>	<b>684,300</b>	<b>100.0</b>	<b>35,000</b>	<b>100.0</b>

NETHERLAND ANTILLES

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<u>2. HEALTH IN HUMAN DEVELOPMENT</u>	<u>41,400</u>	<u>19.7</u>	<u>78,200</u>	<u>37.2</u>
PUBLIC POLICY AND HEALTH	41,400	19.7	24,700	11.7
HEALTH IN SOCIOECONOMIC DEVELOPMENT	HSD 41,400	19.7	24,700	11.7
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS	0	-	53,500	25.4
HEALTH SITUATION AND TREND ASSESSMENT	HST 0	-	53,500	25.4
<u>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</u>	<u>53,000</u>	<u>25.2</u>	<u>41,600</u>	<u>19.8</u>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	53,000	25.2	41,600	19.8
UNIVERSAL ACCESS TO HEALTH CARE	UAH 53,000	25.2	36,700	17.4
ORAL HEALTH	ORH 0	-	4,900	2.3
<u>4. HEALTH PROMOTION AND PROTECTION</u>	<u>26,400</u>	<u>12.5</u>	<u>27,800</u>	<u>13.2</u>
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	26,400	12.5	6,000	2.9
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 26,400	12.5	6,000	2.9
HEALTHY LIFESTYLES AND MENTAL HEALTH	0	-	19,800	9.4
SETTINGS FOR HEALTH PROMOTION	STP 0	-	19,800	9.4
NUTRITION, FOOD SECURITY AND SAFETY	0	-	2,000	1.0
FOOD AND NUTRITION	NUT 0	-	2,000	1.0
<u>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</u>	<u>39,800</u>	<u>18.9</u>	<u>42,200</u>	<u>20.1</u>
ENVIRONMENTAL HEALTH	39,800	18.9	42,200	20.1
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA 39,800	18.9	42,200	20.1

NETHERLAND ANTILLES

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

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
6. DISEASE PREVENTION AND CONTROL	49,800	23.7	20,600	9.8
CONTROL OF COMMUNICABLE DISEASE	49,800	23.7	20,600	9.8
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	0	-	3,800	1.8
OTHER COMMUNICABLE DISEASES	49,800	23.7	16,800	8.0
GRAND TOTAL	210,400	100.0	210,400	100.0

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NICARAGUA

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
<u>2. HEALTH IN HUMAN DEVELOPMENT</u>	<u>1,203,000</u>	<u>42.3</u>	<u>1,155,100</u>	<u>39.1</u>	
<u>PUBLIC POLICY AND HEALTH</u>	<u>180,000</u>	<u>6.3</u>	<u>133,800</u>	<u>4.5</u>	
HEALTH IN SOCIOECONOMIC DEVELOPMENT	HSD	180,000	6.3	133,800	4.5
<u>NATIONAL HEALTH POLICIES &amp; PROG. DEVELOP. &amp; MGMT.</u>		<u>842,200</u>	<u>29.6</u>	<u>854,000</u>	<u>28.9</u>
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS	842,200	29.6	854,000	28.9
<u>TECHNICAL COOPERATION AMONG COUNTRIES</u>		<u>180,800</u>	<u>6.4</u>	<u>167,300</u>	<u>5.7</u>
<u>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</u>	<u>780,100</u>	<u>27.4</u>	<u>672,000</u>	<u>22.7</u>	
<u>ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC</u>		<u>780,100</u>	<u>27.4</u>	<u>582,800</u>	<u>19.7</u>
UNIVERSAL ACCESS TO HEALTH CARE	UAH	780,100	27.4	582,800	19.7
<u>ESSENTIAL DRUGS</u>		<u>0</u>	<u>-</u>	<u>89,200</u>	<u>3.0</u>
<u>4. HEALTH PROMOTION AND PROTECTION</u>	<u>160,000</u>	<u>5.6</u>	<u>193,400</u>	<u>6.5</u>	
<u>FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES</u>		<u>0</u>	<u>-</u>	<u>94,200</u>	<u>3.2</u>
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH	0	-	94,200	3.2
<u>HEALTHY LIFESTYLES AND MENTAL HEALTH</u>		<u>160,000</u>	<u>5.6</u>	<u>99,200</u>	<u>3.4</u>
HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED	160,000	5.6	99,200	3.4
<u>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</u>	<u>200,000</u>	<u>7.0</u>	<u>198,500</u>	<u>6.7</u>	
<u>ENVIRONMENTAL HEALTH</u>		<u>200,000</u>	<u>7.0</u>	<u>198,500</u>	<u>6.7</u>
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA	200,000	7.0	198,500	6.7

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NICARAGUA

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
6. DISEASE PREVENTION AND CONTROL =====	500,000	17.6	737,100	24.9
CONTROL OF COMMUNICABLE DISEASE -----	500,000	17.6	737,100	24.9
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID	0 -	49,600	1.7
AIDS	GPA	0 -	47,200	1.6
TUBERCULOSIS	TUB	0 -	47,200	1.6
MALARIA AND OTHER TROPICAL DISEASES	CTD	0 -	47,200	1.6
OTHER COMMUNICABLE DISEASES	OCD	500,000 17.6	545,900	18.5
=====	=====	=====	=====	=====
GRAND TOTAL	2,843,100	100.0	2,956,100	100.0
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NICARAGUA

PROGRAM BUDGET - EXTRABUDGETARY FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
2. HEALTH IN HUMAN DEVELOPMENT =====	2,380,200	25.6	28,000	0.5
PUBLIC POLICY AND HEALTH -----	71,600	0.8	28,000	0.5
WOMEN, HEALTH AND DEVELOPMENT WHD	71,600	0.8	28,000	0.5
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT. -----	2,302,200	24.8	0	-
EMERGENCY AND HUMANITARIAN ACTION EHA	2,302,200	24.8	0	-
TECHNICAL COOPERATION AMONG COUNTRIES TCC	6,400	0.1	0	-
3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT =====	4,240,600	45.6	3,910,000	74.1
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC -----	4,220,700	45.4	3,910,000	74.1
UNIVERSAL ACCESS TO HEALTH CARE DISABILITY PREVENTION AND REHABILITATION ORAL HEALTH UAH DPR ORH	4,209,900 100 10,700	45.3 - 0.1	3,910,000 0 0	74.1 - -
HUMAN RESOURCES FOR HEALTH ----- HRH	19,900	0.2	0	-
4. HEALTH PROMOTION AND PROTECTION =====	17,000	0.2	15,000	0.3
NUTRITION, FOOD SECURITY AND SAFETY -----	17,000	0.2	15,000	0.3
FOOD AND NUTRITION NUT	17,000	0.2	15,000	0.3
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT =====	578,000	6.2	405,000	7.7
ENVIRONMENTAL HEALTH -----	578,000	6.2	405,000	7.7
WATER SUPPLY AND SANITATION ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT CWS ERA	6,700 571,300	0.1 6.1	0 405,000	- 7.7

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NICARAGUA

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
6. DISEASE PREVENTION AND CONTROL =====	2,079,400	22.4	920,000	17.4	
CONTROL OF COMMUNICABLE DISEASE -----	2,079,400	22.4	920,000	17.4	
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID	1,731,600	18.6	800,000	15.2
DIARRHEAL DISEASES	CDD	110,000	1.2	0	-
AIDS	GPA	229,300	2.5	120,000	2.3
MALARIA AND OTHER TROPICAL DISEASES	CTD	8,500	0.1	0	-
=====	=====	=====	=====	=====	
GRAND TOTAL =====	9,295,200	100.0	5,278,000	100.0	

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NORTHERN CARIBBEAN

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT	95,300	100.0	95,300	100.0
=====	=====	=====	=====	=====
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	95,300	100.0	95,300	100.0
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UNIVERSAL ACCESS TO HEALTH CARE	UAH 95,300	100.0	95,300	100.0
=====	=====	=====	=====	=====
GRAND TOTAL	95,300	100.0	95,300	100.0
=====	=====	=====	=====	=====

PANAMA

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<u>2. HEALTH IN HUMAN DEVELOPMENT</u>	<u>884,700</u>	<u>40.0</u>	<u>945,500</u>	<u>42.0</u>
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	791,100	35.8	858,800	38.1
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 791,100	35.8	858,800	38.1
TECHNICAL COOPERATION AMONG COUNTRIES	TCC 93,600	4.2	86,700	3.8
<u>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</u>	<u>876,900</u>	<u>39.6</u>	<u>818,000</u>	<u>36.3</u>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	876,900	39.6	742,500	32.9
UNIVERSAL ACCESS TO HEALTH CARE	UAH 876,900	39.6	742,500	32.9
HUMAN RESOURCES FOR HEALTH	HRH 0	-	75,500	3.4
<u>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</u>	<u>284,100</u>	<u>12.8</u>	<u>271,000</u>	<u>12.0</u>
ENVIRONMENTAL HEALTH	284,100	12.8	271,000	12.0
WATER SUPPLY AND SANITATION	CWS 284,100	12.8	271,000	12.0
<u>6. DISEASE PREVENTION AND CONTROL</u>	<u>167,000</u>	<u>7.5</u>	<u>219,100</u>	<u>9.7</u>
CONTROL OF COMMUNICABLE DISEASE	167,000	7.5	93,000	4.1
OTHER COMMUNICABLE DISEASES	OCD 167,000	7.5	93,000	4.1
CONTROL OF NONCOMMUNICABLE DISEASES	0	-	126,100	5.6
OTHER NONCOMMUNICABLE DISEASES	NCD 0	-	126,100	5.6
<u>GRAND TOTAL</u>	<u>2,212,700</u>	<u>100.0</u>	<u>2,253,600</u>	<u>100.0</u>

PANAMA

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<u>2. HEALTH IN HUMAN DEVELOPMENT</u>	<u>75,300</u>	<u>10.2</u>	<u>45,000</u>	<u>10.8</u>
PUBLIC POLICY AND HEALTH	70,600	9.6	45,000	10.8
WOMEN, HEALTH AND DEVELOPMENT	WHD 70,600	9.6	45,000	10.8
TECHNICAL COOPERATION AMONG COUNTRIES	TCC 4,700	0.6	0	-
<u>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</u>	<u>29,600</u>	<u>4.0</u>	<u>0</u>	<u>-</u>
HUMAN RESOURCES FOR HEALTH	HRH 29,600	4.0	0	-
<u>4. HEALTH PROMOTION AND PROTECTION</u>	<u>41,000</u>	<u>5.6</u>	<u>15,000</u>	<u>3.6</u>
NUTRITION, FOOD SECURITY AND SAFETY	41,000	5.6	15,000	3.6
FOOD AND NUTRITION	NUT 24,000	3.3	0	-
FOOD SAFETY	FOS 17,000	2.3	15,000	3.6
<u>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</u>	<u>495,300</u>	<u>67.2</u>	<u>355,000</u>	<u>85.5</u>
ENVIRONMENTAL HEALTH	495,300	67.2	355,000	85.5
WATER SUPPLY AND SANITATION	CWS 4,100	0.6	0	-
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA 491,200	66.6	355,000	85.5
<u>6. DISEASE PREVENTION AND CONTROL</u>	<u>96,300</u>	<u>13.1</u>	<u>0</u>	<u>-</u>
CONTROL OF COMMUNICABLE DISEASE	96,300	13.1	0	-
AIDS	GPA 86,400	11.7	0	-
MALARIA AND OTHER TROPICAL DISEASES	CTD 9,900	1.3	0	-
<u>GRAND TOTAL</u>	<u>737,500</u>	<u>100.0</u>	<u>415,000</u>	<u>100.0</u>

PARAGUAY

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<u>2. HEALTH IN HUMAN DEVELOPMENT</u>	<u>818,200</u>	<u>31.5</u>	<u>915,300</u>	<u>32.5</u>
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	716,100	27.5	820,800	29.2
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 716,100	27.5	820,800	29.2
TECHNICAL COOPERATION AMONG COUNTRIES	TCC 102,100	3.9	94,500	3.4
<u>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</u>	<u>838,700</u>	<u>32.3</u>	<u>763,500</u>	<u>27.1</u>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	709,700	27.3	688,000	24.5
UNIVERSAL ACCESS TO HEALTH CARE	UAH 709,700	27.3	688,000	24.5
HUMAN RESOURCES FOR HEALTH	HRH 129,000	5.0	75,500	2.7
<u>4. HEALTH PROMOTION AND PROTECTION</u>	<u>62,000</u>	<u>2.4</u>	<u>55,600</u>	<u>2.0</u>
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	62,000	2.4	55,600	2.0
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 62,000	2.4	55,600	2.0
<u>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</u>	<u>364,300</u>	<u>14.0</u>	<u>337,200</u>	<u>12.0</u>
ENVIRONMENTAL HEALTH	364,300	14.0	337,200	12.0
WATER SUPPLY AND SANITATION	CWS 364,300	14.0	337,200	12.0
<u>6. DISEASE PREVENTION AND CONTROL</u>	<u>517,000</u>	<u>19.9</u>	<u>742,200</u>	<u>26.4</u>
CONTROL OF COMMUNICABLE DISEASE	393,800	15.1	416,200	14.8
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID 36,200	1.4	38,600	1.4
MALARIA AND OTHER TROPICAL DISEASES	CTD 54,000	2.1	56,500	2.0
OTHER COMMUNICABLE DISEASES	OCD 303,600	11.7	321,100	11.4

PARAGUAY

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

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
CONTROL OF NONCOMMUNICABLE DISEASES	42,000	1.6	54,500	1.9
OTHER NONCOMMUNICABLE DISEASES	NCD 42,000	1.6	54,500	1.9
VETERINARY PUBLIC HEALTH	81,200	3.1	271,500	9.6
FOOT-AND-MOUTH DISEASE	FMD 26,200	1.0	0	-
ZONOSIS	ZNS 55,000	2.1	271,500	9.6
===== GRAND TOTAL =====	2,600,200	100.0	2,813,800	100.0

PARAGUAY

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<u>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</u>	<u>47,100</u>	<u>11.7</u>	<u>0</u>	<u>-</u>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	36,300	9.0	0	-
ORAL HEALTH	ORH	36,300	9.0	0
ESSENTIAL DRUGS	EDV	10,800	2.7	0
<u>4. HEALTH PROMOTION AND PROTECTION</u>	<u>163,000</u>	<u>40.5</u>	<u>0</u>	<u>-</u>
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	163,000	40.5	0	-
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH	163,000	40.5	0
<u>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</u>	<u>123,300</u>	<u>30.6</u>	<u>0</u>	<u>-</u>
ENVIRONMENTAL HEALTH	123,300	30.6	0	-
WATER SUPPLY AND SANITATION	CWS	123,300	30.6	0
<u>6. DISEASE PREVENTION AND CONTROL</u>	<u>69,000</u>	<u>17.1</u>	<u>0</u>	<u>-</u>
CONTROL OF COMMUNICABLE DISEASE	69,000	17.1	0	-
AIDS	GPA	69,000	17.1	0
<u>GRAND TOTAL</u>	<u>402,400</u>	<u>100.0</u>	<u>0</u>	<u>0.0</u>

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PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<u>2. HEALTH IN HUMAN DEVELOPMENT</u>	<u>2,535,200</u>	<u>43.8</u>	<u>2,663,600</u>	<u>45.3</u>
PUBLIC POLICY AND HEALTH	333,500	5.8	403,400	6.9
HEALTH IN SOCIOECONOMIC DEVELOPMENT	HSD 333,500	5.8	403,400	6.9
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	1,737,500	30.0	1,787,300	30.4
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 1,737,500	30.0	1,787,300	30.4
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS	318,600	5.5	338,400	5.8
HEALTH SITUATION AND TREND ASSESSMENT	HST 318,600	5.5	338,400	5.8
TECHNICAL COOPERATION AMONG COUNTRIES	TCC 145,600	2.5	134,500	2.3
<u>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</u>	<u>1,342,500</u>	<u>23.2</u>	<u>1,179,100</u>	<u>20.0</u>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	1,041,100	18.0	877,700	14.9
UNIVERSAL ACCESS TO HEALTH CARE	UAH 1,041,100	18.0	877,700	14.9
HUMAN RESOURCES FOR HEALTH	HRH 301,400	5.2	301,400	5.1
<u>4. HEALTH PROMOTION AND PROTECTION</u>	<u>788,200</u>	<u>13.6</u>	<u>824,400</u>	<u>14.0</u>
HEALTHY LIFESTYLES AND MENTAL HEALTH	788,200	13.6	824,400	14.0
HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED 788,200	13.6	824,400	14.0
<u>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</u>	<u>518,600</u>	<u>9.0</u>	<u>560,000</u>	<u>9.5</u>
ENVIRONMENTAL HEALTH	518,600	9.0	560,000	9.5
WATER SUPPLY AND SANITATION	CWS 518,600	9.0	560,000	9.5

PERU

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

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
6. <u>DISEASE PREVENTION AND CONTROL</u>	607,100	10.5	653,900	11.1
<u>CONTROL OF COMMUNICABLE DISEASE</u>	607,100	10.5	653,900	11.1
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID 218,900	3.8	241,400	4.1
OTHER COMMUNICABLE DISEASES	OCD 388,200	6.7	412,500	7.0
<u>GRAND TOTAL</u>	<u>5,791,600</u>	<u>100.0</u>	<u>5,881,000</u>	<u>100.0</u>



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PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
6. DISEASE PREVENTION AND CONTROL =====	95,500	8.5	2,800	0.4
CONTROL OF COMMUNICABLE DISEASE -----	95,500	8.5	2,800	0.4
DIARRHEAL DISEASES	CDD 3,000	0.3	2,800	0.4
AIDS	GPA 44,500	4.0	0	-
TUBERCULOSIS	TUB 48,000	4.3	0	-
=====	=====	=====	=====	=====
GRAND TOTAL =====	1,120,500	100.0	754,000	100.0

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 PUERTO RICO

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
2. HEALTH IN HUMAN DEVELOPMENT =====	0	-	38,300	16.2
TECHNICAL COOPERATION AMONG COUNTRIES -----	0	-	38,300	16.2
3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT =====	199,000	100.0	197,500	83.8
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC -----	199,000	100.0	197,500	83.8
UNIVERSAL ACCESS TO HEALTH CARE -----	199,000	100.0	197,500	83.8
=====	199,000	100.0	235,800	100.0
GRAND TOTAL =====	199,000	100.0	235,800	100.0
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SAINT KITTS AND NEVIS

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT	91,400	56.0	82,900	41.9	
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	91,400	56.0	82,900	41.9	
UNIVERSAL ACCESS TO HEALTH CARE	UAH	91,400	56.0	82,900	41.9
4. HEALTH PROMOTION AND PROTECTION	40,800	25.0	0	-	
HEALTHY LIFESTYLES AND MENTAL HEALTH	40,800	25.0	0	-	
HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED	40,800	25.0	0	-
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT	30,900	18.9	33,700	17.0	
ENVIRONMENTAL HEALTH	30,900	18.9	33,700	17.0	
WATER SUPPLY AND SANITATION	CWS	30,900	18.9	33,700	17.0
6. DISEASE PREVENTION AND CONTROL	0	-	81,100	41.0	
CONTROL OF COMMUNICABLE DISEASE	0	-	35,900	18.2	
AIDS	GPA	0	-	35,900	18.2
CONTROL OF NONCOMMUNICABLE DISEASES	0	-	45,200	22.9	
OTHER NONCOMMUNICABLE DISEASES	NCD	0	-	45,200	22.9
GRAND TOTAL	163,100	100.0	197,700	100.0	

SAINT LUCIA

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT	116,800	61.4	114,800	58.1	
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	116,800	61.4	114,800	58.1	
UNIVERSAL ACCESS TO HEALTH CARE	UAH	116,800	61.4	114,800	58.1
4. HEALTH PROMOTION AND PROTECTION	38,500	20.2	33,200	16.8	
HEALTHY LIFESTYLES AND MENTAL HEALTH	38,500	20.2	33,200	16.8	
HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED	38,500	20.2	33,200	16.8
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT	35,000	18.4	40,700	20.6	
ENVIRONMENTAL HEALTH	35,000	18.4	40,700	20.6	
WATER SUPPLY AND SANITATION	CWS	35,000	18.4	40,700	20.6
6. DISEASE PREVENTION AND CONTROL	0	-	9,000	4.6	
CONTROL OF COMMUNICABLE DISEASE	0	-	9,000	4.6	
AIDS	GPA	0	9,000	4.6	
GRAND TOTAL	190,300	100.0	197,700	100.0	

ST. VINCENT AND THE GRENADINES

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT	114,000	61.2	110,800	56.0	
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	114,000	61.2	110,800	56.0	
UNIVERSAL ACCESS TO HEALTH CARE	UAH	114,000	61.2	110,800	56.0
4. HEALTH PROMOTION AND PROTECTION	34,400	18.5	42,400	21.4	
HEALTHY LIFESTYLES AND MENTAL HEALTH	34,400	18.5	42,400	21.4	
HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED	34,400	18.5	42,400	21.4
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT	38,000	20.4	44,500	22.5	
ENVIRONMENTAL HEALTH	38,000	20.4	44,500	22.5	
WATER SUPPLY AND SANITATION	CWS	38,000	20.4	44,500	22.5
GRAND TOTAL	186,400	100.0	197,700	100.0	

SURINAME

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b>	<b>717,300</b>	<b>52.9</b>	<b>737,300</b>	<b>54.3</b>
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	588,000	43.3	611,400	45.0
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 588,000	43.3	611,400	45.0
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS	48,000	3.5	50,600	3.7
HEALTH SITUATION AND TREND ASSESSMENT	HST 48,000	3.5	50,600	3.7
TECHNICAL COOPERATION AMONG COUNTRIES	TCC 81,300	6.0	75,300	5.5
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b>	<b>112,000</b>	<b>8.3</b>	<b>106,000</b>	<b>7.8</b>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	61,000	4.5	47,600	3.5
UNIVERSAL ACCESS TO HEALTH CARE	UAH 61,000	4.5	47,600	3.5
HUMAN RESOURCES FOR HEALTH	HRH 51,000	3.8	58,400	4.3
<b>4. HEALTH PROMOTION AND PROTECTION</b>	<b>32,300</b>	<b>2.4</b>	<b>58,600</b>	<b>4.3</b>
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	32,300	2.4	30,800	2.3
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 32,300	2.4	30,800	2.3
NUTRITION, FOOD SECURITY AND SAFETY	0	-	27,800	2.0
FOOD AND NUTRITION	NUT 0	-	27,800	2.0
<b>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</b>	<b>336,600</b>	<b>24.8</b>	<b>344,600</b>	<b>25.4</b>
ENVIRONMENTAL HEALTH	336,600	24.8	344,600	25.4
WATER SUPPLY AND SANITATION	CWS 336,600	24.8	344,600	25.4

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 SURINAME  
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PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
6. DISEASE PREVENTION AND CONTROL =====	159,000	11.7	110,700	8.2
CONTROL OF COMMUNICABLE DISEASE -----	159,000	11.7	110,700	8.2
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID 51,000	3.8	57,600	4.2
OTHER COMMUNICABLE DISEASES	OCD 108,000	8.0	53,100	3.9
=====	=====	=====	=====	=====
GRAND TOTAL =====	1,357,200	100.0	1,357,200	100.0
=====	=====	=====	=====	=====

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SURINAME

PROGRAM BUDGET - EXTRABUDGETARY FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT =====	674,000	97.9	0	-	
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC -----	674,000	97.9	0	-	
UNIVERSAL ACCESS TO HEALTH CARE	UAH	674,000	97.9	0	-
6. DISEASE PREVENTION AND CONTROL =====	14,400	2.1	2,500	100.0	
CONTROL OF COMMUNICABLE DISEASE -----	14,400	2.1	2,500	100.0	
AIDS	GPA	11,700	1.7	0	-
LEPROSY	LEP	2,700	0.4	2,500	100.0
=====	=====	=====	=====	=====	
GRAND TOTAL =====	688,400	100.0	2,500	100.0	

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TRINIDAD AND TOBAGO

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b>	<b>947,900</b>	<b>42.3</b>	<b>952,200</b>	<b>42.3</b>
PUBLIC POLICY AND HEALTH	49,500	2.2	48,200	2.1
WOMEN, HEALTH AND DEVELOPMENT	49,500	2.2	48,200	2.1
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	758,500	33.9	769,600	34.2
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS. EMERGENCY AND HUMANITARIAN ACTION	758,500 0	33.9 -	764,700 4,900	34.0 0.2
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS	27,500	1.2	30,300	1.3
HEALTH SITUATION AND TREND ASSESSMENT	27,500	1.2	30,300	1.3
TECHNICAL COOPERATION AMONG COUNTRIES	112,400	5.0	104,100	4.6
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b>	<b>813,400</b>	<b>36.3</b>	<b>810,200</b>	<b>36.0</b>
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	813,400	36.3	810,200	36.0
UNIVERSAL ACCESS TO HEALTH CARE	813,400	36.3	810,200	36.0
<b>4. HEALTH PROMOTION AND PROTECTION</b>	<b>29,000</b>	<b>1.3</b>	<b>27,300</b>	<b>1.2</b>
NUTRITION, FOOD SECURITY AND SAFETY	29,000	1.3	27,300	1.2
FOOD SAFETY	29,000	1.3	27,300	1.2
<b>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</b>	<b>348,300</b>	<b>15.6</b>	<b>351,100</b>	<b>15.6</b>
ENVIRONMENTAL HEALTH	348,300	15.6	351,100	15.6
WATER SUPPLY AND SANITATION ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	323,300 25,000	14.4 1.1	351,100 0	15.6 -

TRINIDAD AND TOBAGO

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

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
6. DISEASE PREVENTION AND CONTROL =====	101,100	4.5	108,900	4.8	
CONTROL OF COMMUNICABLE DISEASE -----	18,000	0.8	18,400	0.8	
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID	18,000	0.8	18,400	0.8
CONTROL OF NONCOMMUNICABLE DISEASES -----	83,100	3.7	90,500	4.0	
OTHER NONCOMMUNICABLE DISEASES	NCD	83,100	3.7	90,500	4.0
=====	=====	=====	=====	=====	
GRAND TOTAL	2,239,700	100.0	2,249,700	100.0	
=====	=====	=====	=====	=====	

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TURKS AND CAICOS ISLANDS

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
<b>2. HEALTH IN HUMAN DEVELOPMENT</b> =====	<b>10,100</b>	<b>13.3</b>	<b>4,900</b>	<b>6.4</b>	
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS -----	10,100	13.3	4,900	6.4	
HEALTH SITUATION AND TREND ASSESSMENT	HST	10,100	13.3	4,900	6.4
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b> =====	<b>31,000</b>	<b>40.7</b>	<b>54,000</b>	<b>71.0</b>	
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC -----	29,600	38.9	54,000	71.0	
UNIVERSAL ACCESS TO HEALTH CARE	UAH	29,600	38.9	54,000	71.0
QUALITY OF CARE AND HEALTH TECHNOLOGY -----	1,400	1.8	0	-	
QUALITY OF CARE AND HEALTH TECHNOLOGY ASSESSMENT	QAC	1,400	1.8	0	-
<b>4. HEALTH PROMOTION AND PROTECTION</b> =====	<b>23,100</b>	<b>30.4</b>	<b>4,600</b>	<b>6.0</b>	
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES -----	14,000	18.4	0	-	
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH	14,000	18.4	0	-
HEALTHY LIFESTYLES AND MENTAL HEALTH -----	1,300	1.7	2,600	3.4	
HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED	1,300	1.7	2,600	3.4
NUTRITION, FOOD SECURITY AND SAFETY -----	7,800	10.2	2,000	2.6	
FOOD SAFETY	FOS	7,800	10.2	2,000	2.6
<b>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</b> =====	<b>11,900</b>	<b>15.6</b>	<b>12,600</b>	<b>16.6</b>	
ENVIRONMENTAL HEALTH -----	11,900	15.6	12,600	16.6	
WATER SUPPLY AND SANITATION	CWS	6,400	8.4	12,600	16.6
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA	5,500	7.2	0	-
=====	=====	=====	=====	=====	
<b>GRAND TOTAL</b> =====	<b>76,100</b>	<b>100.0</b>	<b>76,100</b>	<b>100.0</b>	

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 UNITED STATES OF AMERICA  
 PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT =====	396,400	100.0	396,400	100.0
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC -----	346,400	87.4	396,400	100.0
UNIVERSAL ACCESS TO HEALTH CARE	UAH 346,400	87.4	396,400	100.0
HUMAN RESOURCES FOR HEALTH -----	HRH 50,000	12.6	0	-
=====	=====	=====	=====	=====
GRAND TOTAL =====	396,400	100.0	396,400	100.0

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URUGUAY

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<u>2. HEALTH IN HUMAN DEVELOPMENT</u>	<u>1,115,100</u>	<u>60.6</u>	<u>1,172,000</u>	<u>62.8</u>
<u>PUBLIC POLICY AND HEALTH</u>	39,000	2.1	30,800	1.7
HEALTH IN SOCIOECONOMIC DEVELOPMENT	HSD 39,000	2.1	30,800	1.7
<u>NATIONAL HEALTH POLICIES &amp; PROG. DEVELOP. &amp; MGMT.</u>	803,000	43.7	861,300	46.2
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 803,000	43.7	861,300	46.2
<u>BIOMEDICAL AND HEALTH INFORMATION AND TRENDS</u>	178,500	9.7	192,400	10.3
HEALTH AND BIOMEDICAL INFORMATION	HBI 178,500	9.7	192,400	10.3
<u>TECHNICAL COOPERATION AMONG COUNTRIES</u>	TCC 94,600	5.1	87,500	4.7
<u>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</u>	<u>81,000</u>	<u>4.4</u>	<u>69,500</u>	<u>3.7</u>
<u>ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC</u>	81,000	4.4	69,500	3.7
UNIVERSAL ACCESS TO HEALTH CARE	UAH 81,000	4.4	69,500	3.7
<u>4. HEALTH PROMOTION AND PROTECTION</u>	<u>440,500</u>	<u>23.9</u>	<u>429,700</u>	<u>23.0</u>
<u>HEALTHY LIFESTYLES AND MENTAL HEALTH</u>	440,500	23.9	429,700	23.0
SETTINGS FOR HEALTH PROMOTION	STP 440,500	23.9	429,700	23.0
<u>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</u>	<u>112,000</u>	<u>6.1</u>	<u>105,200</u>	<u>5.6</u>
<u>ENVIRONMENTAL HEALTH</u>	112,000	6.1	105,200	5.6
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA 112,000	6.1	105,200	5.6



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 URUGUAY

PROGRAM BUDGET - EXTRABUDGETARY FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT =====	191,000	70.5	0	-
ENVIRONMENTAL HEALTH -----	191,000	70.5	0	-
WATER SUPPLY AND SANITATION	CWS 191,000	70.5	0	-
6. DISEASE PREVENTION AND CONTROL =====	80,000	29.5	0	-
CONTROL OF COMMUNICABLE DISEASE -----	80,000	29.5	0	-
AIDS	GPA 80,000	29.5	0	-
=====				
GRAND TOTAL =====	271,000	100.0	0	0.0

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VENEZUELA

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<u>2. HEALTH IN HUMAN DEVELOPMENT</u>	<u>1,606,700</u>	<u>40.9</u>	<u>2,429,000</u>	<u>51.8</u>
<u>PUBLIC POLICY AND HEALTH</u>	<u>114,400</u>	<u>2.9</u>	<u>12,900</u>	<u>0.3</u>
HEALTH IN SOCIOECONOMIC DEVELOPMENT	HSD 63,400	1.6	12,900	0.3
WOMEN, HEALTH AND DEVELOPMENT	WHD 51,000	1.3	0	-
<u>NATIONAL HEALTH POLICIES &amp; PROG. DEVELOP. &amp; MGMT.</u>	<u>916,300</u>	<u>23.4</u>	<u>1,839,300</u>	<u>39.2</u>
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 916,300	23.4	1,839,300	39.2
<u>BIOMEDICAL AND HEALTH INFORMATION AND TRENDS</u>	<u>438,700</u>	<u>11.2</u>	<u>449,800</u>	<u>9.6</u>
HEALTH SITUATION AND TREND ASSESSMENT	HST 410,700	10.5	426,000	9.1
HEALTH AND BIOMEDICAL INFORMATION	HBI 28,000	0.7	23,800	0.5
<u>TECHNICAL COOPERATION AMONG COUNTRIES</u>	<u>137,300</u>	<u>3.5</u>	<u>127,000</u>	<u>2.7</u>
<u>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</u>	<u>1,097,100</u>	<u>28.0</u>	<u>1,129,700</u>	<u>24.1</u>
<u>ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC</u>	<u>577,200</u>	<u>14.7</u>	<u>587,800</u>	<u>12.5</u>
UNIVERSAL ACCESS TO HEALTH CARE	UAH 528,600	13.5	568,100	12.1
ORAL HEALTH	ORH 48,600	1.2	19,700	0.4
<u>HUMAN RESOURCES FOR HEALTH</u>	<u>440,900</u>	<u>11.2</u>	<u>461,400</u>	<u>9.8</u>
<u>ESSENTIAL DRUGS</u>	<u>79,000</u>	<u>2.0</u>	<u>80,500</u>	<u>1.7</u>
<u>4. HEALTH PROMOTION AND PROTECTION</u>	<u>316,800</u>	<u>8.1</u>	<u>449,200</u>	<u>9.6</u>
<u>FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES</u>	<u>201,400</u>	<u>5.1</u>	<u>197,300</u>	<u>4.2</u>
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 201,400	5.1	197,300	4.2

VENEZUELA

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

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
HEALTHY LIFESTYLES AND MENTAL HEALTH	0	-	170,600	3.6
SETTINGS FOR HEALTH PROMOTION	0	-	170,600	3.6
STP				
NUTRITION, FOOD SECURITY AND SAFETY	115,400	2.9	81,300	1.7
FOOD AND NUTRITION	115,400	2.9	81,300	1.7
NUT				
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT	176,400	4.5	118,500	2.5
ENVIRONMENTAL HEALTH	176,400	4.5	118,500	2.5
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	176,400	4.5	118,500	2.5
ERA				
6. DISEASE PREVENTION AND CONTROL	726,800	18.5	560,900	12.0
CONTROL OF COMMUNICABLE DISEASE	248,200	6.3	116,900	2.5
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	38,000	1.0	44,600	1.0
OTHER COMMUNICABLE DISEASES	210,200	5.4	72,300	1.5
CONTROL OF NONCOMMUNICABLE DISEASES	134,400	3.4	87,500	1.9
OTHER NONCOMMUNICABLE DISEASES	134,400	3.4	87,500	1.9
NCD				
VETERINARY PUBLIC HEALTH	344,200	8.8	356,500	7.6
FOOT-AND-MOUTH DISEASE	29,000	0.7	0	-
ZOOZONOSIS	315,200	8.0	356,500	7.6
FMD				
ZNS				
GRAND TOTAL	3,923,800	100.0	4,687,300	100.0

VENEZUELA

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
2. HEALTH IN HUMAN DEVELOPMENT	700	.*	700	6.5
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	700	.*	700	6.5
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 700	.*	700	6.5
3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT	1,946,200	49.7	0	-
ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	5,900	0.2	0	-
ORAL HEALTH	ORH 5,900	0.2	0	-
HUMAN RESOURCES FOR HEALTH	HRH 1,907,400	48.7	0	-
ESSENTIAL DRUGS	EDV 32,900	0.8	0	-
6. DISEASE PREVENTION AND CONTROL	1,970,100	50.3	10,000	93.5
CONTROL OF COMMUNICABLE DISEASE	1,566,100	40.0	10,000	93.5
MALARIA AND OTHER TROPICAL DISEASES	CTD 1,515,500	38.7	0	-
OTHER COMMUNICABLE DISEASES	OCD 50,600	1.3	10,000	93.5
VETERINARY PUBLIC HEALTH	404,000	10.3	0	-
FOOT-AND-MOUTH DISEASE	FMD 404,000	10.3	0	-
GRAND TOTAL	3,917,000	100.0	10,700	100.0

\* INDICATES LESS THAN .05 PERCENT

FIELD OFFICE: US/MEXICO BORDER

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
2. HEALTH IN HUMAN DEVELOPMENT =====	1,219,400	100.0	1,219,400	100.0
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT. -----	998,900	81.9	1,084,600	88.9
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.      CPS	998,900	81.9	1,084,600	88.9
BIOMEDICAL AND HEALTH INFORMATION AND TRENDS -----	220,500	18.1	134,800	11.1
HEALTH SITUATION AND TREND ASSESSMENT                      HST	220,500	18.1	134,800	11.1
=====				
GRAND TOTAL =====	1,219,400	100.0	1,219,400	100.0

FIELD OFFICE: US/MEXICO BORDER

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
4. HEALTH PROMOTION AND PROTECTION =====	99,100	32.7	0	-
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES -----	24,900	8.2	0	-
WOMEN AND CHILD HEALTH AND FAMILY PLANNING      WCH	24,900	8.2	0	-
HEALTHY LIFESTYLES AND MENTAL HEALTH -----	74,200	24.4	0	-
PREVENTION AND CONTROL OF SUBSTANCE ABUSE      ADT	74,200	24.4	0	-
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT =====	20,000	6.6	0	-
ENVIRONMENTAL HEALTH -----	20,000	6.6	0	-
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT      ERA	20,000	6.6	0	-
6. DISEASE PREVENTION AND CONTROL =====	184,400	60.8	0	-
CONTROL OF COMMUNICABLE DISEASE -----	134,400	44.3	0	-
OTHER COMMUNICABLE DISEASES      OCD	134,400	44.3	0	-
CONTROL OF NONCOMMUNICABLE DISEASES -----	50,000	16.5	0	-
OTHER NONCOMMUNICABLE DISEASES      NCD	50,000	16.5	0	-
=====	=====	=====	=====	=====
GRAND TOTAL =====	303,500	100.0	0	0.0
=====	=====	=====	=====	=====



**VI. BUDGET TABLE:  
REGIONAL & INTERCOUNTRY**

**VI. BUDGET TABLE:  
REGIONAL & INTERCOUNTRY**

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 INTERCOUNTRY PROGRAMS  
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PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b> =====	<b>36,236,800</b>	<b>45.9</b>	<b>38,689,500</b>	<b>47.0</b>
----- GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT	9,401,600	11.9	11,947,600	14.5
----- PROGRAM DEVELOPMENT AND MANAGEMENT				
STAFF DEVELOPMENT	GPD 5,565,300	7.0	7,881,300	9.6
EXTERNAL COORDINATION	SDP 1,269,600	1.6	0	-
PUBLIC INFORMATION	ECO 308,500	0.4	1,567,000	1.9
	INF 2,258,200	2.9	2,499,300	3.0
----- PUBLIC POLICY AND HEALTH	8,625,400	10.9	8,679,400	10.5
----- HEALTH IN SOCIOECONOMIC DEVELOPMENT	HSD 2,565,800	3.2	2,825,600	3.4
HEALTH LEGISLATION, HUMAN RIGHTS AND ETHICS	HLE 1,673,800	2.1	1,588,400	1.9
RESEARCH POLICY AND STRATEGY DEVELOPMENT	RPS 3,251,600	4.1	3,090,900	3.8
WOMEN, HEALTH AND DEVELOPMENT	WHD 1,134,200	1.4	1,174,500	1.4
----- NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	5,672,100	7.2	5,236,100	6.4
----- DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 4,948,200	6.3	4,501,000	5.5
EMERGENCY AND HUMANITARIAN ACTION	EHA 723,900	0.9	735,100	0.9
----- BIOMEDICAL AND HEALTH INFORMATION AND TRENDS	12,241,300	15.5	12,622,400	15.3
----- HEALTH SITUATION AND TREND ASSESSMENT	HST 4,341,200	5.5	4,507,100	5.5
HEALTH AND BIOMEDICAL INFORMATION	HBI 7,900,100	10.0	8,115,300	9.9
----- TECHNICAL COOPERATION AMONG COUNTRIES	TCC 296,400	0.4	204,000	0.2
-----				
<b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b> =====	<b>16,068,500</b>	<b>20.3</b>	<b>16,403,700</b>	<b>19.9</b>
----- ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	8,677,800	11.0	8,626,600	10.5
----- UNIVERSAL ACCESS TO HEALTH CARE	UAH 7,910,500	10.0	7,807,200	9.5
DISABILITY PREVENTION AND REHABILITATION	DPR 350,600	0.4	335,200	0.4
ORAL HEALTH	ORH 416,700	0.5	484,200	0.6
----- HUMAN RESOURCES FOR HEALTH	HRH 5,140,400	6.5	5,378,400	6.5
----- ESSENTIAL DRUGS	EDV 863,800	1.1	849,700	1.0
----- QUALITY OF CARE AND HEALTH TECHNOLOGY	1,386,500	1.8	1,549,000	1.9
----- CLINICAL, LABORATORY AND IMAGING TECHNOLOGY	CLT 1,386,500	1.8	1,549,000	1.9

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INTERCOUNTRY PROGRAMS

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

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001		
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL	
<b>4. HEALTH PROMOTION AND PROTECTION</b>	<b>7,481,700</b>	<b>9.5</b>	<b>7,738,800</b>	<b>9.4</b>	
-----					
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES	2,578,300	3.3	2,439,100	3.0	
-----					
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH	1,490,200	1.9	1,325,900	1.6
ADOLESCENT HEALTH	ADH	751,200	1.0	842,100	1.0
HEALTH OF THE ELDERLY	HEE	336,900	0.4	271,100	0.3
-----					
HEALTHY LIFESTYLES AND MENTAL HEALTH		3,130,700	4.0	3,404,200	4.1
-----					
HEALTH EDUCATION AND SOCIAL COMMUNICATION	HED	545,400	0.7	843,500	1.0
PREVENTION AND CONTROL OF SUBSTANCE ABUSE	ADT	361,000	0.5	571,300	0.7
MENTAL HEALTH	MNH	962,300	1.2	945,400	1.1
SETTINGS FOR HEALTH PROMOTION	STP	1,262,000	1.6	1,044,000	1.3
-----					
NUTRITION, FOOD SECURITY AND SAFETY		1,772,700	2.2	1,895,500	2.3
-----					
FOOD AND NUTRITION	NUT	1,330,500	1.7	1,384,600	1.7
FOOD SAFETY	FOS	442,200	0.6	510,900	0.6
-----					
<b>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</b>	<b>4,459,700</b>	<b>5.6</b>	<b>4,604,400</b>	<b>5.6</b>	
-----					
ENVIRONMENTAL HEALTH		4,459,700	5.6	4,604,400	5.6
-----					
WATER SUPPLY AND SANITATION	CWS	1,811,000	2.3	1,858,200	2.3
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA	1,525,800	1.9	1,558,300	1.9
MANAGEMENT OF SOLID WASTE AND HOUSING HYGIENE	MWH	479,400	0.6	511,200	0.6
CHEMICAL SAFETY	PCS	60,100	0.1	95,700	0.1
WORKERS' HEALTH	OCH	583,400	0.7	581,000	0.7
-----					
<b>6. DISEASE PREVENTION AND CONTROL</b>	<b>14,732,700</b>	<b>18.7</b>	<b>14,878,000</b>	<b>18.1</b>	
-----					
CONTROL OF COMMUNICABLE DISEASE		11,284,300	14.3	11,730,200	14.3
-----					
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID	2,794,300	3.5	2,907,400	3.5
ACUTE RESPIRATORY INFECTIONS	ARI	608,000	0.8	612,100	0.7
DIARRHEAL DISEASES	CDD	618,300	0.8	558,000	0.7
AIDS	GPA	940,200	1.2	1,009,600	1.2
SEXUALLY TRANSMITTED DISEASES	STD	192,500	0.2	180,100	0.2
TUBERCULOSIS	TUB	516,200	0.7	530,900	0.6
MALARIA AND OTHER TROPICAL DISEASES	CTD	3,448,600	4.4	3,394,400	4.1
RESEARCH IN TROPICAL DISEASES	TDR	378,100	0.5	411,900	0.5
OTHER COMMUNICABLE DISEASES	OCD	1,414,300	1.8	1,767,500	2.1
LEPROSY	LEP	373,800	0.5	358,300	0.4

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 INTERCOUNTRY PROGRAMS

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS (CONT.)  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
CONTROL OF NONCOMMUNICABLE DISEASES	1,427,800	1.8	1,319,500	1.6
OTHER NONCOMMUNICABLE DISEASES	NCD 1,427,800	1.8	1,319,500	1.6
VETERINARY PUBLIC HEALTH	2,020,600	2.6	1,828,300	2.2
FOOT-AND-MOUTH DISEASE	FMD 236,100	0.3	245,700	0.3
ZOOZOSIS	ZNS 1,784,500	2.3	1,582,600	1.9
===== GRAND TOTAL =====	===== 78,979,400 =====	===== 100.0 =====	===== 82,314,400 =====	===== 100.0 =====

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INTERCOUNTRY PROGRAMS

PROGRAM BUDGET - EXTRABUDGETARY FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b> =====	<b>13,474,300</b>	<b>32.3</b>	<b>4,825,000</b>	<b>26.3</b>
----- GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT	3,188,500	7.6	1,297,400	7.1
----- PROGRAM DEVELOPMENT AND MANAGEMENT				
STAFF DEVELOPMENT	GPD 1,995,200	4.8	692,000	3.8
EXTERNAL COORDINATION	SDP 350,000	0.8	0	-
PUBLIC INFORMATION	ECO 386,600	0.9	343,400	1.9
	INF 456,700	1.1	262,000	1.4
----- PUBLIC POLICY AND HEALTH	1,551,900	3.7	345,000	1.9
----- HEALTH IN SOCIOECONOMIC DEVELOPMENT	HSD 202,300	0.5	57,000	0.3
HEALTH LEGISLATION, HUMAN RIGHTS AND ETHICS	HLE 198,100	0.5	180,000	1.0
RESEARCH POLICY AND STRATEGY DEVELOPMENT	RPS 390,100	0.9	108,000	0.6
WOMEN, HEALTH AND DEVELOPMENT	WHD 761,400	1.8	0	-
----- NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT.	7,507,800	18.0	2,708,200	14.8
----- DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 103,100	0.2	0	-
EMERGENCY AND HUMANITARIAN ACTION	EHA 7,404,700	17.7	2,708,200	14.8
----- BIOMEDICAL AND HEALTH INFORMATION AND TRENDS	1,064,200	2.5	474,400	2.6
----- HEALTH SITUATION AND TREND ASSESSMENT	HST 90,900	0.2	106,400	0.6
HEALTH AND BIOMEDICAL INFORMATION	HBI 973,300	2.3	368,000	2.0
----- TECHNICAL COOPERATION AMONG COUNTRIES	TCC 161,900	0.4	0	-
----- <b>3. HEALTH SYSTEMS AND SERVICES DEVELOPMENT</b> =====	<b>4,885,100</b>	<b>11.7</b>	<b>1,948,900</b>	<b>10.6</b>
----- ORGANIZATION/MGMT OF HEALTH SYSTEMS BASED ON PHC	2,676,800	6.4	1,304,900	7.1
----- UNIVERSAL ACCESS TO HEALTH CARE	UAH 2,205,700	5.3	1,304,900	7.1
ORAL HEALTH	ORH 471,100	1.1	0	-
----- HUMAN RESOURCES FOR HEALTH	HRH 940,100	2.3	305,000	1.7
----- ESSENTIAL DRUGS	EDV 491,800	1.2	113,000	0.6
----- QUALITY OF CARE AND HEALTH TECHNOLOGY	776,400	1.9	226,000	1.2
----- CLINICAL, LABORATORY AND IMAGING TECHNOLOGY	CLT 716,600	1.7	226,000	1.2
QUALITY, SAFETY & EFFICACY OF DRUGS & BIOLOGICALS	DSE 59,800	0.1	0	-

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 INTERCOUNTRY PROGRAMS  
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PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>4. HEALTH PROMOTION AND PROTECTION</b> =====	<b>4,954,400</b>	<b>11.9</b>	<b>1,874,400</b>	<b>10.2</b>
<b>FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES</b> -----	<b>3,600,800</b>	<b>8.6</b>	<b>1,599,100</b>	<b>8.7</b>
WOMEN AND CHILD HEALTH AND FAMILY PLANNING	WCH 3,286,800	7.9	1,599,100	8.7
ADOLESCENT HEALTH	ADH 117,000	0.3	0	-
HEALTH OF THE ELDERLY	HEE 197,000	0.5	0	-
<b>HEALTHY LIFESTYLES AND MENTAL HEALTH</b> -----	<b>884,400</b>	<b>2.1</b>	<b>162,300</b>	<b>0.9</b>
PREVENTION AND CONTROL OF SUBSTANCE ABUSE	ADT 624,800	1.5	162,300	0.9
MENTAL HEALTH	MNH 217,100	0.5	0	-
SETTINGS FOR HEALTH PROMOTION	STP 42,500	0.1	0	-
<b>NUTRITION, FOOD SECURITY AND SAFETY</b> -----	<b>469,200</b>	<b>1.1</b>	<b>113,000</b>	<b>0.6</b>
FOOD AND NUTRITION	NUT 469,200	1.1	113,000	0.6
<b>5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT</b> =====	<b>2,145,600</b>	<b>5.1</b>	<b>780,100</b>	<b>4.2</b>
<b>ENVIRONMENTAL HEALTH</b> -----	<b>2,145,600</b>	<b>5.1</b>	<b>780,100</b>	<b>4.2</b>
WATER SUPPLY AND SANITATION	CWS 396,600	0.9	265,000	1.4
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA 1,538,100	3.7	515,100	2.8
MANAGEMENT OF SOLID WASTE AND HOUSING HYGIENE	MWH 59,500	0.1	0	-
CHEMICAL SAFETY	PCS 124,300	0.3	0	-
WORKERS' HEALTH	OCH 27,100	0.1	0	-
<b>6. DISEASE PREVENTION AND CONTROL</b> =====	<b>16,317,700</b>	<b>39.1</b>	<b>8,928,900</b>	<b>48.6</b>
<b>CONTROL OF COMMUNICABLE DISEASE</b> -----	<b>15,142,400</b>	<b>36.2</b>	<b>8,440,100</b>	<b>46.0</b>
VACCINE-PREVENTABLE DISEASES AND IMMUNIZATION	VID 7,414,500	17.7	4,401,500	24.0
ACUTE RESPIRATORY INFECTIONS	ARI 1,222,000	2.9	1,030,600	5.6
DIARRHEAL DISEASES	CDD 3,324,200	8.0	2,552,000	13.9
AIDS	GPA 935,800	2.2	183,000	1.0
SEXUALLY TRANSMITTED DISEASES	STD 15,400	*	0	-
TUBERCULOSIS	TUB 523,300	1.3	0	-
MALARIA AND OTHER TROPICAL DISEASES	CTD 351,200	0.8	82,600	0.4
RESEARCH IN TROPICAL DISEASES	TDR 200,500	0.5	0	-
OTHER COMMUNICABLE DISEASES	OCD 999,600	2.4	100,000	0.5
LEPROSY	LEP 155,900	0.4	90,400	0.5

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 INTERCOUNTRY PROGRAMS

PROGRAM BUDGET - EXTRABUDGETARY FUNDS (CONT.)

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
CONTROL OF NONCOMMUNICABLE DISEASES	588,000	1.4	188,800	1.0
CANCER	CAN 137,900	0.3	33,900	0.2
CARDIOVASCULAR DISEASES	CVD 163,000	0.4	12,400	0.1
OTHER NONCOMMUNICABLE DISEASES	NCD 287,100	0.7	142,500	0.8
VETERINARY PUBLIC HEALTH	587,300	1.4	300,000	1.6
ZOOZOSIS	ZNS 587,300	1.4	300,000	1.6
=====	=====	=====	=====	=====
GRAND TOTAL	41,777,100	100.0	18,357,300	100.0
=====	=====	=====	=====	=====

\* INDICATES LESS THAN .05 PERCENT

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 LATIN AMERICAN AND CARIBBEAN CENTER FOR HEALTH SCIENCES INFORMATION

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
2. <u>HEALTH IN HUMAN DEVELOPMENT</u>	1,611,000	100.0	1,647,700	100.0
<u>BIOMEDICAL AND HEALTH INFORMATION AND TRENDS</u>	1,611,000	100.0	1,647,700	100.0
HEALTH AND BIOMEDICAL INFORMATION	1,611,000	100.0	1,647,700	100.0
HBI	1,611,000	100.0	1,647,700	100.0
<u>GRAND TOTAL</u>	<u>1,611,000</u>	<u>100.0</u>	<u>1,647,700</u>	<u>100.0</u>

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 LATIN AMERICAN AND CARIBBEAN CENTER FOR HEALTH SCIENCES INFORMATION

PROGRAM BUDGET - EXTRABUDGETARY FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
2. <u>HEALTH IN HUMAN DEVELOPMENT</u>	3,680,100	100.0	2,850,000	100.0
<u>BIOMEDICAL AND HEALTH INFORMATION AND TRENDS</u>	3,680,100	100.0	2,850,000	100.0
HEALTH AND BIOMEDICAL INFORMATION	3,680,100	100.0	2,850,000	100.0
HBI	3,680,100	100.0	2,850,000	100.0
<u>GRAND TOTAL</u>	<u>3,680,100</u>	<u>100.0</u>	<u>2,850,000</u>	<u>100.0</u>

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 CARIBBEAN EPIDEMIOLOGY CENTER

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
6. DISEASE PREVENTION AND CONTROL =====	1,452,900	100.0	1,444,800	100.0
CONTROL OF COMMUNICABLE DISEASE -----	1,452,900	100.0	1,444,800	100.0
OTHER COMMUNICABLE DISEASES                      OCD	1,452,900	100.0	1,444,800	100.0
=====	=====	=====	=====	=====
GRAND TOTAL =====	1,452,900	100.0	1,444,800	100.0

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 CARIBBEAN EPIDEMIOLOGY CENTER

PROGRAM BUDGET - EXTRABUDGETARY FUNDS  
 -----

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
6. DISEASE PREVENTION AND CONTROL =====	77,800	100.0	0	-
CONTROL OF COMMUNICABLE DISEASE -----	77,800	100.0	0	-
OTHER COMMUNICABLE DISEASES                      OCD	77,800	100.0	0	-
=====	=====	=====	=====	=====
GRAND TOTAL =====	77,800	100.0	0	0.0

PAN AMERICAN CENTER FOR SANITARY ENGINEERING AND ENVIRONMENTAL SCIENCES

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT	3,893,100	100.0	5,473,700	100.0
ENVIRONMENTAL HEALTH	3,893,100	100.0	5,473,700	100.0
WATER SUPPLY AND SANITATION	CWS 2,679,400	68.8	3,122,400	57.0
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA 958,300	24.6	2,077,700	38.0
MANAGEMENT OF SOLID WASTE AND HOUSING HYGIENE	MWH 255,400	6.6	273,600	5.0
GRAND TOTAL	3,893,100	100.0	5,473,700	100.0

PAN AMERICAN CENTER FOR SANITARY ENGINEERING AND ENVIRONMENTAL SCIENCES

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
5. ENVIRONMENTAL PROTECTION AND DEVELOPMENT	4,202,000	100.0	1,908,300	100.0
ENVIRONMENTAL HEALTH	4,202,000	100.0	1,908,300	100.0
WATER SUPPLY AND SANITATION	CWS 2,811,300	66.9	1,388,300	72.8
ENVIRONMENTAL HEALTH RISK ASSESSMENT & MANAGEMENT	ERA 1,390,700	33.1	520,000	27.2
GRAND TOTAL	4,202,000	100.0	1,908,300	100.0



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 LATIN AMERICAN CENTER FOR PERINATOLOGY AND HUMAN DEVELOPMENT

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
4. HEALTH PROMOTION AND PROTECTION =====	2,035,400	100.0	1,990,300	100.0
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES -----	2,035,400	100.0	1,990,300	100.0
WOMEN AND CHILD HEALTH AND FAMILY PLANNING      WCH	2,035,400	100.0	1,990,300	100.0
=====	=====	=====	=====	=====
GRAND TOTAL	2,035,400	100.0	1,990,300	100.0
=====	=====	=====	=====	=====

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 LATIN AMERICAN CENTER FOR PERINATOLOGY AND HUMAN DEVELOPMENT

PROGRAM BUDGET - EXTRABUDGETARY FUNDS  
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PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
4. HEALTH PROMOTION AND PROTECTION =====	773,000	100.0	333,000	100.0
FAMILY/COMMUNITY HEALTH AND POPULATION ISSUES -----	773,000	100.0	333,000	100.0
WOMEN AND CHILD HEALTH AND FAMILY PLANNING      WCH	773,000	100.0	333,000	100.0
=====	=====	=====	=====	=====
GRAND TOTAL	773,000	100.0	333,000	100.0
=====	=====	=====	=====	=====



PAN AMERICAN INSTITUTE FOR FOOD PROTECTION AND ZOOSES

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
4. HEALTH PROMOTION AND PROTECTION	1,983,200	58.0	2,310,100	71.1
NUTRITION, FOOD SECURITY AND SAFETY	1,983,200	58.0	2,310,100	71.1
FOOD SAFETY	FOS 1,983,200	58.0	2,310,100	71.1
6. DISEASE PREVENTION AND CONTROL	1,434,000	42.0	937,800	28.9
VETERINARY PUBLIC HEALTH	1,434,000	42.0	937,800	28.9
ZOOSES	ZNS 1,434,000	42.0	937,800	28.9
GRAND TOTAL	3,417,200	100.0	3,247,900	100.0

PAN AMERICAN INSTITUTE FOR FOOD PROTECTION AND ZOOSES

PROGRAM BUDGET - EXTRABUDGETARY FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
4. HEALTH PROMOTION AND PROTECTION	754,600	42.0	710,000	45.4
NUTRITION, FOOD SECURITY AND SAFETY	754,600	42.0	710,000	45.4
FOOD SAFETY	FOS 754,600	42.0	710,000	45.4
6. DISEASE PREVENTION AND CONTROL	1,040,800	58.0	855,000	54.6
VETERINARY PUBLIC HEALTH	1,040,800	58.0	855,000	54.6
ZOOSES	ZNS 1,040,800	58.0	855,000	54.6
GRAND TOTAL	1,795,400	100.0	1,565,000	100.0

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 PAN AMERICAN FOOT-AND-MOUTH DISEASE CENTER  
 PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS  
 -----

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
6. DISEASE PREVENTION AND CONTROL =====	9,264,500	100.0	8,209,600	100.0
VETERINARY PUBLIC HEALTH -----	9,264,500	100.0	8,209,600	100.0
FOOT-AND-MOUTH DISEASE                      FMD	9,264,500	100.0	8,209,600	100.0
=====	=====	=====	=====	=====
GRAND TOTAL =====	9,264,500	100.0	8,209,600	100.0

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 PAN AMERICAN FOOT-AND-MOUTH DISEASE CENTER  
 PROGRAM BUDGET - EXTRABUDGETARY FUNDS  
 -----

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
6. DISEASE PREVENTION AND CONTROL =====	4,541,600	100.0	3,504,600	100.0
VETERINARY PUBLIC HEALTH -----	4,541,600	100.0	3,504,600	100.0
FOOT-AND-MOUTH DISEASE                      FMD	4,541,600	100.0	3,504,600	100.0
=====	=====	=====	=====	=====
GRAND TOTAL =====	4,541,600	100.0	3,504,600	100.0

TECHNICAL AND ADMINISTRATIVE DIRECTION

PROGRAM BUDGET - PAHO AND WHO REGULAR FUNDS

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
2. HEALTH IN HUMAN DEVELOPMENT =====	9,647,600	27.1	8,539,800	23.9
GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT -----	7,634,000	21.4	6,207,400	17.4
EXECUTIVE MANAGEMENT	EXM 4,236,100	11.9	4,599,300	12.9
PROGRAM DEVELOPMENT AND MANAGEMENT	GPD 1,839,900	5.2	0	-
STAFF DEVELOPMENT	SDP 405,600	1.1	1,608,100	4.5
EXTERNAL COORDINATION	ECO 1,152,400	3.2	0	-
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT. -----	2,013,600	5.7	2,332,400	6.5
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 2,013,600	5.7	2,332,400	6.5
7. ADMINISTRATIVE SERVICES =====	25,959,200	72.9	27,123,200	76.1
PERSONNEL -----	PER 3,951,100	11.1	4,652,700	13.0
GENERAL ADMINISTRATION -----	GAD 12,160,200	34.2	11,669,400	32.7
BUDGET AND FINANCE -----	BFI 8,046,500	22.6	9,135,200	25.6
LOGISTICAL SUPPORT TO COUNTRY PROGRAMS -----	SUP 1,801,400	5.1	1,665,900	4.7
=====	=====	=====	=====	=====
GRAND TOTAL =====	35,606,800	100.0	35,663,000	100.0

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 TECHNICAL AND ADMINISTRATIVE DIRECTION  
 PROGRAM BUDGET - EXTRABUDGETARY FUNDS  
 -----

PAHO PROGRAM CLASSIFICATION	1998-1999		2000-2001	
	AMOUNT	% OF TOTAL	AMOUNT	% OF TOTAL
<b>2. HEALTH IN HUMAN DEVELOPMENT</b> =====	<b>1,010,600</b>	<b>10.2</b>	<b>825,000</b>	<b>10.2</b>
GENERAL PROGRAM DEVELOPMENT AND MANAGEMENT -----	956,000	9.7	825,000	10.2
EXECUTIVE MANAGEMENT	EXM 312,000	3.2	300,000	3.7
PROGRAM DEVELOPMENT AND MANAGEMENT	GPD 154,800	1.6	0	-
EXTERNAL COORDINATION	ECO 489,200	5.0	525,000	6.5
NATIONAL HEALTH POLICIES & PROG. DEVELOP. & MGMT. -----	54,600	0.6	0	-
DEVELOPMENT, MANAGEMENT & COORD. OF COUNTRY PROGS.	CPS 54,600	0.6	0	-
<b>7. ADMINISTRATIVE SERVICES</b> =====	<b>8,869,800</b>	<b>89.8</b>	<b>7,256,000</b>	<b>89.8</b>
PERSONNEL -----	PER 710,400	7.2	1,001,500	12.4
GENERAL ADMINISTRATION -----	GAD 3,715,000	37.6	1,500,000	18.6
BUDGET AND FINANCE -----	BFI 3,305,000	33.5	3,308,000	40.9
LOGISTICAL SUPPORT TO COUNTRY PROGRAMS -----	SUP 1,139,400	11.5	1,446,500	17.9
<b>GRAND TOTAL</b> =====	<b>9,880,400</b>	<b>100.0</b>	<b>8,081,000</b>	<b>100.0</b>

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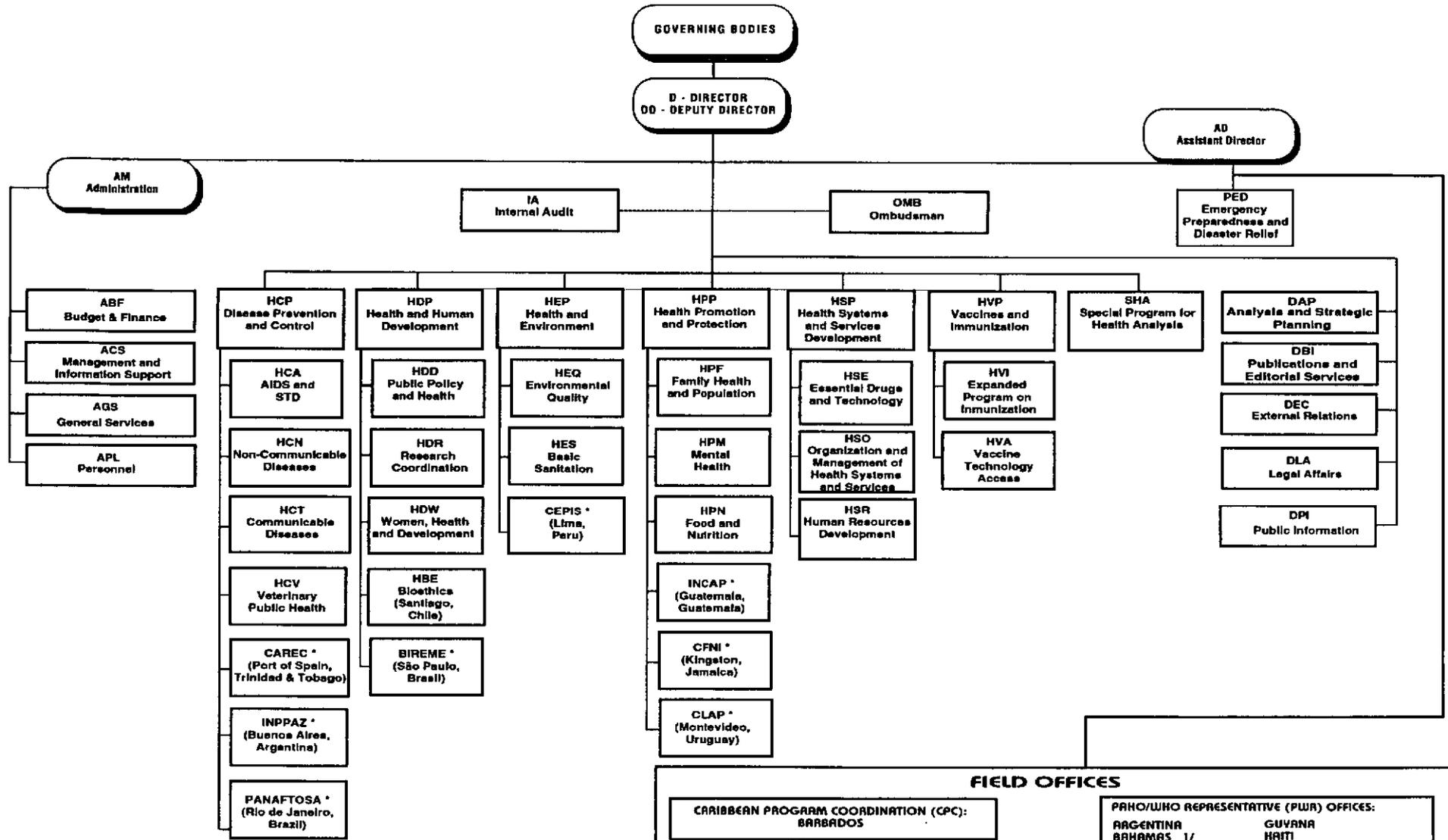
VII. ORGANIZATIONAL  
STRUCTURE



VII. ORGANIZATIONAL  
STRUCTURE



# PAHO ORGANIZATIONAL CHART



\* PAN AMERICAN CENTERS

- BIREME LATIN AMERICAN AND CARIBBEAN CENTER ON HEALTH SCIENCES INFORMATION
- CAREC CARIBBEAN EPIDEMIOLOGY CENTER
- CEPIS PAN AMERICAN CENTER FOR SANITARY ENGINEERING AND ENVIRONMENTAL SCIENCES
- CFNI CARIBBEAN FOOD AND NUTRITION INSTITUTE
- CLAP LATIN AMERICAN CENTER FOR PERINATOLOGY AND HUMAN DEVELOPMENT
- INCAP INSTITUTE OF NUTRITION OF CENTRAL AMERICAN AND PANAMA
- INPPAZ PAN AMERICAN INSTITUTE FOR FOOD PROTECTION AND ZOOSES
- PANAFTOSA PAN AMERICAN FOOT-AND-MOUTH DISEASE CENTER

## FIELD OFFICES

CARIBBEAN PROGRAM COORDINATION (CPC):  
BARBADOS

OFFICE RESPONSIBLE FOR ACTIVITIES IN:

- ANTIGUA AND BARBUDA
- BARBADOS
- DOMINICA
- GRENADA
- ST. HITS & NEVIS
- ST. LUCIA
- ST. VINCENT & THE GRENADINES

EASTERN CARIBBEAN:

- ANGUILLA, BRITISH VIRGIN ISLANDS, MONTSERRAT

FRENCH DEPARTMENTS IN THE AMERICAS:

- FRENCH GUIANA, GUADELOUPE, MARTINIQUE, ST. MARTIN & ST. BARTHOLOMEW

PAHO/WHO REPRESENTATIVE (PW/R) OFFICES:

- ARGENTINA
- BAHAMAS 1/
- BELIZE
- BOLIVIA
- BRAZIL
- CHILE
- COLOMBIA
- COSTA RICA
- CUBA
- DOMINICAN REPUBLIC
- ECUADOR
- EL SALVADOR
- GUATEMALA
- GUYANA
- HAITI
- HONDURAS
- JAMAICA 2/
- MEXICO
- NICARAGUA
- PANAMA
- PARAGUAY
- PERU
- SURINAME
- TRINIDAD AND TOBAGO
- URUGUAY
- VENEZUELA 3/

OFFICE RESPONSIBLE FOR ACTIVITIES IN:

- 1/ Turks and Caicos Island
- 2/ Northern Caribbean: Bermuda, Cayman Islands
- 3/ Netherlands Antilles

FIELD OFFICE US-MEXICO BORDER:  
EL PASO, TEXAS



# ORGANIZATIONAL STRUCTURE

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## *Introduction*

1. On 1 March 1999 the Pan American Sanitary Bureau's (PASB) structure was modified as follows:
2. The Special Program of Vaccines and Immunization (SVI) has been changed to a Division of Vaccines and Immunization (HVP).
3. A new Special Program for Health Analysis (SHA) has been established.
4. The Information Systems Program (HSI) has been disestablished and its components have been incorporated into the Programs on Essential Drugs and Technology (HSE) and Organization and Management of Health Systems and Services (HSO).
5. Following are the functional descriptions of all Headquarters units, Pan American centers, and country offices.

## *Functional Descriptions*

### **OFFICE OF THE DIRECTOR/DEPUTY DIRECTOR**

6. The Office of the Director, which includes the Office of the Deputy Director, oversees the five Staff Offices, the Office of Internal Audit, and the Office of the Ombudsman. The Staff Offices are: Analysis and Strategic Planning; Publications and Editorial Services; External Relations; Legal Affairs; and Public Information.
7. The Office of the Ombudsman has been established to perform the following functions: To assist staff members individually or collectively with problems or grievances relating to conditions of employment, working conditions, and relations with supervisors and colleagues in a manner that contributes to an improvement in the overall working environment in the Organization.

8. The functions of the Office of the Director/Deputy Director are: To provide overall leadership to the Organization to ensure that the mandates of PAHO's and WHO's respective Constitutions are met, that the resolutions and recommendations of the Governing Bodies are adhered to, that the strategic and programmatic orientations are carried out, and that the Bureau functions in the most efficient and effective manner possible.

9. To represent the Organization in all legal and official capacities, serving the Governing Bodies during their meetings, and ensuring the sound financial management of the Organization.

10. The Office of the Deputy Director is responsible for relations and program activities in Canada, the United States of America, and Puerto Rico.

11. The Director is supported by the Director's Cabinet for decision-making regarding policy, structure, and management of the Bureau, and the integration of regional and country actions.

### **OFFICES UNDER D/DD**

#### *Office of Analysis and Strategic Planning (DAP)*

12. Supports the process of strategic planning for the Secretariat itself, taking account of the external environment and possible future scenarios.

13. Coordinates the process of formulating the strategic and programmatic orientations for the technical cooperation as well as the relevant process of planning, programming, monitoring, and evaluation of technical cooperation through the American Region Planning, Programming, Monitoring, and Evaluation System (AMPES).

14. Acts as technical secretariat for the Subcommittee on Planning and Programming of the Executive Committee.

15. The Chief of DAP shall serve as Secretary to the Director's Cabinet.

***Office of Publications and Editorial Services (DBI)***

16. DBI comprises Editorial Services; Marketing, Distribution and Sales; and the Headquarters Library. DBI manages the Organization's scientific, technical, and policy-related information assets and the supply chain that conveys those assets from source to user:

17. Administers the selection of information to be issued as journals, articles, books, electronic text and documents; and edits, translates, and publishes selected information.

18. Promotes and markets awareness and recognition of PAHO/WHO's information services and products.

19. Delivers information by internal and external channels and over traditional print and electronic methods.

20. Provides reference services and manages the PAHO/WHO institutional memory.

***Office of External Relations (DEC)***

21. Coordinates the external relations of the Organization with emphasis on the inter-American system, the United Nations System, international lending institutions, bilateral cooperation agencies, nongovernmental organizations, and relevant foundations.

22. Coordinates the mobilization of voluntary resources and the provision of technical support in the acquisition and management of international cooperation for health.

23. Coordinates the Project Review Process.

***Office of Legal Affairs (DLA)***

24. Provides advice and legal counsel to PAHO/WHO's Governing Bodies, the Director, the administration, technical divisions, special program,

PAHO/WHO representatives (PWRs), and Pan American centers in all legal matters, including the application of national and international law to the Organization's programs and activities as well as constitutional, administrative, and procedural matters.

25. Drafts, reviews, and/or negotiates contracts, treaties, agreements, resolutions, and any other type of instrument which has legal implications for the Organization.

26. Represents and defends the Organization before the Administrative Tribunal of the International Labor Organization and other judicial and quasi-judicial fora.

***Office of Public Information (DPI)***

27. Expands the knowledge of PAHO/WHO's mission, programs, and activities to the critical selected publics.

28. Publishes and produces materials about PAHO/WHO including *Perspectives in Health/Perspectivas de Salud, PAHO Today/La OPS Ahora* and public service announcements.

29. Creates and produces material on PAHO/WHO for use by all the communications media.

30. Assumes the main responsibility for the public relations function in PAHO/WHO.

31. Provides media training and assistance with communication strategies and tactics to PAHO/WHO staff.

***Office of Internal Audit (IA)***

32. Ensures maintenance of the internal financial controls in the Organization, safeguarding the proper receipt, deposit, and disbursement of all funds and other resources of PAHO/WHO.

33. Examines financial operations to ensure that the commitments, obligations, and expenditures related to budget allocations or other financial authorizations

conform to the established objectives, regulations, and other provisions.

***OFFICE OF THE ASSISTANT DIRECTOR (AD)***

34. Coordinates and supports the formulation, monitoring, and evaluation of the technical cooperation country programs and supervises the PAHO/WHO representatives' offices, the Caribbean Program Coordination (CPC), and the Field Office/U.S.-Mexico Border (FO/USMB).

35. Supervises the Program on Emergency Preparedness and Disaster Relief.

36. Coordinates the technical cooperation activities among countries (TCC), the subregional integration initiatives, and the Health and Tourism initiative.

37. Coordinates the country managers' subregional meetings and the PAHO/WHO Managers' Meetings.

38. Articulates normative functions and technical cooperation among global, regional, subregional, and country levels.

***PROGRAM AND OFFICES UNDER AD***

***Program on Emergency Preparedness and Disaster Relief (PED)***

39. Provides technical cooperation for improving the countries' capabilities to prepare for or reduce the damage caused by disasters.

40. Responds to emergencies and coordinates humanitarian assistance in the health sector.

41. Coordinates and liaises with all national or international organizations that contribute to a reduction in health risks or that provide support for the countries in emergency situations.

***COUNTRY OFFICES***

42. Represent PAHO/WHO and advocate for health.

43. Promote interagency collaboration and intersectoral action for national health development.

44. Coordinate and program the use of all resources and all technical cooperation directed towards satisfying identified national priorities for technical cooperation from PAHO/WHO.

45. Assume primary responsibility for collecting, maintaining and analyzing the data on the national health situation.

46. Facilitate the fulfilling of those mandates of the Governing Bodies that are global/regional in scope, but specific regarding the main national priorities.

47. Support national authorities in their participation at regional and global Governing Bodies meetings, including their contribution to the global health agenda.

48. The PWR, CPC, and Chief of the FO/USMB are responsible for the technical and administrative supervision of all staff assigned to these offices.

***OFFICE OF ADMINISTRATION (AM)***

49. The Office of Administration has four departments: Budget and Finance; Management and Information Support; General Services; and Personnel.

50. Provides administrative support to PAHO/WHO through its Headquarters 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, procurement, and corporate information services.

***DEPARTMENTS UNDER AM***

***Department of Budget and Finance (ABF)***

51. Formulates and maintains budgetary policies and procedures required for the implementation of PAHO/WHO's program activities.

52. Oversees accounting policies and procedures; financial rules and regulations; and the control,

disbursement, and reporting of regular funds and funds from external sources, as well as monitors the inflow of funding and utilization of these resources.

53. Is responsible for Staff Health Insurance, banking and investments, the monitoring of the field offices' financial administration, and the processes involved in pension and income tax reimbursement.

***Department of Management and Information Support (ACS)***

54. Recommends appropriate information technology strategies to PAHO/WHO management.

55. Maintains the corporate computing infrastructure of the Organization in both Headquarters and field offices.

56. Develops and maintains all corporate software application and communications systems.

57. Provides end user support, support to users of the PAHO/WHO corporate systems, and assists field offices and Headquarters units in selecting appropriate information technology.

***Department of General Services (AGS)***

58. Provides conference, translation, procurement, building, and office services at Headquarters in support of PAHO/WHO programs; general supervision of acquisition and maintenance of all PAHO/WHO premises; in the case of procurement, these services are extensive to Member Governments and other Regions of WHO.

59. Develops administrative norms and guidelines related to the world-wide procurement of goods and services, and is responsible for shipment of material to their final consignees, management of communications and mail, building maintenance, inventories, office supplies and equipment, transportation, security and safety, and reproduction.

60. Plans and coordinates meetings of the Governing Bodies and their subcommittees, and arranges for the translation of technical and administrative documents into the four official languages of the Organization.

***Department of Personnel (APL)***

61. Oversees recruitment and assignments, post classification and salary systems, performance appraisal system, staff entitlements, staff rules and personnel policies and procedures, as well as the maintenance of personnel records and files.

62. Assesses the training needs of the Headquarters and field offices of the Organization and consolidates them into an overall program.

63. Oversees the provision of medical services to staff at Headquarters.

***TECHNICAL DIVISIONS***

64. The technical divisions are: Disease Prevention and Control; Health and Human Development; Health and Environment; Health Promotion and Protection; Health Systems and Services Development; and Vaccines and Immunization.

***DIVISION OF DISEASE PREVENTION AND CONTROL (HCP)***

65. The Division of Disease Prevention and Control has four programs and three Pan American centers: Acquired Immunodeficiency Syndrome and Sexually Transmitted Diseases; Non-Communicable Diseases; Communicable Diseases; Veterinary Public Health; Caribbean Epidemiology Center; Pan American Institute for Food Protection and Zoonoses; and Pan American Foot-and-Mouth Disease Center.

66. The functions of the Division are: Promote, coordinate and implement technical cooperation activities directed towards the prevention, control, and elimination of communicable diseases and non-communicable diseases, including intentional and unintentional injuries. Its main focus is on raising the awareness of national institutions to the fact that, while infectious and re-emerging diseases continue to pose a

significant problem in the Region, chronic and non-communicable diseases are on the rise.

**PROGRAMS AND PAN AMERICAN CENTERS  
UNDER HCP**

***Program on Acquired Immunodeficiency Syndrome  
and Sexually Transmitted Diseases (HCA)***

67. Strengthens national capacities to focus more specifically on HIV/AIDS-related health issues, such as program management, the safety of the blood supply, and intervention models that foster healthy behaviors and health care, while continuing to promote a broader intersectoral response.

68. Promotes surveillance and control programs of sexually transmitted diseases.

***Program on Non-Communicable Diseases (HCN)***

69. Strengthens national capacities to develop efficient policies, strategies, and models for interventions and working partnerships for controlling non-communicable diseases with special emphasis on cardiovascular disease, cervical cancer, and diabetes.

70. Promotes partnerships and develops tools for prevention and control of intentional and unintentional injuries, as well as the prevention of violence.

71. Promotes the establishment of a regional network of countries that use an integrated approach for non-communicable diseases control.

72. Supports the development and improvement of national and regional surveillance of non-communicable diseases and their risk factors.

***Program on Communicable Diseases (HCT)***

73. Strengthens national capacities for managing programs to combat tropical diseases, infectious diseases, emerging and re-emerging diseases, and fosters research in communicable diseases.

74. Improves national and regional disease surveillance and response, including the application of new techniques and the detection and reporting of antibiotic resistance.

75. Supports the introduction of the new International Health Regulations.

76. Promotes and supports the strategy for integrated management of childhood illnesses in priority countries.

***Program on Veterinary Public Health (HCV)***

77. Promotes and supports national programs for food protection; rabies prevention; elimination of bovine tuberculosis and brucellosis; eradication of foot-and-mouth disease and echinococcus/hydatidosis.

78. Promotes the conservation of neotropical primates and the development of biomedical models for human disease and vaccines development.

***Caribbean Epidemiology Center (CAREC)***

79. Conducts disease surveillance and evaluation of the health status of the population in the Caribbean, aimed at supporting the countries in the implementation of public health interventions.

80. Provides reference services in microbiology and immunology as well as strengthening of national laboratories in the Caribbean.

81. Strengthens national health capacities to address HIV/AIDS.

***Pan American Institute for Food Protection and Zoonoses (INPPAZ)***

82. Strengthens national capacities to develop programs of food protection.

83. Improves regional networks to support food protection.

***Pan American Foot-and-Mouth Disease Center  
(PANAFTOSA)***

84. Strengthens national capacities to prevent outbreaks of foot-and-mouth disease in countries that are free of the disease and to expand eradication zones in the Andean countries and northern Brazil.

85. Strengthens national capacities to address zoonoses of public health importance.

***DIVISION OF HEALTH AND HUMAN  
DEVELOPMENT (HDP)***

86. The Division of Health and Human Development has four programs and one Pan American center: Public Policy and Health; Research Coordination; Women, Health and Development, all based in Washington; the Regional Program on Bioethics, based in Santiago, Chile, and the Latin American and Caribbean Center on Health Sciences Information (BIREME) in São Paulo, Brazil.

87. The functions of the Division are: Promote, coordinate and implement technical cooperation activities directed towards increasing equity in health and improving the health sector's contribution to human development. Its main focus is on the development of an intersectoral, holistic, and global approach to understanding the social, economic, and political determinants of population health in order to promote and advocate for healthy public policies, as well as for the generation and dissemination of scientific and technical knowledge and information that will support countries' efforts to attain sustainable health and human development.

***PROGRAMS AND PAN AMERICAN CENTERS  
UNDER HDP***

***Program on Public Policy and Health (HDD)***

88. Supports regional and national efforts to improve the analysis of the social, economic, and political determinants of population health and health equity, including the effects on health of major trends such as globalization, and the impact of these interrelationships with respect to health and human development.

89. Identifies and analyzes the determinants of health policy, including those regarding health legislation and health financing, and their implications for equity.

90. Strengthens the capacity of major actors and institutions to influence the development of healthy public policies.

***Program on Research Coordination (HDR)***

91. Strengthens the ability of the countries to define policies and set priorities in health science and technology.

92. Develops the research infrastructure, through institutional support, the training of researchers and support for research activities.

93. Coordinates the efforts of PAHO/WHO's technical units in support of the generation of knowledge and the dissemination and use of research findings in the Organization's priority areas.

***Program on Women, Health and Development  
(HDW)***

94. Promotes and supports national and regional programs in response to the challenge of achieving greater gender equity in health and human development.

95. Strengthens the capacity to use the gender perspective as a framework for the analysis of health programs and policies, as well as for the analysis of health manifestations of gender inequities.

***Program on Bioethics (HBE)***

96. Promotes and supports activities related to the ethical assessment of results from biomedical and psychosocial research, health care and general or professional education, and to the academic and applied development of health-related disciplines from the standpoint of bioethical methods and procedures.

97. Identifies individuals and institutions in the Region involved in the field of bioethics in order to

develop networks for the strengthening of research, teaching, and public communication.

98. Serves as reference point for conceptualizing emergent problems related to accessibility, equity, values, and social support of public policies on health.

***Latin American and Caribbean Center on Health Sciences Information (BIREME)***

99. Coordinates and supports the Latin American and Caribbean System of Health Sciences Information, which includes national and PAHO/WHO documentation centers, and other specialized networks.

100. Develops and promotes the use of tools for technical databases.

101. Supports training and research activities in countries for the development of the database known as LILACS (Latin American and Caribbean Literature on Health Sciences) and the Virtual Health Library (VHL), for managing health science information in the Region.

***DIVISION OF HEALTH AND ENVIRONMENT (HEP)***

102. The Division of Health and Environment has two programs and one Pan American center: Basic Sanitation; Environmental Quality; and Pan American Center for Sanitary Engineering and Environmental Sciences.

103. The functions of the Division are: Promote, coordinate and implement technical cooperation activities directed towards diminishing the inequities related to the exposure to environmental risks. Its main focus is on the development of an intersectoral, holistic, and global approach to identify, evaluate, prevent, and control environmental risks for public health, with particular emphasis on the most vulnerable groups.

***PROGRAMS AND PAN AMERICAN CENTERS UNDER HEP***

***Program on Environmental Quality (HEQ)***

104. Strengthens the capacity of national institutions to conduct studies on the impact of environmental

factors on public health; promotes chemical safety and the evaluation and management of environmental risks for public health.

105. Strengthens ministries of health in management and leadership for protecting environmental quality for public health.

106. Promotes the development and implementation of programs aimed at reducing the environmental risks that affect the most susceptible groups such as children and particularly child workers.

107. Supports the strengthening of national institutions in the area of workers' health including the improvement of the work environment, the strengthening of health care services, legislation, and the promotion of workers' health.

***Program on Basic Sanitation (HES)***

108. Strengthens the capacity of national institutions to manage health aspects related to water supply for human consumption, sanitary excreta and solid waste disposal, as well as housing and urban sanitation.

109. Develops regulations and technologies to provide the best possible disinfection of water in water supply systems and in households.

110. Promotes and supports studies and the development and implementation of projects for environmental sector reform and modernization.

111. Promotes and supports institutional development processes including decentralization and the development of policies, norms, and plans for regulating the sector.

***Pan American Center for Sanitary Engineering and Environmental Sciences (CEPIS)***

112. Strengthens the capacity of national institutions to develop technologies for managing environmental risks for public health. The main focus is on water contamination, waste management, chemical safety, technological accidents, workers health, and air contamination.

113. Serves as a clearinghouse to test and disseminate new technologies, particularly appropriate technologies for rural and marginal urban populations.

114. Captures and disseminates specialist bibliography in the areas of environmental health and related sciences.

115. Strengthens the capacity and improve the quality of environmental health laboratories in the Region.

116. Strengthens the national capacities to use studies of environmental impact on human health.

### ***DIVISION OF HEALTH PROMOTION AND PROTECTION (HPP)***

117. The Division of Health Promotion and Protection has three programs and three Pan American centers: Family Health and Population; Mental Health; Food and Nutrition; Institute of Nutrition of Central America and Panama; Caribbean Food and Nutrition Institute; and Latin American Center for Perinatology and Human Development.

118. The functions of the Division are: Promote, coordinate, and implement technical cooperation activities aimed at creating a new culture of health promotion and protection where health becomes a social value. Its main focus is to incorporate health promotion as a key element in the objectives of health sector reform as well as in family and population health, mental health, and food and nutrition, and in addition, foster the use of the life cycle, family cycle, and gender approaches in health promotion.

### ***PROGRAMS AND PAN AMERICAN CENTERS UNDER HPP***

#### ***Program on Family Health and Population (HPF)***

119. Promotes the use of the life cycle, family, and gender perspectives in the development of national health plans, policies, programs, and tools to incorporate the health promotion strategies.

120. Designs and strengthens methodologies and models for the incorporation of the strategies of

health promotion in healthy spaces such as municipalities, communities, and schools, with emphasis on health throughout the life cycle.

121. Provides technical cooperation in family health and population with attention to social communication for promoting and assuring healthy growth and development at all ages.

122. Provides a regional reference point for knowledge and strategies that strengthen programs and services in child, adolescent, and reproductive health, and the health of the older adult.

#### ***Program on Mental Health (HPM)***

123. Promotes the development and adoption of policies, programs, and intersectoral norms to control the use of tobacco and other dependency drugs.

124. Fosters the reorganization of psychiatric services.

125. Develops policies, programs, and norms for the treatment of disabling mental and neurological disorders, particularly at the primary level.

#### ***Program on Food and Nutrition (HPN)***

126. Promotes and supports activities related to food and nutrition security by fostering a healthy diet and physical activity throughout the life cycle, as well as breastfeeding and complementary feeding.

127. Strengthens national capacities to develop norms, policies, and programs for the prevention and control of specific nutritional deficiencies.

128. Fosters the development of national programs for nutrition surveillance, food quality, and the prevention and treatment of various forms of malnutrition.

#### ***Institute of Nutrition of Central America and Panama (INCAP)***

129. Strengthens national capacities to improve food and nutrition security and prevent malnutrition in the countries of Central America and Panama as well as improve their maternal and child health services.

130. Develops and disseminates technologies, methods, and models for the production of nutritionally improved food.

*Caribbean Food and Nutrition Institute (CFNI)*

131. Strengthens national capacities to improve food and nutrition security and nutrition programs to prevent and control particularly chronic diseases, undernutrition, obesity, and its co-morbidities.

132. Maintains information systems regarding the nutritional situation in the Caribbean countries to support the decision-making processes.

*Latin American Center for Perinatology and Human Development (CLAP)*

133. Supports the countries in the development and implementation of perinatal health programs.

134. Cooperates in the design, execution, and evaluation of programs for prenatal care, delivery, puerperium, and reproductive and newborn health.

135. Adapts technologies to improve the quality of care and the training of human resources in perinatology.

***DIVISION OF HEALTH SYSTEMS AND SERVICES DEVELOPMENT (HSP)***

136. The Division of Health Systems and Services Development has three programs: Essential Drugs and Technology; Organization and Management of Health Systems and Services; and Human Resources Development.

137. The functions of the Division are: Promote, coordinate, and implement technical cooperation activities aimed at strengthening national capabilities related to the development and institutional organization of the health system and the organization and management of health services that make universal access to quality health care possible and sustainable. Its main focus is the strengthening of the sectoral steering capacity, the organization and management of health systems and services, the

financing of sector activities, and the monitoring and evaluation of the reform processes.

***PROGRAMS UNDER HSP***

*Program on Essential Drugs and Technology (HSE)*

138. Strengthens national capacities to develop policies and strategies to regulate and supply essential drugs as well as to develop efficient pharmaceutical services.

139. Improves national and subregional capacity for regulation, harmonization, and evaluation of the efficacy and security of drugs, medical supplies, and equipment.

140. Supports the establishment of public health laboratory networks and the development and strengthening of blood banks and transfusion services.

141. Provides guidelines for the organization and development of imaging, radioprotection, and radiotherapy services.

142. Strengthens national institutions to develop programs for the planning, operation, maintenance, and renovation of the physical and technology infrastructure.

143. Develops national, subregional, and regional capacity for incorporating and assessing health technologies, especially those related to the information needs of the health services.

*Program on Organization and Management of Health Systems and Services (HSO)*

144. Strengthens national capacities, including the development of information systems, to conduct sectoral analysis, formulate policies and strategies, and develop implementation plans for the development of health systems and services and investments in the health sector.

145. Develops and maintains a clearinghouse on health care systems and monitoring and evaluation of the reform process.

146. Develops national capacities for the analysis of sectoral financing, resource allocation mechanisms in the health sector, as well as strengthening and development of payment mechanisms to health care providers.

147. Promotes and supports the development of national quality assurance programs for health services; and promotes and redirects health care services models to incorporate elements of promotion and prevention aimed at improving health care.

148. Supports the development of insurance mechanisms in health as well as the reform of social security.

149. Within the context of the reform process, strengthens the sectoral steering capacity and contributes to the fulfillment of essential public health functions.

150. Supports the development of programs and services for oral health, ocular health, care for the disabled, and health of indigenous people.

***Program on Human Resources Development (HSR)***

151. Strengthens national capacities for planning, development, management, regulation, and performance evaluation of human resources in health.

152. Contributes to the redirection of educational programs in public health disciplines aimed at responding to the needs of sectoral reform and reformulation of essential public health functions.

153. Coordinates the PAHO/WHO Training Program in International Health and the Fellowships Program.

154. Supports the production, distribution and utilization of training material with emphasis on continuing education of in-service health personnel through the Expanded Program of Textbooks and Instructional Materials (PALTEX).

***DIVISION OF VACCINES AND IMMUNIZATION (HVP)***

155. The Division of Vaccines and Immunization has two programs: Expanded Program on Immunization and Vaccine Technology Access.

156. The functions of the Division are: Promote, coordinate, and implement technical cooperation activities aimed at improving the criteria for the adoption of policies governing immunization programs, as well as promote the strengthening and development of programs for production of high quality vaccines.

***PROGRAMS UNDER HVP***

***Program on Vaccine Technology Access (HVA)***

157. Supports subregional and regional mechanisms for the regulation and harmonization of vaccine production and promotes the adoption of vaccine safety standards.

158. Promotes research and development of vaccines, in collaboration with public sector laboratories, ensuring that local vaccine production is economically and technically viable and adheres to good manufacturing practices, as well as national and international norms and standards.

159. Fosters the establishment of a consortium of laboratories that produce vaccines; the adoption of good manufacturing practices; and the regional certification process for vaccine producers.

***Expanded Program on Immunization (HVI)***

160. Strengthens the capacity to improve national and regional surveillance systems for vaccine-preventable diseases aimed at increasing the speed with which suspected cases are reported and confirmed.

161. Supports the expansion and improvement of vaccinations carried out by the public and private sectors, including nongovernmental organizations.

162.Promotes the development of public health laboratories and national, subregional, and regional diagnostic laboratory networks.

163.Supports the vaccine and procurement systems to contain costs and increase availability of priority vaccines.

***SPECIAL PROGRAM FOR HEALTH ANALYSIS (SHA)***

164.Strengthens the epidemiological capacity of Member States and of the Bureau to analyze, utilize, and disseminate information on health situation and trends for the planning, implementation, and evaluation of public health policies and programs.

165.Provides technical cooperation for the reorganization and functioning of epidemiological and statistical services to improve the production and effective use of health information and vital statistics.

166.Promotes the establishment of integrated networks on health information, including the development of the core health data systems in the Member States and in PAHO/WHO's regional programs and field offices.

167.Develops methodologies, norms, and standards for the collection, analysis, and interpretation of data and information, particularly to assess and monitor inequities in health trends and to evaluate the impact of health-related interventions.



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PROGRAM BUDGET BY ORGANIZATIONAL STRUCTURE - PAHO AND WHO REGULAR FUNDS  
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		1998-1999		2000-2001	
		AMOUNT	%	AMOUNT	%
GOVERNING BODIES		2,480,100	1.0	2,454,500	1.0
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DIRECTOR/DEPUTY DIRECTOR		15,335,600	6.1	16,103,200	6.3
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D/DD	OFFICE OF THE DIRECTOR/DEPUTY DIRECTOR	1,646,300	0.7	1,763,400	0.7
DAP	ANALYSIS AND STRATEGIC PLANNING	1,839,900	0.7	2,021,900	0.8
DBI	PUBLICATIONS AND EDITORIAL SERVICES	6,256,700	2.5	6,461,800	2.5
DEC	EXTERNAL RELATIONS	1,460,900	0.6	1,567,000	0.6
DLA	LEGAL AFFAIRS	1,111,600	0.4	1,238,900	0.5
DPI	PUBLIC INFORMATION	2,258,200	0.9	2,499,300	1.0
IA	INTERNAL AUDIT	762,000	0.3	550,900	0.2
ASSISTANT DIRECTOR		3,033,900	1.2	3,271,500	1.3
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AD	OFFICE OF THE ASSISTANT DIRECTOR	2,310,000	0.9	2,536,400	1.0
PED	EMERGENCY PREPAREDNESS AND DISASTER RELIEF	723,900	0.3	735,100	0.3
ADMINISTRATION		35,559,300	14.1	37,290,300	14.6
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AM	OFFICE OF ADMINISTRATION	725,200	0.3	1,054,200	0.4
ABF	BUDGET AND FINANCE	8,046,500	3.2	9,135,200	3.6
ACS	MANAGEMENT AND INFORMATION SUPPORT	5,565,300	2.2	5,859,400	2.3
AGS	GENERAL SERVICES	15,596,000	6.2	14,980,700	5.8
APL	PERSONNEL	5,626,300	2.2	6,260,800	2.4
TECHNICAL DIVISIONS		80,293,300	32.0	79,877,300	31.1
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HCP	DIVISION OF DISEASE PREVENTION AND CONTROL	26,279,100	10.5	25,138,100	9.8
HDP	DIVISION OF HEALTH AND HUMAN DEVELOPMENT	10,236,400	4.1	10,327,100	4.0
HEP	DIVISION OF HEALTH AND ENVIRONMENT	9,869,300	3.9	10,078,100	3.9
HPP	DIVISION OF HEALTH PROMOTION AND PROTECTION	15,045,700	6.0	15,022,900	5.9
HSP	DIVISION OF HEALTH SYSTEMS AND SERVICES DEVELOPMENT	16,068,500	6.4	16,403,700	6.4
HVP	DIVISION OF VACCINES AND IMMUNIZATION	2,794,300	1.1	2,907,400	1.1

PROGRAM BUDGET BY ORGANIZATIONAL STRUCTURE - PAHO AND WHO REGULAR FUNDS

	1998-1999		2000-2001	
	AMOUNT	%	AMOUNT	%
SPECIAL PROGRAM FOR HEALTH ANALYSIS	4,120,700	1.6	4,507,100	1.8
COUNTRIES	104,287,400	41.5	106,463,100	41.5
REGIONAL DIRECTOR'S DEVELOPMENT PROGRAM	2,204,400	0.9	1,777,000	0.7
CONTRIBUTION TO RETIREES' HEALTH INSURANCE	3,949,300	1.6	4,501,000	1.8
TOTAL =====	251,264,000 =====	100.0 =====	256,245,000 =====	100.0 =====

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PROGRAM BUDGET BY ORGANIZATIONAL STRUCTURE - EXTRABUDGETARY FUNDS  
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		1998-1999		2000-2001	
		AMOUNT	%	AMOUNT	%
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GOVERNING BODIES		110,300	0.1	90,000	0.1
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DIRECTOR/DEPUTY DIRECTOR		2,269,600	1.4	1,433,400	2.1
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D/DD	OFFICE OF THE DIRECTOR/DEPUTY DIRECTOR	23,800	-	15,000	-
DAP	ANALYSIS AND STRATEGIC PLANNING	189,800	0.1	-	-
DBI	PUBLICATIONS AND EDITORIAL SERVICES	618,400	0.4	288,000	0.4
DEC	EXTERNAL RELATIONS	901,800	0.6	868,400	1.3
DLA	LEGAL AFFAIRS	33,000	-	-	-
DPI	PUBLIC INFORMATION	502,800	0.3	262,000	0.4
ASSISTANT DIRECTOR		8,580,800	5.5	2,708,200	3.9
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AD	OFFICE OF THE ASSISTANT DIRECTOR	293,600	0.2	-	-
PED	EMERGENCY PREPAREDNESS AND DISASTER RELIEF	8,287,200	5.3	2,708,200	3.9
ADMINISTRATION		11,801,700	7.5	8,313,000	12.1
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AM	OFFICE OF ADMINISTRATION	568,600	0.4	285,000	0.4
ABF	BUDGET AND FINANCE	3,305,000	2.1	3,308,000	4.8
ACS	MANAGEMENT AND INFORMATION SUPPORT	1,960,200	1.2	692,000	1.0
AGS	GENERAL SERVICES	4,907,500	3.1	3,026,500	4.4
APL	PERSONNEL	1,060,400	0.7	1,001,500	1.5
TECHNICAL DIVISIONS		45,787,800	29.2	24,795,400	36.1
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HCP	DIVISION OF DISEASE PREVENTION AND CONTROL	15,046,300	9.6	9,550,700	13.9
HDP	DIVISION OF HEALTH AND HUMAN DEVELOPMENT	5,241,700	3.3	3,195,000	4.7
HEP	DIVISION OF HEALTH AND ENVIRONMENT	6,445,100	4.1	2,688,400	3.9
HPP	DIVISION OF HEALTH PROMOTION AND PROTECTION	6,801,200	4.3	3,010,900	4.4
HSP	DIVISION OF HEALTH SYSTEMS AND SERVICES				
	DEVELOPMENT	4,885,100	3.1	1,948,900	2.8
HVP	DIVISION OF VACCINES AND IMMUNIZATION	7,368,400	4.7	4,401,500	6.4

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PROGRAM BUDGET BY ORGANIZATIONAL STRUCTURE - EXTRABUDGETARY FUNDS  
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	1998-1999		2000-2001	
	AMOUNT	%	AMOUNT	%
SPECIAL PROGRAM FOR HEALTH ANALYSIS	81,200	0.1	106,400	0.2
COUNTRIES	88,220,600	56.2	31,214,600	45.5
TOTAL	156,852,000	100.0	68,661,000	100.0