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STRATEGIC AND PROGRAMMATIC ORIENTATIONS FOR THE PAN AMERICAN SANITARY BUREAU, 1999-2002

The Strategic and Programmatic Orientations constitute the policy guidelines for the Pan American Sanitary Bureau in each quadrennium. They represent an analysis of conditions and needs in the countries of the Region of the Americas and are directed toward the achievement of the world goal of Health for All. Moreover, they represent the response of the Bureau to the new global policy of Health for All in the 21st Century and to the transition from the Ninth to the Tenth General Program of Work of the World Health Organization.

This document presents a summary of the most relevant political, economic, environmental, social, and general living conditions that will determine and influence the health conditions of the population during the period 1999-2002. Inequity in general, and in health in particular, is considered the basic issue that must be addressed, and there is recognition that, despite the successes achieved, enormous efforts will be needed to overcome it.

In addition, the most important environmental factors that will have to be addressed to meet the needs of the Region's inhabitants are noted, and there is a description of strategic and programmatic orientations that the Pan American Sanitary Bureau will focus on in its technical cooperation with the Member States of the Pan American Health Organization during the period 1999-2002.

This proposal for the Strategic and Programmatic Orientations for the Pan American Sanitary Bureau is submitted for the consideration of the 30th Session of the Subcommittee on Planning and Programming of the Executive Committee, with a view to obtaining comments and suggestions for improving the proposal prior to its presentation at the next session of the Executive Committee.

CONTENTS

Page

<i>EXECUTIVE SUMMARY</i>	<i>3</i>
<i>1. Introduction</i>	<i>6</i>
<i>2. Current Situation</i>	<i>7</i>
2.1 General Situation	7
2.2 Health Situation	8
2.3 Environmental Situation	15
2.4 Demographic Situation	17
2.5 Political Situation	18
2.6 Socioeconomic Situation	19
<i>3. Challenges for the Quadrennium</i>	<i>21</i>
3.1 Environmental Challenges	21
3.2 Main Health Challenge for the Period	25
<i>4. Response of the Pan American Sanitary Bureau</i>	<i>25</i>
4.1 Regional Goals for the Period	26
4.2 Strategic and Programmatic Orientations	28
4.3 Technical Cooperation and International Coordination	42
<i>References</i>	<i>44</i>

EXECUTIVE SUMMARY

In order to ensure that the countries make progress in attaining the highest level of health for their peoples, the Pan American Sanitary Bureau (PASB), Secretariat of the Pan American Health Organization, cooperates technically with them, promotes technical cooperation among them, and facilitates international coordination in health. Policy orientations have been developed to guide PASB activities and serve as a frame of reference for the programming of technical cooperation. These same orientations can also serve as a useful reference for the countries, if they consider it appropriate.

The Strategic and Programmatic Orientations (SPO) constitute the policy guidelines for PASB in each quadrennium. They represent an analysis of conditions and needs in the countries of the Region of the Americas and are geared toward achievement of the world goal of Health for All. They also represent the response of PASB to the new global policy of Health for All in the 21st Century and to the transition from the Ninth to the Tenth General Program of Work of the World Health Organization.

Utilizing materials from the publication *Health in the Americas*, 1998 edition, and other sources, the present document outlines the political, economic, environmental, social, and general living conditions that determine and influence the health conditions of the population. In addition, the document describes the health conditions of the population of the Region, identifying the specific problems that will have to be addressed to meet the needs of the Region's inhabitants. It also outlines the strategies that PASB will use and the programming orientations that it will emphasize in its technical cooperation to the Member States of the Pan American Health Organization.

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

The document highlights and analyzes the relevant political and socioeconomic phenomena as some of the determinants of the health and living conditions of the population of the Region, noting the significant advances made in the democratization of the societies and the substantive increases in economic growth, as well as the enormous inequities that exist in access to economic and social benefits. From an examination of the findings with regard to poverty, unequal income distribution, unemployment, real wages, and the magnitude of the wage gaps, it concludes that economic growth in the Region, especially in Latin America and the Caribbean, has not contributed to an improvement in the serious human underdevelopment that still persists.

The document shows, moreover, that the general improvement in the health status of the population does not mask the differences between countries and the different population groups within them, and the disparities between those who lack social benefits and those who enjoy greater access to goods and services are becoming more accentuated.

The document also analyzes aspects external to health, that is, the environment, that affect not only the health conditions of the people but also the work of the international organizations and institutions, whose criteria the countries must make efforts to meet.

In order to determine the main theme that will guide the actions of PASB during the period 1999-2002, the prevailing situation is analyzed and the key health challenge for the period identified. There have been significant advances in health, such as increased life expectancy and communicable disease control, with the consequent reduction in infant mortality due to progress in poliomyelitis, measles, and diphtheria control. However, the three WHO evaluations on progress toward the achievement of Health for All by the Year 2000 indicate that the countries still have an enormous task ahead of them, since major population groups do not have access to basic health services.

In this regard, the targets and goals established in the SPO for the period 1995-1998 have largely not been met. The differences between specific population groups in terms of the benefits offered by the health systems are still enormous, and major reforms are needed in the operation of the services to guarantee universal access. This situation justifies a renewed and vigorous effort to make the WHO proposal of Health for All a reality.

The Region of the Americas is marked by persistent inequalities that lead to differential access to social benefits by the population, depending on educational and income levels, place of residence, racial or ethnic origin, sex, age, and type of employment. This situation affects the population's ability to participate in political life, the degree to which its economic needs are met, the possibility of receiving basic or higher education, and, in terms of health, the likelihood of survival or death, the risk of disease, and access to the benefits offered by health systems and services. In light of all this, the Strategic and Programmatic Orientations for the period 1995-1998 adopted the struggle against inequity as the key challenge. Inequity in access to and coverage by the health systems and services remains the key challenge that must be addressed by the countries of the Region in the quadrennium 1999-2002 as well, through their own efforts and within the Pan American Health Organization.

The document therefore proposes that emphasis be placed on gradually reducing domestic structural obstacles to sustainable human development, through both a reduction in inequality and priority attention to essential human needs, among them health and a frontal attack on extreme poverty.

Further on, it proposes that, bearing in mind the goal of Health for All and assuming that it is achievable, PASB should respond with an ongoing effort to seek the highest level of physical, mental, and social well-being for all the inhabitants of the Region, reducing existing inequities in health until they are eliminated altogether. One of the frameworks for action is the new global policy of Health for

All in the 21st Century, currently awaiting approval by WHO, which represents the renewal of the goal of Health for All.

As part of this response, the document suggests regional goals related to health outcomes, intersectoral action on health determinants, and health policies and health systems.

Finally, it describes the Strategic and Programmatic Orientations, together with the technical cooperation and international coordination activities that PASB intends to promote to help the countries meet the targets set and reduce health inequities among the population. In this regard, the document proposes that the five strategic and programmatic orientations adopted for the period 1995-1998—that is, Health in Human Development, Health Systems and Services Development, Health Promotion and Protection, Environmental Protection and Development, and Disease Prevention and Control—be retained to guide PASB activities in the next quadrennium. These five orientations cover the natural sphere of health and are considered valid, since the challenge that inspired them has yet to be overcome. It is therefore recommended that PASB lead the effort during the quadrennium 1999-2002, but focusing more precisely on the areas that are expected to be the object of the efforts in the Region.

1. Introduction

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

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

The Strategic and Programmatic Orientations (SPO) constitute the policy guidelines for PASB in each quadrennium. They represent an analysis of conditions and needs in the countries of the Region of the Americas and are geared toward the achievement of the world goal of Health for All (HFA). Moreover, they represent the response of the Bureau to the new global policy of Health for All in the 21st Century (HFA21) and to the transition from the Ninth to the Tenth General Program of Work (GPW) of the World Health Organization (WHO).

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

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

2. Current Situation¹

2.1 General Situation

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

The general improvement in the health status of the population does not mask the differences between countries and between the different population groups. The disparities between those who lack social benefits and those who enjoy greater access to goods and services are becoming more accentuated.

The health situation of the countries of the Region is a product of the interaction between the other components of socioeconomic development. Health, in turn, has proved not only to have an impact on the economic, social, and political components of human development taken separately but also on human development in general.

The life of the Region's inhabitants unfolds within the context of growing globalization and interdependence with the transnational environment. This process is not only economic but social and political as well and has led to a redistribution of power between the State, civil society, and the market. Despite the strong market influence, civil society, through its organizations, is experiencing a resurgence, offering new options for the development of health. The emergence and expansion of this new paradigm of production not only implies a change in the role of the nations' sectors but also has been manifested in the replacement of the technology links that once reigned supreme by others, created by the advances in computer technology, telematics, and biotechnology. This new paradigm also implies an impact on other spheres of human activity—witness for example, the advances in communications that have produced changes in consumption and urbanization patterns, lifestyles, social representation, and values that are moving the world toward the cultural homogenization of society. These advances in technology are strongly reflected in the socialization of information.

In the majority of the countries of the Region, the growth of international trade in goods and services in the field of health has had a visible impact on both the public and the private sectors, although up to now this impact in the public sector has been concentrated in the area of goods:

¹ This section highlights the most important aspects of health in the Region of the Americas. Its main source is *Health in the Americas*, 1998 edition. See this publication for more detailed information.

equipment, drugs, biologicals, and medical-surgical materials.² In the private sector, the impact is also expressed in the volume of expenditures abroad by people who travel in search of medical care and in the procurement of health services from transnational companies that have established health facilities in the countries. In the immediate future, telemedicine services will begin to capture a market share in both sectors.

The energizing force is exclusively economic in nature and connected with globalization and the growth of the market. Some of the areas where changes in consumption patterns linked with health are visible are food and nutrition; alcoholic beverages, with the associated traffic accidents; and tobacco, manifested particularly in growing use by women and young people.³

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

The global processes currently under way in the Region will not change significantly in the near future. On the contrary, they are expected to become more patent and widespread.

2.2 Health Situation

Health conditions, measured in terms of the trends in mortality and life expectancy, are continuing to improve overall. However, the health gaps between countries and population groups defined by geography, sex, income, education, and ethnic group persist and are growing (2).

Public policies geared toward State modernization and reform and the privatization of essential services in the Region have already found expression in the health sector. Thus, environmental and basic sanitation services, including water supply in urban areas, are in an advanced stage of privatization. Many countries have designed or are carrying out health sector reform, which includes schemes for the decentralization of public health services, greater private sector participation in health service delivery, and various changes, including the privatization of health care financing models. These reforms will affect how the countries provide health services.

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

³ Tobacco and alcohol consumption patterns are different in the developed and the developing countries because of the public policies adopted. In the United States of America, there has been a significant drop in tobacco consumption as a result of programs such as ASSIST and the dissemination of information about the dangers of tobacco use.

At the same time, the Region is in the process of a demographic transition marked by changing patterns of morbidity that influence the demand for health care and, hence, the education and training of primary health care workers. Thus, while infectious and reemerging diseases remain a significant problem in the Region, the need for resources to provide care and services to people with chronic and noncommunicable diseases is growing. This has begun to produce a mild tension between the resources needed for investments in curative medicine and those needed to promote healthy behaviors and healthy environments that will facilitate attainment of optimal health, well-being, and healthy aging.

Concerning financial support to the sector, although the trend has been toward an increase in the proportion of the gross domestic product (GDP) allocated to health in the countries, there are still marked differences among the countries in terms of the financial resources allocated to health. In upper-income countries, national health expenditure represents more than 10% of GDP—in per capita terms, more than US\$ 1,600 a year. In middle- and lower-income countries, in contrast, this figure is less than \$90 and \$35, respectively, or nearly 6% of GDP. Generally speaking, countries with higher income per capita spend 45 times more on health than lower-income countries.

Moreover, total health expenditures grew from 5.7% of the regional GDP in 1990 to 7.3% in 1995. This higher growth, however, has been at the expense of the disposable income of population, since public spending, which accounted for 43% of the total expenditure in 1990, fell to 41.5% in 1995. This has led an increase in private health care providers, relegating the functions of regulating, managing, and monitoring the health systems to the State, which in most cases has retained the responsibility for providing coverage to the lower-income population. Innovative forms of health insurance, financing, and service delivery are being developed as a result of these changes.

In addition, it has been observed that the accessibility, coverage, and availability of medical care decrease as GDP per capita falls. The same holds true for the geographical location of the population. While 84% of urban inhabitants in the Americas have access to drinking water, only 41% of the rural population has it, since the financing of investment in drinking water and sanitation systems appears to be a predominantly urban process. Furthermore, in a number of developing countries only 5% to 10% of workers have access to occupational health services, in comparison with 20% to 50% in the industrialized countries.

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

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

Despite the efforts toward improvement, and perhaps precisely because the progress is slow, the results expressed in the sectoral reform objectives have still not materialized. Thus, utilization rates for the available resources and infrastructure are still low despite an increase in the availability of physicians, nurses, and dentists in all the countries, and hospitals are in the throes of a financial and management crisis that has prevented them from meeting their contractual commitments or offering better wages, thereby jeopardizing the provision of supplies and the maintenance or procurement of equipment—elements that are essential to quality health care delivery.

2.2.1 *Mortality*

Mortality indicators have improved over the past seven five-year periods for all age groups, with rare exceptions, in every country in the Americas. However, the encouraging trends in mortality and the health status of the population belie the enormous disparities in the Region and in the countries, as indicated in the differential mortality by age group and cause of death in a particular country versus other countries with similar levels of economic development.

Mortality trends differ between groups of countries, according to per capita income adjusted by the purchasing power of their currency. This evolution varies with the age group analyzed. For children under 1 year of age, mortality has remained stable or declined slightly in the middle-income countries but remains high and is rising in the lower-income group.

However, a comparison of mortality by age group between countries with similar incomes, adjusted by population, reveals reducible gaps and preventable deaths.⁴ Deliberate investment by the countries, the appropriation of resources, and their effective utilization, together with the establishment of concrete policies and programs aimed at reducing the risk of dying from certain causes in specific population groups, ensure a path toward the reduction or elimination of these gaps and preventable deaths.

The variations in the behavior of mortality in the Region are significant. However, it can be said that in countries with higher income per capita some 4.7% of deaths could have been prevented in the 45- to 64-year age group, while in the lower-income countries up to 62% of deaths in the population under 65 could have been prevented. This indicates that it still is both possible and necessary to make a deliberate effort to prevent foreseeable death and reduce the differences among age groups and countries.

Concerning the differentials in the risk of dying among the population of the countries, even though that risk decreased in children under 1 in all the countries of the Region between the periods

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

1960-1964 and 1990-1994, in only a very few did the relative risk in the countries with lower rates also decrease. For all the other countries, that risk has increased during the 5-year periods from 1960-1964 to 1980-1984, with the trend stabilizing or undergoing a mild reversal in the past three five-year periods. Generally speaking, the values for the relative risk of dying before the first year of life in the countries with the lowest risk in the Region showed a certain degree of homogeneity. However, a trend has gradually been emerging in which the countries with the highest risk are worsening and those with the lowest risk are improving.

Reducible gaps in mortality from specific causes have also been found, which means that it is possible to reduce the number of deaths from communicable diseases. Thus, in children under 1 year, up to 80% of deaths could be prevented, in comparison with the countries in which greater achievements have been obtained in the prevention of death from these same causes.

It is estimated that if between 1990 and 1994 every country in the Americas had succeeded in reducing mortality in each age group under 65 to the lowest levels achieved by any country of the same economic level in this Region and, in the case of the United States of America and Canada, to the levels achieved by Sweden and Japan, some 1,100,000 deaths a year could have been prevented in people under the age of 65. This represents 47% of the estimated deaths in the Region in those ages during that period. The infant mortality rate in the Americas for 1998 would be around 10 per 1,000 live births, and life expectancy at birth would be among the highest in the world, over 75 years.

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

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

2.2.2 *Morbidity*

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

Despite this progress, however, diarrheal diseases, acute respiratory infections, and malnutrition remain the leading causes of death in the population under 5 years of age in most of the medium- and lower-income countries of the Region. The cholera epidemic has become endemic in many of the countries, with more than 1.3 million cases to date, more than 11,500 of them fatal. Chronic undernutrition has replaced acute malnutrition in children, and together with micronutrient deficiencies

is characteristic of the nutritional picture in the lower-income countries. Furthermore, the levels of iron deficiency and anemia continue to be high and the levels of vitamin A deficiency have remained stable. At the same time, overweight, obesity, and chronic diseases linked with diet have increased. This picture is consistent with urbanization and changing lifestyles.

National immunization programs in the Region are having a great impact on reducing morbidity and mortality from vaccine-preventable diseases. Immunization coverage against diphtheria, tetanus, typhoid, poliomyelitis, measles, and tuberculosis for children under 1 year of age has exceeded 80%. Poliomyelitis was eradicated in 1991, neonatal tetanus has been brought under control, and measles incidence has reached the lowest levels ever.

Furthermore, the number of vaccines registered and used in the developed countries in recent years has risen dramatically, and this trend is expected to persist. The new vaccines are safer and more effective and are having a significant impact on the incidence of disease. However, the developing countries have not benefited from these new vaccines because they are costly and technologically more complex—and hence, difficult—to produce. The introduction of conjugated vaccines against *H. influenzae*, *S. pneumoniae*, *N. meningitidis*, *S. typhi*, and other encapsulated bacteria could produce a significant epidemiological change in the Region. All these vaccines consist of conjugated polysaccharide proteins; thus, the methodology used to produce one of them would facilitate the production of the others. However, 40% of the vaccines used in the immunization programs in the Region are currently of unknown quality.

In addition, new communicable diseases have emerged in the Region, some diseases have reemerged that were thought to be well under control, and the resistance of some infectious organisms to antibiotics has increased.

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

The incidence of AIDS continued to rise in the Region during the past quadrennium, but at a slower rate than in Africa, Asia, and Eastern Europe. All countries now have national programs and surveillance systems. The replacement of the Global Program on AIDS by UNAIDS has resulted in the decreased availability of external resources for countries, and a great deal of time and effort has been spent on reestablishing structures, procedures, roles, and working relationships. Meanwhile, massive research efforts have resulted in promising—but expensive and complex—treatment regimes.

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

Malaria has expanded its borders and the high-risk population has increased. Morbidity (as measured by the annual parasite incidence rate) began to rise steadily in the mid-1970s. It fell 1993, only to rise again in 1994 and 1995, reaching rates more than double those recorded two decades ago. A similar trend can be observed in the case of dengue.

The Region has acted on the WHO resolution to eliminate leprosy as a public health problem (prevalence below 1 case per 10,000 population) by the year 2000. All countries except Brazil, Colombia, Paraguay, and Venezuela have already reached this goal. There has been more than a 75% reduction in prevalence since the initiative began. Attention must also be paid to the continued promotion of multidrug therapy and the assessment and evaluation of plans.

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

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

Dengue has reemerged as a major health problem in the Region, with more than a quarter of a million cases reported in each of the past three years. The vector, *Aedes aegypti*, is now present in all countries of the Region except Bermuda, Canada, and Chile, and all four serotypes of the virus are circulating widely in the Region. This increases the risk of dengue hemorrhagic fever, which is now endemic in Venezuela. Elimination of this vector is costly and does not appear to be sustainable.

Some foodborne diseases, while known, are considered emerging because they are occurring more frequently and have produced epidemic outbreaks in several countries in the past 10 years, revealing the weakness of programs for the prevention and control of foodborne diseases. Salmonella remains a leading cause of outbreaks from contaminated food, chiefly in the lower-income countries.

The active involvement of the private sector and the establishment of community committees have been key factors in the successful eradication of foot-and-mouth disease from Argentina, Paraguay, and Uruguay and some states of Brazil and Colombia.

Food protection programs have been developed along five lines of action, including the promotion of intersectoral national programs, the establishment of laboratory networks, the introduction of modern inspection programs, improved surveillance of foodborne illness, and public education. Increased trade opportunities have given countries an additional incentive to upgrade these programs.

There has been a significant reduction in the incidence of human and canine rabies. Success has been due to country plans that include risk analysis, mass immunization campaigns for dogs, and

better primary care for those exposed to potentially rabid animals. Most human cases now occur in cities with populations of about 50,000 and where treatment protocols are not yet in place. Meanwhile, the incidence of bat rabies continues to rise at a steady rate.

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

While infectious diseases remain an important health threat, there has been increasing recognition of the burden caused by noncommunicable diseases. Noncommunicable diseases presently account for almost three-quarters of all mortality and morbidity in Latin America and the Caribbean. The major contributors are cardiovascular disease (45%), cancer (20%), injuries (10%), and diabetes.

Cancer of the cervix kills more than 25,000 women annually in this Region. There is growing recognition of diabetes as a major health problem in the Region and one whose incidence and end results can often be prevented. Violence is a major public health problem, and programs to address the prevention of injuries must receive special attention.

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

A dual pattern of production, in which traditional forms of production exist side by side with new forms based on sophisticated technologies such as biotechnology, microelectronics, automation, and mechanization to increase productivity, are changing the epidemiological profile of occupational or work-related diseases, generating a dual profile of morbidity and mortality among workers. The old and still uncontrolled occupational diseases, such as lead, mercury, and asbestos poisoning, silicosis, occupational deafness, occupational dermatitis, and high accident indexes, are still there, together with emerging or reemerging infectious diseases such as malaria and tuberculosis, zoonoses, and diseases such as occupational cancer, occupational asthma, new musculoskeletal, reproductive, and mental health problems associated with new ways of organizing work and new occupational risks, including unemployment and underemployment.

According to recent studies by WHO, Harvard University, and the World Bank, employment ranks second as the leading cause of years of life with disability in the Region. Despite the lack of adequate systematic records on occupational health problems, estimates (ILO, WHO) put the number of work-related accidents at 5 million a year—that is, 36 accidents per minute of work.

2.3 Environmental Situation

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

At present, analytical and decision-making processes significantly underestimate the real impact of environmental factors on human health. For example, it is a very different thing to view environmental health problems from the standpoint of the burden of death, disease, and disability and to rank the relative importance of the various environmental factors.

Housing and the basic sanitation services related to it are extremely important, since a good proportion of people's lives is spent in the home. Estimates from the Economic Commission for Latin America and the Caribbean (ECLAC) (3) put the total housing shortage in Latin America and the Caribbean at approximately 50 million dwellings. Some 19 million new dwellings are required. Of the existing dwellings, some 23%, though habitable, are unhealthy but can be upgraded, and 14% are unrecoverable and require total replacement. The poorest housing conditions are found in rural and marginalized urban areas. At the same time, in the countries with the largest indigenous populations in the Region, nearly 100% of that population lives in unhealthy dwellings.

Thus, one extremely important problem in the Region is the interior air quality in housing. There is a growing tendency in urban areas to use gas as a household fuel, thus reducing exposure to smoke from cooking or heating; here, the deterioration in interior air quality is due primarily to smoking. In rural areas, however, the exposure to smoke from the burning of wood or coal is still significant. A direct correlation has been observed between exposure to polluted interior air and a significant increase in the risk of acute respiratory infections (ARI), especially in children. Estimates indicate that approximately 60% of the total ARI burden is related to interior air pollution and other environmental factors.

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

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

Diarrheal diseases are also intimately linked to poor sanitation and hygiene and to fecal contamination of water and food. It is relevant to observe the correlation between water supply

coverage and the incidence of diarrheal diseases. Approximately 80,000 children a year still die from diarrheal diseases, largely due to deficiencies in this area.

Some 70% of all the refuse produced daily in the Region is collected, but only 30% receives proper disposal. While different methods are used, the most frequent is the sanitary landfill.

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

During the Kyoto Conference (5) of December 1997, it was noted that, although the industrialized nations account for only 20% of the world's population, they have produced 90% of the global emissions of carbon into the atmosphere since the beginning of the industrial revolution, and they continue to produce two-thirds of those emissions today. The protocol adopted in Kyoto, which must be ratified by the countries, will make it possible to move toward a reduction in polluting emissions, especially from fossil fuels, through cooperation among countries.

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

Some 80,000 chemical substances are currently sold in the Region, and between 1,000 and 2,000 new substances are put on the market annually. A precise evaluation of the human health consequences of exposure to those substances that are toxic is extremely difficult. However, it is known that acute poisoning is a frequent cause of hospitalization, and chronic poisoning constitutes a serious threat to health. Poisoning can occur from different forms of discharging chemicals into the environment. Chemicals in the environment are manifested not only in poisonings, but also in birth defects, cancer, and fertility problems, as well as behavioral and immune disorders (7).

A significant problem in the Region is pesticide pollution from agriculture, given the fact that some countries have tripled the volume of pesticide use in the past four years. Equally important is heavy metal pollution, especially from mining and from the use of these metals as a fuel additive for motor vehicles; the residual persistence of these elements in the environment is from 70 to 200 years.

Estimates put the annual number of deaths in the workplace at 100,000 out of a total of five million foreseeable occupational accidents. The total costs associated with these accidents are between 10% and 15% of the regional GDP, not including accidents in the informal sector.

Since industries such as mining, construction, and transportation are likely to assume greater importance as the economies develop, severe occupational health problems in the Region can be anticipated if urgent preventive action is not taken.

This is particularly important in the less developed countries, where workers suffer not only from occupational illnesses and accidents but also from infectious diseases, malnutrition, and other problems linked with poverty.

2.4 Demographic Situation

The population of the Americas in 1998 is calculated at about 800 million, or 13.5% of the world population (8). Disparities in population size among the countries are a fundamental characteristic. For example, Brazil, Mexico, and the United States of America contain two-thirds of the population of the Region. By the year 2003 that population will exceed 850 million, but its distribution by country will not change substantially.

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

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

The age structure of the population reflects the increase in the population over age 65, with growth rates in excess of 3% annually (except for the Latin Caribbean, North America, and the Southern Cone, where the figure ranges from 1% to 2% a year). This trend is expected to continue. Hence, the aging of the population will mean the predominance of this population group.

The working population constitutes from 40% to 60% of the total population of the Region on average. The economically active population (EAP) was estimated at 357.5 million in 1995 and will reach 399 million by the year 2000. Moreover, it is estimated that 19 million children are part of the Region's work force. By the close of the 1990s, the EAP in Latin America is expected to increase by 25.9% and in North America by 11.1%. This population spends approximately 60% of its time in the work environment. If work in the informal sector and work in the home are considered, most of the

Region's population is exposed to occupational risks and conditions that, increasingly, are having an adverse impact on health.

The changes in the structure and composition of the work force also have repercussions for health. The drop in real family income, as well as changes in the family structure, place the burden of developing subsistence strategies for dealing with poverty on women and children. This is reflected in the widespread employment of women in hazardous and poorly paid jobs and in the early entry of children and adolescents in the work force.

Geographical trends in population distribution are in the direction of higher growth in urban areas and lower growth in rural areas. However, there has been an important change in terms of concentration in metropolitan areas, whose growth has slowed. This phenomenon implies a more rapid growth in medium-size cities that still have the capacity to respond to new demands and a reduction in the excessive pressure on the major cities of the Region.

International migration, whose origins lie chiefly in the armed conflicts of the preceding decades, is another important factor that must be considered. However, the nature of the migration has changed in this decade, and it is now mainly work-related. Although insufficient information is available in this regard, there appears to have been a resurgence in these migratory flows, which has placed significant pressure on the health services of the receiving countries. Everything indicates that, for the time being, there will be no substantive changes in this pattern, either in the national or international area.

2.5 Political Situation

The frontiers of democracy have expanded considerably in the Hemisphere. Improving the quality of life requires a climate of freedom in which confidence and the assurance of a future characterized by growing equity form part of the system of democratic values. However, the stability and continuity of democracy depends to a great extent on the effectiveness of its institutions and the credibility of the political system among the population (9). There are marked lags in the level of participation in the public and private sphere compared to countries with older, consolidated democracies. This is related to the impact of economic and sectoral policies on governance.

State reform in the countries of the Americas means many things, but basically implies the search for efficiency, responsibility, and participation. These reforms have led to the transfer of some responsibilities to the private sector and local levels, through decentralization processes that have fostered growing participation and given a voice to local governments and regions within the countries. This has had a direct impact on the development of social policies and social safety systems in the countries. One characteristic today is a change in the autonomy of national governments (10) with respect to the international processes of which they have become part, as well as changes within the

State, linked on the one hand to the delegation of its responsibilities in the economic sphere, within the framework of expanding market economies, and on the other to the strengthening of civil society.

2.6 Socioeconomic Situation

During the present decade, the countries have implemented economic policies aimed at the resumption of economic growth. However, they have also implemented the proposal of the economic authorities of the Region suggesting that they follow a model of growth with social equity. There is a significantly difference between earlier efforts to obtain a macroeconomic balance and seeking growth with social progress.

A general improvement in the macroeconomic indexes was observed in the last 5-year period. Average GDP growth rate was 1.1% in the preceding decade, increasing to 3.1% between 1991 and 1996. In this latter period it ranged from 3.4% to 5.3%. Average GDP per capita in the preceding decade showed 0.9% negative growth, compared to positive growth of 1.1% between 1991 and 1996. Annually, from 1991 to 1996 (excluding 1995), GDP per capita grew from 1.7% to 3.5%. At the same time, inflation fell from 887.4% to 19.3%. The analysis of social expenditure is also positive. In a sample of 15 countries, 11 increased their social expenditure between 1990 and 1994, and 7 surpassed the indexes of the 1980s. From 1990 to 1995 social expenditure increased in the Region by nearly \$50 per capita, a 27.5% increase. It should be noted, moreover, that this progress has been more pronounced in countries that have undertaken more extensive reform processes. However, within this growth greater priority has been given to the education and social security sectors than to health (11).

This is reflected in the marked rise in literacy in the Americas. However, the achievements are mixed, since while some countries have reduced illiteracy to 1%, others have rates as high as 57.4% of the general population, with disadvantages for the rural population, the indigenous population, and women in all contexts (12). In addition, there have been quantitative advances in the educational systems (13), understood as higher school enrollment per year. However, while some countries have achieved 100% enrollment of school-age children in the educational system, others have only achieved 30%.

Also, high retention and dropout rates together with low performance levels can be seen: in 1995, only 66% of the school-age population managed to complete the fourth grade, and the average number of years of schooling for the work force did not exceed six years (14).

Nevertheless, while real GDP growth rates for Latin America and the Caribbean are indicative of an economic recovery in the countries of this subregion during the 1990s, both ECLAC and the Inter-American Development Bank (IDB) consider these rates "moderate" (15) or "not entirely satisfactory" (16). Although the average 3% growth rate for the period 1990-1996 is a clear improvement over the stagnation of the 1980s, it has still not reached the levels achieved by these economies in the decades prior to the 1980s (17). These same sources consider the growth "unstable" (18). In general, the

recovery of per capita consumption in the Latin American and Caribbean subregion during the period 1991-1995 did not offset the contraction that occurred in the period 1981-1990 (19).

The 1996 GDP in 14 countries of the subregion, weighted by population and expressed in 1990 dollars, was lower than that of 1980, and investment was the most important component of growth, exceeding exports and consumption. These gains have not translated into an expansion of society's capital base, since investment rates are below the levels that existed prior to the crisis of the 1980s (20). In this regard, the decrease in public investment was substantial (21). However, direct foreign investment rose from \$6,599 million in 1990 to \$21,288 million in 1995. During this latter year, the tendency to concentrate investment in the mining and oil sectors, which had characterized the period 1990-1994, persisted (22).

At the same time, real expenditure 22% above the social expenditure of the subregion at the close of the 1980s was observed. Social expenditure patterns in health have been different: although health expenditure, like all social expenditure, began to grow in 1989, it fell in 1991 and 1992, dropping to 1981 levels. In 1993, it began to rise again, reaching levels in 1995 that were 22% above those to which it had fallen in 1992 in terms of real expenditure per capita (23).

One characteristic of foreign trade in the subregion is the expansion of intraregional trade (24), which is a determinant of the international operations of the health sector. Furthermore, given the impact of the debt burden on the potential availability of goods for the social sector, and the health in particular, it should be noted that the debt burden continued to decrease (25).

On analyzing the evolution of poverty, income distribution, unemployment and employment generation, real wages, and salaries, the impact of growth levels and economic performance on living conditions can be appreciated.

More than 197 million people were living below the poverty line in 1990, a figure that soared to 209 million in 1994; some 65% of this population was concentrated in urban areas, although the proportion of poor in the total rural population was higher than in the urban population (26). In some countries there was greater poverty than in 1980, notwithstanding the proportional growth of GDP per capita and the reduction in the relative magnitude of poverty in the period 1990-1994. Furthermore, inequality in income distribution has increased in most of the countries of the Region (27). In fact, the share of the richest 10% of households in total income has increased (although it varies from country to country), while that of the poorest 40% has remained stable or declined.

The poor do not belong only to the ranks of the unemployed; they are also found in the formal sector. In 1994, in 7 out of 12 countries in Latin America the percentage of working poor in total wage earners in the private sector, excluding those working in microenterprises, was between 30% and 50%; in three countries it was between 10% and 20%; and in two countries it was between 5% and 6% (28).

Despite the economic recovery, the average annual rate of urban unemployment in Latin America and the Caribbean has been growing without interruption since the late 1980s (29), and the heaviest impact of unemployment has fallen on women and young people (30). This situation has been accompanied by a significant growth in the informal sector.⁵ Thus, 84 out of every 100 jobs created in Latin America and the Caribbean during the period 1990-1995 were in the informal sector, making it the principal generator of employment (31). At the same time, the wage gap has grown steadily as a result of the declining income of workers employed in sectors characterized by low productivity or requiring lower levels of skills in the public or private sector (32). Moreover, there has been a real drop in the purchasing power of wages (33). Even for full-time workers, some 20% to 40% have incomes that are under the minimum threshold required to achieve well-being (34).

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

3. Challenges for the Quadrennium

Health in the Region of the Americas is determined by the realities and actions of the health sector and by the environment in which these actions take place. The national, regional, and global environment creates a series of social, economic, financial, and political determinants. This implies that, for national institutions, subregional and regional agencies, and the Secretariat of PAHO, some of the prevailing conditions in the external environment and the health sector pose real challenges that must be overcome, some general or global in nature and others specific, to the extent that they influence progress toward attaining the highest possible level of health for all the peoples of the Western Hemisphere.

3.1 Environmental Challenges

The closing years of the 20th century have been marked by a number of widespread phenomena found in nearly all the countries in the world and in the Region. Their effects are many, and they have an impact on the economic, social, and political life of not only the countries but also the peoples themselves, including aspects of their health. These phenomena have implications in terms of new marketing possibilities in the national economies, cooperation among countries, and consumption

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

patterns. International institutions are not immune to these realities and are also influenced by the changes in the countries.

Perhaps the most important phenomena today are globalization and the revolution in communications technology.

Some of the effects of globalization are related to the strengthening of democracy, the worldwide adoption of a single economic model, the formation of regional and subregional blocs, the changing role of the State, and social participation.

As democracy has gathered strength, expectations have risen and its mechanisms are being transformed. The number of countries with popularly elected mayors has grown from 3 to 17, and the number with some degree of decentralized public spending has grown from 0 to 16 (35). However, this is a gradual process that in some cases is limited to the formal aspects of voting.

In the economic sphere, there has been a homogenization of the macroeconomy that has resulted in an improvement in the overall economic indexes, without a significant reduction in the inequities in the distribution of goods and services and access to them or in unemployment and underemployment (36). All of this poses a serious challenge for governance and the social sector and, within this latter, for health. This growth characterized by regressive income distribution and unmet needs has led long-neglected sectors to grow tired of waiting, posing a clear threat to the relative prosperity and progress that have been achieved in recent years (37). Awareness of this phenomenon has led to political recognition of the need to concentrate efforts in the social sector, and even to a reorientation of the activities of the international financing institutions, which are intervening increasingly in the social sector, with greater emphasis on education and health.

In trade and, hence, the political sphere, globalization is reflected directly in major progress toward regional integration and, in the Americas, subregional integration. Although the Free Trade Association of the Americas (FTAA) has not moved forward as expected, subregional integration has gathered strength. Significant examples in this area are the North American Free Trade Agreement (NAFTA), MERCOSUR, the Central American Integration System (SICA), and the Caribbean Community (CARICOM). While the principal motive behind these processes is trade, health is an important negotiating factor associated with the environment and sanitation, food protection, the marketing of pharmaceutical products, and the protection of workers and visitors.

In addition, the hemisphere-wide activities launched in 1994 with the Summit of the Americas in Miami have speeded up implementation of the Plan of Action. Here, the collaboration of the various agencies of the Inter-American system, such as PAHO, the Organization of American States (OAS), and IDB, has been significant. Four main areas have been selected for the agenda: democracy and human rights; economic integration and free trade; the eradication of poverty; and sustainable development and conservation of the environment. The importance of health in this process has been acknowledged and is addressed in the chapter on eradicating poverty. This hemisphere-wide

phenomenon appears to be a permanent mechanism, since there is a consensus that these summits should be held periodically. Also in the regional sphere, the Conferences of Wives of Heads of State and Government of the Americas have supported and will continue to support a series of health initiatives (38).

Globalization also affects the financial sector, increasing the availability of investment resources in Latin America and the Caribbean. In fact, as a result of a more favorable regulatory framework, between 1990 and 1996 net foreign investment rose from \$6.6 to \$30.8 million. Although this investment was concentrated in some countries at the beginning of the decade, the number of recipients has grown with time (39).

With respect to State reform, changes in the role of the State have been initiated in nearly every country. It is important to recognize that these proposals have rarely been generated from the social development or health perspective, but rather, have been a reaction by the sector. At the same time, these reforms are indicative of the degree of complexity needed for negotiating resources in the current and future context. Indeed, in order to obtain financial resources, the health sector must negotiate with the financial sectors, vying with other social sectors in a competition for which the health sector is not always very well prepared.

This is accompanied by the transfer of health functions to the regional (provincial, state, departmental) or local level, which, with some exceptions in the Americas, requires major adjustments and preparation to enable it to assume its new responsibilities and achieve the expected results (40).

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

With regard to the international institutions, a far-reaching reform process is under way in the multilateral sphere and in the bilateral agencies cooperating for development. The reform processes that are affecting the United Nations system are directed, *inter alia*, toward more generally coordinated efforts, particularly in the countries. Indeed, all the reforms proposed are geared toward ensuring that the general dialogue on development (although not necessarily the sectoral dialogue) between the international community and governments is maintained among the interagency and national entities providing the respective coordination. It will be difficult for the health sector to carry out this coordination function. The reforms also seek greater interaction with the international financing institutions (41). In the bilateral sphere a trend may be noted toward the decentralization of decision-making on the allocation of cooperation resources for the development of the Country Representative

Offices and local embassies (42). The health sector should develop new skills to make optimum use of these circumstances.

Today's remarkable technology development has not only achieved unprecedented results, but is increasingly affecting the life of societies and populations. Communication without borders, biotechnology, and telematics are giving rise to fantastic changes in science, culture, and the field of health, in addition to their effects on diagnosis and therapy, they are creating conditions for substantially modifying and homogenizing patterns of consumption, forms of behavior, lifestyles, values, and concepts that are having an enormous impact on the health of the population (43).

Another consideration linked with globalization is the marketing and consumption of less desirable products such as alcohol and tobacco, which are having a substantial impact on health.

The trends referred to above have been determining factors in the development of science and technology for health. The national institutions for research and development of health technologies and the entities that formulate national science and technology policy have had to modify their roles and missions in light of the new role of the governments and corresponding emergence of the private sector, the diversification of internal and external sources of financing, and the establishment and consolidation of new channels for access to and the transfer of scientific and technical know-how, particularly knowledge linked to the new information technologies, which are distributed unequally among countries and among groups within the countries.

Moreover, the changing roles of governmental agencies and private actors, as well as the growing complexity of the health system and the interactions between the internal and external factors that determine health conditions, demonstrate the need for incorporating new topics, disciplines, approaches, and methods in health research, in addition to establishing better means for disseminating knowledge and the technologies necessary for increasing the effectiveness and impact of the practice of public health. Among the new disciplines being called upon to enhance knowledge and practice in public health is bioethics, which has become an expanding area of study and concern, given the emergence of new ethical dilemmas deriving from the rapid progress in health science and technology, the ethical dimensions of patients' rights, and the need for equity in allocating health sector resources.

In like manner, demand for transparency in the management of public affairs has recently emerged. The net effect on the sector is a growing need for the countries to justify and report on their work in the field of health to more informed and better educated populations, both as regards their rights and the level of care they expect.

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

3.2 *Main Health Challenge for the Period*

In view of the situation described above, the needs expressed when the strategic orientations and programmatic priorities for PAHO were adopted for the period 1991-1994 are still present (44). The orientations stressed a gradual decrease in domestic structural obstacles to sustainable human development through a reduction in inequality and priority attention to basic human needs, including health and a frontal attack against extreme poverty.

Just as a change is being discerned in the values system, a moral code of common rights and shared responsibilities is being constructed, based on what is now being termed “global ethics” (45). Among these rights and responsibilities are the right to a secure life; equitable treatment; equal access to information and the common goods of humankind; freedom; consideration of the impact of individual actions on the well-being of others; the promotion of equity (including gender equity); and protection of the interests of future generations through the achievement of sustainable human development.

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

Despite the significant achievements chalked up in health, such as the increase in life expectancy and the control of communicable diseases, with the consequent reduction in infant mortality, due mainly to the advances in controlling poliomyelitis, measles, and diphtheria, the three evaluations performed by WHO on the progress toward achieving the goal of Health for All by the Year 2000 indicate that enormous efforts remain to be made, since major population groups do not yet have access to basic health services. In this regard, the targets and goals promulgated in the SPO for the period 1995-1998 have largely not been met. The gaps between specific population groups in regard to the benefits provided by the health systems are still enormous, and extensive reforms in the operation of the services will be needed to guarantee universal access. This situation justifies making a vigorous effort to attain Health for All as proposed by WHO.

4. Response of the Pan American Sanitary Bureau

Among the fundamental purposes of PAHO are prolonging life, combating disease, and seeking the physical and mental well-being of the population in the Western Hemisphere by coordinating and promoting the efforts made by the countries. It is also recognized that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief, and economic or social condition (46). On these bases, and recognizing the differences prevailing in health access, coverage, and service delivery among the populations of the Region, the countries have agreed to renew their commitment to attaining the goal of Health for All. The greatest efforts of PASB will be directed primarily toward that goal in the next quadrennium and in those to come until the highest standard degree of physical, mental, and social well-being is attained for all the inhabitants of the Region, reducing and eventually eliminating the inequities presently existing in health.

One of the frameworks of action is the new global policy of Health for All in the 21st Century, in the process of approval by WHO, which represents the renewal of the goal of HFA and is based on the following values:

- recognition of the highest attainable standard of health as a universal right;
- stronger, ongoing application of ethics to health policy, research, and service delivery;
- implementation of equity-oriented policies and strategies that emphasize solidarity;
- incorporation of a gender perspective into health policies and strategies.

The new global health policy seeks to attain:

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

4.1 Regional Goals for the Period⁶

The Member States of PAHO, through WHO and other international forums, have subscribed to various global commitments to be realized through a combination of national, regional, and global efforts. The assumption of these commitments at the national level corresponds to the sovereign action of the Member States through the formulation of their national policies and plans for development and health. In the regional area they should be expressed in a manner compatible with the development of the Region and with the characteristics, needs, and resources of the countries as a whole. The most

⁶ Some of the goals of the new global policy on Health for All in the 21st Century have been adapted to the specific conditions of the Region of the Americas.

important goals are presented for the Region of the Americas, expressed in terms appropriate to conditions in the Hemisphere and the goals to be adopted by PASB in its commitment to providing technical cooperation to the countries to assist them in meeting their targets.

4.1.1 *Health Outputs*

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

4.1.2 *Intersectoral Actions on the Determinants of Health*

- In all countries at least 80% of the total population will have adequate sewage and excreta disposal services; at least 75% of the total population will have access to safe drinking water; and in those in which 75%-99% had access in 1998, coverage will increase by 10%.

4.1.3 *Health Policies and Systems*

- All countries will have adopted policies to promote Health for All and equitable access to quality health services; all blood for transfusion will be screened for infection with hepatitis B and C, syphilis, *Trypanosoma cruzi*, and HIV, and all blood banks will be participating in quality control programs; all countries will have adopted policies to prevent tobacco use by children and adolescents; all countries will have a health information system that provides verified core health data; fewer than 20% of deaths will be unregistered and fewer than 10% of registered deaths will be assigned to ill-defined causes.

4.2 Strategic and Programmatic Orientations

During the quadrennium 1995-1998, PAHO established five Strategic and Programmatic Orientations to guide the action of the countries and PASB in establishing national plans and programming actions: Health in Human Development, Health Promotion and Protection, Environmental Protection and Development, Health Systems and Services Development, and Disease Prevention and Control. These five orientations encompass the natural area of health and are considered to be in effect, since the challenge that gave rise to them has still not been overcome. Consequently, they will guide the work of PASB during the quadrennium 1999-2002, focusing more specifically, however, on topics foreseen as the object of efforts in the Region.

4.2.1 Health in Human Development

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

- Measuring the incidence of market forces on equity in health and analysis of the impact of structural adjustment programs, globalization/integration processes, and the privatization of health actions, among other determinants.
- Increasing the quality and availability of information and knowledge of inequities in health and their links to economic growth and human development.
- Defining the conceptual aspects related to inequities in health and developing methodological tools for their measurement and surveillance at the national and regional levels.
- Developing the capacity of human health resources to analyze the health situation and the living conditions of the various sectors of the population, the prevailing social inequities—in particular those pertaining to health—and their relation to human development.
- Developing indexes as part of future indicators of equity in health in order to characterize the close link between health and the economy.
- Establishing communication links among the producers of information and knowledge about social inequities—particularly those concerning health—and their relation to human

development and among those responsible for decision-making, all of which has an impact on living conditions and the health situation.

- Supporting the formation of local, national, subregional, and regional intersectoral networks to assist in policy-making and the preparation of plans, projects, and programs aimed at bridging the gaps in health.
- Supporting studies and research on the health profiles of neglected population groups, with a view to orienting interventions in health using criteria based on their impact on social inequities, particularly those pertaining to health.
- Promoting systematic research and documentation on the need for investment in health for the formation of human capital, economic activity, and the development of their potential as a mechanism for redistributing income.

It is necessary to increase the participation of the principal social and political actors in the health sector, and other sectors of the State and civil society, in assessing the topic of health in local, subnational, national, subregional, and regional political agendas, and in the formulation of health policies. Technical cooperation will consequently emphasize:

- Developing a system of analysis and surveillance indicators that will make it possible to increase knowledge about health, poverty, economic growth, and human development.
- Improving knowledge about the impact of structural, macroeconomic, and social policies on the living conditions and health situation of the population in the Region and contributing to the use of this information within the sector, in the social and economic cabinets, and in meetings of ministers and heads of State.
- Developing the capacity to use the gender perspective as a tool for analyzing the impact of globalization on the dimensions of the development process and on structural, macroeconomic, and social policies, with special emphasis on their relation to health.
- Contributing to the generation of knowledge concerning the magnitude of international transactions of capital, goods, and health services that are carried out in the Region and their impact on public and private expenditure on health.
- Promoting the participation of the ministries of health, agriculture, environment, family, labor, and social development in discussing the topics that the ministries of foreign affairs, economy, and foreign trade have included in the agendas on subregional and regional integration processes.

- Providing opportunities for the discussion and analysis of topics that need to be addressed in agendas that deal with subregional and regional integration processes, inviting the participation of economic and social agents who act inside and outside the sector as a means of encouraging them to extend their vision beyond the confines of commercial and economic integration.
- Supporting inclusion of the topic of health in human development on the agendas of presidential summit meetings and on the agendas of the organizations created as a result of the integration processes carried out up to the present time.
- Establishing institutional configurations and relations for the formulation and analysis of policies that will make it possible to arrive at an adequate balance between community participation and the technical and strategic nature of such policies, focusing on the health system as an opportunity for the exercise of citizens' rights and strengthening the mechanisms for consensus-building and political participation.

With the purpose of generating, disseminating, and utilizing the knowledge and practice of public health for the promotion, care, and recovery of health in order to contribute to sustainable human development, cooperation with the countries will be provided to the countries in order to:

- Promote the participation of social and political actors in the preparation of national human development projects that integrate economic and social policies into a strategy with the common purpose of ensuring the well-being of the population.
- Strengthen the capacity of legislative institutions to draft laws that will permit the effective participation of social and political actors in the formulation of policies, plans, and programs in health.
- Assess the importance of the changes produced by globalization on the culture of health and, in particular, the impact such changes have produced in the health demands of social actors and their support or rejection of health policies.
- Identify the social and political actors who play an important role in the governance of the health sector, the State, and society, and promote their participation in the debate on ethical issues in health in human development.
- Reassess the role of health promotion as an essential empowerment tool that will make it possible to measure levels of responsibility, commitment, and social participation by the population, particularly groups at greatest risk who are totally marginalized from access to health care.

The development of public health as a discipline, the research it entails, and the dissemination of the knowledge that it generates requires providing adequate responses to the health needs of the

population, particularly the most neglected and excluded groups. For this purpose, technical cooperation will be concentrated specifically on:

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

4.2.2 *Health Promotion and Protection*

Inasmuch as health is the main component of human development, its promotion must of necessity involve a much broader scope of action than that customarily constituted by the health systems and services.

Most of the considerations related to the health of populations are based on their living conditions, the satisfaction of their basic needs, the quality of their environment, the culture to which they belong, and their knowledge, attitudes, and practices with regard to health. Given the conditions that still persist in the Region, health promotion and protection is considered a powerful strategy in the concept and practice of public health, as well as the fulcrum of a new paradigm aimed at impacting the determinants of health in general.

In order to create, jointly with the countries, a new culture of health promotion and protection in which this concept becomes a social value that produces a situation that involves training individuals, communities, and public, nongovernmental, and private institutions to adopt and carry out, both individually and collectively, their responsibilities of preserving and continually improving their state of health and well-being, technical cooperation will be provided with a view to:

- Developing national capabilities for analyzing and summarizing information on health promotion.

- Promoting the formulation of policies, plans, programs, standards, and tools for health promotion.
- Supporting operational and cooperative research through the network of Collaborating Centers.
- Mobilizing technical, scientific, political, and financial resources to support health promotion.

In order for health promotion and protection to become an important element that contributes to sustainable human development, the exercise of the basic human right to health, social participation, and the search for equity in health, cooperation will concentrate on:

- Promoting the use of social communication in health, especially through the mass media.
- Developing strategies for intersectoral work.
- Developing the ability to forge strategic alliances among health organizations, mayors, nongovernmental institutions, teaching entities, and private enterprises.
- Promoting the creation of networks for technical, political, and social support at all levels.

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

- Disseminating technical and scientific information on the topic to the greatest number and variety of individuals involved in public health in the Region.
- Promoting the incorporation of health promotion strategies in combined form in the greatest number of countries.
- Documenting, analyzing, and disseminating national health promotion experiences.
- Documenting the cost-effectiveness of health promotion strategies versus action for health recovery and rehabilitation.
- Promoting processes that stimulate the adoption of healthy lifestyles and risk prevention through prevention.
- Promoting the use of life cycle, family cycle, and gender approaches.
- Promoting the evaluation of inputs and processes, in addition to the short- and long-term effects of the use of the health promotion strategies.

- Promoting the restructuring of the services to permit them to incorporate these kinds of interventions and make comprehensive health care a reality.

In order to contribute to the consolidation of human development and the prevention of disease throughout the life cycle, priority will be given to cooperation in the following areas:

- Family health and population, which assigns special importance to promoting and assessing growth and development at different ages; this includes programs for adolescent health, reproductive health, and health of the elderly.
- Food and nutrition, especially with regard malnutrition, food fortification with micronutrients, breast-feeding, supplementary feeding, nutritional guidelines for various age groups, and food security.
- Healthy lifestyles and mental health, especially preventing the use of tobacco, alcohol, and drugs, domestic violence, and child abuse, including for the entire Organization social communication in health, health education, and community participation, an area that includes initiatives for healthy schools and municipalities.
- Assessment and documentation on the wide variety of experiences at the local and national levels.

In order to advance in generating a regional health promotion movement and consolidate the success achieved to date, efforts will continue in order to:

- Strengthen advocacy and defend the cause of health promotion.
- Maintain the participation of PAHO in regional forums of Presidents and Heads of State and First Ladies of the Region;
- Promote the analysis and development of healthy public policies.
- Strengthen the strategic alliances of the Pan American Health Organization with the international community and with relevant organizations in the countries.
- Update and disseminate conceptual and programming models for health promotion.
- Make an inventory of the resources, models, and instruments available in the field of health promotion.
- Continue to design and strengthen methodologies and models for the evaluation of programs and interventions in health promotion, the development of environmental initiatives or healthy

spaces in schools and municipios, and the consolidation of networks of mayors, health secretariats, and school health associations.

- Develop training materials that include the strategies devised at the International Conference on Health Promotion, held in Jakarta, and forge strategic alliances.

4.2.3 *Environmental Protection and Development*

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

- Strengthening and developing national intersectoral coordination capabilities.
- Supporting national community mobilization strategies in the environmental area.
- Contributing to human resources education and specialization in epidemiology and environmental toxicology.
- Developing local capabilities for the operation and maintenance of health systems and services.
- Supporting the use of social communication as an effective tool for the mobilization and participation of the community and of nongovernmental organizers.
- Supporting the ministries of health in order to strengthen the capabilities required for exercising leadership and advisory functions in the management of environmental health matters in development plans and projects.
- Collaborating with other development sectors to permit them to include environmental public health in their sectoral policies, plans, and projects and to promote intersectoral cooperation in health.
- Promoting joint programs and projects on the effect of the environment on the health of children, aimed at identifying and eliminating or minimizing environmental factors that have a particularly adverse effect on the health of children as a consequence of their greater susceptibility.

- Supporting the promotion and implementation of activities in primary environmental care within the context of Health for All to provide communities with environments that promote development through their active participation in identifying their needs and proposing solutions.
- Promoting the healthy spaces strategy through multidisciplinary activities and community participation as a vehicle for simultaneous action to reduce a series of environmental health risk factors.
- Developing guidelines and regulations on the quality of the services and their products.
- Promoting the implementation of systems and mechanisms that will make it possible to collect and manage data and information on environmental quality indicators.

To encourage the countries to take action on physical, chemical, and ergonomic factors that adversely effect workers' health in both the formal and informal sectors, PASB technical cooperation will focus on:

- Promoting an updating of legislation and regulations in the field of workers' health.
- Fostering health promotion and disease prevention programs in occupational health.
- Promoting strengthening the care provided by the health services.
- Supporting programs aimed at improving the quality of the work environment.
- Supporting programs to promote protection of child workers exposed to environmental and occupational risks.

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

- Disseminating appropriate, low-cost technologies.
- Promoting community participation and the participation of nongovernmental organizations and the private sector in the expansion of urban and rural services.
- Participating in sectoral studies, in the reform and modernization of the sector and its institutions, in the formulation of priority projects, and in the mobilization of resources.

- Developing regulatory, technical, and technological mechanisms that will result in the best possible disinfection of water in water supply systems and households.

In order to assist in improving the management of municipal solid waste, given the rapid decentralization and privatization, PASB will cooperate in:

- Promoting institutional strengthening and thus the sector's regulatory and organizational capacity.
- Conducting sectoral studies for solid waste management, including hospital waste.
- Identifying needs and opportunities for financing investments.

4.2.4 *Health Systems and Services Development*

Technical cooperation will continue to support the sectoral reform processes of the countries of the Region. For that purpose it will provide cooperation in three general areas: strengthening of the sectoral steering role, organization of health systems and services, and financing of sectoral activities. To this end it will employ the basic strategies of systematic and periodic sharing of national experiences; development and dissemination of methodologies and instruments to support the strengthening of institutional capabilities for analysis, policy-making, implementation and evaluation of sectoral reform programs; and implementation of a regional system for monitoring the dynamics, contents, and impact of the reforms undertaken.

Special attention will also be paid to strengthening and developing the steering role of the ministries of health as one of the essential components of institutional development of the sector. To this end, regional and country programming efforts will concentrate on cooperation activities directed toward the construction, dissemination and promotion of a conceptual and operational frame of reference for the steering role of the ministries of health; cooperation with the Member States for the reorganization and institutional strengthening of the ministries of health so that they may fulfill their function as regulatory entities in the new sectoral situations; the development of methodologies and tools for consolidating the development of the ministries of health in the countries of the Region; and information dissemination and the sharing of national experiences in this regard.

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

- Developing the capacity for analyzing the organization and operation of the sector.
- Strengthening integrated sectoral approaches to the coordination of external assistance.

- Redefining the roles of central, regional, and local governments in the organization and management of public health services and health care within the framework of the decentralization processes.
- Developing national, subregional, and regional capabilities for health technology assessment.
- Improving the capacity for analyzing health expenditure and resource allocation with the criteria of equity, efficiency, and effectiveness.
- Strengthening the ability to formulate policies and strategies, prepare master plans, and design specific proposals for investment in health.
- Strengthening the operating and problem-solving capability of the services at the various levels of care, within the framework of developing integrated service networks.
- Performing a comparative analysis and disseminating experiences in various forms of payment to providers.
- Reformulating care models to support a reorientation of the services with promotion and prevention criteria and improve the quality and scope of the interventions.
- Promoting and supporting the development of quality assurance programs in the health care services.
- Strengthening the regulatory and operational development of health programs and services pertaining to oral health, care for the disabled, and eye health.
- Strengthening the processes for improving the health of indigenous peoples.

With regard to human resources development, during the next quadrennium PASB will take up the development of technical cooperation activities in order to:

- Strengthen national capabilities for planning and managing sectoral human resources.
- Support the development of programs aimed at improving job performance by health workers.
- Strengthen the institutions and integrated processes in public health education.
- Support a reorientation of the education of health professionals and the continuing education of workers in the sector.
- Strengthen national and subregional capabilities for regulating human resources development.

With regard to the development of information systems for health systems and services, technical cooperation will focus its action on:

- Strengthening institutional capacity in the sector for the development and implementation of information systems for programs and services.
- Promoting the development of telemedicine programs for greater coverage of the population.
- Developing performance indicators for health systems and services that will assist in informed decision-making in the sector.

With regard to essential drugs and technology, PASB will focus cooperation on:

- Supporting subregional and regional mechanisms to harmonize the regulation of essential drugs and inputs.
- Strengthening and developing efficient, high quality pharmaceutical services.
- Supporting the development of supply systems to contain costs and increase availability.
- Strengthening and developing programs for the planning, operation, maintenance, and renewal of the physical and technology infrastructures of the health sector.
- Promoting and developing quality assurance programs in nuclear medicine.
- Promoting the adoption of International Basic Safety Standards for Protection against Ionizing Radiation and for the Safety of Radiation Sources.
- Developing and strengthening public health laboratories and national, subregional, and regional diagnostic laboratory networks.
- Supporting improved safety and quality in blood bank operations.

4.2.5 *Disease Prevention and Control*

In order to face regional challenges and reduce and control disease, health service programs must include disease prevention and health promotion components. Success may require community participation as well as individual behavioral change. These changes must be guided by wise policies and practices, which are supported by the evidence.

The technical cooperation provided by PASB in the area of vaccine-preventable diseases will be geared toward:

- Improving the adoption of policies related to immunization programs.
- Expanding and improving vaccination by the public and private sectors, including NGOs.
- Strengthening and supporting national surveillance systems for vaccine-preventable diseases (surveillance should be carried out at the lowest geographical level in order to identify unvaccinated populations) in conjunction with adequate laboratory support systems. For *polio*: expanding national monitoring of indicators of acute flaccid paralysis. For *measles*: expanding national surveillance in order to detect circulation of the virus, determine risk factors, obtain samples for virological confirmation, and determine the needs for supplementary vaccination campaigns.
- Determining disease burdens and ensuring cost-effective inclusion of vaccines against *Haemophilus influenzae*, MR, or MMR in the basic vaccination series.
- Supporting expansion of the Regional Laboratory Network (10 laboratories) to ensure adequate diagnostic capabilities.
- Implementing and strengthening the Regional Network of National Quality Control Laboratories.
- Implementing the Regional Network of National Control Authorities.
- Developing human resources in good manufacturing practices.
- Continuing the regional certification process for vaccine producers.
- Promoting the consortium of public vaccine-producing laboratories.

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

- Encourage countries to expand screening of blood for hepatitis C and *Trypanasoma cruzi* as well as to promote internal and external quality control measures.
- Promote action to reduce the prevalence of leprosy in smaller foci within countries that exceed 1 case per 10,000 population and assist countries in introducing effective surveillance mechanisms into primary health care services to detect future cases.

- Implement effective national and subregional plans to control dengue, based on the PAHO guidelines.
- Promote application of new technology to improve regional surveillance of infectious diseases.
- Establish an electronic intranet for designated regional public health officials to improve the speed of notification and confirmation of suspected cases.
- Assist countries in introducing the prospective new International Health Regulations, which are scheduled for adoption by WHO in 1999.
- Help to expand knowledge of antimicrobial resistance.
- Assist countries in standardizing laboratory-testing methods, improving laboratory quality control, and reporting and utilizing the results of antimicrobial resistance tests.
- Support countries in planning and managing programs and stimulating applied research in tropical diseases and emerging and re-emerging diseases.
- Promote the development of elimination programs using mass treatment of populations at-risk for onchocerciasis and lymphatic filariasis.
- Support countries in focusing more specifically on health issues with regard to HIV/AIDS, such as program management, blood supply safety, and models for health behavior interventions and care, while continuing to promote a wider intersectoral response.
- Promote the AIDS control programs in developing procedures to detect and treat tuberculosis.
- Promote surveillance and programs to control sexually transmitted diseases.
- Support countries in implementing programs to eliminate congenital syphilis.
- Reduce *T. infestans* infestation by extending activities to Bolivia, Paraguay, and southern Peru, and adapt this program to the Central American and Andean countries.
- Promote extended implementation of the global malaria strategy and, due to the existence of drug-resistant *Plasmodium falciparum*, a surveillance system to monitor such resistance in the Amazon countries.
- Promote implementation of the strategy of directly observed therapy (DOTS), which aims to treat tuberculosis patients, reduce transmission, and prevent the development of drug resistance.

- Support adoption of the IMCI strategy, which addresses acute respiratory infections, diarrheal diseases, malaria, malnutrition, measles, and dengue, in selected countries.

Much has been learned about the etiology of noncommunicable diseases and, equally important, significant reductions in incidence and mortality have been shown to be achievable. The major causes of noncommunicable diseases are preventable or can at least be postponed. Many are reversible and many are also amenable to secondary prevention strategies aimed at reducing complications. Knowledge about modifiable risk factors for noncommunicable diseases is continually being developed and adapted to particular situations.

Often the time interval between “cause” and “effect” may be many years. Conversely, it may take years to see reductions in mortality for some of these diseases. Nevertheless, it is clear that enormous health gains are possible if there is commitment, evidence-based policies and programs, and adoption of these by communities, individuals, and clinicians. It is important for health organizations to devote human and financial resources so as to benefit from these possibilities. The focus of PASB technical cooperation will be to:

- Establish a regional network of countries using an integrated approach to non-communicable disease control, focusing at first on cardiovascular disease and adapting the model developed in Europe.
- Disseminate information about demonstrations to reduce mortality from cervical cancer, and support countries adopting a similar approach.
- Support countries in developing efficient policies, models, and working partnerships among physicians, laboratories, and treatment facilities and understanding women’s attitudes and needs in cervical cancer control programs; evaluate demonstration projects; and plan their judicious expansion based on the results.
- Assist countries with implementation of the Declaration of the Americas on Diabetes.
- Support programs to address injury prevention, beginning with an analysis of existing data and resources.
- Identify partners for intentional and unintentional injury prevention activities and priorities.

Veterinary public health is and will be a very important area for countries to advance in food security and safety. Technical cooperation will:

- Assist countries free of foot-and-mouth disease to plan for the prevention of new outbreaks and work with Andean countries and northern Brazil to expand areas of eradication, with special attention to border areas.

- Promote food protection along the five existing lines of action.
- Promote rabies prevention activities along with the establishment of a laboratory network among WHO/PAHO Collaborating Centers.
- Promote the development of laboratory diagnostic capacity for epidemiological surveillance in the areas at risk for Venezuelan equine encephalitis.
- Support the implementation of programs to address bovine tuberculosis and brucellosis, including surveillance, diagnosis, and inspection of abattoirs with a view to disease elimination.
- Support Southern Cone countries in their efforts to eradicate echinococcus/ hydatidosis, with special attention to applied research, risk analysis, and rapid response for emerging zoonoses.

4.3 *Technical Cooperation and International Coordination*

The technical cooperation of PASB with its Member States, together with its coordination of international health matters, is the two constitutional responsibilities of PASB. In order to develop effective technical cooperation in the period 1999-2002, PASB will take into account:

- The programming orientations of the Ninth General Program of Work of WHO for the period 1996-2001, which envisage the integration of health and human development in public policies, ensure equitable access to the health services, promote and protect health, and prevent and control specific health problems.
- The bases for action defined by the new global policy of Health for All in the 21st Century, which promotes action on the determinants of health by considering it the main element in human development and on the development of sustainable health systems that respond to the needs of the people.
- The themes proposed for the Tenth General Program of Work of WHO for the period 2002-2007, which include strengthening policy capacity for Health for All at all levels of WHO and in Member States; promoting collective action for global health; protecting and promoting health, including disease control and environmental health; and building and maintaining sustainable health systems and services.

Continuity will be provided to the modalities employed by PASB to cooperate technically with the countries, which refer to direct technical cooperation, cooperation in emergencies, humanitarian assistance, decentralized technical cooperation, and the promotion of technical cooperation among countries.

PASB will actively continue to promote technical cooperation among countries, assigning special importance to Pan American action in health as a powerful cooperation strategy that has shown evidence of success in the past and that, without a doubt, will facilitate regional progress in the complex environment of transition toward the 21st century.

At the same time, PASB is continuing to refine its functional approaches to technical cooperation, which currently include mobilization of resources, dissemination of information, training, promotion of research, preparation of plans and policies, and technical cooperation among countries.

A specific system (AMPES) exists for the planning, programming, monitoring, and evaluation of technical cooperation, geared to searching for and measuring results, technological development, and the need for action by the PAHO/WHO Representative Offices. The purpose is to simplify managerial processes, program with flexibility, respond more rapidly to the needs of the countries, and seek transparency in the use of resources.

The programming of technical cooperation, the foundation of the biennial program budget, focuses on the formulation of national health priorities, the identification of needs for international technical cooperation, and the preparation of technical cooperation projects that PAHO will provide, specifying the expected results together with a series of indicators for measuring progress. The logical approach for project management will continue to be used, and progress has been made in developing mechanisms to evaluate technical cooperation within the framework of AMPES.

Technical cooperation should be linked to the overall development plan of a country. Well-conceived national development policies and plans that include concrete estimates of costs are essential for mobilizing and coordinating financial and human resources. National strategies should be formulated through a participatory process that includes the representatives of a broad cross-section of society in order to identify its needs and priorities. The international technical cooperation organizations can perform a valuable function by strengthening the capacity of the countries to formulate appropriate national development plans.

Nevertheless, as continuity to the process of rethinking technical cooperation in health, which has been under way since 1996, efforts to explore how to improve and modernize cooperation with the Member States and make it more effective and up-to-date will continue.

PASB understands that technical cooperation has been and continues to be influenced by the criteria and approaches employed in the overall development process. In the current stage, the key concept is “sustainable development,” grounded basically in human capital formation, private sector participation, and environmental protection, all within a framework of equity and social justice. Above and beyond traditional “technical” aspects, such as the search for better ways to investigate, teach, and apply health technology, the international health agenda is currently concerned with the health impact of socioeconomic development, the strengthening of institutional capacity for policy-making, planning

and advocacy in health, and the organization of specific programs for a given country or group of countries.

The need to shift from technical cooperation centered on what kinds of inputs are employed to the adoption of a new approach based on the nature of the proposed cooperation is increasingly clear. There has also been a tendency to abandon the project-based approach in favor of a more programmatic, multisectoral approach that emphasizes the best use of national technical expertise. These changes will make it possible to develop better organized, more competitive, and more sustainable technical cooperation.

With the advances in national technical capability, it will be necessary to assist the countries in identifying sources of this capability and potential suppliers of cooperation from a wide range of public and private organizations, NGOs, academic institutions, and even private enterprise.

PASB efforts in international cooperation will be geared toward strengthening a historical leadership role in international health. Studies conducted by the Organization (47) evidence a proliferation of institutions and actors who participate not only in technical cooperation but also in general health activities that merit a proactive position in PAHO coordination at several levels: between countries, within countries, and in the international organizations (48). PAHO will encourage national governments to assume responsibility for coordinating health efforts in their own countries and will help to strengthen this capability, facilitating the necessary coordination among the parties involved, respectfully and innovatively.

Coordination of technical cooperation takes place at several levels:

- Coordination among countries, so that horizontal coordination among the parties significantly improves the ability to obtain external resources, in addition to the potential generated by the two-directional flow of information and the experiences of the participating countries, which constitute the essence of technical cooperation among countries.
- At the country level, coordination of the programs of international organizations with their respective national counterparts. This coordination should be based on a comprehensive national development strategy formulated by means of an intersectoral participatory process.
- Coordination at the international organization level, mindful that while the organizations may support the same programs, different organizations sometimes apply different policies and strategies and adopt different procedures, which may lead to a wasted resources or even to conflicting orientations.

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