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STRATEGIC ORIENTATIONS AND PROGRAM PRIORITIES FOR THE PAN AMERICAN HEALTH ORGANIZATION IN THE QUADRENNIUMS 1991-1994 AND 1995-1998

The Strategic Orientations and Program Priorities (SOPPs) for the Pan American Health Organization during the Quadrennium 1991-1994 were adopted by the Member Governments at the XXIII Pan American Sanitary Conference in 1990. Subsequently, the Executive Committee, at its 107th Meeting, approved the document entitled *Implementation of the Strategic Orientations and Program Priorities for the Pan American Health Organization during the Quadrennium 1991-1994* as the guide for implementation of the SOPPs for 1991-1994. At that meeting the Executive Committee also adopted the quadrennial targets contained in the document. Those targets were intended to guide the action of the countries and determine the activities of the Secretariat, defining the situations to be attained in the Region by the end of 1994 and outlining the processes that should be carried out in order to attain them. At the same time, the Committee recommended that the Director use additional evaluation schemes to review, on a biennial basis, progress made toward achievement of the quadrennial targets.

Part A of this two-part report documents, in light of the strategic orientations, the progress made toward attainment of the targets and execution of the plans of action established under the program priorities during the two years following the approval of the SOPPs.

Part B presents the proposed policies for the Organization during the next quadrennium, 1995-1988, based on an analysis of the current political, economic, social, and sectoral situation in the Region and on projections of the most probable and desirable future scenario with regard to the health and living standards of the peoples of the Americas.

PART A

PROGRESS REPORT ON THE QUADRENNIAL TARGETS FOR THE SOPPs 1991-1994

The Strategic Orientations and Program Priorities (SOPPs) for the Pan American Health Organization during the Quadrennium 1991-1994 were adopted by the Member Governments at the XXIII Pan American Sanitary Conference in 1990. Subsequently, the Executive Committee, at its 107th Meeting, approved the document entitled *Implementation of the Strategic Orientations and Program Priorities for the Pan American Health Organization during the Quadrennium 1991-1994* as the guide for implementation of the SOPPs for 1991-1994. At that meeting the Executive Committee also adopted the quadrennial targets contained in the document. Those targets were intended to guide the action of the countries and determine the activities of the Secretariat, defining the situations to be attained in the Region by the end of 1994 and outlining the processes that should be carried out in order to attain them. At the same time, the Committee recommended that the Director use additional evaluation schemes to review, on a biennial basis, progress made toward achievement of the quadrennial targets.

This report documents, in light of the strategic orientations, the progress made toward attainment of the targets and execution of the plans of action established under the program priorities during the two years following the approval of the SOPPs. This analysis was used in the formulation of the guidelines for the quadrennium 1995-1998 which are presented in Part B of this document.

Several factors limited the evaluation of progress toward attainment of the targets, including the low sensitivity of some indicators with regard to scope and the limited availability of up-to-date information, which prevented an exhaustive analysis of the national health policies of the countries of the Region.

The evaluation looked essentially at the period 1991-1992, although because it took place in the midst of an ongoing process, some activities or sectoral analyses correspond to 1993.

The Executive Committee is asked to consider this document and make recommendations to the XXIV Pan American Sanitary Conference to be held in September 1994, in fulfillment of the mandate given to the Secretariat of the Organization to monitor the progress made toward achievement of the quadrennial targets adopted under the SOPPs for 1991-1994.

CONTENTS

1. Introduction and Methodology

The Strategic Orientations and Program Priorities (SOPPs) for the Pan American Health Organization during the Quadrennium 1991-1994 were adopted by the Member Governments at the XXIII Pan American Sanitary Conference in 1990. Subsequently, the Executive Committee, at its 107th Meeting, approved the document entitled Implementation of the Strategic Orientations and Program Priorities for the Pan American Health Organization during the Quadrennium 1991-1994 as the guide for implementation of the SOPPs 1991-1994. At that meeting the Executive Committee also approved the adoption of the quadrennial targets contained in the document. Those targets were intended to guide the action of the countries and determine the activities of the Secretariat, defining the situations to be attained in the Region by the end of 1994, and outlining the processes that should be carried out in order to attain them. At the same time, it was recommended that the Director use additional evaluation schemes to review, on a biennial basis, progress made toward achievement of the quadrennial targets.

This report documents, in light of the strategic orientations, the progress achieved toward attainment of the targets and execution of the plans of action established under the program priorities during the two years following the approval of the SOPPs. The programming of PAHO technical cooperation with the countries, as well as national health policies, were used as references for this purpose, the central objective being to determine to what extent the various programs and policies reflect the SOPPs. This analysis, which will be updated at the end of the four-year period, is intended to support the formulation of the orientations for the 1995-1998 quadrennium, which will be presented to the XXIV Pan American Sanitary Conference in September 1994.

The evaluation was limited by several factors, including the low sensitivity of some indicators with regard to the scope of the targets, since they were developed after the targets were established. Another important constraint was the limited availability of up-to-date information, which prevented an exhaustive analysis of the national health policies of the countries of the Region. Finally, it appears that a period of two years may have been too short to allow for an adequate evaluation of trends toward the attainment of the targets, especially those related to morbidity, mortality, and impact.

The evaluation looked essentially at the period 1991-1992, although because it took part in the midst of an ongoing process, some activities or sectoral analyses correspond to 1993.

The extent to which the strategic orientations have been adopted and the program priorities fulfilled was analyzed on the basis of progress toward the quadrennial targets established in relation to those orientations and priorities. The process of evaluating progress toward the quadrennial targets was initiated in 1993 with the development of

indicators that took into consideration the plan of action established for each one of the targets. Whenever possible quantitative indicators were selected that made it possible to describe the situation in the Region. When that was not possible, owing to the nature of some of the targets, quantitative analytical summaries were prepared that described the proportion of countries that had achieved certain results or attained proposed targets or that had carried out activities to that end.

The evaluation also included a review of the Biennial Program Budget (BPB) for 1992-1993 and the Annual Program Budgets (APB) for 1991 and 1992 of the 42 PAHO field offices, which include the programs carried out in the member countries and by the specialized Regional centers.

The Executive Committee of the Pan American Health Organization adopted the following strategic orientations to serve as the foundation for efforts during the quadrennium: health promotion, using social communication, integrating women into health and development, and mobilizing resources. These strategic orientations made it possible to identify priorities for the development of infrastructure (sector analysis, allocation of resources, and sectoral financing) and for the development of programs (health and environment, food and nutrition).

The need to improve the capacity for health situation analysis and identification of high-risk groups was another challenge faced by the Region in addition to those mentioned above. The strategic orientations formulated in response to this need included reorganization of the health sector and targeting of actions to benefit high-risk groups. The following priorities for the development of infrastructure were specified: sector and resources allocation analysis, management of local health systems and local programming, and development of human resources. The priorities for the development of health programs included lifestyles and risk factors, and control and/or elimination of preventable diseases.

The situation analysis revealed the inequities that had resulted from the discrepancies between economic growth and the distribution of income, whence the challenge of formulating policies and programs designed to foster equity in health and increase the coverage of health services in order to make it possible to carry out interventions against health impairments and risks. The strategic orientations proposed for meeting this challenge were: reorganization of the health sector, focusing of action on high-risk groups, health promotion, use of social communication, and mobilization of resources, which was understood to mean efforts to mobilize political will, as well as technical and financial resources. Among the principal priorities identified for the development of health services infrastructure and health programs were: sectoral financing, development of human resources, health and environment, maternal and child health, workers' health, drug addiction, and AIDS.

Given the economic and political situation in the Region, it is considered imperative to address the inefficiency of the sector and the disparities between the characteristics of the health work force and the needs of the services, which have resulted from centralization and non-democratic methods of management and organization. The strategies proposed in this regard emphasized the reorganization of the sector. The program priorities defined included: management of local health systems and local programming, technological development, and development of human resources.

The strategic orientations are intended to serve as general guidelines for the process of improving or transforming national health systems with a view to attaining the goal of "health for all." The program priorities indicate the principal areas in which the Organization needs to take action in order to adequately respond to the problems identified.

The strategic orientation "health in development" is fundamentally geared toward reducing social inequities and their effects on health, while mitigating the impact of the crisis on the most disadvantaged groups through the development of comprehensive programs aimed at engendering social well-being and improving the living and health conditions of the masses--that is, the transformation of health systems with emphasis on health promotion and the prevention of health impairments and risks, and with the participation of the population. "Health in development" can thus be said to form the core of the strategic orientations for the quadrennium 1991-1994.

The quadrennial targets (See Annex) established under the strategic orientations and program priorities are the central elements for the process of monitoring since they provide a basis for assessing the extent to which the strategic orientations have been adopted and the program priorities fulfilled.

Challenges for Health and for the Transformation of the Sector in the 1990s

- Attribute greater importance to health in social policy and in the development process
- Improve the capacity for carrying out situation analysis and for identifying high-risk groups
- Formulate policies and programs that seek equity in health and reduce the widening gap in health services coverage
- Concentrate resources on effective interventions against health impairments and risks
- Make the sector more efficient
- Redefine how the sector is led and organized
- Overcome discrepancies between the work force and the needs of the services

Strategic Orientations for PAHO during the Quadrennium 1991-1994

- Health in development
- Reorganizing the health sector
  - Strengthening and developing local health systems
  - Incorporating the full potential of social security
  - Orienting external financing into the reorganization of the sector
- Focusing actions on high-risk groups
- Health promotion
- Using social communication
- Integrating women into health and development
- Management of knowledge
- Mobilizing resources
- Cooperation among countries

Priorities for the Development of Health Services Infrastructure

- Sector and resource allocation analysis
- Sectoral financing
- Management of local health systems and local programming
- Technological development
- Development of human resources

Priorities for the Development of Health Programs

- Health and the environment
- Food and nutrition
- Lifestyles and risk factors
- Control and/or elimination of preventable diseases
- Maternal and child health
- Workers' health
- Drug addiction
- AIDS

2. Strategic Orientations

2.1 *Health in Development*

Strategic orientations that highlighted the role of health in development were implemented with a view to fostering a different perspective on and approach to the development process. Accordingly, every effort was made to bring health issues to the fore in regional, subregional, and national forums. At the various Ibero-American Summits of Heads of State and Government and the Summit of Heads of State of the Caribbean Community, PAHO/WHO has engaged in intensive promotional and diplomatic efforts to ensure the inclusion of health issues on the agendas of these meetings, at which the inextricable link between health and development has been emphasized and specific aspects of sectoral policy have been discussed.

In a collaborative effort, ECLAC and PAHO are preparing a proposal on the role of health in the process of changing production patterns with equity. This proposal seeks to strengthen the favorable links that exist between health and other aspects of the process of socioeconomic and political development, creating suitable conditions for efficiency and economic competition, but at the same time fostering equity in the distribution of the benfits. One of the principal objectives is to overcome the disregard for and neglect of health and other social issues that characterized the theories and methods applied in regional development efforts during the previous decade.

In the framework of the Central American Health Initiative, health has been linked to the processes of peace-making and consolidation of development and democracy through the mechanisms of technical cooperation among countries and the establishment of common agendas for addressing subregional health problems.

With 23 national legislatures and subregional parliaments--including the Andean Parliament, the Central American Parliament, and the Latin American Parliament (PARLATINO)--areas of cooperation have been established, which has resulted in the establishment of legislative priorities relative to health at the Regional, subregional, and national levels.

In addition, the Organization has cooperated with the OAS and other technical and financial cooperation agencies, including UNICEF, UNESCO, UNDP, IDB, the World Bank, CIDES/OAS, and UNCTAD with a view to ensuring that health issues are given prominent consideration in policies designed to combat poverty and in solidarity and social assistance programs, as well as training of national experts, and specific studies on foreign trade in health services.

In the context of the regional integration agreements that have been negotiated in the Americas, such as NAFTA, MERCOSUR and the Central American and Caribbean Common Markets, an effort has also been made to draw attention to health issues so that they are taken into account from the outset in the processes of integration and development.

Cooperation with the legislatures and parliaments has provided a means of access to future authorities and health officials, which is essential in order to ensure that health issues are included in national political platforms and agendas and in order to forge ties with new health authorities prior to their taking office.

In several countries the ministries of planning, economy and finance, development and social welfare, labor, and social security, among others, have become frequent counterparts in the activities of PAHO/WHO at the national and international levels. At the same time, the Organization has endeavored to promote and strengthen the capacity of the Ministries of Health to enlist participation and support from the agencies responsible for various aspects of the implementation of health policies, thus fostering an intersectoral approach to health issues. Efforts in this regard have intensified lately as the Organization has begun to promote the Regional Plan for Investment in the Environment and Health.

2.2 *Reorganizing the Health Sector*

In order to obtain the broadest possible coverage and meet the basic health needs of the population, PAHO/WHO has advocated sectoral reorganization, through, on the one hand, the political processes of State reform under way in the countries and, on the other hand, the development of local health systems, building on the politico-administrative division existing in the countries so that these systems become an integral part of the local government.

In 1992, 32 countries (91%) of the Region were in the process of modifying the structure or management of the health sector or were making changes in health care and health financing models. Twenty-three countries of the Region (66%) had adopted decentralization policies, 30 countries (86%) had formulated such policies, and 31 countries (89%) had adopted strategies for the development of local health systems. Throughout the Region, 4,799 local health systems were being developed to cover a population of 118,500,000, which is 17.1% of the total population (these figures exclude Chile, for which information is not available).

At the same time, an effort has been made to promote the transition from a health care model that is exclusively curative and individual and responds solely to the demand for health services to a model that, while continuing to give priority attention to urgent

needs, emphasizes health promotion and protection and programmed care with a risk approach, targeting the groups who are at highest risk and have the greatest need. In this regard, there is evidence that the countries are emphasizing health promotion and protection and have incorporated basic sanitation as one of the principal objectives in the development of local health systems. In other cases important social development initiatives are being carried out at the local level with intersectoral participation, especially in the struggle against poverty. Examples include the movement known as "healthy *municipios*" or "healthy communities" and the Project on Health, Environment, and Poverty Alleviation (SMALP Project).

In almost all the countries in which significant levels of development have been achieved, joint efforts and activities have been carried out by the Ministries of Health and the social security institutions, mainly in regard to health care programs. Several countries of the Region continue to execute plans for reform of the health sector that involve the social security system and take into account its relations with the Ministry of Health. These reforms are aimed at allowing greater opportunity for private action in health services delivery; social security systems are seen more as sources of financing and purchasers of services than as institutions that provide services directly.

The economic crisis that has affected almost all the countries of the Region has had a profound impact on sectoral finances. As a result, new forms of financing have been promoted in which the resources of the State are combined with those of social security, and the private sector, as well as international cooperation resources, both technical and financial.

In 1992, the Directing Council of PAHO adopted, through Resolution CD36.R17, the Regional Plan for Investment in the Environment and Health (PIAS), the aim of which is to catalyze the process of reform and modernization of both the health and environment sectors in the Region over the next 12 years. Both the II Ibero-American Summit of Heads of State and Government, held in Madrid in 1992, and the XXXVI Meeting of the Directing Council of PAHO, manifested their support for the creation of a fund to be used to carry out preinvestment activities and attract additional resources for that purpose, both at the regional level and in the countries. That fund is now in operation.

2.3 *Focusing Action on High-risk Groups*

Focusing action was identified as one of the mechanisms for achieving greater equity in health and remedying the growing deficit in health service coverage for high-risk groups, who have the highest-priority health problems.

In order to attain the targets established, it was considered important to develop epidemiological activities at all levels and promote the formation of interdisciplinary and intersectoral groups to study the subject, in addition to increasing the dissemination of scientific information, with emphasis on technical, methodological, and empirical knowledge about how improve health and well-being.

Although the concept of epidemiological stratification has been accepted both in academic circles and at the level of disease control program management, it is not yet being widely practiced. Some countries have adopted forms of epidemiological stratification by age, geographical location, occupation, type of housing, socioeconomic status, or characteristics of contacts and household members in order to focus actions. However, this analytical tool is still not being employed to any great extent for decision-making in health sector planning; its use is limited mainly to specific disease prevention or control programs.

The countries have carried out sectoral studies or situation analyses of communicable diseases, in particular the endemic ones. In addition, at the Regional level methodologies have been developed for calculating estimated rates of mortality for five-year periods by age, sex, cause of death, and country for a study of how different living conditions produce unequal health profiles. These methodologies will also be useful for monitoring social inequities in health and for the study and quantification of gaps between countries according to level of economic and social development.

Priority has been given to the training of human resources in the field of epidemiology and educational modules have been designed for this purpose. In addition, documents have been distributed that will serve as guides for epidemiological characterization, timely and efficient diagnosis, and specific and effective management of the priority communicable diseases in the Region.

2.4 *Health Promotion*

In the 1986 Ottawa Charter on Health Promotion the countries affirmed that the fundamental requirements for health are peace, education, housing, nutrition, income, a stable ecosystem, the conservation of resources, social justice, and equity. In this framework it is clear that health promotion ultimately has to do with the recognition of health as a strategy which can be used to foster greater commitment on the part of all to reduce social inequalities and increase levels of collective well-being within a broad social and ecological context.

Thirty of the 46 countries in the Region (65%) have included health promotion among their national plans, and four of those countries have established written policies on health promotion.

In 1991 the name of the PAHO Program on Health of Adults was changed to Regional Program on Health Promotion, and structural and functional changes were introduced, including strengthening of the social communication and information management components. In 1993 the Division of Health Promotion and Protection was created. The Division includes the Programs on Health Promotion and Social Communication, Health Protection, and Food and Nutrition.

Priority has been given to the provision of advisory services to the countries with a view to ensuring the formulation of public policies and the adoption the health promotion strategy in national programs aimed at improving health and living conditions. Efforts are also being made to promote the use of mass communication and public information as instruments to promote and protect health.

The intersectoral approach that has been taken to management of the cholera epidemic and the healthy communities movement that is being implemented in the countries with the assistance of PAHO are examples of health promotion initiatives that are leading to new ways of conceiving of and carrying out public health activities.

The primary mechanism for implementing the health promotion strategy is encouragement of public participation in health promotion activities through health education activities in schools, dissemination of information, mass communication programs, and community organization. At the same time, an effort is being made to strengthen health infrastructure through decentralization and the development of local health systems, as well as through the modification of health policy, based on strengthening of the epidemiological approach to planning and the promotion of intersectoral action.

In November 1992 representatives of 21 countries attended the International Conference on Health Promotion, held in Bogotá. In June 1993 the first conference on health promotion in the English-speaking Caribbean was held in Trinidad and Tobago; 19 countries and various sectors were represented at that meeting.

In response to the request of the Governing Bodies of PAHO, a proposal for a Regional Plan for Health Promotion has been drawn up and was presented in April 1994 to the Subcommittee on Planning and Programming of the Executive Committee for its consideration.

2.5 *Using Social Communication for Health*

Twenty-six percent of the countries in the Region have indicated that they consider the use of social communication to support health activities a priority. Several countries have developed health communication initiatives with a primarily national

focus, some consolidating traditional practices and all using both the most modern and the more classical mass communication media.

No information is available on which countries have incorporated health education as part of their programs of formal primary education, but it is known that some countries have used volunteers or individuals performing compulsory social service in order to expand the dissemination of information to the community.

The PAHO Office of Information and Public Affairs, which is responsible for the Organization's communication activities among the general public and the mass media, provides support for the other PAHO programs and offices in this regard. The Office's responsibilities include mass communication, especially in relation to the cholera epidemic, public relations and public information, media relations, and production of audiovisual communication aids. An important aspect of this office's work has been the use of teleconferences to provide information to professionals. Teleconferences have been held on the subjects of AIDS and the Expanded Program on Immunization.

2.6 *Integrating Women into Health and Development*

Thus far, eight countries (17.4%) have explicitly included the integration of women into health and development as a part of their national health plans and as a priority for technical cooperation, although a larger number of countries are carrying out activities with a gender perspective.

The processes of advocacy for women's health have been facilitated at the level of the legislatures and parliaments, and an effort has been made to promote the review of existing legislation and the formulation of new laws aimed at eliminating the *de jure* discrimination that prevent women from directly managing their own health. To that end, support has been provided to the lawmakers who are members of legislative commissions on health, and standing commissions on women have been created within the Central American congresses. In addition, proposals for the reform of the penal codes of the countries of the Region have been drawn up. Almost all the countries have named focal points to promote the role of women in health and development.

In order to raise awareness of the innovative "gender and health" approach, considerable effort has been devoted to generating knowledge, carrying out assessments, training, developing methodologies, and disseminating information.

The Governing Bodies of PAHO have made recommendations for regional plans of action and policies on the health of women, defining lines of action for technical cooperation to promote self-care, prevent violence against women and girls, and reduce

maternal mortality. They have also approved the establishment of a regional system for monitoring and assessing the situation of women and sex differentials in health.

With a view to increasing awareness of issues relating to women's health and promoting the protection of women's interests, including health, various activities were carried out with nongovernmental organizations, as were promotional activities aimed at the general public at the Regional, subregional, and national levels.

2.7 *Management of Knowledge*

In the area of scientific and technical production, the countries of the Region have established explicit or implicit policies on health research. In the last four years significant changes have been observed. These changes have been for the better in some countries in which there has been an expansion and diversification of research and development in the health field, both in terms of the subjects and fields studied, and in institutional and financial terms. Other countries, however, have seen deterioration in the health research infrastructure and the level of scientific production achieved in previous years.

The rapidity with which change is occurring, the heterogeneity of situations, and the weakness of existing systems of information on scientific activity make it difficult to accurately assess the situation and trends in health research. The data available on the production of technical and scientific information in the Region are not current or are incomplete for some countries.

Moreover, generally speaking, the communication barriers between the institutions that produce knowledge and those that use it continue to exist.

In order to further the development of health research and information management, in several countries support has been provided for the creation of databases on projects in progress, investigators, and institutions. There has also been considerable collaboration with the Latin American and Caribbean Center on Health Sciences Information (BIREME), particularly in regard to the quality of scientific information. Emphasis has been placed on the development of new information retrieval, storage, and dissemination systems and the use of networks for the exchange of health information, including the specialized systems of the Pan American Centers and the Programs of the Organization: REPIDISCA, ECO, INPPAZ, INCAP, LEYES, SIDORH, and the information systems on health promotion and emergencies and disasters.

2.8 *Mobilizing Resources*

This strategy, in its broadest sense, consists of pooling human, technical, financial, and political resources with a view to promoting health in the Region, viewing health as a component and a product of development. Resource mobilization is thus the substratum of the technical cooperation activities fostered and carried out by PAHO.

In order to promote its policies, strategies, and programs, PAHO continued to strengthen its relations with the United Nations system, the Inter-American system, bilateral agencies, international lending agencies, and nongovernmental organizations. In 1991, an international meeting of donors was organized to prepare the emergency phase of the campaign against cholera, and dialogue was initiated on the initiative that has since become the Regional Plan for Investment in the Environment and Health.

With the collaboration of the Government of Spain the III Madrid Conference was held to mobilize resources to support the second stage of the Central American Health Initiative. In regard to other subregional initiatives, the Government of Italy and PAHO signed a collaboration agreement that contains provisions regarding support for the Caribbean Cooperation in Health and assistance for refugees in Central America.

Together with LAES, UNDP, and ECLAC, the Organization initiated the formulation and execution of Project Convergence, the objective of which is to support regional integration for the development of health technology. After a series of subregional meetings, a regional meeting was held in Santiago, Chile, in July 1992, with 127 participants from 24 countries. At this meeting draft versions were prepared of eight multilateral projects on biologicals, drugs, and other subjects, as well as several subregional projects and bilateral agreements. The monitoring of these agreements and the mobilization of support for regional projects is the responsibility of a multi-institution commission, which has named PAHO as its technical secretariat.

In keeping with decisions of the Governing Bodies that have underscored the growing need to change the management of health systems, promote the decentralization of decision-making, and encourage community participation, since 1991 PAHO has expanded its resource mobilization activities with nongovernmental organizations (NGO). The work with these organizations of civil society has taken place on three fronts: (1) with the technical units at PAHO Headquarters and in the countries, through strengthening of their knowledge about the dynamics of the work of nongovernmental organizations in the areas of health and development, and through the designation of focal points at every Representation to work with these organizations; (2) between nongovernmental organizations themselves, providing opportunities for exchanges between them for the purpose of strengthening collaboration and avoiding duplication of

efforts; and (3) between governments and NGOs with a view to establishing the foundations for systematic collaboration in the area of health.

In order to strengthen ministerial relations, joint training and exchange activities are being carried out with participation by ministries of planning, economy and finance, foreign affairs, and health.

With a view to improving the technical quality of project proposals and annual programming for projects financed with both regular and donor funds, training materials and manuals for the application of the approach to project management known as the logical framework were developed. In addition, a standardized PAHO format for the presentation of profiles and projects was developed, and within the framework of the Central American Health Initiative training activities were conducted with the staff members responsible for projects and the PAHO/WHO Representatives. The logical approach methodology for projects has been incorporated into the AMPES system.

The total amount of non-quota resources channeled through PAHO in 1990, 1991, 1992, and 1993, including funds from all donors, was US$192,139,724 during the biennium 1990-1991 and US$188,470,166 in 1992-1993. External resources have gone from 1% of the total budget of PAHO in 1971 to almost 50% during the last biennium.

Official Development Assistance (ODA) has only averaged around 0.35% of GDP, as compared with the target allocation of at least 0.7%. In 1991, total ODA, including funds from bilateral and multilateral sources, totaled US$56,000 million. Of this total, US$41,000 million (70%) was provided by member countries of the Development Assistance Committee (DAC). A significant trend has been observed toward predominance of bilateral assistance, which accounted for 51.78% of total ODA in 1980, rising to 66% in 1986 and 70% in 1991. Meanwhile, the relative share of multilateral assistance decreased, dropping from 33.62% in 1980 to 24% in 1986 and then levelling off at 26% in 1991.

In 1991 it was reported that of total bilateral ODA, which amounted to US$ 34,000 million, the proportion allocated for health was 10%. Latin America and the Caribbean received 9.8% of the total, while Asia received 31.9%; Africa, 41.4%; and other regions, 17%.

Given the vulnerability of external resources to the fluctuations in assistance policies and in light of the need to strengthen national capabilities for the negotiation and coordination of resources, joint training activities and exchanges were carried out between the ministries of planning, economy and finance, foreign affairs, and health. These activities dealt with issues relating to the management of international cooperation in the health field, the provision of information about sources of cooperation and their

financing policies, and promotion of the health sector in international cooperation projects, with a view to including them in the priorities for national development and related negotiations.

2.9 *Technical Cooperation Among Countries*

In the biennium 1990-1991, 1.2% of the PAHO budget was allotted for the promotion and development of technical cooperation among countries (TCC). For the biennium 1992-1993 this proportion was 1.7%.

The policy adopted by PAHO in this regard advocates the existence of prior national efforts in the form of real commitments for cooperation, accompanied by the allocation of national resources for the implementation of projects. PAHO's support consists of additional technical and financial resources. Given the catalytic nature of the Organization's participation in these projects, the resources mobilized ultimately far exceed the amounts contributed directly by PAHO.

In 1990 the amount approved for TCC was US$ 132,400. In 1991, the figure rose to US$ 420,700. In 1992, the amount approved under the regular budget was US$ 328,300. In addition to this amount, US$ 95,000 in extrabudgetary funds from the Nordic countries was approved for TCC activities in the Central American subregion, which increased the total TCC allocation in 1992 to US$ 423,000.

The countries, with the support of PAHO, have made notable progress with regard to the operation of the revolving fund of the Expanded Program on Immunization, the elimination of Chagas' disease, and the maintenance of close collaboration in activities to combat the cholera epidemic. In addition, the countries have also collaborated on Project Convergence, with the participation of LAES and UNDP; the Pan American Network of Information and Documentation in Sanitary Engineering and Environmental Sciences (REPIDISCA) of CEPIS; and the Network of Scientific and Technical Information Coordinating Centers of BIREME.

Another modality for the development of technical cooperation activities among countries are the subregional initiatives in Central America, the Andean Area, the English-speaking Caribbean, and the Southern Cone.

In Central America, during 1992, 132 national projects were carried out in four priority areas, 17 with external resources and 15 with national resources. In addition, 27 subregional projects were executed, 12 of which received external financing. Five are still being negotiated.

The Andean Cooperation in Health (ACH) has had a very slow take-off, perhaps owing to the frequent changes of authorities in the countries of the subregion, coupled with the tremendous disparities existing between countries at all levels, which has sometimes made it difficult to find common ground for action. However, some successes have been registered, including the meetings of technical officials from each country that are being held with the support of the Secretariat of the Hipólito Unanue Agreement and PAHO, the objective of which is to consider approaches and common activities to be carried out in border areas. These activities have yielded concrete results.

With cooperation from PAHO and CARICOM, the Caribbean Cooperation in Health--established under an agreement approved by the Heads of Government of the subregion--has mobilized, national and external resources for the execution of projects in priority areas. For the period 1992-1993, most of the external resources came from the governments of Italy, France, and the United Kingdom and from the Caribbean Development Bank, the Canadian International Development Agency (CIDA), the Carnegie Foundation, UNICEF, and CARICOM itself.

Under the recently consolidated Southern Cone Health Initiative six priority areas for cooperation in the health field were identified and one country was designated to coordinate the activities in each area. The priority areas and countries responsible for them are: local health systems and technology, Chile; health of adults and health promotion, Uruguay; health problems in border areas, Paraguay; disease control (zoonoses), Bolivia; health and the environment, Brazil; and establishment of standards, Argentina. At the last meeting of Ministers of Health, held in Santiago, Chile in June 1993, the agenda included an item relating to health sector financing policies.

3. The Quadrennial Targets for the Program Priorities

3.1 *Priorities for the Development of Health Services Infrastructure*

3.1.1 *Sector and Resource Allocation Analysis*

In view of the fact that in most of the countries decisions regarding allocation of resources are made outside the health sector, PAHO offered 10 international courses on planning of health development projects designed for high-level officials of ministries of health, social security, planning, the economy, and finance, in addition to educators from schools of public health. These courses provided the participants with up-to-date conceptual elements and technical instruments for analyzing the health sector and identifying target areas for investment in order to expand infrastructure, promote reform, and further institutional development. This activity was redefined in 1993 in the context of the Regional Plan for Investment in the Environment and Health, with a view to

establishing a minimum national capacity and making the countries more self-sufficient in this regard.

At the same time, the most relevant experiences in health sector analysis in the Region have been systematically compiled, and a guide on sectoral analysis for the formulation of health policies has been prepared.

Efforts have also been made to continue to strengthen PAHO's capacity to provide cooperation in the area of strategic planning, introducing new concepts and techniques. There has been collaboration in this regard with several countries as well as with the World Health Organization, the Health Care Forum of California and the Alternative Futures Institute of the United States, and the Governing Committee of Future Health Scenarios of the Netherlands.

3.1.2 *Sectoral Financing*

With cooperation from the World Bank's Economic Development Institute, four subregional seminars on health economics and financing were held. These seminars examined theoretical and practical aspects of the most important current issues in the management of the economic and financial dimensions of health and health services. The participants at these meetings were multidisciplinary teams from 30 countries of the Region, including high-level officials from the ministries of health and finance, social security institutions, and educators in the field of public health.

These seminars had a direct multiplier effect, spawning a number of activities at the national level and leading to the creation of five national health economics associations. More recently, also through cooperation between PAHO/WHO and EDI/World Bank, a Latin American and Caribbean Health Economics Network has been established. This network serves as a mechanism for mutual support and cooperation between the countries, and the demand for its services, especially economic and financial analysis applied to the health sector, is growing exponentially

A review was conducted of the experiences of several countries with regard to health financing during the crisis and the structural adjustment process that took place during the second half of the 1980s and beginning of the 1990s. In addition, a study was carried out on the use of emergency and social investment funds in seven countries of the Region, since these funds have constituted the principal source of financing for the execution of social policy in the countries of Latin America and of the Caribbean.

In order to gradually overcome the enormous deficit existing in health service infrastructure, drinking water quality, and basic sanitation, in 1992 the Organization, in close consultation with the countries, drafted the Regional Plan for Investment in the

Environment and Health (PIAS). The Plan identifies the investments that need to made in Latin America and the Caribbean over the next 12 years in order to surmount the problems and shortfalls that have been accumulating in these areas for decades.

The Plan, together with a proposal for the creation of a multilateral fund for voluntary contributions to finance preinvestment activities, was included on the agenda of the second Ibero-American Summit of Heads of State and Government, held in Madrid, Spain, in July 1992. At the III Ibero-American Summit of Heads of State and Government, held in Salvador, Brazil, in July 1993, the leaders affirmed their support for the Plan and for the establishment of the preinvestment fund.

In order to promote the implementation of the Plan and oversee the establishment and operation of the Multilateral Fund, in November 1992 a new unit, the Executive Secretariat of the Regional Plan for Investment in the Environment and Health, was established within PAHO, along with a Coordinating Group. The purpose of these two bodies is to design, coordinate, and set in motion the activities being carried out by the Organization as a whole under the Plan.

The PIAS basically proposes that approximately US$ 216,000 million be invested over the next 12 years throughout the Region. Seventy percent of that amount is to come from national sources and 30% is to be contributed by external sources. Under the Plan, an annual percentage of public and private national resources equivalent to 0.8% of the GDP of the Region is to be allocated for investments in the environment and health. In addition, the Plan calls for the investment of approximately US$ 5 million in external resources a year--the equivalent of 0.3% of the regional GDP--which will require that at least 20% of all the external financing that flows into the Region every year be channeled into investments in health services, drinking water supply, basic sanitation and other environmental activities.

3.1.3 *Management of Local Health Systems and Local Programming*

The principal feature that has characterized this period has been structural adjustment of the health sector, with changes in the organization, staffing, and administrative processes within the ministries and secretariats of health. This process has been associated with similar general processes aimed at modernization of the State. Twenty countries have reported that structural adjustment in the health sector has had an impact on the quality and quantity of health care services.

In connection with the process of decentralization, 12 countries have initiated the reorganization of health systems, including revision of the mission and functions of the Ministries of Health and support for regionalization and reorganization of the system of health services through the development of local health systems. Other countries

continued processes of change that were already under way. Eleven countries have formulated strategies to guide the preparation of health plans, programs, and projects. Most of them have adopted strategic approaches to health services planning, which has made it possible for them to be more flexible in adapting to the process of sectoral adjustment, community participation, and modernization of the State.

Many of these processes are being supported by financing from international lending institutions and bilateral cooperation agencies, which has helped to diminish the negative impact of adjustment measures through targeted programs, investments in infrastructure, and especially through institutional strengthening aimed at achieving better levels of efficiency.

In order to strengthen local health systems, efforts have been made, especially over the last two years, to implement local strategic administration, accompanied by large-scale in-service training programs in the areas of organizational development, management, administrative decentralization, management information systems, project management, and strengthening of training institutions.

Three basic components are considered essential for information systems designed to support the management process--data collection, data analysis, and data interpretation in order to identify trends and associations, and to facilitate decision-making. For the most part, efforts in the Region of the Americas have been concentrated on the first component, but only limited process has been made. The data collected are often incomplete and most data continue to be processed manually and are only partially processed.

Some system of local programming has been developed in all local health systems, although in many cases the emphasis is on supply of services. Only a few countries have incorporated programming measures relating to the effective use of resources. Progress has been noted in development of the capacity to identify problems and solutions using an approach that emphasizes prevention and control of health impairments and risks, epidemiological and social analysis of the health situation, and local negotiation and consensus-building. However, there continues to an absence or insufficiency of efforts to systematically develop schemes for evaluating performance and assessing the impact of activities carried out by health services.

3.1.4 *Technological Development*

Although all the countries of the Region have established a policy on technological development, scientific and technical infrastructure and production are generally insufficient to cope with the prevailing health problems and the changes occurring in health services and systems. Spending on research and development averages about

0.6% of GNP, compared to 2.7% in the developed countries. The Region as a whole is responsible for only 0.6% of all bibliographic citations. In addition to being relatively limited, scientific production in the Region is very concentrated in few countries.

In terms of health technology development, Latin America and the Caribbean have a significant infrastructure in place for the development and production of biologicals such as sera, vaccines, and reagents for diagnosis. Development in the area of health care equipment has been more recent, but already there are almost 800 companies in the Region manufacturing medical, hospital, and dental equipment. It should be noted that there has been a trend recently toward the establishment of cooperation agreements between university institutions and the producers of health care goods and services.

As a strategy for furthering technological development in the Region, technical cooperation among countries is being strengthened through joint research and cooperation networks.

3.1.5 *Development of Human Resources*

PAHO has promoted advanced training for the personnel responsible for the development of human resources. Activities in this regard have included dissemination of information, research, and strategic planning of human resources; development of continuing education for in-service personnel, involving the PAHO fellowships and textbooks programs; support for greater participation by universities in the process of changing health practice, mobilizing the associations responsible for the educational institutions that train health professionals and supporting the development of professional training, mainly in medicine and nursing; promotion of the development of the theory and practice of public health, promoting the revision of educational curricula and research plans in this field; and promotion of sectoral leadership through the Organization's training program in international health.

An analysis of the human resource situation in the countries of the Region reveals that it has not changed significantly in recent years. Emphasis continues to be placed on the training of physicians at the expense of other health professions. The distribution of human resources corresponds to the distribution of health services, and although in some specific cases health services have been decentralized, the same cannot be said of human resources in the health field. The development of highly sophisticated medical centers which tend to attract large numbers of health professionals has led to the continued existence a greater concentration of professionals in urban areas and in the most economically developed areas.

There has been no change in the profile of human resource development. There is greater resistance to change in academic circles than in institutions responsible for

providing services. In addition, educators present an ideological model of the organization of health care practice that for them is very real, but it is unattainable for their students. That model is characterized by traditional liberal and autonomous practice, on the one hand, and dependence on technology, on the other. Thus, the aspiration that the process of professional training be adapted to the needs and socio-epidemiological reality of the population has yet to be realized.

The fiscal crisis in the public education system has resulted in low salaries for educators and deterioration of equipment and physical installations, all of which exacerbates the situation.

A process of continuing education is being carried out in 16 countries. Efforts in this area include the development of educational methodologies geared to the work of health services, especially in management and administration, public health, epidemiology, maternal and child health, and environmental health. Currently, a new educational proposal is being reviewed that involves the development and promotion of on-the-job training for workers.

A major effort has been made to determine the quantity of human resources in the sector, by category and geographic distribution. Although at the international level more data are available today than in recent years, the use of information systems as a basis for the formulation of sectoral policies by health authorities is still very limited. The vast majority of the Ministries of Health in the Region lack basic information on the number of physicians, dentists, and nurses available in their respective countries.

In addition, there is no uniformity between the countries with regard to the formulation of policies on human resources, mainly because of the necessarily intersectoral nature of such policies, which deal with deal with health, education, science, technology, and labor. Commonly, there is a lack of coordination between the sectors and the policy orientation of "health plans" is not reflected in the development and utilization of personnel.

Although on a small scale, efforts have been made to create flexible modalities of personnel management that can be adapted to the characteristics of the labor markets.

3.2 *Priorities for the Development of Health Programs*

3.2.1 *Health and Environment*

Data on the coverage of health services collected in 25 countries of Latin America and the Caribbean indicate that the population with access to safe drinking water totals 348,000 million (76.7%). "Access to safe drinking water" means that the water is not

contaminated and obtaining it does not require an excessive amount of time. It is also known that there are 86 million people who lack access to drinking water. Access to water varies considerably from country to country, ranging from 50% to 90% in urban areas and from 30% to 70% in rural areas.

Quality control of water for human consumption is practiced only in cities of more than 100,000 inhabitants. In urban environments less than 10% of wastewater is treated or disposed of properly.

Complete information is not available with regard to the percentage of the population in Latin America and Caribbean that in 1992 and 1993 was receiving water that met national standards or the standards established by the World Health Organization. Some countries have drafted national reports that provide this information, but most of the countries have no data on the subject. Most of the countries have adopted national standards for drinking water quality, and some of the countries have recently enacted laws that set water quality standards. Others have adopted the WHO standards for drinking quality.

Nearly 171 million people lack adequate sanitation systems, and scarcely 10% of the total volume of wastewater produced is treated before being disposed of in the rivers and seas of the Region. Some 145 million people do not have sanitary excreta disposal systems, and 300 million people are continually contaminating watercourses through improper wastewater disposal. The percentage of population covered by sanitation services differs from one country to the next, ranging from 30% to more than 90% of the urban population and from less than 30% to more than 70% of the rural population.

It is estimated that the 350 million urban inhabitants of Latin America and the Caribbean produce 250,000 tons of refuse per day; the proportion that is collected ranges from 60% to 95%. An accelerated trend toward private concessions for the operation of solid waste collection services is being noted--much more so than in other areas of basic sanitation. Almost all the major cities have in place some type of program for recycling of solid waste. In the last 30 years more than 20 solid waste recycling centers have been established in the Region. These facilities were designed to produce fertilizer or compost to enrich the soil. However, 90% of them have had to close as a result of the failure to conduct adequate preliminary studies to determine the market for the resulting product.

In Latin America and the Caribbean, the companies that manage water systems suffer losses of between 40% and 60% due to problems with billing and production. Economic difficulties, coupled with the shortage of water and the deterioration of its quality, have underscored the need to make the most effective use possible of this resource. A project to conserve water resources and monitor drinking water quality has

been implemented, with support from CEPIS and GTZ in some countries. In all the countries of the Region, PAHO is encouraging the institutions that supply water to develop mass communication campaigns to encourage the community to use water more efficiently.

Efforts continued to promote the development and use of appropriate technologies, notably those relative to use of vehicles for refuse collection and manual sanitary landfills.

Since 1990 at least three countries have enacted legislation on environmental impact assessment, and most of the countries in the Region have revised their environmental legislation relating to environmental pollution, urban sanitation, air quality control, and creation of education programs.

Several factors have influenced the nature of legislation on health and the environment in the Region since the start of the 1990s: the increase in popular participation, a result of the revitalization of democratic institutions; the United Nations Conference on Environment and Development (UNCED); and the integration processes that are taking place in the Region.

A number of countries have taken steps to formulate environmental health plans and programs and to advise local authorities on the formulation of policies on the environment.

In the area of the environmental law, an agreement establishing the Central American Commission on Environment and Development (CCAD) was signed in 1991.

In the countries of the Region there is growing recognition of the need to carry out environmental impact studies prior to implementing infrastructure investment projects. Although some countries have established their own requirements for these evaluations, most still have considerable work to do in this regard.

PAHO has promoted and participated in numerous activities aimed at ensuring and facilitating the implementation of environmental interventions at the local level and stepping up the introduction of environmental services in local communities.

The cholera epidemic has prompted an intensive effort to disseminate appropriate technical information through mass communication and information campaigns, as well as through the creation of information networks. In the area of food safety, in January 1992 the activities of the Pan American Institute for Food Protection and Zoonoses (INPPAZ) were initiated. Despite the cholera epidemic, only 10 countries have established integrated food safety and epidemiological surveillance programs.

3.2.2 *Food and Nutrition*

It is estimated that some 12% of the children under five in Latin America and the Caribbean suffer from moderate to severe overall malnutrition.

Numerous countries have strengthened their programs for the control of iodine deficiency, and significant technological advances have been made in this area, including the use of more sensitive indicators than detection of the presence of goiter. One such indicator is the level of urinary excretion of iodine in specific communities. Many countries of the Region are developing surveillance systems that use this indicator and are also monitoring the iodization of salt. The cut-off points for determining when iodine deficiency is to be considered a public health problem are still being defined. The problem tends to be concentrated in certain geographic areas of the countries. All the countries of Latin America, except Cuba and the Dominican Republic, have current legislation mandating salt iodization.

It is estimated that iron deficiency anemia affects at least 30% of pregnant women in the Region. Practically all the countries of the Region have iron supplementation programs for pregnant women; however, the coverage is limited and compliance is low. Few countries have programs for the enrichment of foods with iron.

Vitamin A deficiency is a problem in some geographic and socioeconomically depressed areas of eleven countries. In recent years vitamin A supplementation campaigns have been carried out among young children in conjunction with vaccination campaigns. In the countries of Central America, there are programs for the enrichment of sugar with retinol palmitate.

All the countries of the Region collect information on the nutritional status of the children seen at health services, but few countries have developed a national intersectoral system of food and nutrition surveillance. The information from health services is usually not transmitted to the central level, except in some countries, where it is utilized for programming. However, with the decentralization of health services, the information collected at the local level is generally used only for local programming of interventions. In some cases impoverished areas are mapped using various indicators (unmet basic needs, height surveys of schoolchildren, household surveys, etc). Pregnant women and the children under 5 are considered the population groups at highest risk for nutritional problems.

3.2.3 *Lifestyles and Risk Factors*

The target of carrying out interventions at the individual and population levels aimed at changing common risk factors and lifestyles causally associated with the most

prevalent noncommunicable chronic diseases (NCD) has not been expressly embraced by the Member Countries, with three exceptions. In some countries, the governments have stated their intention of initiating health promotion activities, but there is no information to indicate that these statements have been translated into concrete programs.

Five countries have launched intersectoral projects under the "healthy communities" initiative, which can be considered the initiation of practical health promotion activities. These projects are in various stages of development and are ongoing.

Most of the countries of the Region have launched efforts to prevent and control smoking, whether through legislation, education or individual support programs. However, there is still a need for systematic measurement of the prevalence of risk factors associated with unhealthy lifestyles.

3.2.4 *Control and/or Elimination of Preventable Diseases*

Thirty-two countries (69.5%) have identified this as a priority area for technical cooperation.

Preventable diseases continue to be of great importance for public health and are responsible for a large proportion of morbidity and mortality in the countries. In addition, because they are most prevalent among the groups that have the least access to the knowledge and technologies produced by humankind, these diseases reflect the inequities in social and health conditions in the Region.

In Latin America a reduction in the overall prevalence of leprosy has been observed, with the rate declining from 8.41 per 10,000 population in 1990 to 5.84 per 10,000 population in 1992. Nevertheless, while the prevalence has shown a downward trend it continues to be very high, especially in five countries. A conference on leprosy control in the Americas was held at which it was agreed to develop strategies and plans of action at the regional and national level for the elimination of leprosy as a public health problem (i.e., a prevalence rate of less than 1 case per 10,000 population) by the year 2000.

In 1990, 70 cases of pinta in Mexico and the existence of foci in Brazil and Venezuela was reported. In 1992, the existence of foci was reported only in those countries. Seventy-eight cases of yaws were reported in Colombia and foci were reported in Ecuador, Haiti, Panama, and Suriname. In 1992 foci were reported in those five countries and Guyana.

Tuberculosis remains a serious public health problem, as is evidenced by the fact that the prevalence rate has remained the same or declined only slowly, while the incidence is high and has recently risen as a consequence of the spread of HIV. In several countries in which tuberculosis is a serious problem, the government has assigned the disease highest priority. Several countries have made significant progress in implementing control programs, although they have not all achieved the same results; some countries have had rapid reductions in morbidity, whereas others have achieved only limited reductions or none at all.

To date, it has not been possible to evaluate, in quantitative terms, progress toward attainment of the target established for Chagas' disease, since the only data available are from 1982-1985. The Organization provided support for the first meeting of the Intergovernmental Commission of the Southern Cone Initiative, the purpose of which is to develop a program aimed at eliminating *Triatoma infestans* and interrupting transmission of *Trypanosoma cruzi* through blood transfusion. The countries participating in the initiative prepared their national programs for 1992-1995, and the activities planned under the integrated subregional program were implemented, even though there has not been any significant contribution of resources.

Emphasis was placed on the promotion of comprehensive control of vector-borne diseases. To that end, in addition to efforts to reduce the use of chemical substances, environmental management, biological control, health education, and community participation were promoted. The measures to control dengue in the countries are geared toward control of *Aedes* with a view to interrupting transmission. In general, two extreme situations are noted in the Region. At one extreme are a few countries with successful programs which have achieved their objective of impeding colonization of the vector; at the other, are the majority of countries, in which the epidemiological situation remains worrisome despite the efforts made.

In 1990-1991, efforts at stratification of malarious areas continued and the use of basic control strategies yielded some benefits. However, the concept of stratification has not been readily adopted. Progress has been made in some countries in integrating malaria diagnosis and treatment services, which is essential for reducing the interval between suspicion and treatment of the infection. In other countries, however, there continue to be difficulties in integrating this specialized service into general health services, which has hindered the implementation of prevention and control activities at the local level. As a result, the malaria situation in the Region continues to be severe, with 39% of the population living in ecological conditions that are propitious for transmission of the disease.

In regard to the control of foot-and-mouth disease, major advances have been made in recent years. The disease has been eradicated in Chile, and an area along the

border between Colombia and Panama has become free from foot-and-mouth disease. Large-scale epidemics have disappeared from the Region, and progress has been made in controlling the disease in large areas.

The Region has made significant headway in the effort to eliminate urban rabies from the Hemisphere. Between the 1989 and 1992, four of the capital cities reported cases of rabies, and of the 414 cities targeted by the Rabies Control Program, 50 reported cases. Since 1990, a notable decline in canine rabies cases has been registered: from 11,700 cases in 1990 to 5,700 in 1992. It has not been possible to attain the proposed target of elimination, but the actions necessary for the elimination of urban rabies from the Hemisphere are continuing.

Since August 1991 no cases of poliomyelitis confirmed by isolation of wild poliovirus have been reported in the Region. The effort to certify the Region of the Americas as a region free from indigenous wild poliovirus is continuing.

With regard to measles, the situation in some countries remains unstable, although the overall number of cases decreased 59% between the 1990 and 1992 (from 237,553 to 99,423). Vigorous efforts have been implemented to control measles in the Region, drawing on the experience gained with other vaccine-preventable diseases.

Thanks to maternal vaccination with tetanus toxoid, the incidence of neonatal tetanus has diminished and most of the 478 *municipios* in Latin America identified as high-risk during 1988-1989 are now free from the disease. During the period 1990-1992 the number of cases declined by 30%.

Particularly indicative of the extent to which the Region has fallen behind in the areas of health, the environment, and social well-being is the cholera epidemic that struck the Americas in 1991, after several cholera-free decades. Indeed, the resurgence of cholera in January of that year in Peru, and its later spread to the Andean Area, the Southern Cone, Mexico, and Central America has sounded an alarm to the countries with regard to the need to address the tremendous accumulation of deficiencies in the infrastructure of health services, water supply, and sanitation, which have seriously hampered efforts to respond to the most basic needs of the population.

3.2.5 *Maternal and Child Health*

All the countries in the Region have made maternal and child health a priority in their policies and programs, and have also identified this as an important area for technical cooperation. Generally speaking, the lack of reliable information has been an obstacle for assessing the progress made at the regional and national levels. With regard to the target of reducing infant mortality to no more than 30 per 1000 live births in all

the countries by the end of 1994, information is available from only three countries for the 1992 and from 17 countries for 1991.

According to the estimates of the United Nations population division, which are very close to the figures reported by the countries for the five-year period 1985-1990, of the 29 countries of Latin America and the Caribbean, 12 had infant mortality rates of under 30 per 1000 live births, and this number increased to 14 in the following five-year period. The regional estimates for those same periods are 53 and 47 per 1,000 live births, respectively.

With regard to maternal mortality, again, the information available does not reveal the true magnitude of the problem, and there are substantial differences in the quality of the information that does exist on the reproductive health of women in the various countries of the Region. In addition to the deficiencies of information systems, the situation is complicated by the fact that the definition of maternal death used up to now has excluded deaths of women occurring more than 42 days after the termination of a pregnancy, which has contributed to the underregistration already existing. The Tenth Revision of the International Classification of Diseases, which includes the definition of late maternal death, should help to alleviate this problem.

The data available on maternal mortality are from around 1990. Disaggregated information for 1991 (information is available only from 17 countries) and for 1992 (data are available for 3 countries) is lacking. Although these circumstances make it difficult to assess progress toward attainment of the target, it is possible to state that significant headway has been made in this area, as maternal mortality has decline at a rate of 5.7% a year.

Of the 17 countries that reported on their progress in reducing maternal mortality, all but three have formulated a National Plan for the Reduction of Maternal Mortality. More than 70% of the countries that submitted information also indicated that they had some type of system for epidemiological surveillance of maternal mortality.

With regard to the reduction, by 1994, of mortality from diarrheal diseases by 50% and the reduction of mortality from acute respiratory diseases by 30% with respect to 1990 levels, the most recent data available correspond to the five-year period 1985-1990.

It is difficult to evaluate progress toward the target of reducing the proportion of children born weighing under 2500 gr to 10% by 1994, since reliable, up-to-date information is available only for four countries. The other countries have large gaps in the data needed to accurately calculate this indicator, owing to failure to report birth weight and/or to the low coverage of institutional delivery.

3.2.6 *Workers' Health*

All the countries of the Region have made a political commitment to develop plans and policies on workers' health, but only 14 (30.4%) have made this area a priority for technical cooperation. In 16 countries (35%) of Latin America national committees or councils have been formed with the participation of various sectors, and national plans for the development of worker's health have been prepared. The countries of the English-speaking Caribbean, in keeping with the general commitment made, have initiated the preparation or revision of their national plans.

Graduate courses in workers' health have been launched in eight countries (five in 1991 and three in 1992), raising to 22 the number of programs in which PAHO/WHO is cooperating directly out of the 32 programs with which it maintains connections.

Dissemination of public information increased in 90% of the countries. Several Latin American multicountry and national congresses, seminars, courses, and workshops were also held. Four countries have revised and published legislative instruments on workers' health, and the Latin American Parliament has included the subject on its agenda.

The commitment made in regard to workers' health in most of the countries has emanated not only from the Ministry of Health but also from the Ministry of Labor. Support has also been voiced by ministers of education and agriculture, and by the directors of social security systems. In some countries, this commitment has been underscored by presidential decrees and broad participation has been obtained, not only by governmental institutions but also by the commercial sector, workers' associations, and NGOs have been involved in efforts in this area.

Within PAHO, an interprogram group on workers' health was formed and has analyzed the activities planned by 17 programs to determine their impact on workers' health.

In the Andean area, labor unions have given special attention to the issue of workers' health. In the Andean, Central American, and Southern Cone subregions, governmental delegates, legislators, and representatives of workers and employers, together with representatives form PAHO, the ILO, NGOs, universities, and other experts, have discussed their National Plans in order to define the lines and strategies to e applied in implementing them.

3.2.7 *Drug Addiction*

Drug dependency is a growing problem in the countries of the Region, especially in urban areas and especially among the adolescent and young adult population. Drug use is frequently associated with chronic conditions, job absenteeism, school drop-out, personality disorders, and a variety of social and cultural problems.

An examination of government health plans and national priorities for technical cooperation reveals that drug dependency is a priority concern in 10 countries of the Region (21.7%).

Nine countries carry out epidemiological surveillance programs in this area and the Regional Epidemiological Surveillance System is linked to the Uniform Statistics System of CICAD/OAS. The existing information is not sufficient to permit a comprehensive analysis of the problem in the Region because not all the countries have data, or the data available concern only a few cities or specific population groups.

However, support was provided for various activities aimed at alleviating the lack of basic information, revising and updating the instruments and methodologies for monitoring of drug abuse, and proposing the corresponding guidelines and protocols. In addition, training activities were carried out in the areas of biostatistics and epidemiological surveillance of drug addiction in Central America and the Andean subregion.

Resources were mobilized for drug abuse monitoring programs, training activities, and for the continuation of a monitoring study in Central America.

Progress was made toward the implementation of a project to establish minimum standards for the treatment of drug dependency, and a proposal was prepared for a training program in treatment of drug dependency for students and workers in the health and related sciences.

PAHO participates as a technical resource on the Inter-American Council for Education, Science, and Culture (CIECC/OAS) and CICAD/OAS in the Central America Program in Preventive Education, which involves the ministries of health and education of the countries. The Organization was also involved in the launching of a project on participatory education for the prevention of drug dependency with the Inter-American Children's Institute, CICAD/OAS, and the Colombian Association to Combat Drug Dependency. With CICAD/OAS a project on mass communication on drug dependency is also being carried out.

In order to strengthen the leadership of the health sector in the formulation of policies, guidelines, and national programs to reduce the demand for psychoactive substances, most of the countries (90%) have created national intersectoral commissions.

3.2.8 *AIDS*

All the countries of the Region have included prevention of the transmission of human immunodeficiency virus (HIV) as one of their program priorities. As of 31 December 1992 more than 600,000 AIDS cases had been reported to the World Health Organization, 58% of them by countries in the Americas. Conservative estimates indicate that the number of people currently infected with human immunodeficiency virus (HIV) in the Region is around 2.5 million--1 million in North America and 1.5 million in Latin America and Caribbean.

In recent years an important change in the epidemic has been noted: Whereas before it was concentrated mainly in the male homosexual and bisexual population, now it is affecting growing numbers of heterosexuals, with consequent increases in the number of AIDS cases and the prevalence of HIV infection among women and children.

In general, the incidence of sexual transmission of AIDS in Latin America appears to have stabilized. In the Caribbean, on the other hand, sexual transmission of AIDS has increased. In the Andean Area the incidence of sexual transmission of AIDS has tended to decrease during the period.

Between 1990 and 1992 the incidence of HIV transmission through blood transfusion and blood products remained stable in all the countries of the Americas.

With regard to the target of strengthening comprehensive care for AIDS patients and of HIV-infected persons, 41 of the 46 countries of the Region (89%) have a national program for prevention of AIDS, and 16 countries provide comprehensive care to AIDS patients and people infected with HIV.

Almost all the countries are carrying out coordinated activities aimed at controlling both AIDS and other sexually transmitted diseases. In 9 countries (19.5%) these activities are also coordinated with those of the national tuberculosis control program.

In at least six countries, AIDS program activities have been decentralized to local health systems, and in three countries advances have been made in prevention and management with emphasis on the delivery of long-term medical and social services for patients.

As of 1991 a total of 561 research projects on AIDS had been carried out in Latin America and the Caribbean in the following areas: epidemiology, basic sciences, clinical studies, and social, behavioral, and intervention studies.

All the countries of the Region are using appropriate technology for the diagnosis of HIV and at least 15 countries have produced reagents for laboratory tests for the diagnosis HIV infection.

No clinical trials of vaccines against HIV are under way at present, although Brazil is preparing to carry out field trials in collaboration with the Global Programme on AIDS.

The information available on the composition of national and international financing for several countries of Latin America and Caribbean, indicates that most funding comes from external sources.

In regard to information systems, all the countries, with the exception of one, report quarterly to the Surveillance Program of PAHO, sending information broken down by age, sex, and risk factor.

4. Conclusion

It can be affirmed that from the political-strategic point of view, health is increasingly part of the regional political agenda. The stability and strengthening of democracy and continuing economic growth increase the possibility for expansion of this agenda, and also increase the likelihood that political statements will be translated into action, with emphasis on the mobilization of resources to meet the accumulation of unsatisfied needs in terms of the health and well-being of the population.

Improvement of the capacity for sectoral analysis continues to be a challenge in the Region. Despite the efforts made in terms of reorganization of the sector and the activities already carried out under the Regional Plan for Investment in the Environment and Health, the information base necessary for carrying out this type of analysis is still weak.

Although there are signs that the Region is emerging from the economic crisis, there is still doubt as to whether or not this renewed growth will result in the development of policies intended to bring about the redistribution of wealth as a means of extending coverage and thereby ensuring equity in health. Hence, this regional challenge will remain, pointing up the need to reverse some of the trends toward reduction of the role of the State in order to promote social development.

Some progress has been made in terms of control and elimination of preventable diseases, maternal and child health, and food and nutrition, but there continue to be deficiencies in continuous monitoring of the situation and in the activities aimed at preventing or eliminating diseases and health impairments that could be reduced considerably with the knowledge and technology currently available.

The effort to reorganize the sector and make it more efficient, as mechanisms for increasing the effectiveness of the actions taken with regard to health problems and the control of health risks and impairments, also continues to be a challenge for the health sector and, as such, is part of an ongoing process of improvement. The countries continue to seek solutions through technological development, the processes of decentralization, the reorganization of sectoral financing, and human resources development.

All the strategies aimed at reorganization of the health sector ultimately seek to overcome the imbalances between the characteristics of the health work force and the needs of the services. Nevertheless, these imbalances will tend to persist and will become worse until the education sector--which has its own logic and is experiencing its own internal crisis--is involved in solving the problem. This reality points up the need for the countries and the Secretariat to redouble their efforts to define orientations that will lead to greater coordination between sectors.

Finally, it should be emphasized that monitoring of progress toward quadrennial targets should be part of the regular activities of the Technical Units of the Organization through its incorporation into the continuous monitoring of programming. It should also be incorporated into the actions of the countries, through the improvement of information systems and the capacity for situation analysis.

ANNEX

STRATEGIC ORIENTATIONS AND PRIORITIES FOR THE DEVELOPMENT OF HEALTH PROGRAMS

Strategic Orientations

1. Health in Development

Targets:

To incorporate elements for improving health into the objectives of the economic and social development policies of the Member States, including actions to fight poverty and social welfare programs, in order to reduce the inequalities in the health status and access to services among the social groups within the countries.

To improve the relative position of health on the political agendas in all the countries of the Region, and in decisions made on resource allocation.

2. Reorganizing the Health Sector

Targets:

By the end of 1994 **the deficit in health services coverage** in the Region that existed at the beginning of the quadrennium **will be reduced by 30%.**

All the Member Countries will make progress in **drawing up national strategies and plans of operation to strengthen and develop local health systems** by strengthening sectoral and intersectoral coordination and population-based comprehensive health actions, with priority attention to the most disadvantaged social sectors.

To expand the action of social security institutions in the Member States, both in terms of expanding their coverage to vulnerable population groups, and by expanding the health and social welfare services they offer, and to improve their coordination with the Ministries of Health.

By 1994, at least 10 countries in the Region will have **mobilized reimbursable financial cooperation of a sectoral nature** for projects aimed at making progress in the reorganization of the health sector in the Member Countries in question.

3. Focusing Action on High-Risk Groups

Targets:

To develop methodologies and techniques for ongoing assessment of the living and health conditions of different population groups; these methods and techniques should be suitable for measuring short-and long-term changes in the economic conditions that affect the population of the countries of the Region.

To strengthen the institutional capacity for health situation analysis at the regional, subregional, national, and local levels, **so that the most affected groups can be identified,** and health actions can be geared toward them on a priority basis, and later the impact of these interventions can be assessed.

To make progress in reorganizing the health services, concentrating resources on effective interventions aimed at changing the living conditions and reducing or eliminating risk factors and health impairments that constitute public health problems. Thus, **premature mortality will be reduced** by the end of the quadrennium, **and by 1994 all the countries of the Region will have reached the target of life expectancy at birth of at least 68 years.**

4. Health Promotion

Targets:

To promote the full development and comprehensive use of human abilities through the **strengthening of good health** among the inhabitants of the Member States.

To promote the development of intersectoral health action plans and strengthen social support systems in favor of health in order to improve the living conditions of the most affected groups.

5. Using Social Communication in Health

Targets:

To encourage the use, on a larger scale and with better technology, **of social communication in order to increase the health knowledge** of the general public and special groups involved in making decisions that affect health.

To increase the informational content on health of basic educational programs.

6. Integrating Women into Health and Development

Targets:

To strengthen the institutional capacity to **mobilize national and international resources for the promotion and development of women and their health.**

To facilitate the **formulation and evaluation of policies, programs, and health services from the gender perspective.** Also, **to revise and reform the legal instruments** that either directly or indirectly affect women's health and their access to certain services.

7. Management of Knowledge

Targets:

By the end of 1994, all the countries of the Region will have formulated health research policies and strategies, whose frame of reference is the need to improve the application and expansion of knowledge to support national developments in the area of health.

By the end of 1994, all the countries will have formulated strategies to guarantee a higher degree of **utilization of the knowledge produced by health services.**

8. Mobilizing Resources

Targets:

To increase **mobilization of the human, technical, and financial resources** that exist in the countries, coordinating efforts of the various sectors of the economy and society **to benefit the health of the most vulnerable groups.**

To increase awareness of the mechanisms and complementary potential of external financing for health; **to strengthen the ability** of the Ministries of Health and other entities in the sector **to negotiate external assistance** and **to increase the available supply of current information** on the trends in Official Development Assistance (ODA), so as to increase the flow of external financing for priority health projects in the countries.

9. Technical Cooperation Among Countries

Target:

By the end of 1994 **the volume of technical cooperation activities for health between countries will have increased,** as will the number of solutions of scale to common health problems on the **subregional level,** as a complement to multilateral technical cooperation for health.

Program Priorities

1. Priorities for the Development of Health Services Infrastructures

1.1 *Sector and Resource Allocation Analysis*

Target:

To strengthen, in all Member Countries, the ability of the health sector to analyze its resources and their utilization, in light of the sector's needs for transformation.

1.2 *Sectoral Financing*

Target:

To increase the capacity of the Member States to attain more equity and efficiency **in the economic and financial management** of the health sector.

1.3 *Management of Local Health Systems and Local Programming*

Targets:

To bolster, at the local level, the capacity for epidemiological analysis and health information systems as the basic formula for supporting management of the local health systems.

To incorporate, in all the Member States, the content and activities of **the programs to prevent and control** health impairments and risks **into the programming systems** of local health systems.

To incorporate, in all the countries of the Region, conceptual and methodological developments in the area of **local strategic administration** as the basic formula for **improving the management of local health systems.**

1.4 *Technological Development*

Target:

To promote the formulation and implementation of national policies to develop health technology based on criteria of equity, effectiveness, and efficiency, and to encourage intercountry cooperation and regional integration in this area.

1.5 *Development of Human Resources*

Targets:

To increase the capacity to conduct quantitative and qualitative analysis of the process of development of human resources for health in order to strengthen policy-making in this field.

To attain a high degree of **interinstitutional and intersectoral coordination in the planning and orientation of interventions in the field of human resources**, which implies effective linkage between institutions that provide training and institutions that deliver health services.

To ensure that **undergraduate and graduate institutions make progress in understanding health problems and their origins** so that they can develop in their students the ability to think critically and produce professionals who are competent and sensitive to the reality of their people.

To expand **the incorporation of continuing education in the countries**, centering on the reality of the services and how they work, in order to provide more effective, higher quality health care.

2. Priorities for the Development of Health Programs

2.1 *Health and the Environment*

Targets:

All the countries of the Region **will improve the quality of the water supplied** for human consumption by water supply systems, and will increase the efficiency and effectiveness of the existing systems.

The institutional capacity in each of the countries of the Region **to document and analyze the effects of the environment on health will either be created or strengthened,** in order to **implement activities to control environmental hazards** and to **formulate intervention policies and programs** on environmental health.

To strengthen the institutional capacity of the countries of the Region **to institute comprehensive food safety programs** that have broad capacity for analysis, inspection, and epidemiological surveillance.

2.2 *Food and Nutrition*

Targets:

By 1994, to ensure that at least 85% of the children in all the countries fall within the percentiles established by the reference tables of **weight-for-height** for the Region as constituting **normal nutritional status.**

To make significant progress toward the elimination of vitamin A and iodine deficiency, and **to reduce the prevalence of iron deficiency anemia.**

To strengthen, in all the countries of the Region, the **food and nutrition surveillance systems,** and **to promote the use of this information in policy-making and in the planning and evaluation of food and nutrition programs,** so that interventions can be aimed at high-risk groups and the poorest sectors of society.

2.3 *Lifestyles and Risk Factors*

Targets:

To carry out interventions at the individual and population levels, aimed at **changing common risk factors and lifestyles causally associated with the most prevalent noncommunicable chronic diseases (NCD).**

By 1994 all of the Member Countries should have attained significant reductions in the prevalence of smoking.

2.4 *Control and/or Elimination of Preventable Diseases*

Targets:

To reduce, and in some cases eliminate, the transmission of residual preventable infectious diseases that constitute public health problems in several countries of the Region **(onchocerciasis, leprosy, yaws, pinta, tuberculosis, and Chagas' disease)** through well-structured programs that use comprehensive measures of prevention and control based on criteria of epidemiological stratification.

To expand the malaria-free area and reduce the endemic area in the Region by the end of 1994.

To reduce the populations of Aedes sp. to levels compatible with the absence of dengue transmission in the affected countries of the Region.

To certify the interruption of transmission of indigenous wild poliovirus in the Region of the Americas.

To obtain the virtual elimination of neonatal tetanus in all the countries of the Region.

To reduce morbidity from measles in the Region to 50% of 1990 levels.

To eliminate urban rabies from the Hemisphere by 1992 and to maintain the necessary action to consolidate that effort.

To reduce animal morbidity from foot-and-mouth disease during the quadrennium, in keeping with the efforts aimed at eliminating it from the Hemisphere by the year 2000.

2.5 *Maternal and Child Health*

Targets:

To reduce infant mortality to no more than 30 per 1,000 live births in all the countries of the Region.

To reduce maternal mortality by 30% compared to 1990 levels.

To reduce mortality from diarrheal diseases by 50% with respect to current levels.

To reduce mortality from acute respiratory diseases by 30% with respect to current levels.

By 1994, to ensure that at least 90% of newborns in all the countries of the Region have a birth weight of more than 2500 g.

2.6 *Workers' Health*

Target:

To improve, in all the countries of the Region, **the ability to develop effective programs to protect against occupational hazards, and the capacity to provide health care for workers,** both in the formal and informal sectors of the economy, **coordinating the different social groups and institutions** that can act on the issue.

2.7 *Drug Addiction*

Targets:

To develop a database in all the countries of the Region on the magnitude, type, consequences, and trends of the abuse of psychoactive substances among different social groups.

To develop and strengthen services for the prevention and control of drug addiction and the **rehabilitation of drug addicts**, using the approaches of community participation and support.

To strengthen the leadership and decision-making capacity of the health sector in the formulation of policies, directives, and national programs to reduce the demand for psychoactive substances.

2.8 *AIDS*

Targets:

To slow or reduce the rates of sexual transmission of human immunodeficiency virus (HIV) in the Region.

To eliminate the transmission of HIV through blood transfusion and blood products in all the countries of the Americas.

To strengthen the comprehensive care of AIDS patients and of persons infected with HIV.

To strengthen national capacity for basic, clinical, epidemiological, and behavioral research to support the development of programs for the prevention and control of AIDS.

PART B

STRATEGIC ORIENTATIONS AND PROGRAM PRIORITIES FOR THE PAN AMERICAN HEALTH ORGANIZATION, 1995-1998

The Strategic Orientations and Program Priorities (SOPP) for the Pan American Health Organization, 1995-1998, will form the basis for health action in the Americas for the forthcoming quadrennium. They represent those orientations that will guide the strategies that must be employed to address the priority health problems through a set of appropriately crafted programs.

The introduction gives the background to the development of the SOPP and links them firmly to the Ninth General Program of Work (GPW) of the World Health Organization. The major social and economic trends that may affect health are described, followed by a summary presentation of the most import health conditions of the Region.

The document emphasizes that the primary challenge for the health sector is to ensure equity in access to and coverage of health services that may reduce or eliminate inequities in health conditions that exist among various groups. A series of regional goals are presented--adapted from those given in the Ninth GPW and representing those health objectives that the Organization as a whole will try to achieve in the quadrennium.

Strategic Orientations are presented in five areas: Health in Development; Health Sector Reform; Health Promotion and Protection; Environmental Protection and Development; and Disease Prevention and Control.

The Program Priorities in these five areas elaborate on the areas of work that should occupy the Organization as a whole--Member States and Bureau--and the lines of action along which the technical cooperation of the Bureau will be directed.

The manner in which the Bureau will work is outlined, with emphasis given to a description of the functional approaches of the technical cooperation to the Member States. The planning, programming and evaluation system (AMPES) is described briefly to show how the technical cooperation program is developed, planned and executed.

Finally, some possible responses of the countries are suggested with emphasis on the role they must play in coordinating the inputs from various sources to address their priority problems.

The Executive Committee is asked to review the SOPP for 1995-1998 and comment on the appropriateness of the structure and content for addressing the major health problems of the Americas.

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1. Introduction

The enjoyment by all peoples of the highest possible level of health is the stated objective of the World Health Organization, and the fundamental purpose of the Pan American Health Organization is to promote and coordinate efforts of the countries of the Western Hemisphere to combat disease, lengthen life, and promote the physical and mental health of the people. The attainment of these noble goals is facilitated through the development of policies and strategies that guide the practices of the two Organizations.

The framework for global health policy and the work of the World Health Organization has always been expressed in General Programs of Work. Since 1978 these General Programs have been designed specifically to guide the world health community toward achieving health for all through implementation of the primary health care strategy.

In the Region of the Americas, the Pan American Sanitary Conference, as the supreme governing authority of the Pan American Health Organization, sets the general policy guidelines that orient the work of the Organization. For the last two quadrennia, these guidelines have been cast as Strategic Orientations and Program Priorities. While the latter have focused closely on health problems and approaches of particular importance for the Americas, they have also been crafted to reflect the global orientations found in the General Programs of Work.

In the Orientation and Program Priorities approved by the XXII Pan American Sanitary Conference in 1986, emphasis was placed on three priority areas:

- development of health services infrastructure;

- responses to priority health problems of vulnerable groups; and

- management of knowledge required to advance in the above two areas.

The experience gained in implementing these strategies was used in formulating the Strategic Orientations and Program Priorities approved by the XXIII Pan American Sanitary Conference in 1990. At that time it was agreed that in order to address the major health challenges in the Region and bring about a transformation of the sector in the 1990s it was essential to ensure that the importance of health was recognized in the formulation of social policy and in the development process. It was also considered necessary to, inter alia, develop policies and programs that sought equity in health and concentrated resources on interventions that would be effective against the most pressing

health problems. The Conference decided that transformation of the health sector would require a series of strategic orientations to underpin the implementation of programs for the development of health services infrastructure as well as programs targeting priority health problems.

The orientations adopted for the next quadrennium must reflect some continuity vis-à-vis the strategies adopted previously. However, the Regional agenda for 1995-1998 will be determined mainly on the basis of careful analysis of the current regional situation and acceptance of the global validity of the Ninth General Program of Work (GPW), which will guide the efforts of all the countries of the world during the period 1996-2001. The Strategic Orientations and Program Priorities for PAHO during the 1995-1998 quadrennium will therefore embrace the general principles and directions of the Ninth GPW, but will also reflect Regional realities and differences, where they exist.

The purpose of the current proposal is to present the major orientations that will guide the work of the Organization for the quadrennium 1995-1998 and to give some indication of how these will find expression in the Bureau's technical cooperation with the Member States. The proposal describes the broad approaches that will be taken to ensure that such cooperation is pertinent and efficient.

The Strategic Orientations and Program Priorities presented here indicate those health outcomes to which the Organization as a whole--the Member States and Bureau alike--are firmly committed and, at the same time, they make clear those activities for which the Bureau, as part of its technical cooperation, accepts managerial responsibility. The transformation of these general orientations into specific plans and activities will be a later step in the process, which can and must be taken only in close consultation with the major stakeholders--the Member States.

2. Regional Situation and Prospects

2.1 *Social and Economic Issues*

2.1.1 *Political Trends*

In the majority of the countries of the Region democracy, in the form of civilian governments elected by popular vote, has prevailed. In a number of cases the population has moved away from traditional political parties and figures and opted for leaders who represent new or renewed parties, thus sending a clear message of its desire for fresh solutions to old and new problems relating to living conditions and overall development.

The increased stability of democracy in the Americas has been associated with growing citizen participation and control over the actions of those in power, which in some cases has led to the removal of officials who have failed to demonstrate integrity and respect for the law and ethical standards.

The ability to govern in the Region has been determined by the ability of governments to satisfy the basic needs of their populations and adopt economic measures that catalyze economic growth without severely eroding the income level of the citizenry in the short term. In this context, the suitability of various development models has been debated and a broad consensus has emerged, according to which the sole purpose of the development process should be to enhance the well-being of the population. This view has been espoused officially and openly by regional financing institutions.

In the next quadrennium it is expected that the pluralistic democratic culture will expand and it will be increasingly possible to resolve conflicts through dialogue, negotiation, and consensus-building, as has already occurred in some countries of the Region which in past decades were the scene of bitter armed conflict. In addition, governments are expected to rely increasingly on plebiscites and other forms of consultation with the population--and this, too, is already happening--in making decisions that are crucial to the future of their nations.

The trend toward participatory democracy will be further supported by constitutional reforms, which are already underway in some countries of the Region. These reforms include the introduction of constitutional provisions ensuring greater protection of citizens' rights, respect for humans rights, regional autonomy through decentralization, streamlining of the structure and functioning of the government apparatus, and establishment of controls on public administration. The aim is to reform institutions and processes that are considered obsolete and to ensure that the State fulfills its obligations in the most efficient, cost-effective, and appropriate way.

2.1.2 *Economic Issues*

In general terms a trend toward interdependence of countries and globalization of the world economy is being noted. The expressions of this trend include the establishment of new trade relations and the flow of capital between countries, as well as multinational and subregional initiatives for the formation of economic or trading blocs. In addition, the incorporation of the results of scientific and technology progress into worldwide productive activity is changing traditional management styles and ways of working.

The Region as a whole appears to be emerging from the crisis of the 1980s and entering a new stage characterized by greater hope for the future of the countries. During the 1980s drastic economic adjustment measures were imposed to control inflation, reduce fiscal deficits, and reestablish favorable conditions for the stimulation of investment. As a result, the per capita gross domestic product (GDP) fell 8.9% between 1981 and 1990. However, between 1991 and 1993 the countries of Latin America and the Caribbean saw growth in their economies and per capita GDP rose 4.3%.

The trend toward economic discipline and efficiency can be expected to continue, generating greater global investment and internal savings, which should result in greater availability of resources for investment in the social sector. Income derived from employment is also expected to increase, as is overall family income due to the participation of more family members in the work force. The fact that the Region has a relatively large working-age population should also be to its advantage from an economic standpoint.

Globalization of the economy is expected to continue to be the dominant trend in the Region. The formation of free trade areas today may eventually lead to the establishment of a single area encompassing the entire Region.

2.1.3 *Demographic Patterns*

The Region has seen the total population growth rate fall as fertility has declined and a pattern of moderate growth has been established. The age structure of the population has also changed as the proportions of working-age persons and those over the age of 55 have increased. Reductions in mortality, both general and age-specific among the youngest groups, have led to a relative increase in the size of the economically active population, which in turn has reduced dependency rates. By 1995, it is projected that 47.7% of the population of Latin America and the Caribbean will be between 15 and 44 years of age. Life expectancy at birth in the Region has increased from an average of 57.5 years for both sexes between 1950 and 1955 to 70.3 years for the period 1990-1995, although there are significant variations among and within the countries.

The population has tended to concentrate in urban areas--including not just large capital cities but medium-sized cities as well--which has placed tremendous pressure on local authorities to deliver services and has also created high demand for new sources of employment. At present, more than 40% of the population in the majority of the countries of the Region is urban, and in some the proportion of urban population is as high as 80%. The forecast is that 74.2% of the population of Latin America and the

Caribbean will be living in urban centers in 1995 and 91% of the population increase projected for the rest of the century will take place in cities.

2.1.4 *Social Problems*

During the first half of the 1980s unemployment rose considerably, reaching the highest levels ever in the Region (6.0% overall and 10.1% urban). The rate began to decline in 1986, levelling off at 4.5% overall and 7.8% in urban areas. The fact that the Region's population is heavily concentrated in urban areas means that unemployment is higher in those areas, and despite economic recovery employment rates in the cities remain below 1980's levels. In addition, most of the economically active population in urban areas is being absorbed by the service, commerce, and informal sectors, to the detriment of manufacturing and other industrial activities.

Whereas individual incomes have declined, total family incomes have risen as a result of the entry of more family members into the work force. Women, in particular, have joined the labor force in unprecedented numbers over the last decade, although they continue to earn salaries that are less than those of similarly qualified men, regardless of educational level. Children are also contributing to family earnings. Some 20% of the population aged 10-14 in the Region works, and in some geographical areas persons in this age group make up 12% of the economically active population.

The reduction in personal income, coupled with the increase in poorly paid employment in the informal, commercial, and service sectors, has meant that more people have slipped below the poverty line. The relative proportion of poor people is greater in rural areas, but in terms of absolute numbers of people affected, poverty is more prevalent in urban areas. From the standpoint of individuals, the crisis of the 1980s might be described as a crisis of income.

There are huge social inequalities between and within the countries of the Region, and in many cases the gap between the rich and the poor is widening. The ranks of the poor, especially in urban areas, have swelled over the last several five-year periods, reaching more than 200 million in the countries of Latin America and the Caribbean (more than 46% of the total population). At least 100 million people in these countries (22.9% of the total) have no access to either public or private basic health services.

There is tremendous optimism in the Region's economic sector stemming from the global recovery and the resumption of productive activity. However, social conditions appear less favorable. While increasing numbers of workers have been pushed into poverty, those in the upper-income strata have used the mechanisms at their disposal to shield themselves from the effects of recession and crisis. The result is that the

situation of inequity in the Region has become more acute than ever before. As the earnings of low- and middle-income groups have eroded, income has become increasingly heavily concentrated among the wealthiest segments, and in some countries the richest 20% of the population now receives between 40% and 67.5% of total income, whereas the poorest 20% earns no more than 7.5%. Unless the Governments take prompt structural action to alter the distribution of income, the successes achieved in the Region in restoring macroeconomic balance are not likely to translate into benefits for the population, which is the very purpose of development.

In regard to education, levels of schooling have continued to rise as a result of substantial and sustained increases in enrollment rates, as well as maintenance of the ratio between the numbers of available teachers and enrolled students. Enrollment rates have reached between 80% and 100% of the primary-school-age population. The level is between 40% and 80% at the secondary level, but below 35% at the post-secondary level. However, female enrollment rates are equal to or higher than those of males in only 50% of the countries. In addition, there has been a notable deterioration in the quality of education, which has had repercussions in the labor market, where there are sizable discrepancies between workers' level and type of education and the fields in which they eventually find jobs.

The information available on the quantity and quality of housing in the Region is limited. The Economic Commission for Latin America and the Caribbean (ECLAC) has estimated that between 20% and 30% of the children in Latin American and Caribbean countries live in conditions of overcrowding (three or more people per bedroom), a phenomenon which is closely associated with poor school performance.

2.2 *Health Issues*

2.2.1 *Health Conditions*

The Region's health profile reflects the myriad complex processes that are influencing the living conditions of the people.

Significant gains have been made in the Region. The infant mortality rate, which for the period 1965-1970 was 91 per 1,000 live births, has been estimated at 47 per 1,000 for 1990-1995. Life expectancy at birth for the latter period is 68 years in Latin America and the Caribbean and 76.1 in the United States and Canada. Nevertheless, in most of the countries, during recent five-year periods specific mortality rates have decreased at a slower pace in almost all age groups under the age of 65, and in many cases the reducible gaps in mortality have either not declined at all or have increased. According to estimates to be published in the 1994 edition of *Health Conditions in the*

Americas, around 1990 these gaps represented 45.5% (ranging from 71% to 5%) of the deaths in Latin America and the Caribbean, whereas in the United States and Canada this figure was between 1.6% and 7.1%. This means that each year deaths of 1.5 million persons under 65 could be avoided. These gaps are highest in the countries with the greatest social inequities and the lowest levels of social development. They also vary with the age structure of the population.

In the poorest and least socially developed countries, more than 70% of all avoidable deaths occur in the under-15 age group. In countries with intermediate levels of social development, 40% of all avoidable deaths are of persons under the age of 15 and between 25% and 30% are of persons aged 15-44. In the countries with the best living conditions, more than 60% of all avoidable deaths occur among the population aged 45-64.

The mortality differentials within countries are extremely large in some cases, reflecting the substantial social differences that exist. In Mexico City, for example, the infant mortality rate ranges from 13.4 per 1,000 live births in the most affluent districts to 109.76 in the poorest areas. There are also sizable differences between geographic regions within the countries. In Venezuela the infant mortality rate for the poorest areas in the country (31.2 per 1,000 live births) is twice the rate in areas with better living conditions, and in Ecuador the prevalence of malnutrition among children under 5 ranges from 8% to 42.6%, depending on the socioeconomic level of the region.

Urban-rural differentials exist as well. In Brazil, for example, a rural inhabitant in the northeast can expect to live 20 years less than a medium- to high-income city dweller in the south. In Peru, whereas in Lima the infant mortality rate was 50 per 1,000 live births, in some rural areas it was over 140. The rates also vary considerably by ethnic origin. In Panama, the risk of dying for an indigenous child under the age of 1 is 3.5 times higher than for a non-indigenous child, and although the indigenous population makes up only around 8.3% of the country's total population, it accounts for close to 30% of total mortality in the under-1 age group.

In order to begin to reduce avoidable mortality at the same rate as in the past, the huge social inequities in the societies of the Region must be recognized and addressed, and living conditions must be improved for the most deprived and vulnerable groups.

Infectious disease continue to be a significant cause of morbidity and mortality in most of the countries. The most important ones are acute diarrheal diseases, acute respiratory infections and tuberculosis, zoonoses, vector-borne diseases, and AIDS and sexually transmitted diseases.

The cholera epidemic that began in January 1991 has affected all the countries in the Hemisphere, except Uruguay and Canada. By late 1993 close to a million cases had been reported, and the disease is showing a tendency to become endemic in areas in which basic sanitation is deficient and the educational level of the population is low. Although the incidence of acute diarrheal disease has diminished somewhat, this continues to be a significant cause of avoidable death in most of the countries, especially among the poorest segments of the population.

After many years of sustained decline in the incidence of and mortality from tuberculosis, the incidence rates have levelled off in recent five-year periods and have shown a rising trend in Bolivia, Ecuador, Panama, and the United States. It is quite probable that the incidence is increasing in a number of other countries as well.

Around 40% of the population of the Americas lives in places in which conditions are ecologically propitious for the transmission of malaria and more than 200 million people live in malaria transmission areas. The number of cases increased considerably in the affected countries between 1974 and 1991 and then began to decline again in 1991.

Dengue has become endemic, with periodic epidemic outbreaks in most of the countries located in tropical zones, providing evidence of high rates of *Aedes aegypti* infestation. Outbreaks of dengue hemorrhagic fever have occurred, and there is a continuing risk of major epidemics of this form of the disease.

Chagas' disease continues to be a problem, mainly in rural areas of tropical or subtropical zones. The disease is associated with low socioeconomic levels and poor quality housing. It is estimated that at least 16-18 million people in the region live in dwellings infested with *T. infestans* or other household vectors of Chagas'.

The increase in immunization coverage among children under 5 has been one of the most important successes achieved in the Region in recent years. Poliomyelitis appears to have been eradicated from the Region, and there has been a marked decline in the frequency of measles, diphtheria, and whooping cough. The occurrence of neonatal tetanus has decreased dramatically, and cases continue to occur in only a small number of areas in 16 countries of Latin America.

Thanks in large measure to the efforts of the Regional Program for the Elimination of Urban Rabies, in 1992 only four countries in Latin America reported human cases of this disease and there was a substantial decline in the number of canine rabies cases in urban areas.

The upward trend of sexually transmitted diseases continues. AIDS has now spread to all the countries of the Region and, although the characteristics of the epidemic vary from country to country, in general heterosexual transmission is becoming increasingly prevalent. The risk of transmission tends to be higher among poor populations. By March 1994 a cumulative total of 445,000 AIDS cases had been reported in the Americas, and 250,000 of those affected had died. It is estimated that at least 3 million people in the Region are HIV-infected.

Violence, especially domestic violence and other intentionally inflicted injury, has become one of the most serious public health problems in the large cities of the Region. In Colombia, for example, homicide is now the leading cause of death in the general population. Between 1987 and 1992 the total number of violent deaths in that country surpassed the total number of AIDS deaths in the entire Region during the same period.

As mortality from communicable diseases in the early years of life has declined, there has been a proportional increase in chronic and degenerative diseases, although the incidence and prevalence of such diseases has not increased and in some cases it has fallen.

Cancer currently accounts for more than 10% of all deaths in all the countries, and in some it accounts for as much as 20%. The fact that mortality from lung cancer is increasing and death rates from cervical, breast, and stomach cancer remain very high is particularly noteworthy, considering that a large proportion of these deaths could be avoided.

There are few countries of the Region in which cardiovascular diseases account for less than 20% of all deaths and in many this cause is responsible for over 30%. Although most of the countries have shown reductions in age-specific rates for both sexes, especially among the population over the age of 45, in many cases these rates could still be reduced substantially.

Mental health problems are an increasingly important component of the Regional health profile, particularly those problems that are associated with habits and behaviors--alcoholism, smoking, and drug addiction. An estimated 30% of adults in large cities suffer from some kind of mental disorder, including depression and the various forms of anxiety. It is estimated that at least 12% can be considered excessive or habitual drinkers. The prevalence of smoking in the Region has been estimated at around 37% of the male population and 20% of the female population. The rate has tended to decrease in the more developed countries but has remained constant or increased in the less developed countries and in the lower socioeconomic strata of the population. In

recent years there has been an increase in the use of drugs and psychoactive substances, particularly cocaine and heroine.

Finally, although little information is available, the growing importance of occupational accidents and diseases should be noted, as should the increasing frequency of health problems associated with air pollution in urban areas.

2.2.2 *Health Sector Development*

Health care infrastructure in the Region has not expanded and there are obvious signs that, in fact, it has deteriorated, mainly as a result of reductions in public spending on health. There has, however, been considerable growth in the private health care sector, not only in infrastructure but also in terms of the incorporation of new technology and in the modernization of its organization.

In the public health sector, emphasis has been placed on decentralization and local development in the context of processes aimed at modernizing the State. Decentralization, in this process, is seen as one of the ways in which the public sector can be made more effective. The greatest strides in this area have been made in the legal sphere, in training of personnel to meet the challenges posed by decentralization, and in establishment of the conditions necessary for modernizing the management and development of health care systems.

The coverage of social security systems has not expanded and in some cases it has decreased. This is partly because social security coverage is offered only to workers in the formal sector, and the largest increase in jobs has been in the informal sector. At the same time, the functional integration of social security services with the direct health care services provided by the State--something which has been recommended and promoted--has failed to become a reality except in a very few cases. On the contrary, social security institutions have been weakened by increasing competition from private insurers and plans, which in some countries have been proposed as means of increasing coverage. The limitation of social security coverage to a select group of workers, while excluding rural workers and the huge numbers of people who work in the informal sector, is one of the factors that has exacerbated the profound inequities in the health sector.

For the lowest-income segments of the population and for those who work in the informal sector, public health services offered directly by the State are the only health care option available. These groups are placed at a particular disadvantage by the fact that the current coverage capacity of public health care systems is not sufficient to ensure total access by everyone who requires it.

Progress has been made toward a comprehensive conception of the health sector, in which the actions of the various subsectors are coordinated and complementary, not only in the area of personal health care but also in environmental protection, and in which activities relating to health promotion, disease prevention, and recovery are interconnected. There has not been much success, however, in translating this conceptual progress into practice.

2.2.3 *Health Financing*

Total spending on health in the Region has increased from 5.8% of GDP on average a decade ago to 6.4% at present--the equivalent of $133 per person per year. Per capita spending on health of the lowest-income countries is one-fourth that of the highest-income countries. While total spending has risen, public spending on health has declined from 51% to 44% of the total over the last decade. The overall increase has been due to increases in spending by individuals, which currently accounts for an average 56% of total national health expenditure. The uneven distribution of health spending among the different income groups in the countries is further confirmation of the inequities that exist in the sector: the wealthiest 20% of the population accounts more than 60% of private spending, whereas the poorest 20% accounts for only 3%.

3. The Challenge for the Quadrennium

The primary challenge facing the health sector is **inequity**, as manifested in differences in access to and coverage of health services and in health conditions, which in turn are reflections of the prevailing social and economic inequities in the Region at present. All the resources of the sector, and of society in general, should be directed toward meeting this challenge.

Inequity is not manifested in the same way in all countries or population groups. It is therefore essential to approach the differences in health conditions and health care coverage taking into account the features that distinguish the various groups, including gender, ethnicity, income, place of residence, and educational level. In each country, it will be necessary to establish the profile and characteristics of inequity in different population groups and geographic areas in order to determine what action should be taken to eliminate it.

4. The Regional Response

The Organization's efforts over the next quadrennium should be directed toward addressing the situations described above. Through intensive discussions within the Secretariat and informal consultations with the national authorities in the countries of the

Americas, five major strategic orientations have been identified to guide those efforts. These orientations must find expression in the planning and programming of the work of the Organization as a whole and, to the extent that form follows function, must also be reflected in the manner in which the Bureau is structured. As their name implies, they represent those considerations that must guide the Organization in developing the broad strategies to address the major health problems previously described. These orientations are intended not only to guide the work of the Bureau but also to suggest priority areas of action for the Member States.

The five strategic orientations are:

- Health and Development.
- Health Sector Reform.
- Health Promotion and Protection.
- Environmental Protection and Development.
- Disease Prevention and Control.

These orientations are essentially identical to the policy orientations described in the Ninth General Program of Work, except that environmental protection is highlighted in recognition of the crucial importance of the environment and bearing in mind the commitments made under Agenda 21, adopted at the United Nations Conference on Environment and Development (UNCED), and similar declarations.

4.1 *Regional Goals*

The following goals represent those objectives to which the Organization as a whole should be committed. They are based on the goals in the WHO Ninth General Program of Work but modified to take account of the health situation of the Americas and the possibility of the countries and the international community to address it. Specific targets will be developed by country or subregion within the framework of detailed planning that must include indicators that are specific in terms of quantity, quality and time.

The goals are:

- to increase the span of healthy life for all people in such a way that health disparities between social groups are reduced;

- to ensure universal access to an agreed upon set of basic health services of acceptable quality, emphasizing the essential elements of primary health care;

- to ensure survival of children and healthy development of children and adolescents;

- to improve the health and well-being of target priority population groups;

- to ensure healthy population development;

- to eradicate, eliminate, or control major diseases constituting regional health problems;

- to enable universal access to safe and healthy environments and living conditions;

- to enable all people to adopt and maintain healthy lifestyles and behavior.

4.2 *Strategic Orientations*

4.2.1 *Health in Development*

Health is an essential objective of development and the capacity to develop socially and economically is itself dependent on health conditions. The majority of the countries in the Region have a long way to go in order to achieve their health objectives and their more general developmental objectives. Nevertheless, the countries appear to be emerging from the stagnation of the past decade and moving toward recovery, which will make it possible to resume the path toward development through new productive activities in open economies, generating a dynamic that simultaneously fosters the modernization of production, competitive participation in global trade, and a sustainable improvement in social equity levels within the countries' economies.

The pursuit of development in the economic, educational or health sphere alone may obscure the ultimate purpose of development, which is to improve the quality of life of all people. In recent years there have been instances in which a narrow focus on economic development has had adverse effects on the health status and living conditions of the population, particularly the most vulnerable groups such as women, the elderly, the unemployed, and children. Increasingly, these vulnerable groups have been excluded from the benefits of development. All too often the development process has only served to make them more vulnerable through its direct or indirect consequences on health, economic, and environmental conditions. All these negative consequences of "development" stand in the way of equity, social justice, and satisfaction of basic human

rights. It has become clear that greater wealth--whether for countries, communities, or individuals--is not sufficient to improve health status because of the arbitrary manner in which decisions are made about how resources will be allocated.

In view of the difficulties the countries face in seeking to avoid increased social inequities, PAHO and other agencies are stressing the need to ensure that due consideration is given to ethical concerns in the development process. From an ethical perspective, human suffering is not an individual problem but a concern of society as a whole. The prime interest of the health sector is in bioethics, which has steadily gained ground as a field of study and practice. Initially, bioethics was concerned mainly with decisions in clinical medicine and research, but it has now come to embrace such issues as planning, delivery of health care and use of environmental resources. In recognition of the growing importance of the field, the Governing Bodies have approved the establishment of a Regional Program in Bioethics that will not only provide a forum for discussion but will provide technical cooperation to the Member States.

It has also been emphasized that the health sector unquestionably makes a tremendous contribution to overall economic development. As a major employer and producer of goods and services, the sector generates considerable economic activity, a contribution which is often overlooked. Expenditure on health and related aspects of human development is sometimes perceived as a drain on national or community resources, but in fact it is an investment in a nation's human capital inasmuch as health enhances people's ability to contribute actively to overall economic and social development. Nevertheless, improving the population's health cannot be viewed only as a means for attaining a more productive society. The alleviation of suffering and improvement of the quality of life should be the principal objectives of development.

The Region has experienced sustained changes in demographic patterns, notably falling population growth rates, increases in the relative size of the economically active population, modification of the age structure, and concentration of the population in urban areas. While these changes have significantly improved the possibilities for overall development, they have also created tremendous demand for health services.

Thus, demographic changes that could represent a comparative advantage for the Region become obstacles, owing to the failure to find suitable and timely ways of dealing with them. For the health sector, it is imperative to increase the capacity to identify, analyze, and monitor such changes, which will require both human resource and institutional development.

It is necessary to strengthen the countries' ability to analyze and formulate health policies and projects, and given the intersectoral nature of health problems, these policies

and projects must be consistent with national social development strategies. Efforts in this direction should take into account the rapidity of change and the nature of the external factors that influence the sector, the multiplicity of institutions that make up the sector, the frequent turnover of authorities, technological innovations, and the medium-term sustainability of the goals being pursued.

In recent years a lack of financial resources has hampered the capacity of the health sector to respond adequately to the demands that have been made. In order to reestablish the flow of investment in the health and environment sectors; reorient capital expenditures on health services, drinking water supply, and basic sanitation; and support the process of sectoral reform through mobilization of resources for investment, PAHO has formulated the Regional Plan for Investment in the Environment and Health (PIAS), the aim of which is to coordinate the efforts of the Latin American and Caribbean countries to generate US$ 217,000 million in investment over the next 12 years.

This effort implies making yearly investments of about 1.2% of the GDP of the countries of the Region, as well as expanding, rehabilitating, and improving the performance of sanitation and health services in order to reduce the existing deficits. The PIAS has received support at the highest political levels in the Region and was endorsed by the participants in the Ibero-American Summit of Heads of State and Government and the Conference of Heads of State of the Caribbean Community, held in 1992 and 1993, respectively.

The countries of the Region are the key players in this process inasmuch as the various investment plans and projects will be implemented and the bulk of the resources needed will be mobilized at the national level. However, bilateral and multilateral cooperation agencies also have an important role to play by providing political, technical, and financial support to complement national efforts.

4.2.2 *Health Sector Reform*

Because the number and variety of agents involved in the generation of good and services in the health sector is so great (Ministries of Health, social security institutions, nongovernmental organizations, private providers), it is essential to define more clearly the role of each one in order to ensure that their activities reinforce and complement each other, make the sector more effective, and extend coverage to the entire population. The State has an inalienable governing and regulatory function to play, in addition to its responsibility to ensure the availability of health care services for the poor and indigent. The participation of other agencies in the provision of health care--under clearly defined rules and regulations, with the necessary guarantees of adequate performance, and in a framework of common objectives--will help to extend coverage and increase access.

No significant change in the prevention and control of the most important problems can be expected unless there is intersectoral action aimed at improving the population's living conditions as part of a comprehensive development strategy. Under the leadership and supervision of the State, sectoral reform should take place in the context of institutional and sectoral pluralism. This statement applies not just to the organization of the sector, but to the provision of goods and services, and the financing of sector development and expansion. A number of countries have already embarked upon such reforms and are striving to find the most appropriate public-private mix in the organization, financing, and delivery of health services.

Attaining equity in the area of health means ensuring **universal coverage** for the population by guaranteeing access to health care for population groups that currently lack it without detracting from the health care that other groups currently enjoy. The achievement of greater equity with respect to health risks and access to health services is the goal of the proposal on health, social equity, and changing production patterns developed jointly by PAHO and ECLAC. The attainment of this goal will require that priorities for resource allocation be set and that there be more efficient resource allocation and more effective health interventions. Marginalized groups, the poor, indigenous populations, women, and mothers and children, because they are particularly vulnerable and face specific risks, are considered priority groups and have been recognized as such by the Governing Bodies of the Organization. Various resolutions have established that the Organization should give priority to these groups and should carry out specific activities targeting them.

Each country, through consultation among all health care providers, should establish a basic set (basket) of health services to which all citizens will be guaranteed access, and these services should be of equal quality for all, regardless of income level. The basket's content and the quality standards for the services included in it will depend not only on existing needs but on available resources, the response capacity of the health system, and the level of technological development that has been achieved.

It will be most feasible to supply a basic basket of services and to target expenditure at the local level, where with appropriate resource management and sufficient autonomy it will be possible to determine the ways in which coverage will be extended to specific delimited population groups in well-defined geographical areas.

The health systems and services in the Region are faced with the challenge of achieving equity in health while maintaining maximum quality and efficiency. Quality will be measured by the results achieved and the satisfaction of the population. Efficiency will depend on the appropriate use of human resources and technology and on

the application of interventions that produce the greatest possible impact at the least possible cost.

The structural adjustment measures introduced in response to the economic crisis of the 1980s led to a lack of financing for public health systems at the national, provincial, and local levels. The private sector was also affected, as the majority of the population found itself increasingly unable to meet rising health care costs. As the Region has emerged from the crisis, which severely hindered progress toward equity, the economic stability achieved in some countries has not necessarily been reflected in any substantial increase in access to health services for the neediest segments of the population. It is therefore urgent to take maximum advantage, over the next few years, of economic stability and growth and the consolidation of democratic systems of government in order to meet the needs of these population groups.

Decentralization and local health system development are providing the impetus for institutional development at the local level and are also shaping the changes occurring throughout the health sector. The local health system strategy will assist in the development of the movement known as "healthy cities" or "healthy communities," which is an expression not just of the transfer of decision-making capacity and responsibility to the local level but also of the change to a health care model that encourages behavioral changes and the adoption of health lifestyles. Within the decentralization process, hospitals, health centers, and other health care institutions, both public and private, will undertake to form networks of services involving public institutions at the national, provincial, or municipal level as well as private institutions.

Health services research will be needed to obtain knowledge about experiences under way in the creation of decentralized units, the analysis of equity and quality, costs, productivity, and technological development. Such research can yield valuable information for decision-making at the both the general and operational levels of the health care system.

The training, use, distribution, and management of health personnel are important considerations in the reorganization of the health system. There is growing interest in the countries in the development of training activities linked with practice as one means of fostering the development of leadership and teamwork.

Reform must include strengthening further the capacity of the health sector in regard to disaster management. The Region has matured since the decade of the 1970s, when the major concern was with disaster response, to a stage in which there is full appreciation of the need for disaster preparedness, prevention, and mitigation. The activities of the International Decade for Natural Disasters Reduction have also stressed

the intersectoral nature of disaster management and emphasized that post-disaster development programs and activities also deserve specific planning. The expertise gained by the health sector in disaster management can be applied to emergencies of various types, and the sector will be involved increasingly in responding to the growing need for humanitarian assistance in man-made disasters.

4.2.3 *Health Promotion and Protection*

Many of the factors associated with prevalent health problems have to do with lifestyles, cultural concepts, and attitudes toward health and disease. In order to address many of the prevailing health problems in the Region, it is therefore essential to vigorously develop health promotion activities to encourage healthy attitudes and practices. This will require the development of broad-based information and education programs designed to disseminate knowledge about health to the population, with emphasis on issues relating specifically to local and national health profiles.

An effort should be made to promote a culture of health at the local level, employing strategies such as the promotion of healthy cities or communities, in order to mobilize the broadest possible support for the attainment of health goals, with the participation of both governmental institutions and community organizations.

Health promotion is a component of overall development strategies in the sense that it contributes to the well-being of a population, reduces the risk of disease, and ensures the availability of a healthy and productive population. In order for health promotion activities to be effective, however, other complementary measures of a social and economic nature must be implemented in order to address the most pressing problems, provide public assistance to the neediest segments of the population, eliminate inequities, and at the same time reduce the health care needs of the population in the future.

In addition to the health problems that are closely linked to poverty, such as malnutrition and other consequences of inequity, the countries of the Region must deal with problems associated with risks generated by demographic changes, rapid urbanization, and industrialization. Health impairments and injuries caused by violence or abuse of harmful substances, the rising incidence of noncommunicable diseases associated with unhealthy habits and behaviors, among others, are part of the new epidemiological profiles in the Region.

The heavy concentration of population in urban areas, together with the inability of impoverished segments to satisfy their basic needs, failure by policy makers to agree on a solution to the problem of poverty, and the growing prevalence of highly lucrative

criminal activities, have generated a sustained rise in rates of violence in the Region. Indeed, violence has become one of the most pressing problems that needs to be addressed in coming years. Specific national plans are needed that are comprehensive and intersectoral and provide for broad social participation in order to change the environment of violence, which stands in the way of human well-being and the ability to lead a dignified and productive life.

The issues raised above make plain the challenges that the Member States must meet and point up the need for a change in the role and work of the health sector, which must take an active part in development processes in the countries. Health promotion, while it is not an instant solution, is a vitally important solution with tremendous potential for addressing the health needs in the Americas. Health promotion involves processes aimed at engendering well-being through citizen action and the mobilization of social and institutional resources. It consists of actions aimed at identifying the factors that limit health and well-being and eliminating them in order to enable individuals and societies to realize their full potential. By its very nature, health promotion extends beyond the confines of the health sector and therefore obliges the sector to extend its role beyond health care to the promotion of social development.

4.2.4 *Environmental Protection and Development*

In response to global commitments to preserve, protect, and restore the environment in order to safeguard the well-being of the population and not allow development to compromise the future, national environmental agendas will need to be established to address issues relating to the general environment, the work environment, and housing, with priority attention to the neediest groups and the most urgent problems. Given the magnitude of the environmental degradation in some countries and the needs of their citizens, it will be essential to obtain the broadest possible participation in this effort by a variety of institutions, other sectors, and the population, under the leadership of the State as the regulator and facilitator of action.

In view of the harmful effects of many development projects on human health, it is essential that the health sector change its traditionally reactive position toward these effects and adopt a proactive attitude. The sector must insist that health issues be considered in all phases of project design and execution in order to prevent them from having negative consequences on the environment and on the health of people.

Environmental policy issues have taken on singular importance in the Region, as evidenced by the concerns expressed in relation to the North American Free Trade Agreement (NAFTA) and the Southern Common Market (MERCOSUR). In both cases the issues raised have had to do with the macroenvironment as well as work

environments. Environmental initiatives involving several countries are also taking shape in the Region. One example is the Central American Commission on Environment and Development (CCAD). At the international level, environmental protection is also an important issue, as demonstrated by the United Nations Conference on Environment and Development (UNCED), held in Rio de Janeiro in 1992, the United Nations World Conference on Sustainable Development in Small Developing Island Countries, held in Barbados in 1994, and the Basle Convention on hazardous waste, among others. At the local level, a number of conservationist or environmental protection groups have been created and are attracting community participation. In the political arena, ecology-oriented or "green" parties have emerged, and traditional political parties are attaching increasing importance to the environment in their platforms. Concern for the environment is also being manifested at the legislative level, through the creation of specialized commissions within national legislatures, subregional parliaments, and the Latin Parliament.

The basic thesis advanced at UNCED is that development should be aimed at increasing people's options and it must be sustainable. Accordingly, economic, fiscal, commercial, energy, agricultural, industrial, and other policies must be formulated with a view to ensuring that development is sustainable from an economic, social, and ecological standpoint. This implies raising awareness about the importance of factoring environmental costs into the production of goods and services. It also means giving greater attention to the economic costs associated with cleaning up pollution in the environment and treating the diseases caused by deterioration of the quality of the environment.

In most of the Region's cities insufficient attention has been given to environmental management measures aimed at ensuring safe drinking water, protecting public spaces, safely eliminating waste, and preserving the quality of the air and water. Rapid urbanization, population growth, and industrialization have led to a number of problems, including increased automobile traffic, environmental pollution, overcrowding, noise, and others. Changes in consumption patterns have engendered what some have called a "throw-away society," which produces growing volumes of solid and liquid waste, exacerbates pollution, and wastes natural resources.

The phenomenon of urbanization in the Region poses a difficult problem, since on the one hand it promotes a more productive economy, but on the other it creates tremendous demand for housing and health, water, and waste disposal services, which it is beyond the capabilities of local governments to meet. The efforts of local authorities are often hampered by insufficient tax collection, poor financial management, lack of qualified personnel, and budget cuts that reduce the coverage and quality of health and environmental services even further.

A number of the social and psychological problems prevalent in cities can be largely attributed to housing and environmental problems. Where conditions are poor, a wide range of social and psychological problems often arise, including alienation, loneliness, drug addiction, family breakup, and violence. These urban social problems intensify in cities in which employment is in short supply. The growth of the informal labor market and the proliferation of small family businesses are products of this situation, which generate a series of occupational health problems and create the need for health services to treat diseases resulting from exposure to harmful substances and inadequate working conditions.

Urbanization, industrialization, exploitation of natural resources, and excessive use of pesticides in agriculture in the countries of Latin America and the Caribbean are producing health problems similar to those of the developed countries. At the same time these countries continue to grapple with problems related to the lack of basic sanitation services. The water and sanitation sector in many countries has undergone a series of institutional changes that have left it without clear leadership or a clear definition of functions. As a result it is increasingly difficult to have monitoring systems that provide information for national planning.

During the 1980s investment in sanitation infrastructure fell to extremely low levels in many countries, which resulted in sizable gaps in coverage and deterioration of the quality of existing services. Currently, less than 10% of the waste water generated in the Region is being treated, and it is estimated that the countries of Latin America and the Caribbean are spending only about $80 per person per year on basic sanitation, water supply, and waste disposal services. The cholera epidemic is one of the most obvious manifestations of these deficiencies. The Regional Plan for Investment in the Environment and Health was conceived as a mechanism for generating the investment needed to rehabilitate and expand environmental health infrastructure and services.

4.2.5 *Disease Prevention and Control*

All the countries in the Region of the Americas are experiencing changes in the profiles of their populations and the health problems they confront. They have all shown declines in infant and childhood mortality and increases in life expectancy at birth, a result primarily of the control of infectious diseases in the early years of life. As populations have aged and concentrated in large urban areas, chronic and degenerative diseases, particularly cardiovascular disease and cancer, have become more important as causes of morbidity and mortality. The countries that have reduced early mortality the most and have achieved the lowest birth rates have the highest incidence of chronic diseases, while at the other end of the spectrum are countries with high infant and childhood mortality caused primarily by infectious agents that produce diarrhea and acute

respiratory illness. However, even the countries that have reduced infectious diseases must maintain programs capable of preventing their recurrence and dealing with new problems, such as HIV/AIDS, hemorrhagic fevers, and hantavirus infections. Perhaps the most serious of these is AIDS, which threatens to compromise many of the gains made in health development.

While the control of childhood infections has resulted in part from improved living conditions and nutrition, the greatest successes in this area have been achieved through immunization programs. No cases of paralysis from wild poliovirus infection have occurred in the Americas during the last three years, and the incidence of other vaccine-preventable diseases of childhood, such as measles, has dropped dramatically. However, the maintenance of these successes will require sustained immunization programs that reach a high proportion of infants and children.

Promotion of the use of oral rehydration salts has reduced deaths from diarrhea significantly, and systematic approaches to the management of acute respiratory infections in children is likewise reducing mortality from this common cause of childhood illness. Continued success in controlling those diseases will require strong and effective programs that can reach all segments of the population. In addition, it will be important to ensure that preventive measures, such as safe food-handling and water disinfection, are implemented to reduce the incidence of common infections.

Other infectious diseases continue to be significant health problems in the Americas, in spite of the existence of well-known and effective means of treatment and control. Foremost among these is malaria, the incidence of which has increased, especially in areas experiencing influxes of migrants looking for new opportunities. Another ancient scourge which has failed to yield to control efforts is tuberculosis, which poses new threats with the emergence of multidrug resistance and because of its association with the HIV epidemic. Since the early 1980s, the Region has experienced numerous epidemics of dengue. The various types of hepatitis virus are endemic in most countries. Rabies is a continuing problem, though considerable success has been achieved in controlling rabies transmitted by dogs. Many other viral, parasitic, and bacterial diseases and zoonoses remain endemic or epidemic in the Americas.

A third group of diseases may be classified as new or resurgent. Since 1991, most countries of the Americas have been struck epidemic cholera, with over 950,000 cases reported by the end of 1993. Other food-borne and water-borne infectious agents, such as *E. coli* O157:H7 and cryptosporidiosis, are new threats compounding the endemic problems caused by salmonella and shigella. Hemorrhagic fevers have caused illness and death in Venezuela and Argentina. Perhaps the most serious of the new

diseases is AIDS, a rapidly spreading epidemic which threatens to compromise the significant gains made thus far in health and development.

5. Program Orientations

5.1 *Health in Development*

5.1.1 *Major Areas of Work*

A. The process of subregional and regional integration has great potential for accelerating progress toward the attainment of the objectives of the health sector. At the same time, health can be a factor that contributes to integration. The countries face enormous challenges in terms of the need to agree on common norms and standards; an additional challenge is to analyze existing legislation in order to make it conform to the new order to be established.

B. The countries of the Region are undergoing a process of increasing development of social policies that offers clear advantages for the development of health policies. There is an urgent need to mobilize a variety of actors, including national and regional organizations, parliaments, social organizations, unions, associations, that influence the formulation of national and regional policies for the development of social and economic programs.

C. The Regional Plan for Investment in the Environment and Health provides a basis for an alliance among various agencies to address the deficits in the infrastructure in the health and environmental sectors. The Plan includes a careful analysis of the sectors, determination of priority areas, and a methodology for developing project proposals aimed at facilitating mobilization of the necessary resources.

D. Economic and political organization, social structure, and cultural background, as well as demographic and macroecological processes have to be considered in order to discern long-term trends of the health/disease process in a society. Health status is also related to the individual biological and social characteristics. Age, sex, lifestyle, and genetic and immunological makeup are expressed as different susceptibilities or exposures to risk factors. Development of the capacity to establish good information systems and to analyze these various factors will allow a more precise definition of priorities, better programming, and improved monitoring and evaluation of health programs.

E. Changes in the economic, political, and social situation in Latin America have created a new context for the orientation of science and technology in the Region. There

is growing demand from the governments for information about options that have proven effective in other countries and regions and in presenting criteria, models, and instruments that have demonstrated their utility in promoting the development of science and technology.

The main areas of interest include: incorporation of scientific and technological progress in the health field into efforts to promote development of the societies of the Region; promotion of technical cooperation among countries as a means to enhance their ability to develop and acquire needed knowledge and technology; integration of the scientific production and distribution processes; and promotion of research in areas that are consonant with the policy orientations for the quadrennium. Special attention must be paid to enhancing the Regional capacity for production of vaccines and biologicals needed to address the priority health problems.

F. One concern in the development and application of scientific and technical knowledge in general, and in the health field in particular, is the ethics of decisions and interventions that affect life. Thus, special attention should be given to expanding activities in the area of bioethics.

G. The emergence of new technologies and the advent of the information era has changed drastically the behavior and approach to information gathering and access. The relative low price of microcomputers has brought a new possibility to the developing countries for accessing scientific and technical knowledge.

The collection and dissemination of scientific and technical information in the health field must be promoted. There is a need for a coordinated health information network, health databases, and the organization of national information centers.

H. More prominence is now being given to the role of women in, and the relation of women's health to, human development. An increasing number of institutions are insisting that gender be one of the categories of analysis in the planning and programming of activities in all sectors and this should have repercussions for public health programs in all countries.

5.1.2 *Lines of Action*

PAHO will orient its technical cooperation with the countries in this area so as to:

- develop the capacity for policy analysis, planning, and formulation, and for the development and management of projects in the sector;

- encourage the development, implementation, and effective use of information systems that will make it possible to monitor changes in the population, living conditions, health conditions with emphasis on health levels and inequities among the population, and participation by the population in decision-making and sectoral-planning processes;

- promote the participation of the health sector in integrated programs to combat poverty;

- monitor the impact of macroeconomic policies on health and analyze the economic worth of the production and consumption of health goods and services;

- enhance coordination of the activities of social security institutions, community organizations, local governments, and the private sector in the production of good and services;

- promote the development of national legislation that will permit effective exercise of the rights and responsibilities of citizens, the State, and private institutions with regard to health;

- develop national capabilities in epidemiological practice and in the collection, processing, and analysis of information to support decision-making and facilitate evaluation and monitoring of the health status of various population groups and the impact of health policies and programs;

- monitor and analyze health research, collaborate with the national agencies engaged in formulating policies and managing health science and technology, and promote cooperation among countries in the development and use of technology;

- support the development of new and better vaccines, quality control, and good manufacturing practices;

- identify and review and promote the implementation of policies and programs related to bioethics;

- develop national capabilities for the organization and operation of national health information systems as an integral part of a Latin American and Caribbean health sciences information system;

- promote the development, harmonization, and use of technology (e.g., LILACS, CD-ROM) to achieve more effective levels of indexing, processing, and retrieval of scientific and technical information;

- focus attention on the importance of women's health, the interaction among women, health and development, and development of gender awareness at all levels.

5.2 *Health Sector Reform*

5.2.1 *Major Areas of Work*

A. The need to achieve equity and universal access to health care for the neediest population groups in the context of decentralization and local development processes means that central administrative levels must adopt a new role with regard to the formulation and development of policies, social participation, regulation and control of activities, identification and selection of financing mechanisms, and redistribution of resources. Priority must be given to the use of strategies that target specific groups, placing emphasis on social and epidemiological factors and taking into account geographic location.

B. The level defined as local by every country is the political, administrative, geographic, and financial sphere within which the health interventions aimed at specific populations are actually carried out. Local health systems and the public and private institutions at the local level must be supported in the effort to devise health care models that give greater emphasis to health promotion, disease prevention, recuperation, and rehabilitation; the coordination of programs, and intersectoral coordination in urban and rural areas.

C. Work must be undertaken on the development of policies on drugs, the implementation of specific programs aimed at increasing the population's access to essential drugs, the study of legislative issues relating to drugs, and the reorganization, modernization, and financing of the network of clinical laboratory services and diagnostic imaging and radiotherapy services.

D. The approach to disaster reduction will be based on efforts to prevent and mitigate the impact of disasters. There must be political support and commitment, and attention should be given to popular participation, the strengthening of institutions, and fostering of intercountry collaboration.

E. The countries still fact major problems in training and utilization of health personnel. There is constant need to review the relevance of the current systems of training health professionals, especially in relation to needs for public health practice.

5.2.2 *Lines of Action*

PAHO will orient its technical cooperation with the countries in this area so as to:

- foster the development of leadership and managerial capacity in the Ministries of Health and other institutions of the sector and promote the development of sector analysis at the national and local levels in the context of decentralization, social participation, and intersectoral coordination for the development of local health systems;

- analyze and develop options for the organization and financing of health systems, services, and institutions, including the use of local strategic administration, the development of information systems, and improvement of maintenance of physical facilities;

- promote the development of human resources in all fields critical for the efficient functioning of health services;

- promote the use of approaches that target priority population groups, including the poor and marginalized, indigenous groups, women, and mothers and children;

- support the formulation of policies on essential drugs that deal with legislation, regulation, production, marketing, use, and financing, and promote the strengthening of pharmaceutical services, knowledge of drugs among health care personnel, and health education for the public in order to encourage the rational use of drugs;

- strengthen the development of clinical laboratory services, blood banks and transfusion services, and diagnostic imaging and radiotherapy services, especially in relation to policy formulation, quality assurance, biosafety;

- strengthen the capacity of the health and other relevant sectors in the areas of disaster preparedness, prevention, and mitigation.

5.3 *Health Promotion and Protection*

5.3.1 *Major Areas of Work*

A. Efforts will be made toward encouraging recognition and internalization of the concept of health as an individual and social good and as resource for and investment in development; the formulation of sectoral and intersectoral policies at the local and national level designed to improve living conditions; and the legislative expression of these policies at the various levels of government and their translation into intersectoral plans and programs for the development of healthy communities.

B. In the area of protection of specific population groups, preventive interventions will be oriented toward controlling the risks of illness, protecting high-risk groups, and developing social, environmental, and safety measures to reduce risks, treat and rehabilitate the sick, and help to enhance the quality of life. Action in this area will be aimed at reorganizing health services and developing more effective health care models for the management of noncommunicable diseases, mental health problems, health problems of the elderly, eye disorders, accidents, abuse of drugs, including tobacco and alcohol, and prevention of violence.

C. The size, growth, age structure, and distribution of the population are crucial issues and are important factors in determining the needs to which the health sector must respond, whence the importance the Governing Bodies of the Organization have attached to matters relating to population and reproductive health.

D. The use of information as an instrument of change will be a major area of work. The transmission of information to individuals and groups through social communication will create the knowledge that will form the basis for changes of attitude and practice. Information will be targeted to specific community groups as well, with a view to influencing policy or encouraging the adoption of health-oriented public policy, which is a key component of health promotion.

E. Action in the area of food and nutrition will be geared toward individuals and specific population groups and will be aimed at optimizing physical and mental development and protecting people from diseases associated with unhealthy eating habits and the nutritional deficiencies that are most prevalent in the Region.

5.3.2 *Lines of Action*

PAHO will orient its technical cooperation with the countries in this area so as to:

- foster social development based on the principles of equity and the right of all people to health and well-being through the formulation and application of health-oriented public policy relating to food and nutrition, drug addiction and smoking, and prevention and control of violence;

- encourage the development of a culture of health founded on a healthy environment and the adoption of lifestyles that promote health through the development of strategic interventions designed to create healthy options for the population;

- support the development the health sector's capacity to identify, support, and lead intersectoral processes that will promote and protect health, recognizing that it is at the local level that health promotion and protection activities must be implemented and supporting local efforts to mobilize resources and improve health and well-being;

- support the generation, evaluation, dissemination, and use of information relating to health in general and health promotion and protection in particular;

- promote the development of policies and programs relating to population issues, reproductive health, and fertility regulation, with special emphasis on adolescents, in accordance with the conditions and needs in each country. In addition, enhance the coordination of health promotion activities and reproductive health services, and strengthen the development of human resources and the mobilization of national and international resources;

- ensure continued improvements in the nutritional status for all population groups.

5.4 *Environmental Health and Development*

5.4.1 *Major Areas of Work*

A. In the area of basic sanitation services, the principal challenge will be to increase the coverage of water supply services and to ensure that the water supplied is of good quality, and to extend waste and excreta disposal services. All of this will be done in a framework of changing social and political changes, notably processes of privatization, which will mean that careful attention will have to be paid to ensuring universality and equality.

B. In the area of environmental quality, the challenge in general consists of ensuring that environmentally sustainable development is achieved, in keeping with the

agreements signed at UNCED. Health issues must be given adequate consideration in the framework of environmental and ecological concerns; in order for this to happen, the health sector must have the support necessary to enable it to take an active part in establishing criteria and standards for environmental quality, conducting studies and monitoring the human health problems caused by environmental factors. Because the quality of the environment is a universal concern, partnerships must be formed with business and industry, nongovernmental organizations, and the community, to raise awareness of the environmental impact of development activities.

5.4.2 *Lines of Action*

PAHO will orient its technical cooperation with the countries in this area so as to:

- through the Regional Plan for Investment in the Environment and Health, encourage the countries to redirect their national planning to place greater emphasis on social issues, allocating a larger percentage of the GDP to health services, basic sanitation services, the protection of water sources, and environmental quality;

- develop the managerial, financial, and planning capacity of the sector and its institutions in the areas of drinking water supply, sanitation, solid waste disposal, and protection of water sources;

- support technological development, research, and human resource training in the areas of evaluation and control of environmental hazards, including risks to human health in work environments;

- promote respect for the principles of universality and equity in the delivery of basic sanitation services, as well as respect for the right of "informed consent" with regard to the placement of infrastructure works, industry, services, and any other activity that might be detrimental to health or well-being;

- support the institutional and organizational development of the various entities and agencies responsible for environmental and natural resource management, including local governments, communities, and other types of governmental and nongovernmental organizations.

5.5 *Disease Prevention and Control*

5.5.1 *Major Areas of Work*

A. Programs for the control of vaccine-preventable diseases of childhood, diarrheal diseases, and acute respiratory infections will be maintained and strengthened. Special emphasis must be placed on measles and tetanus, and the activities aimed at achieving certification of the elimination of poliomyelitis from the Region will be stepped up. Leprosy control efforts will also continue. As national and international resources permit, effective new vaccines, such as the hepatitis B vaccine, should be added to those covered under existing immunization programs. Research must continue into the development of new and improved vaccines and technologies suitable for application at the community level for the prevention of infections.

B. Practical methods for preventing food-borne and diarrheal diseases, including safe food processing and handling and water disinfection, should be implemented as soon as feasible.

C. Significantly greater effort will be made to support programs aimed at preventing the transmission of HIV and other sexually transmitted infections and reducing their impact. Such efforts need to be coordinated with other intergovernmental, multilateral, and bilateral agencies and nongovernmental organizations, including HIV/AIDS programs of the United Nations and Inter-American systems.

D. Programs for the control of vector-borne diseases should continue to be given priority, particularly those for malaria, and other parasitic, viral, and bacterial infections, including tuberculosis, which pose serious threats to public health in the Region. The countries will have to confront new types of infections which result from changes in human behavior and the environment.

E. Veterinary public health programs will be directed toward improving animal health and agricultural productivity and enhancing the quality and safety of foods. Emphasis will be placed on assuring access to international markets through the establishment of and compliance with international standards.

F. Noncommunicable diseases, particularly cancer and cardiovascular disease, as well as injuries and violence must receive increasing attention as populations age and social conditions change. Approaches to the control of these problems must include effective surveillance and research and be coordinated with efforts to improve living conditions and promote healthy lifestyles and community involvement.

5.5.2 *Lines of Action*

PAHO will orient its technical cooperation with the countries so as to:

- collect relevant information about the distribution and determinants of health problems as an essential prerequisite for the planning, execution, and evaluation of programs;

- promote the integration of disease control programs into health services, particularly at district and local levels, with appropriate decentralization of authority and resources;

- target programs to known risk groups and risk factors, employing the basic approaches of risk analysis and stratification;

- establish and sustain programs of immunization for effective vaccination against diseases of major public health importance;

- eradicate or eliminate certain health problems, including poliomyelitis, leprosy, rabies transmitted by dogs, onchocerciasis, and household transmission of Chagas' disease by *Triatoma infestans*;

- support national efforts to coordinate activities for the control and prevention of HIV/AIDS and strengthen the local capacity to diagnose and treat sexually transmitted diseases.

6. The Work of the Pan American Sanitary Bureau

6.1 *Constitutional Responsibilities*

6.1.1 *International Coordination*

As the Regional Office of the World Health Organization, the Bureau has a constitutional mandate to direct and coordinate international health work in the Region. Accordingly, PAHO's efforts in this regard will be directed mainly toward asserting its leadership in health matters.

6.1.2 *Technical Cooperation*

The bulk of the Organization's efforts in the quadrennium will be expended in the area of technical cooperation. Two complementary approaches will be used:

technical cooperation by the Bureau with the Member States and, in keeping with the Organization's constitutional responsibility, facilitation of cooperation among the Member States. The Organization represents a cooperative venture among the American States for the purpose of improving health conditions individually and collectively. A basic role of the Bureau within the Organization is to facilitate that cooperation. PAHO has over the last two quadrennia evolved and matured in its conceptualization of what the essential elements of its technical cooperation are and how it will support cooperation among the countries. Although these approaches may be subject to modification over time, during the quadrennium PAHO will express its cooperation in the following basic ways.

Mobilization of Resources. PAHO will assist countries in mobilizing the resources necessary to address the major problems. Some will be obtained from external sources, but the vast majority will come out of national budgets. Every effort will be made to ensure that the resources mobilized are used efficiently. PAHO will also assist countries in identifying potential sources of funding and in mastering the various aspects of project development and management. Particular attention will be paid to the institutional resources--universities, institutes, collaborating centers, and others--that can devote time and talent to health. A wide range of human and information resources will be targeted. PAHO will continue to play an advocacy role in health and will endeavor to mobilize the political support that is essential to the success of any national program.

Dissemination of Information. At the simplest level, work in this area will involve collecting and distributing information to Member States. At the most sophisticated level, it will entail action by all parts of the Organization in order to make maximum use of information as the powerful instrument that it is for bringing about the changes that must take place at the sectoral, community, and individual levels. In addition to the direct dissemination of technical information in specific areas, PAHO will continue to strengthen national information systems to enable the countries to exchange information among themselves.

Training. This is an area of ongoing action by PAHO, the aim being to transfer essential knowledge, attitudes, and practices. All the PAHO technical programs will continue to identify training needs and PAHO itself will undertake training activities when necessary, but more often an effort will be made to encourage local training institutions to meet those needs. PAHO will also continue to provide fellowships for study abroad, as this is one of the aspects of training that continues to be most highly valued by the Member States.

Research Promotion. A prime responsibility of all the technical programs will be to promote research, regardless of the source of funding. Efforts in this area will

range from the identification of research needs to the development of protocols and assistance in identifying sources of funding.

Development of Plans and Policies. A key aspect of the Organization's technical cooperation is the Bureau's work in assisting Member States to develop their own plans and policies to guide health programs.

Technical Cooperation among Countries. PAHO will continue to fulfill its Constitutional role facilitating technical cooperation among countries (TCC) and will continue to earmark specific funds for this purpose. Cooperation activities may take a variety of forms. Countries may cooperate among themselves to solve a particular common problem or set of problems. Much of the success achieved under subregional initiatives and programs has been the result of this approach. One country may also cooperate with another to solve a problem that is not necessarily mutual.

The enormous potential of TCC for the solution of some of the Region's problems has not been fully realized. During the quadrennium PAHO will renew its efforts to sensitize the countries to the importance of this approach and establish mechanisms to systematize and disseminate information about the most successful experiences with this type of cooperation.

6.2 *Planning, Programming, and Evaluation*

The American Region Planning, Programming, Monitoring, and Evaluation System (AMPES) has been designed to facilitate the uniform preparation of work plans to achieve specific objectives. The System has evolved over the years as PAHO's understanding of the application of basic principles of planning to technical cooperation has matured. It has benefited from feedback provided by the Member States.

AMPES, like any system, has various components and is made operational through a series of instruments. Over time, the System has had to be adapted to accommodate the various time frames and sets of health objectives established globally and regionally. The broad goal of Health for All and the various strategies and plans of action for achieving it made up the initial framework for planning. Subsequently, the WHO General Programs of Work and the Strategic Orientations and Program Priorities of PAHO established planning periods of six and four years, respectively. Other planning instruments that are short-termed and more specific are also used. These include the following:

The ***Biennial Program Budget (BPB)***, which is approved by the Governing Bodies, includes:

- *Health Situation Analysis* for each of the Member States and regional program areas. This analysis includes information on political, social, and health conditions in the countries, national health priorities, and descriptions of the areas in which technical cooperation is needed, in particular PAHO technical cooperation.

- *Technical Cooperation Strategy*, which describes what the Secretariat will do in order to cooperate with the countries in solving the problems and challenges identified in the health situation analysis.

- *Technical Cooperation Programs* identified in accordance with the program classification list. These programs respond to priorities for PAHO technical cooperation at the regional level.

The ***Annual Program Budget (APB)*** is derived from the biennial program and is perhaps the most important planning and programming tool of the Organization. At the country level it is the expression of PAHO's commitment to provide technical cooperation in defined areas. The process of formulating the APB is a joint one and involves essentially three phases:

- definition of national health priorities;

- identification of areas in which technical cooperation is needed;

- development of technical cooperation projects through which PAHO support will be provided.

The ***Four-Month Work Plan (PTC)*** is the instrument used to break down the activities programmed under the APB into short-term tasks with specific allocations of resources. The programs and projects are always described in the framework of the program classification structure established by the General Program of Work and modified to accommodate the Regional situation and needs.

One of the weaknesses of AMPES in the past has been the difficulty in evaluating what PAHO has accomplished in relation to the goals established in the GPWs of WHO, the SOPP, and other plans of action approved by the Governing Bodies. This difficulty in evaluating came about largely because more attention has been given to planned activities and resources than to the results of the technical cooperation.

The new Strategic Orientations and Program Priorities for PAHO for the period 1995-1998 will be the framework for all planning, programming, monitoring, and

evaluation done through AMPES. The BPBs for each of the three biennia included within the Ninth GPW will emphasize what PAHO will do--i.e., the outputs of its technical cooperation with the countries within the framework of the SOPPs for 1995-1998.

The methodology known as the "Logical Approach to Project Management" will be used to establish the biennial program budgets for the regional units and country offices so that a hierarchy of objectives with a clearly defined cause/effect relationship exists in each BPB. The biennial targets for each regional program area and the national priorities for PAHO technical cooperation should reflect what needs to be done to accomplish the goals of the Ninth GPW.

The APB will also be prepared using the Logical Approach to Project Management, which will make it possible to show quantitatively how the yearly activities will be executed in order to achieve the expected results; how the expected results, if achieved, will contribute to the attainment of project purposes; and how the overall goals, if reached, will contribute to the achievement of the global, regional and national priorities for PAHO technical cooperation.

Monitoring and evaluation will be emphasized in AMPES by defining indicators for each level of the hierarchy of objectives (goals, targets, national priorities for PAHO technical cooperation, project purposes, and expected results). Yearly evaluation of APB projects will examine the degree to which the expected results of technical cooperation have been achieved.

7. The National Response

The Pan American Sanitary Bureau and the countries of the Region agree on the adoption of objectives aimed at attaining the highest possible levels of individual and collective health for the population and ensuring that all human beings have the right to enjoy the highest possible level of health. Achievement of the health goals and effective action in the areas of work outlined in this document will require joint action by the Governments, the Bureau, and civil society in the countries. Only through the commitment of the national governments and the international community, the allocation of human and financial resources, and persistent effort will it be possible to achieve acceptable health levels for the countries within a model of development that gives priority to the achievement of equity in health.

The Bureau's functions are to provide technical cooperation based on an analysis of the health problems in the countries, to seek consensus on the priority health problems identified by the countries, and to mobilize resources and international action in order

to support efforts to solve these problems. It has the responsibility to support and cooperate with the countries in areas related to health in development, health sector reform, health promotion and protection, environmental protection and development, and disease prevention and control, which are the areas defined as strategic orientations for the Organization during the next four years.

The countries can therefore expect and demand cooperation from the Bureau in the formulation and evaluation of policies and program in these areas; the establishment of national mechanisms for the analysis, formulation, and implementation of intersectoral policies; and the promotion of research on factors that influence health and development, the health impact of actions taken in other sectors, and the effect of health sector activities on the evolution of other sectors.

The health risks to which the population is exposed vary widely from country to country in the Region of the Americas, and each government must therefore review Regional health goals, which express results to be achieved at the level of the Region as a whole, and adapt them to the national context based on an analysis of health conditions and the health sector in the country. Doing so will facilitate the formulation of intersectoral health plans and policies designed to address the problems identified.

The countries should improve their ability to negotiate support for national priorities with technical cooperation and lending agencies, as well as their ability to invest national health resources more effectively and achieve results that will ensure equity in access to health services. It is crucial that the countries have the capacity to identify their national health priorities and be prepared to exercise their right and responsibility to coordinate all the resources that are directed towards those priorities. This is a necessary, though not sufficient, prerequisite for fulfilling the responsibilities they assumed under the WHO Constitution for improving the health of their peoples through the "provision of adequate health and social measures."