executive committee of
the directing council

PAN AMERICAN
HEALTH
ORGANIZATION

working party of
the regional committee

WORLD
HEALTH
ORGANIZATION

113th Meeting
Washington, D.C.
27 June - 1 July 1994

Provisional Agenda Item 4.1

CE113/INF/2 (Eng.)
10 June 1994
ORIGINAL: SPANISH

PROGRESS REPORT ON THE QUADRENNIAL TARGETS OF THE STRATEGIC ORIENTATIONS AND PROGRAM PRIORITIES 1991-1994

CONTENTS

I. INTRODUCTION

The Strategic Orientations and Program Priorities (SOPPs) for the Pan American Health Organization during the Quadrennium 1991-1994 were adopted by the Member Countries at the XXIII Pan American Sanitary Conference in 1990. The SOPPs adjust the General Program of Work of the World Health Organization to the particular situation of the Americas and are the product of a collective strategic planning process adopted by the member countries to serve as a framework for the formulation of policies and the implementation of activities in the health field. Following approval of the SOPPs by the Directing Council, 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 the 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 direct 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.

The aim of this report is to review and document, in light of the strategic orientations, the progress achieved toward attainment of the targets and execution of the plans of action defined in accordance with the program priorities during the two years following their approval. The main documents used in programming PAHO technical cooperation with the countries (the Biennial Program Budget (BPB) and the Annual Program Budgets (APB)), produced by the American Region Planning, Programming, Monitoring, and Evaluation System (AMPES), were used for this purpose, as were documents on national health policies. The central objective was to determine to what extent the various programs and policies reflect the SOPPs. This analysis was also intended to provide information for the formulation of the orientations for the quadrennium 1995-1998, which will be submitted 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, especially those related to morbidity, mortality, and impact.

The document consists of three sections: Introduction, Background, and Quadrennial Targets. The Introduction describes the framework for evaluation of progress toward the targets and presents the objectives. The Background section presents the strategic orientations and program priorities in light of the challenges they pose for the health sector. The description of the challenges emerged from the a situation analysis carried out at the beginning of the 1990s, through which the strategic orientations and priorities for the development of infrastructure and programs were identified. The strategic orientations identify the major directions to be taken in an effective process of improvement or transformation of national health systems in order to achieve the goal of Health for All set out for the Organization. The program priorities, on the other hand, indicate the principal areas in which action needs to be taken within the program structure of the Organization in order to adequately respond to both new problems and problems that have accumulated through the years. Thus, the strategic orientations are neither independent of one another nor mutually exclusive. To the contrary, they are intertwined and reinforce one another, and the general objectives they express have a bearing on various specific programs. The third section contains the essence of the document. It examines the progress made toward fulfillment of the quadrennial targets associated with each one of the nine strategic orientations and the thirteen program priorities (Tables 1, 2, and 3).

The Conclusion that follows the third section presents various ideas regarding how the Secretariat's activities might be reoriented in order to improve future monitoring and better comply with the resolutions adopted by the Member Countries.

The process of evaluating the quadrennial targets was initiated in 1993 with the development of indicators that took into consideration the plan of action described for each one of the targets. The indicators were applied to the situations that needed to be addressed or changed and to the targets established in program or strategic terms. The technical units at PAHO Headquarters were asked to participate in the development of these indicators.

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 proposed targets or that had carried out activities to that end. The indicators served as a basis for preparing a survey, which was distributed to the PAHO technical units. Each unit completed the sections that were directly related to its program activities. The same survey was utilized as guide for reviewing the 53 Biennial Program Budgets (BPB) for 1992-1993 and the 53 Annual Program Budgets (APB) for 1991 and 1992.

In addition, many of the data necessary for the evaluation were derived from the most recent reports submitted for the publication "Health Conditions in the Americas, 1994 Edition," in addition to documents prepared by the countries, documents and technical reports prepared by the various units of the Organization, and documents of other institutions.

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

Table 1

STRATEGIC ORIENTATIONS OF PAHO FOR 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

Table 2

PRIORITIES FOR THE DEVELOPMENT OF THE HEALTH SERVICES INFRASTRUCTURE

- SECTOR AND RESOURCE ALLOCATION ANALYSIS
- SECTORAL FINANCING
- MANAGEMENT OF LOCAL HEALTH SYSTEMS AND LOCAL PROGRAMMING
- TECHNOLOGICAL DEVELOPMENT
- DEVELOPMENT OF HUMAN RESOURCES

Table 3

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

II. BACKGROUND

The nine strategic orientations and the thirteen program priorities were proposed in order to address the principal challenges faced by the Region in the 1990s (Table 4). The challenges were identified by means of an exhaustive sociopolitical and economic analysis of the situation during the 1980s. It was determined that the period had been characterized by the stagnation of economic growth, an extensive fiscal crisis, and the emergence of social processes that had led to deterioration of the quality of life, and that all these factors had had an impact on health. The situation analysis also pointed up several flaws in the development model that has been applied in the Region of the Americas in recent decades. It showed that the efforts that had been made in many of the countries to boost production, create domestic markets, protect domestic industry, and substitute imports had taken place in a framework of inadequate social development models, as revealed, inter alia, by the unequal distribution of wealth, the failure to ensure minimum levels of social well-being for the majority of the population, and a widening of the technological and educational gap between the developing and developed countries.

Is was considered necessary for the countries of the Region, on their own terms, to seek a new development model, based on the ideals of humanistic modernism. This implied the intensification of democratic, representative, and participatory trends in the countries and the implementation of structures and forms of production that would satisfy the basic material needs of the population and be compatible with the availability of natural and financial resources, while enabling the countries to compete advantageously in the increasingly interdependent world economy. All this was intended to contribute to the gradual reduction of internal structural obstacles that were impeding the achievement of sustainable human development, which was understood to mean the elimination of inequality, the forging of consensus between heterogeneous sectors for the attainment of common objectives of social and cultural progress, the rational incorporation of scientific and technological progress, and the assignment of priority attention to essential human needs, among them health and the struggle against extreme poverty.

In order to contend with this situation it was considered essential to give greater importance to health in the sphere of social policy and in the process of development. The Executive Committee of the Pan American Health Organization adopted the following strategic orientations to serve as the foundation for efforts to meet this challenge: 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).

Table 4

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

The need to improve the capacity for health situation analysis and for identifying 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, targeting of actions to benefit 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.

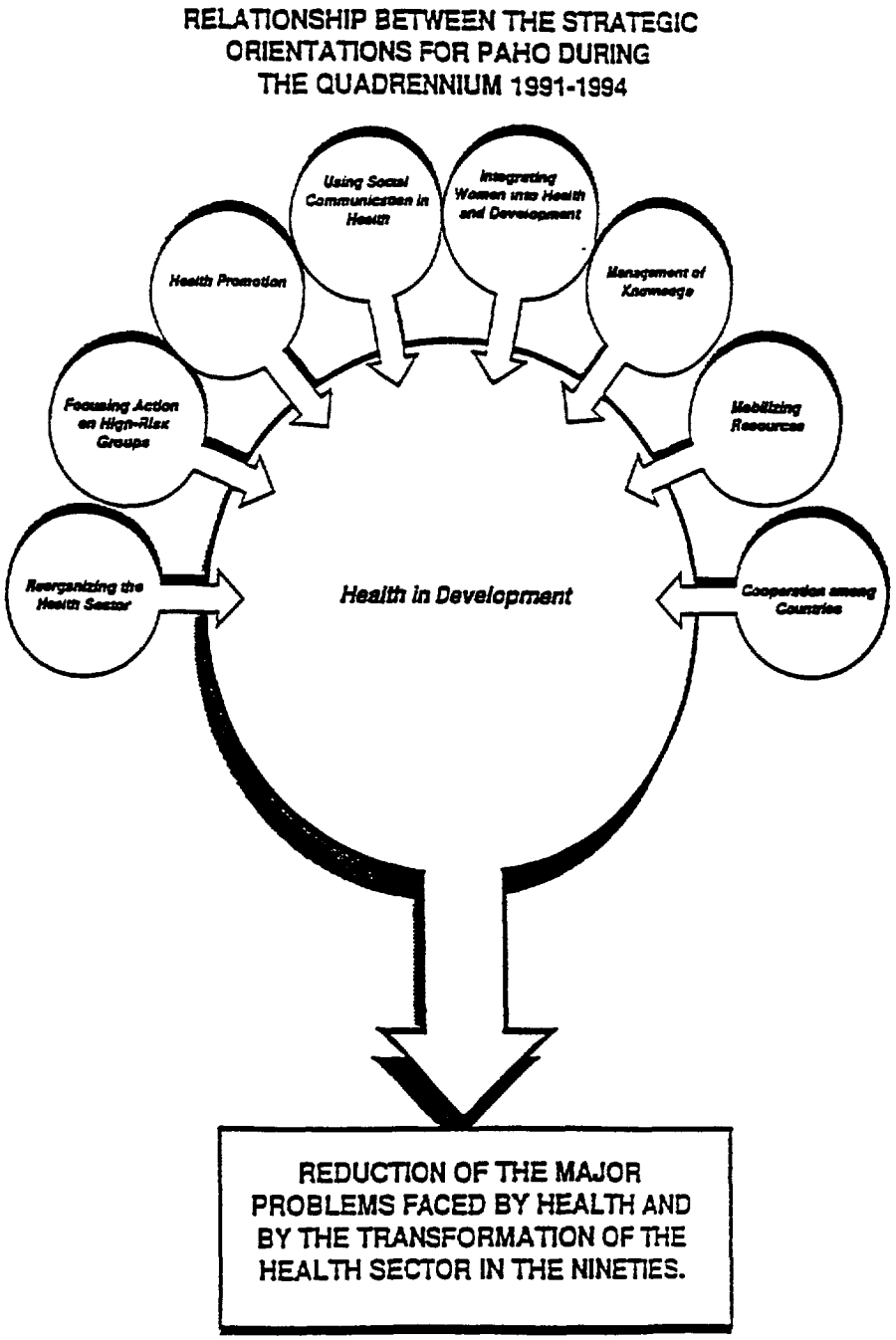
Given the economic and political situation in the Region, it was considered imperative to address the inefficiency of the sector and the disparities between the characteristics of the health work force and the needs of the services, which had resulted from centralization and non-democratic methods of 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 were intended to establish general guidelines for enhancing the process of improvement or transformation of national health systems with a view to attaining the goal of "health for all," while the program priorities indicated the principal areas in which the Organization needed 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 (Figure 1).

Figure 1

ARTICULATION OF THE STRATEGIC ORIENTATIONS FOR PAHO DURING THE QUADRENNIUM 1991-1994



III. THE QUADRENNIAL TARGETS

The quadrennial targets 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.

A. Strategic Orientations

Presented below is an analysis of the targets set for each of the nine strategic orientations with a view to fostering progress toward strengthening and modernizing the health sector in the countries of the Region and generating more efficient, effective, and equitable responses to the health needs of the peoples of the Americas.

1. *Health in Development*

Targets:

To incorporate elements for improving health into the objectives of the economic and social development policies of the Member Countries, 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.

Given the situation described in summary form in the previous section, it was determined that a strategic orientation that highlighted the role of health in development should be implemented in order to foster a different perspective on and approach to the development process. Accordingly, PAHO/WHO has made every effort 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, PAHO/WHO has engaged in intensive promotional and diplomatic efforts to ensure the inclusion of health issues on the agendas (see Box 1). All of the declarations emanating from these Summits have linked health inextricably to development, encompassing specific aspects of sectoral policies. Activities are currently under way to bring the principal health problems in the Caribbean community to the attention of the Heads of State of the countries of that subregion.

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, which will be submitted to the Governments of the Region in 1994 through the Governing Bodies of both organizations. This proposal seeks to strengthen the favorable links that exist between health and other aspects of the process of socioeconomic and political development. 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 last decade.

PAHO has worked with other agencies, in particular the Organization of American States (OAS), with a view to developing the political dimensions of health. In this regard, it is worthy of note that the theme adopted for the second phase of the Central American Health Initiative--which in its first phase was oriented toward making health a bridge for peace--is "Health and Peace for Development and Democracy".

In addition, the Organization has cooperated with the OAS and other technical and financial cooperation agencies, including IDB, UNDP, UNESCO, UNICEF, and the World Bank, 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. Support was provided for the Inter-American Center for Social Development (CIDES/OAS) in Buenos Aires for training courses offered to national experts on health aspects of policies to combat poverty.

Together with the United Nations Conference on Trade and Development (UNCTAD) the Organization undertook a pioneering study--the first of its kind in the world--on foreign trade in health services, which looked at the cases of Colombia, Costa Rica, Cuba, Jamaica, Mexico, and the United States of America. This study has demonstrated that health services constitute a fast-growing area of foreign trade, which may have favorable implications for the development of the countries, provided that it is ensured that the export of services does not affect the availability of these services in the exporting countries.

An effort has also been made to promote issues relating to health and health services in the context of the regional integration agreements that have been negotiated in the Americas. In the framework of the Andean Pact, the signing of an agreement on social security has been promoted, as has the introduction of a single identification card that would give all inhabitants of the subregion access to health services. Similar initiatives are being encouraged under the other integration agreements, including NAFTA, MERCOSUR, and the Central American and Caribbean Common Markets.

An effort has also been made to work with the legislative bodies of the Region through the Democracy and Health project, which has resulted in cooperative ties with

23 national and subregional legislatures and parliaments, including the Andean Parliament, the Central American Parliament, and the Latin American Parliament (PARLATINO). The latter has defined five regional priorities in regard to health: supply of essential drugs, workers' health, maternal and child health, environment and health, and national health system reform. The Andean and Central American Parliaments have also established specific priorities for their respective subregions which largely coincide with the priorities of the subregional health initiatives PAHO/WHO is carrying out.

Through the Democracy and Health project work has been undertaken with the legislatures and parliaments in the countries with a view to giving expression in each country to the priorities established by the corresponding subregional or regional parliaments. The importance of working with the legislatures and parliaments has become especially apparent during this period of rapid turnover of ministerial authorities. In this regard, the legislatures--and by extension political parties and other representatives of the people--have become crucial forums for the identification of problems, the definition of policies, and the negotiation of the resources necessary for the implementation thereof.

Cooperation with the legislatures has provided a means of access to future authorities and health officials, thereby often shortening the time lag between their taking office and the implementation of specific policies of interest to the health sector. This access has been essential for ensuring that health issues are included in national political platforms and agendas. In addition, it has been possible to initiate cooperation with new health authorities prior to their taking office. Bolivia, Ecuador, and Paraguay have served as true test cases for this new type of PAHO/WHO cooperation, and the results have been quite favorable, not just in these countries but also in others that have undergone or will undergo constitutional changes during 1993 and 1994.

On the one hand, this work has been facilitated by the emergence in the early 1990s of an international climate more favorable to issues relating to social development, including health. The World Bank's choice of the theme "Investment in Health" for its World Development Report for 1993 and the Forum on Social Reform and Poverty, organized by the Inter-American Development Bank, are two illustrative expressions of this new trend.

An attempt has also been made to expand contact and cooperation between PAHO/WHO and governmental agencies other than its conventional counterparts. 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 areas of development in the implementation of health policies that take an intersectoral approach to health issues.

Box 1

Health at the Summits of Heads of State and Government

The United Nations Conference on Environment and Development (UNCED), which was held in Rio de Janeiro, Brazil, in June 1992 was the event that mobilized the greatest number of political leaders during this period. PAHO/WHO was actively involved in the preparatory stage of the Conference and made important contributions to the Declaration of Rio de Janeiro and the drafting of Agenda 21, which is the plan of action of the Conference. The final declaration (included in Agenda 21) contains a chapter on protection and promotion of health, which encompasses five program areas: meeting primary health care needs, particularly in rural areas; control of communicable diseases; protection of vulnerable groups; urban health; and reduction of health risks from environmental pollution and hazards. A summary of the implications of UNCED for the countries and for PAHO is contained in the "Report on the United Nations Conference on the Environment and Development and its Significance for the Work of the Pan American Health Organization" (Document CD36/22 of 17 August 1992), presented to the XXXVI Meeting of the Directing Council.

In compliance with Resolution XVII of the XXXV Meeting of the Directing Council of the Organization and in response to the mandate issued by the First Ibero-American Summit of Heads of State and Government, held in Guadalajara, Mexico, in July 1991, PAHO/WHO prepared, in close consultation with the countries, the Regional Plan for Investment in the Environment and Health. The Directing Council decided to approve the Plan as the framework for the investment needed in Latin America and the Caribbean over the next 12 years in order to gradually overcome the existing deficit in the infrastructure of health services, basic sanitation, drinking water supply, and drinking water quality assurance.

The Second Ibero-American Summit of Heads of State and Government, held in Madrid in 1992, endorsed the Organization's proposal for the intensification of investment in the infrastructure of health services, water supply, and sanitation, coupled with institutional development and improvement of management processes. This proposal, organized through the Regional Plan for Investment in the Environment and Health, will help guide the countries, development financing institutions, and cooperation agencies in the effort to address the lack of access to health services, water supply, and sanitation, which are causing misery and death for millions of inhabitants of the Region. The document of conclusions issued by the Second Ibero-American Summit fully endorsed the PIAS and its implementation in each country. That declaration also recommended the creation of a fund for preinvestment activities in the area of environment and health.

At the III Ibero-American Summit of Heads of State and Government, held in Salvador, Bahia, in July 1993, and at the Meeting of Heads of Government of the countries of the Caribbean community (CARICOM), the participants recognized the principal achievements made under the Plan during its first two years of existence, both in the Member Countries and within the Secretariat of the Organization.

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.

In 1991 it was estimated that of the 400 million inhabitants of Latin America and the Caribbean at least one third (35% of the population) did not have regular access to health care services. Another 37 million in the United States of America lacked health insurance coverage that would allow them permanent access to health services (see Box 2).

In 1994 the population of Latin America and the Caribbean is expected to number 474 million, which implies that, in order to attain the target set, the Region's health services should be capable of covering 350 million people. The data currently available from the various assessments of health care coverage correspond to the start of the decade. For social security, which includes health care coverage for certain segments of the population, the weighted average of regional coverage at the end of the last decade was 64.12%. This figure takes into account a coverage level of 100% in Brazil, without which the regional average would be only 43.47%. In order to adequately analyze health service coverage research needs to be conducted to obtain current data on aspects of coverage such as physical, geographical, and cultural access of the population to health

services, especially in light of the changes that are occurring in health and social security systems as a result of the processes of decentralization and State reform, especially as regards its role in the promotion of social policies.

One point of departure for this research might be an analysis of the process of local health system development, inasmuch as these systems represent an operational tactic for achieving democratization and community participation in the search for equity, accessibility, and targeting of risk groups.

According to statistics from the information system on local health systems, in 1992, 32 countries (91%) of the Region were making changes in the structure of the sector, in administration, or 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. With the exception of Chile, for which information is not available, in 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.

From the outset, under the proposal on local health systems it has been emphasized that the development of these systems should be framed by the overall processes of change under way in each country. Today it can be stated that in most of the countries the processes of decentralization of the health sector and development of local health systems have been motivated and have originated outside the health sector. The political processes of State reform, the economic crisis and its implications for the financing of public services, and the processes of democratization have been the principal driving forces behind health sector reform.

In many cases local development in the area of health has centered around local political-administrative units, that is, mayoralties or other government offices at the "municipio" level. The global processes that are taking place concurrently with the decentralization of the health sector underscore the notion that local health systems should be developed in specific territorial areas.

Another important process of change has been the development of the health care models applied in local health systems, which seeks to promote the transition from an exclusively individual, curative model that 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," the Bogota Declaration on health promotion adopted at the first International Conference on Health Promotion, held in 1992 in Colombia, and the Project on Health, Environment, and Poverty Alleviation (SMALP Project) in Brazil, the Dominican Republic, and Peru, which is being carried out with support from the Government of Italy.

Another extremely important development is the incorporation by most of the countries of programs for the eradication and control of diseases in the activities of local health systems. Of particular note are the efforts aimed at eradicating the wild poliovirus from the American hemisphere, which are being bolstered by activities at the local level, where health services and the organized community have assumed primary responsibility for this process. The same approach can be effective in facing new challenges in the control and elimination of measles, neonatal tetanus, Chagas' disease, and malaria. Mental health problems, accidents, noncommunicable diseases, and veterinary public health can also be effectively dealt with at the local level. In the epidemics of cholera and AIDS, decentralization and participatory approaches are crucial, since through decentralization and the development of local health systems the local levels, health services, and the organized population are meeting the challenge of stretching limited resources to contend with these diseases.

With regard to social security, it has been observed that in almost all the Latin American countries in which significant levels of development have been achieved, this has been the result of joint action and effort between the Ministry of Health and the social security system, mainly in regard to health care programs. However, the results achieved vary considerably from country to country. For example, in Costa Rica it has been agreed that the Costa Rican Social Security Fund (CCSS) will take responsibility for health services delivery, with the Ministry assuming a regulatory and supervisory role vis-à-vis the health sector and the programs carried out by the CCSS. In contrast, under agreements reached in Nicaragua, the Ministry of Health, through the establishments it operates, provides services to social security beneficiaries, while the cost of those services is underwritten by the National Social Security and Welfare Institute (INSSBI). In Guatemala and Honduras joint programs are being developed in which the health sector and social security coordinate responsibilities and the supply of inputs necessary to fully meet the health care needs of the population, regardless of the insurance status of individuals. The programs that have benefited most from this coordinated approach are those that are oriented toward health promotion and disease prevention. In Guatemala, an effort is being made to extend the Escuintla Project, initiated in 1988, with a view to ensuring coverage by the Guatemalan Social Security Institute to the entire population, at least at the primary health care level. In Panama, where for years services have been provided under an integrated health services model, efforts have concentrated

on maintaining this system in the face of administrative difficulties that are jeopardizing the successes achieved. In El Salvador, it has not yet been possible to achieve closer coordination between the two principal health institutions of the country, owing to problems of an administrative and legal nature.

During 1992, several countries of the Region continued to carry out health sector reform plans that had a direct impact on social security systems and their relationship to the Ministries of Health. These reforms are aimed at allowing greater opportunity for private action in the development of health services delivery, and social security systems are seen more as sources of financing and purchasers of services than as institutions that provide services directly. In those cases in which the social security system has been allowed to continue to operate clinics, dispensaries, or hospitals, an attempt has been made to provide them with managerial elements borrowed from private enterprise. Undoubtedly, this type of development will modify coordination with the Ministries of Health.

In Bolivia, Brazil, Colombia, the Dominican Republic, Paraguay, and Peru major reforms of national social security and health care models are being studied. These reforms will affect the Ministries of Health and social security systems, and will obviously also have an impact on the relationship between the two institutions.

In the other countries of the Region, efforts at health sector reform continued without significant change: in Chile efforts to promote the development of ISAPRES are ongoing; in Venezuela there are difficulties in maintaining the social security system and its relationship to the Ministry of Health; in Ecuador the efforts to achieve greater coordination between the two institutions has yet to bear fruit; in Uruguay no notable changes were made in the health care model or the role of the institutions of the sector; and finally, in Belize and the countries of the Caribbean, social security systems do not deliver health care directly, so strengthening of this strategy has not been a concern. In Cuba, which has a unified health system, the social security system does not carry out health care delivery programs, either.

Finally, in Mexico, although excellent relations exist between the Ministry of Health and the principal institutions of the social security system (IMSS and ISSSTE), each has a clearly defined area of action, and there is practically no coordination of their activities.

The economic crisis that has affected almost all the countries of the Region has had a profound impact on social security systems, which have had serious difficulties maintaining the coverage of their programs owing to a shortage of human resources and inputs, which has also affected the quality of the services provided. Moreover, the crisis has increased the demand for public health services by persons who in better economic circumstances would seek care in the private sector.

According to data from the World Bank publication "Recursos Humanos en América Latina y el Caribe: Prioridades y Medidas a Tomar" [Human Resources in Latin America and the Caribbean: Priorities and Steps to be Taken], published in January 1993, during the period 1991-1993 eight countries of the Region (Bolivia, Brazil, Colombia, Chile, Guyana, Honduras, Mexico, and Paraguay) mobilized some US$427 million in reimbursable financial cooperation from the World Bank for health and nutrition projects. For projects in the water and sanitation sector, the resources mobilized amounted to $1,028 million. The World Bank has agreed to provide $160 million to the Ministry of Health of Brazil, which will be applied over the next four years to strengthen the program on sexually transmitted diseases and AIDS.

PAHO mobilized $171,792 in resources from the World Bank during the 1990-1991 biennium, especially in the area of health policies, and $4,143,845 from the Inter-American Development Bank (IDB) for projects on communicable diseases (cholera and polio eradication). For the 1992-1993 biennium $30,491 was mobilized from the World Bank for water and sanitation projects, and $1,562,714 was obtained from IDB for investment and family health projects in two countries of the Region, and for the regional programs on environmental health and communicable diseases.

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. The Plan establishes that the preinvestment needs in the countries of Latin America and the Caribbean amount to at least $1,200 million for the 12-year period. 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 seed fund for the development of preinvestment activities as a mechanism for implementing the PIAS. The initial proposal was to mobilize around $7 million a year, which would spur preinvestment activities and attract additional resources for that purpose, both at the regional and national levels. To date, letters of commitment have been received from Colombia, Nicaragua, and Peru regarding the establishment of preinvestment funds in those countries; in the case of Guatemala, a governmental agreement and a memorandum of understanding have been issued for the generation of a similar mechanism in that country. Conversations on the matter with Argentina, Bolivia, Brazil, Chile, Costa Rica, the Dominican Republic, Ecuador, Honduras, Mexico, Panama, Paraguay, Uruguay, and Venezuela have yielded progress toward the establishment of specific funds in each of those countries. In addition, the Government of Spain contributed the sum of $700,000 to the Central Fund in 1993. PAHO has made its contribution of $1,200,000, and negotiations are under way with the Inter-American Development Bank with a view to obtaining its participation in the Preinvestment Fund, either through international technical cooperation or through a special agreement providing preferential access to the new preinvestment funding mechanism being created within that institution.

Box 2

President Clinton's Proposal for Reforming the United States Health Care System
The Ethical Imperative to Ensure Universal Coverage

In his address to the Congress of the United States of America on 22 September 1993, President William Clinton presented his proposal for reforming the health care system in that country.

He emphasized that despite the dedication of talented health professionals, health care in the United States continues to be too uncertain, too expensive, too bureaucratic, and too wasteful.

His proposal is based on six principles:

- Security - Those who do not have health care coverage will have it, and for those who do have it, it will never be taken away.

- Simplicity - Reduction of the burden of activities that are not directly related to the treatment of patients through the simplification of bureaucratic paperwork, administration, and regulatory, billing, and reporting requirements.

- Savings - Increasing competition among health care providers, reducing administrative costs, and imposing tighter controls on the budgets of government programs.

- Choice - Consumers, not employers, will select the health care plan that is best for them, and should the plan they choose not live up to their expectations, they will be able to change plans.

- Quality - Through the establishment of standards and guidelines for health professionals, quality control programs designed to measure results, increased support for medical research, and promotion of preventive and primary care.

- Responsibility - Changing the attitudes of the society as a whole (insurance companies, employers, citizens) so that everyone accepts responsibility and participates in solving the problem.

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.**

The strategic orientation of focusing action on high-risk groups was identified as one of the mechanisms for achieving greater equity in health and remedying the growing deficit in health service coverage by increasing the capacity to direct efforts toward the groups at highest risk, who have the highest-priority health problems.

The health sector needs to give new direction to its practices, incorporating specific disease prevention and control efforts within the activities carried out by the services. In other words, health care models need to go considerably beyond a passive response to the demand for services once health impairments have occurred. Health care needs to be improved through the implementation of comprehensive programs, accompanied by monitoring and evaluation of indicators of health risks and impairments.

In order to attain the targets established, it was considered important to develop methodologies and techniques for health analysis that would make it possible to better document the impact of the crisis on the living and health conditions of the various segments of the population. Accordingly, it was essential to strengthen 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 and methodological knowledge and the exchange of experiences with efforts to 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, the practice has not been widely implemented. Some countries utilize epidemiological stratification by age, geographical location, occupation, type of housing, socioeconomic condition, or characteristics of contacts and household members in order to focus actions. For example, in all the countries, with the exception of the United States of America, BCG vaccination efforts target children under five; malaria control activities in South America, Central America, Panama, and Belize target rural populations aged 15-64; in Argentina, Bolivia, Brazil, Chile, Uruguay, and Paraguay, efforts to combat American trypanosomiasis are aimed at rural inhabitants under the age of 44; all the countries, except Bolivia, Haiti, Peru, and Paraguay, focus leprosy control activities on the urban and rural population aged 5-64. In the characterization of health hazards in tourist areas, five groups of problems are analyzed: infectious and parasitic diseases, diarrheal diseases, sexually transmitted diseases (including AIDS), accidents and deviant social behavior (alcoholism, drug addiction). The Regional Plan for the Elimination of Rabies focuses particularly on urban areas, although activities have been initiated to characterize areas and populations at risk for wildlife rabies, including occupational groups (miners, members of the armed forces), in Brazil, Peru, and Suriname.

The health plans of several countries have established specific objectives and goals for certain population groups utilizing criteria such as risk, age, geographic distribution, and income. Communicable disease control programs target certain groups, toward which, in theory, the greatest effort is directed, depending on the countries and diseases involved. These groups are more or less protected depending on the political situation and national financial situation. For example, BCG vaccination coverage among children under 1 year is over 90%. The coverage of multiple drug therapy for leprosy (rifampicin, dapsone, and clofazimine) is generally 50%, except in Cuba, Ecuador, Central America, Panama, and Uruguay, where it ranges from 70% to 100%.

Most of the programs for the control of vector-borne diseases in the countries of the Region have continued with little change. However, the programs aimed at preventing diseases transmitted through blood transfusion have been strengthened, as has the use of BCG to prevent tuberculous meningitis and multidrug therapy for the control of leprosy.

The countries have carried out sectoral studies or situation analyses in regard to communicable diseases, mainly endemic diseases. Particularly noteworthy are the

national coverage studies carried out on malaria in Brazil, Costa Rica, Guatemala, Honduras, and Nicaragua, and on onchocerciasis in Ecuador, Guatemala, and Mexico. There have also been subregional coverage studies on Chagas' disease in Argentina, Brazil, Bolivia, Chile, Paraguay, Peru, and Uruguay. In 1991, the Regional Program on Health Situation Analysis (HDA) has prepared the Regional Evaluation of the Strategies for Health for all by the Year 2000, and every year a summary of the health situation is to be included in the Annual Report of the Director. The 1994 edition of "Health Conditions in the Americas" is currently being readied for publication, and other studies are being carried out, including one on the health of indigenous people and another on health in Latin American megalopolises.

The training of human resources is an important element for the execution of programs, formation of human capital, and strengthening of the capacity for research. Within this context, PAHO has perfected the modules on malaria epidemiology and epidemiological stratification of malaria, and has prepared and distributed documents to provide guidelines for epidemiological characterization, timely and efficient diagnosis, specific and effective management of the priority communicable diseases in the Region (malaria, dengue, tuberculosis, taeniasis, cysticercosis, onchocerciasis, leprosy, leishmaniasis, intestinal protozoiases, and Chagas' disease, among others).

Several countries requested PAHO technical cooperation for graduate-level human resources education in epidemiology. These requests for cooperation are a reflection of the urgent need within control programs for education and training in epidemiology in order to strengthen programs for diagnosis and epidemiological surveillance, not only of health impairments but also of the basic risk factors that determine them. In order to respond to this demand, the Department of Epidemiology and Biostatistics of the Graduate School of Public Health at the University of Puerto Rico in 1991 offered its first summer course in the epidemiology of communicable diseases for professionals from Latin America and the Caribbean. One of the innovative elements of this summer session, which was offered again in 1992, was that it was specially designed to respond to the need for in-service training of professional personnel in the methodologies utilized in epidemiological stratification of the risks associated with communicable diseases. In 1992, with PAHO technical cooperation, training was provided for 230 professionals from 42 countries.

In connection with the objectives of improving the countries' capacity for health situation analysis and concentrating resources on more effective interventions for reducing or eliminating risks, PAHO has developed a geographically based methodology for studying how differences in living conditions lead to unequal health profiles and monitoring social inequalities in health, and it has provided support for the countries to aid them in adopting the methodology. In addition, a methodology was developed for calculating estimated rates of mortality for five-year periods, by age, sex, cause of death,

and country, and a methodology for the study and quantification of gaps between countries according to level of economic and social development is currently being applied.

The information on mortality contained in PAHO database is updated periodically based on figures on registered deaths provided by the countries and population estimates provided by United Nations and the Latin American Demographic Center (CELADE). The currentness of the data depends on the completeness of death records in each country and on the speed with which mortality data are recorded. The most recent information received from the countries corresponds to around 1989-1990. Very few have provided data for 1991, and the quality of death records varies considerably from one country the next. Thus, for purposes of comparison it is indispensable to look at estimated mortality. According to World Health Organization estimates, all the countries of the Region have shown an increase in life expectancy at birth, although some, including Bolivia, Brazil, Ecuador, the Dominican Republic, El Salvador, Guatemala, Guyana, Haiti, Honduras, Nicaragua, Paraguay, and Peru, will not have attained the established target of 68 years by the end of the five-year period 1990-1995.

Although most of the countries have undertaken a revision of current health care models, with emphasis on decentralization and the development and strengthening of local health systems, efforts to systematically evaluate performance and measure the results of the activities carried out by health services--based on the analysis of risk factors and health impairments--are still lacking. Such evaluation would help to guide the use of limited resources toward more effective interventions.

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.

There is an increasing need in the Region to incorporate health promotion as a part of political agendas and governmental plans. Thirty of the 46 countries of the Region

(65%) have included health promotion in their national plans. Four countries have formulated written policies on health promotion: Argentina, Chile, Colombia, and Cuba. Undoubtedly this movement toward health promotion has been influenced by the high cost of strictly curative care and the relatively insignificant impact that such care has on the living conditions and well-being of the vast majority of the population, changes in the profiles of morbidity and mortality, and the increase in awareness of the socioeconomic determinants of diseases.

The concept of health promotion was given renewed impetus by the Ottawa Charter on Health Promotion, signed in 1986, which affirms 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 incorporation of health as a strategy that is intended to foster a greater commitment on the part of all to diminish social inequalities and increase levels of collective well-being within a broad social and ecological context.

In order to reinforce this strategic orientation, 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. The Program's mandate includes application of the health promotion strategy in several technical areas, as well as collaboration with other units and programs in the assimilation of concepts, principles, and operational mechanisms needed in order to implement the strategy in the Member Countries. Health promotion is seen as a point of departure for addressing various problems prevalent in most of the countries of the Region, including noncommunicable chronic diseases, mental disorders, drug dependency, injuries, and accidents. The Program on Health Promotion provides technical support for programs and policies designed to further the well-being of specific groups, such as the elderly and adolescents, and it promotes improvement of the quality of life and human development.

In accordance with the Program's orientations, assistance is being provided to the countries to implement model population intervention programs aimed at reducing morbidity and mortality and facilitating the formulation of policies, plans, and programs with a view to improving the quality of life. In this regard, high priority is being given to social communication and information management, as instruments for the promotion and protection of health. Training activities are also being emphasized, including the subregional workshop for the countries of Central America, carried out in Honduras in 1993 with support from the Spanish Government, and various national workshops and seminars, which have had a positive impact at the local level.

As for interprogram activities, efforts are being made with other programs of the Organization to implement health promotion approaches and mechanisms, emphasizing the role of the sector in intersectoral work. The management of the cholera epidemic is a good example of this type of work. The "healthy *municipios*" movement that is being implemented in the countries with the assistance of PAHO is another example of a health promotion initiative that is leading to new ways of conceiving and developing public health actions.

The mechanisms for implementing the health promotion strategy center on encouraging 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.

At least two major events relating to health promotion have occurred in the Region in recent years. In November 1992, 550 representatives from 21 countries attended the International Conference on Health Promotion held in Bogota, Colombia. Because it was the first international conference on health promotion to be held in a developing region, the Bogota meeting lent a greater sense of urgency to the concepts of development, equality, consensus, civil society, and participation by both sexes and by all sectors, cultures, and resources for the achievement of health (see Box 3).

The English-speaking Caribbean organized the first conference on health promotion in that subregion in Trinidad and Tobago in June 1993. The conference was attended by representatives from 19 countries and various sectors. The Caribbean Charter for Health Promotion proposes the strategic approaches for action and the implementation of intersectoral activities, recognizing that equity must be the central consideration for decision-making in the area of health.

Box 3

Declaration of the International Conference on Health Promotion
Santa Fe de Bogota, November 1992

The right to and respect for life and peace are the fundamental ethical values of the culture of health. As a result, it is indispensable to the promotion of health in Latin America that these values be accepted, cultivated and practiced daily.

Commitments

1. Instill the concept that health is conditioned by political, economic, social, cultural, environmental, behavioral, and biological factors, and that health promotion is a strategy to change these conditioning factors.

2. Enlist social forces in the application of the health promotion strategy, subordinating economic interests to social goals, with the purpose of creating and maintaining family, physical, natural, labor, social, economic, and political settings that promote life rather than degrade it.

3. Encourage public policies that guarantee equity and favor adopting healthy environments and options.

4. Refine coordination and negotiation mechanisms among the social and institutional sectors in order to follow through with health promotion activities, keeping in mind the overall improvement of well-being and fostering the transfer of social investment resources to civilian organizations.

5. Consolidate a committed and effective plan to curtail unproductive spending in areas such as military budgets, diversion of public funds for producing private gains, excessively centralized bureaucracies, and other sources of inefficiency and waste.

6. Strengthen the ability of the people to participate in the decision-making that affects their lives, and to choose healthy lifestyles.

7. Eliminate the excessive burden of inequity on women. The participation of women, providers of life and well-being, constitutes an indispensable axis of health promotion in Latin America.

8. Stimulate dialogue among intellectual leaders so that the process of health development is incorporated in the cultural heritage of the Region.

9. Strengthen the health sector's capacity to mobilize resources toward social production of health, assigning responsibility for tasks to the social players in their actions related to health.

10. Recognize the people committed to the process of health promotion as health workers and agents, in the same way that professionals trained to provide health services are recognized.

11. Encourage health promotion research to generate appropriate science and technology, and disseminate the knowledge gained in a way that transforms it into a means for liberation, change, and participation.

5. *Using Social Communication*

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.

The provision of relevant information on health through the mass media, educational curricula, and community discussions is essential in order to ensure that the population is able to make decisions relating to individual, family, and community health. Twenty-six percent of the countries of the Region have indicated that they consider this strategy a priority for technical cooperation in health. Other countries have developed initiatives with a primarily national focus.

In the Andean area, Bolivia has an active social communication program under the Ministry of Health, which places particular emphasis on the indigenous populations. In Peru a mass communication program has been developed through the mass media (press, radio, and television). Information on health issues is scheduled during the peak viewing and listening hours, both in urban and rural areas, and training seminars have been organized for journalists on mass communication for health. The newspaper "La Republica" prepares and distributes free of charge a weekly magazine on health. In Colombia, various newspapers carry columns in which health issues are discussed. In Venezuela, emphasis is placed on support for health promotion and activities to promote healthy lifestyles for urban and rural populations. In Brazil and Uruguay, social communication is an important component of health programs such as those on AIDS, cholera, cancer, accident prevention, and maternal and child health. Both public and private electronic media are used for this purpose. In Uruguay mass communication programs are evaluated by a company specializing in publicity, and in Brazil health promotion campaigns are conducted and evaluated by international agencies in collaboration with national agencies.

In the English-speaking Caribbean numerous mass communication activities relating to health are carried out. CAREC writes a monthly column on traffic safety. The Barbadian newspaper "The Nation" carries a column on the environment. Several

institutions and agencies are carrying out campaigns on health-related issues using the mass media: The Caribbean Food and Nutrition Institute in Jamaica is sponsoring competitions on food security; the sanitation company of Trinidad and Tobago is sponsoring campaigns on the importance of a clean environment; the Environment Association of Barbados organizes annual competitions between cities for the improvement of the environment.

No information is available on which countries have incorporated health education as part of their programs of formal primary education, but several countries, including Colombia, Costa Rica, Cuba, Ecuador, El Salvador, Nicaragua, and Panama, have produced materials at the local level for mass health education. These materials have been tailored to the characteristics of local communities.

In addition to the mass communication activities carried out by the countries and by the Regional Program on Health Promotion, the PAHO Office of Information and Public Affairs carries out communication activities aimed at the general public and the mass media, providing support for the other PAHO programs and offices in this regard. The Office's responsibilities include public relations and public information, media relations, and the production of audiovisual communication aids.

The Office also carries out a comprehensive program called "Communicating for Health," which is supported by a committee responsible for mobilizing funding for this initiative and by other PAHO programs and the specialized centers.

The cholera epidemic has required an increase in information dissemination activities. With a financial contribution of $2 million from the Netherlands, a regional information program was developed to combat the disease. In addition, PAHO serves as a repository for educational materials on cholera, including posters, slides, and audiovisual aids.

The Organization has been involved in and has promoted immunization campaigns, especially in the Caribbean subregion (the "Making Measles History" campaign), in Central America ("Eliminemos el Sarampión"), and in the Andean Region ("Viva la Vida"). With a view to eliminating poliomyelitis worldwide, joint mass communication campaigns have been carried out with Rotary International, UNICEF, and other agencies.

The PAHO Representations in Colombia, Costa Rica, Guatemala, Honduras, Paraguay, Peru, and Venezuela, and the Caribbean Program Coordination have journalists who work with national authorities in order to provide health information to the public. In order to effectively implement the strategy of using social communication, PAHO organized a series of seminars devoted to the subject of health and science for journalists from 18 countries who work for the mass media (radio, television,

newspapers, and magazines). Particularly noteworthy in this regard is the recent establishment in Central America of the Central American Association of Health Journalists.

In the area of public information, the demand for information grew from 2,000 requests per year in 1990 to more than 3,000 in 1993.

Global health promotion events such as "World Health Day," "World No-Tobacco Day," and "World AIDS Day" continued to be organized and promoted.

As for special projects, PAHO carried out the Third Pan American Teleconference on AIDS, a special program for "Health for All" television, and it participated in EXPO '92, held in Spain, in which PAHO acted as the coordinating agency for the OAS, the IDB, and the Inter-American Institute for Cooperation in Agriculture.

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.

In recognition of the importance of integrating women into efforts to promote health and development, and this strategic orientation was proposed with a view strengthening actions aimed at increasing respect for and strengthening women's decision-making capacity, promoting their self-esteem and their individual and social fulfillment, protecting their rights, preventing abuse and violence against women, and promoting policies and actions aimed at bringing about changes in social, political, legal, and labor standards so as to favor equal participation by both sexes in the development of the countries of the Region.

In order to implement this strategy, the Regional Program on Women, Health, and Development designated focal points within the PAHO Representations to promote efforts

and monitor progress toward the targets. The main role of the focal points was to coordinate activities with organizations and agencies concerned with women's issues, mobilize resources, and promote national or subregional initiatives, raising awareness of gender gaps in health, promoting actions to strengthen the institutional capacity of the health sector for the development of policies and programs with a gender approach, and promoting legislative initiatives and the legal equality of women, in addition to mobilizing, organizing, and developing the leadership capacity of women to promote, protect, and monitor their own health.

To mobilize national and international resources for the advancement and development of women and their health, the Regional Program has directed its activities toward strengthening interagency, interprogram, and interinstitutional coordination for the identification, formulation, and implementation of initiatives and projects at the regional, subregional, and national levels.

Various projects on the subject were developed. With the support of the Nordic countries, seven countries in Central America (including Belize) participated in the Project on Comprehensive Health of Women in Central America 1990-1994 through the Ministries of Health, offices of women's affairs, universities, and NGOs. These same countries, through their local health systems, health services at the primary care level, and local organizations of women, will participate in the Project "Health-Sector Interventions to Prevent and Address the Problem of Violence against Women," which is scheduled to begin in 1995. The English-speaking countries of the Caribbean--Barbados, Dominica, Guyana, Jamaica, Saint Vincent and the Grenadines, and Trinidad and Tobago--are carrying out the Project "Women, Health, and Development" with resources mobilized from the Carnegie Foundation.

At the Regional level, PAHO and IDB staff and planners and project developers from governmental and nongovernmental organizations are involved in the Project "Criteria for Incorporating the Gender Perspective in the Formulation and Evaluation of Projects and Loan Proposals," under the sponsorship of the IDB and PAHO. Currently under negotiation with UNIFEM is a project for the formation of community networks to provide health education aimed at preventing violence against women and girls, to be carried out by primary health care services and community organizations at the local level.

An analysis of the APBs of the PAHO Representations reveals that eight countries (17.4%) have explicitly included this orientation 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. Mexico and Peru have defined national plans for the advancement of women. In the case of Mexico, the approach taken involves training in family health. In Belize, Chile, Colombia, El Salvador, Guatemala,

Honduras, and Venezuela, policies on comprehensive care for women have been formulated, and programs have been developed to prevent sexual violence and provide care for victims, as well as to educate women's leaders and advocates to promote self-care.

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 review existing legislation and draft new laws aimed at eliminating the "de jure" discrimination that prevent women from managing their own health. To that end, through the Democracy and Health initiative, information was provided to the lawmakers who are members of legislative commissions on health, and standing commissions on women were created within the Central American congresses, with the support of the initiative on woman, health, and legislation in Central America. Among the activities undertaken to ensure punishment for perpetrators of violence against women and girls, the penal codes of the countries of the Region were reviewed and proposals for reform were made.

In order to raise awareness of the innovative "gender and health" approach and its incorporation into studies and research on the subject of women, the Regional Program on Women, Health, and Development has put considerable energy into generating knowledge, carrying out situation assessments, and disseminating information at the regional and subregional levels. The activities carried out have included assessments of the situation of women in Mexico, Guatemala, Honduras, El Salvador, Costa Rica, Venezuela, Colombia, the countries of the English-speaking Caribbean, Suriname and Haiti; distribution 5,000 copies in English and Spanish of the scientific publication "Gender, Women, and Health in the Americas" and of the publications "La Salud de la Mujer y los Diferenciales de Género" [Women's Health and Gender Differentials] and "Evaluación de la Década de la Mujer 1985-1995: La Salud de la Mujer en las Américas" [Evaluation of the Decade for Women 1985-1995: The Health of Women in the Americas], produced jointly by PAHO, ECLAC, UNESCO, ILO, and UNFPA.

In regard to institutional strengthening of the sector for the development of policies and programs with a gender perspective, the actions of the Regional Program on Women in Health and Development emphasized sensitization and training of health personnel in this approach. For this purpose operational frameworks and methodologies for work were developed to facilitate specific activities in the countries, even at the level of local health systems in the cities of Maracay, Venezuela and Quito, Ecuador. The Governing Bodies of PAHO made recommendations for regional plans of action and policies on the health of women, defining lines of action for technical cooperation in regard to the promotion of self-care, the reduction of violence against women and girls, and maternal mortality. The Governing Bodies also approved the establishment of a regional system for monitoring and evaluation of the situation of women and of sex differentials.

One of the most important lines of action for involving women in the process of development is unquestionably consciousness-raising and empowerment, while promoting the protection of women's interests and advocating their rights, one of which is health. The activities carried out in this regard included: a regional meeting attended by 120 female representatives of 75 NGOs from 17 Latin American countries, which culminated in the publication of the "Declaration of Buenos Aires, 1991: Women in the Struggle against AIDS;" an informative campaign to mobilize participation in the World Day of Action for Women's Health (28 May) and the World Day to Stop Violence against Women (25 November); the Regional Meeting of the Women's Health Network of Latin America and the Caribbean, held in Santiago, Chile in October 1992; and a series of subregional and local activities designed to promote women's health and self-esteem.

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.**

The production, dissemination, and use of knowledge and new technologies is crucial for the comprehensive development of societies today. In the health field, ever-greater importance is being placed on research and its translation into new knowledge and technological resources that will facilitate the solution of health problems.

This strategic orientation was formulated with the understanding that the promotion of scientific and technical production, its broad dissemination, and the rational incorporation and use of technology will depend on bringing the scientific and technological strategies of the sector into line with the general priorities of economic and social development of the countries of the Americas.

Explicitly or implicitly, the countries of the Region have established policies on health research. In the last four years there has been a major shift in the sources and mechanisms for financing research activities, new actors have emerged, and traditional

roles have changed--notably the role of governmental agencies. In some countries this process has resulted in 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, while in others it has meant a deterioration of the infrastructure and of the scientific production achieved in previous years. The rapidity of the changes, the heterogeneity of situations, and the weakness of existing systems of information on scientific activity make it difficult to establish a more precise diagnosis of the situation and its trends.

The data available on the production of technical and scientific information in the Region are not current and are not complete for some countries. The Center for Scientific and Humanistic Information (CICH) of the Autonomous National University of Mexico has identified 77,925 articles published between 1979 and 1988 in six countries of the Region (Argentina, Brazil, Chile, Cuba, Mexico, and Venezuela); 56% of these articles were published in journals of the author's country of residence and 44% in international journals. According to an IDB report, the whole of Latin America accounted for 0.97% of the scientific articles included in the database of the Institute for Scientific Information in 1973, a much smaller contribution than that of countries such as Belgium, Czechoslovakia, or Israel. The situation had not changed significantly by 1984, when Latin America produced 1.14% of all articles published that year, an extremely small proportion if it is taken into account that the Region accounts for 8% of the world's population, 11.5% of all enrollment in institutions of higher learning, and 2.42% of the world's scientific professionals.

Efforts have been made to ensure that the knowledge produced through research is utilized by health services, but communication barriers between the institutions that produce knowledge and those that use it continue to exist. PAHO has supported courses and workshops for health service personnel on the preparation of research projects in health services (Mexico and Brazil), with the problems identified by these professionals serving as the basis for the projects prepared. Of the 20 projects supported by the PAHO Research Grants Program in 1991-1992, ten emerged from these courses and workshops.

In order to further the dissemination of scientific and technical information, the creation of databases on projects in progress, investigators, and institutions has been supported in five countries. In collaboration with the Latin American and Caribbean Center on Health Sciences Information (BIREME), a study was carried out to determine the mechanisms used to assess the quality of articles to be published in the 507 Latin American journals indexed in the LILACS database. Seminars and workshops for the editors of these journals are planned, also in conjunction with BIREME.

As a fundamental instrument to support the management of knowledge, PAHO has emphasized the development of scientific and technical information through the

implementation of new information search, storage, and dissemination systems and the creation of networks for the exchange of health knowledge. With a view to expanding the coverage of the Regional Health Sciences Information System and keep better track of the literature generated in the Region, while also increasing the number of health professionals with access to scientific information, the Latin American and Caribbean Center on Health Sciences Information of PAHO (BIREME) has created a system of specialized networks or subnetworks over the last two years, which may be incorporated into a Regional or national system. In addition, BIREME is developing products and services aimed at specialized segments of the health field (nursing, dentistry, and health services management). The Regional Health Sciences Information System also incorporates the specialized information systems of the Pan American Centers and the programs of the Organization: REPIDISCA, ECO, INPPAZ, INCAP, the disasters database, the LEYES database, SIDORH. One of the most important of these is REPIDISCA, a subsystem that coordinates a network of specialized Cooperating Centers in Latin America.

To support the development of national health systems with emphasis on issues relating to health promotion, information has been recorded and disseminated to the countries on disease prevention and risk factors, as well as on the promotion of healthy lifestyles. In addition, the documentation in the collection of the Program on Health Promotion has been indexed, yielding a total of 1,912 entries. This information is contained in the bibliographic data of the Division, the PPHD database at the PAHO library, and on LILACS.

In connection with the recent inauguration of the Center for Information on Health Protection and Promotion, printed and audiovisual materials on policies, methods, and local experiences worldwide have been identified and compiled for dissemination to the countries of the Region.

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.

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 thus forms the substratum for the technical cooperation activities fostered and carried out by PAHO. In this sense, resource mobilization is most directly related to the strategic orientations of health in development, management of knowledge, and cooperation between countries.

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, of which PAHO has been named 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). PAHO now has available an information system that collects data on approximately 300 NGOs, which has facilitated the effort to promote their inclusion in the planning and execution of health programs. 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.

PAHO's activities with regard to the mobilization of resources are based on observation of the trends in Official Development Assistance (ODA) and on its analysis of the health situation in the Region. One of the essential components of this analysis is the determination of the extent to which the target of allocation of at least 0.7% of GDP for development assistance is being met. Since 1979, the amount allocated for this purpose has averaged only around 0.35%. In 1991, total ODA, which includes funds from bilateral and multilateral sources, totaled $56,000 million. Of this total, $41,000 million (70%) was provided by member countries of the Development Assistance Committee (DAC). For the distribution of ODA in the Americas, see Graphic 1.

In order to strengthen ministerial relations several joint training and exchange activities are being carried out between the ministries of planning, the economy, housing, foreign affairs, and health.

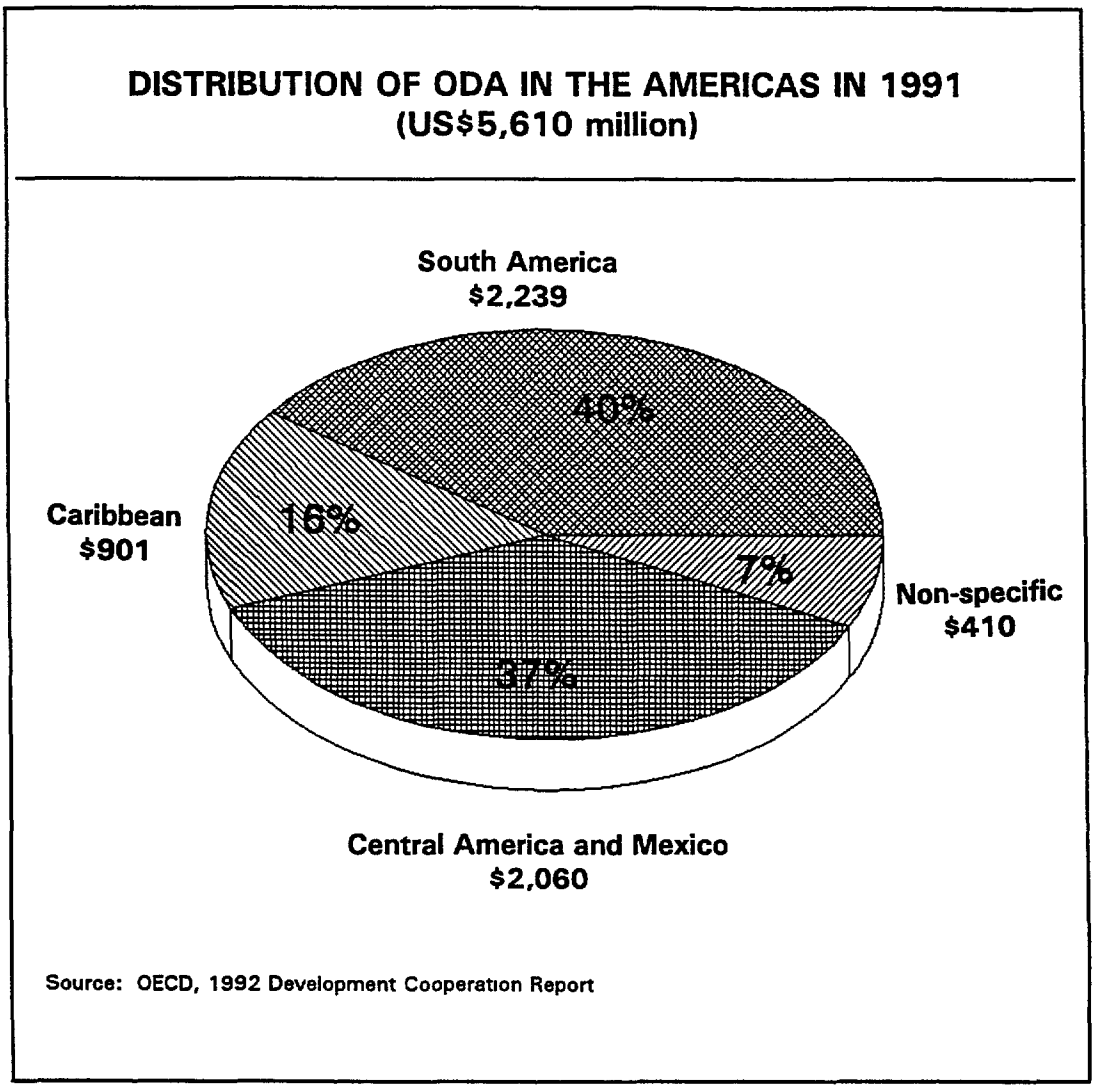
Observation of the trend of bilateral and multilateral assistance as a proportion of total ODA reveals that bilateral assistance made up 51.78% of ODA in 1980; this proportion rose to 66% in 1986 and 70% in 1991. The relative importance of multilateral assistance, on the other hand, declined from 33.62% in 1980 to 24% in 1986, stabilizing at around 26% in 1991. Data from a WHO study carried out in 1991 show that of total bilateral ODA, which amounted to $34,000 million in 1989, the proportion allocated for health was on the order of 10%.

The geographical distribution of ODA in 1991 was as follows: Latin America and the Caribbean, 9.8%; Asia, 31.9%; and Africa, 41.4%, with 17% going to other regions.

The resources derived from international cooperation are vulnerable to changes in the policies on external assistance established by DAC. As a result, the health sector in the countries needs to step up efforts to identify priorities, translating them into appropriate proposals to be negotiated with the international community. The total amount of extrabudgetary resources from all donors channeled through PAHO in 1990, 1991, 1992 and 1993 totaled $192,139,724 for the biennium 1990-1991 and $188,470,166 for 1992-1993. It should be noted that external resources have grown from 1% of the total budget of PAHO in 1971 to almost 50% during the last biennium.

These events are aimed at enhancing action in three areas: management of international cooperation for health, provision of knowledge about sources of cooperation and their financing policies, and promotion of the health sector in international cooperation projects in order to ensure that health is included among national development

Graphic 1



priorities. Three subregional seminars on international cooperation for health were organized, one in Central America (September 1992), one in the Andean Area (March 1992), and the third in the Southern Cone (August 1993). In addition, meetings have been held at the country level for the discussion of proposals and projects.

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 project management approach 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.

Information on the trends in Official Development Assistance was updated. The documents published included: "La Cooperación Internacional en Salud, Perfiles de Agencias" [International Cooperation in Health: Agency Profiles] (1992), which is intended to provide information on the principal sources of international cooperation and their policies and procedures; documents on international cooperation for health presented at the training seminars in Central America, the Southern Cone, and the Andean Area; "Organismos No Gubernamentales" [Nongovernmental Organizations], a document which explains the function of NGOs in development and compares them to other public- and private-sector organizations; and the report of the colloquium with nongovernmental organizations on health and the environment in Central America, held in December 1992.

9. *Technical Cooperation among Countries*

Targets:

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.

Pursuant to the mandate from the XXIII Pan American Sanitary Conference, PAHO has continued to promote the development of technical cooperation among countries as a powerful strategy for addressing some of the needs of the Member Governments.

Noteworthy among the types of technical cooperation carried out in the Region was the formalization of Technical Cooperation among Developing Countries (TCDC) following the United Nations Conference held in Buenos Aires in 1978. TCDC is aimed, above all, at promoting and strengthening the individual and collective self-sufficiency of the developing countries through the sharing and use of their technical resources and the development of their complementary capacities.

The events of the last decade, including the formation of large economic blocs, and accelerated and exponential growth of communications technology, have pointed up the need to expand the concept of technical cooperation among countries. In the health sector, this need has become particularly acute with the emergence of cholera and AIDS. Accordingly, in 1992 PAHO reviewed its policy on technical cooperation among countries and began to place greater emphasis on promoting technical cooperation among all countries, regardless of their level of development. Technical cooperation is seen as a form of action that is the same, independently of the origin of the resources, and as a result technical cooperation from PAHO or between countries can be programmed in the same way.

As concerns the financing and management of technical cooperation among countries (TCC), innovative ideas have been proposed, including shared cooperation, or "triangulation," in which the country offering the cooperation enters into a partnership with another country, institution, or bilateral agency with which it shares interests, to provide cooperation to the requesting country. This mechanism is feasible provided that good communication and negotiating capacity exist between the parties. PAHO allocates a specific share of its budget to promote cooperation between countries (TCC allotments). This support is considered mainly catalytic, since these funds cannot constitute the primary source of funding for projects. This catalytic activity is directed principally toward providing support for the formulation of projects or funding activities under formulated projects.

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

In 1990 the use of $132,400 for these purposes was approved. In 1991, the amount rose to $420,700. In year 1992, the figure approved from the regular budget was $328,300. In addition to this amount, $95,000 in extrabudgetary funds from the Nordic countries was approved for TCC activities in the subregion of Central America, which increased the total allocation for TCC in 1992 to $423,000. Activities were carried out in the areas of human resources, health services development, rehabilitation, vector-borne disease control, support for national health plans and programs, maternal and child health, veterinary public health, mental health, and technological development, among others. The strategies for the execution of these activities were based on support and strengthening of local health systems, targeting of action to high-risk groups, management and exchange of knowledge, and regional integration.

At the Regional level, the countries, with the support of PAHO, have made notable efforts with regard to the operation of the revolving fund of the Expanded Program on Immunization, the elimination of Chagas' disease, the maintenance of close

collaboration in activities to combat the cholera epidemic, and humanitarian aid to Haiti (see Box 4). In addition, other projects have been carried out by the countries jointly and with the support of the Organization. Noteworthy among them is Project Convergence, initiated in 1991, which also involves LAES and UNDP. Its objective is to promote technological development in the health field in Latin America and the Caribbean, activating and strengthening the potential of national institutions to design and produce technology suited to specific health needs and at the same time contribute to economic and social development. Also worthy of mention are the institutional cooperation networks between the countries promoted by the Pan American centers, including the Pan American Network of Information and Documentation in Sanitary Engineering and Environmental Sciences (REPIDISCA), and the Network of Coordinating Centers in Scientific and Technical Information 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.

Since its first phase, "Health as a Bridge for Peace," initiated in 1983, the **Central American Health Initiative** has helped to maintain an important degree of stability in national health priorities, even in the face of the political instability the subregion has experienced. The Initiative continues to be an important element for international cooperation, social equality, and regional integration. In 1992, the health sectors in the countries of the subregion pooled their efforts to support the peace movement. The historic United Nations-mediated peace agreement between the Government of El Salvador and the FMLN, representing the opposing forces, brought with it the urgent need to provide various health services among the demobilized forces. PAHO was asked by the parties concerned to coordinate the delivery of those services. In addition, a series of intercountry activities were conducted in the midst of conflicts between governments, such as the activities between Honduras and Nicaragua, and Nicaragua and Costa Rica. Also, within the framework of the Initiative direct discussions were carried out for the first time at the ministerial level between Guatemala and Belize. The development, implementation, and financing of projects was strengthened, and health information networks were created. In addition, in-service training was provided in all the Central American countries. The Initiative has contributed significantly to the mobilization of external resources, facilitating technical and financial support for more than 25 agencies and organizations.

During the Presidential Summit held in Managua in June 1992, the Heads of State of the Central American countries reaffirmed their support for the second phase of the Initiative, "Health and Peace toward Development and Democracy." PAHO participated as an observer in this meeting, and also provided technical cooperation to the Council of Health Ministers and to the Meeting of the Health Sector of Central America (RESSCA).

RESSCA, which throughout the years has provided political leadership for the Initiative, has become the highest-level decision-making body in the health sector in the subregion and therefore constitutes an important factor for subregional integration. At RESSCA VIII (1992), resolutions were adopted that underscore the importance of the Initiative and call for the mobilization of resources in the four priority areas of the second phase: infrastructure of health services, health promotion and disease prevention, attention to special groups, and the environment. Special emphasis was placed on the proposal to eradicate measles and on the establishment of a system of regional epidemiological surveillance for Central America.

During 1992, 17 national projects were carried out in the four priority areas with external resources and 15 were carried out with national resources. At the subregional level, 27 subregional projects were executed, 12 of which received external financing. Five are still being negotiated.

With the collaboration of PAHO, the Ministers of Health of the Andean Area in 1987 formulated and adopted a plan of action joint. The general objectives of **Andean Cooperation in Health** (ACH) are to identify mechanisms for cooperation between the countries for the solution of substantive common problems through collective efforts designed to produce positive results in the short and medium term. The approach is to deal jointly with problems of a subregional nature or problems between two or more countries. The ACH seeks to strengthen ties between the participating countries and improve the utilization of internal and external resources in the priority areas selected. The countries that participate actively in this Andean initiative are Bolivia, Colombia, Ecuador, Peru, and Venezuela. Chile has joined recently. Under the Hipólito Unanue Agreement, a Secretariat of Ministers of Health of the subregion coordinates the Initiative jointly with PAHO/WHO. There are seven priority areas for collaboration between the countries: health services development, with emphasis on essential drugs, biologicals, and equipment maintenance; maternal and child health, with attention to nutrition; control of malaria and other vector-borne diseases, cholera, and tuberculosis; drug addiction; disaster preparedness; and environmental health, with special attention to drinking water and solid waste; and workers' health. During REMSAA XVII, held in Cuenca, Ecuador, in November 1993, the Ministers of Health added an eighth priority, which is modernization of the health sector.

The ACH has had a very slow take-off, perhaps owing to the frequent changes of authorities in the countries of the subregion. When the new authorities take office they are unfamiliar with the Initiative, as a result of which little headway has been made in integrating the ACH into national programs, and it continues to be considered a separate initiative. Another factor influencing the development of common activities is the tremendous disparities in health existing between the countries of the subregion at all levels, which sometimes makes it difficult to find common ground for action. However, some successes were registered, such as the meetings of technical officials from each country held with the support of the Secretariat of the Hipólito Unanue Agreement and PAHO, the objective of which was to consider approaches and common activities to be

carried out in border areas. These activities have indeed yielded concrete results. In some of the priority areas established positive effects of the efforts of the ACH have been noted, particularly in the area of maternal and child health, although in most cases true active collaboration between the countries is still lacking.

The **Caribbean Cooperation in Health** initiative was formally established in 1986 at a meeting of Ministers of Health, and was subsequently approved by the Heads of Government. The principal objectives of this initiative are the identification of priority areas for increasing productivity in the use of the countries' resources, the development of specific projects to improve the delivery of services and solve the problems of the health sector, the mobilization of national and external resources in order to address the health problems of the most vulnerable groups, and the promotion of technical cooperation for health between the countries and between agencies and institutions. The Governments initially asked PAHO and CARICOM to coordinate the development of the initiative. Subsequently, the Secretariat of the Caribbean Cooperation in Health was established and given the functions of promotion, project development, programming, documentation and information, and monitoring and evaluation. PAHO maintains its role as technical cooperation agency and CARICOM serves as the Secretariat for the Conference of Ministers.

The priority areas for the Caribbean Cooperation in Health were identified on the basis of an evaluation of the epidemiological profile of the countries. The priorities defined are: environmental protection and vector control, human resources development, control of chronic non-communicable diseases, strengthening of health systems, food and nutrition, and maternal and child health. In 1988, AIDS was included as the seventh priority. For the implementation of projects in the priority areas national and external resources have been mobilized. During the period 1992-1993, most of the external resources came from the governments of Italy, France, and United Kingdom, and from the Caribbean Development Bank, the Canadian International Development Agency (CIDA), the Carnegie Foundation, and UNICEF. Resources were also obtained through CARICOM.

Among the most prominent successes achieved under the Caribbean health initiative are the development of goals and targets to serve as a basis for evaluation and monitoring of activities and the bulletin "CCH Update", published every four months, which is an important vehicle for promotion of the initiative and dissemination of information on activities in the countries and at the subregional level.

At a meeting held in Montevideo in August 1986, the Ministers of Health of Argentina, Brazil, Chile, Paraguay, and Uruguay launched the **Southern Cone Health Initiative** as a forum in which common health problems would be examined and joint actions would planned to address them. In November 1988 Bolivia was incorporated into the Initiative as a full member. The Ministers decided to meet every two years in order to update existing agreements with regard to health problems in border areas and in order to analyze the progress made under the Initiative. The participating countries also agreed

to hold technical discussions once a year for the purpose of promoting the exchange of information and experiences relating to priority health problems, adopting decisions with respect to subregional or bilateral activities aimed at promoting better utilization of resources, and determining to what extent each country has followed the recommendations of the joint technical and ministerial meetings.

The Ministers selected six priority areas for cooperation in health, with each country in charge of the coordination of activities in one area. The areas and countries to which they correspond are: local health systems and technology, Chile; health of the 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, held in Santiago, Chile, in June 1993, the subject of health sector financing policies was included on the agenda. Several resolutions were adopted which designated particular activities and responsibilities for follow-up in each of the technical areas, establishing in each country a National Coordinator and Focal Points for each program area, and assigning responsibility for monitoring and promoting compliance with the resolutions adopted.

Box 4

Humanitarian Aid to Haiti

Since the coup of September 1991, when the constitutionally elected government was overthrown, the Organization has assumed an increasingly important role in coordinating humanitarian aid in the areas of health, water supply, and sanitation.

During the trade embargo that was imposed and is still in effect, PAHO has made efforts to organize and coordinate the activities of multilateral, bilateral, and nongovernmental organizations in support of the Haitian population. PAHO serves as the secretariat for a large group of such agencies, which review and coordinate their actions in consultation with the legitimate Minister of Health of Haiti. It is through this route that most of the humanitarian aid is channeled.

Of particular note is the PROMESS system, which is of vital importance for the distribution of essential drugs throughout the country. PAHO can be credited with the conception, development, management, and implementation of this system, as well as the procurement and delivery of pharmaceutical products.

In the face of the embargo and the threat of reduction of the fuel supplies necessary to continue humanitarian aid, PAHO was persuaded by the UN and the OAS to oversee the purchase and management of the necessary petroleum products. Although this type of activity falls outside the scope of the Organization's mission, it has nevertheless undertaken to import sufficient supplies every month for those involved in providing humanitarian aid in the health sector.

PAHO has also developed, together with the Ministry of Health and other agencies, an Emergency Plan that has constituted the basis for the support provided by donors. On the technical side, PAHO has developed a plan for the prevention of cholera in Haiti.

PAHO has played and continues to play a key role in promoting humanitarian assistance to the citizens of Haiti.

B. Program Priorities

Presented below is an analysis of the targets related to each of the program priorities established with a view to overcoming insufficiencies and building a better response capacity to address both old and new problems of the health sector.

The program priorities were divided into five areas for the development of health services infrastructure and eight priorities for the development of programs.

1. *Priorities for the Development of Health Services Infrastructures*

a. 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.***

This program priority was identified taking into account that changes in health systems should be supported by comprehensive analysis of the sector, including analysis of the health status of the population, the situation of the services, the economic implications of sectoral activity, and the possibilities for rechanneling health spending toward highly effective actions and programs that will lead to equity.

In this area the Organization 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 aimed at expansion of infrastructure, reform, and/or institutional development. Although most of the graduates of these courses continue to work in health-related areas, the high turnover rate among the staffs of government agencies compromises efforts to make full use of these specialized human resources and hinders the development of the countries' capacity in this area. This activity was redefined in 1993 in the context of the Regional Plan for Investment in the Environment and Health, in order to establish a minimum capacity to reproduce these courses at the country level.

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 with a view to facilitating the work of new governments or new health authorities, who have tended to change frequently in the Region. The guide has been tested by new health authorities in Ecuador during a transition period in that country and may be adjusted for use in the development of projects for reform and/or investment in the health sector.

As concerns sectoral analysis in the areas of water and sanitation, under the Regional Plan for Investment in the Environment and Health (PIAS) a collaborative effort involving PAHO, the Agency for International Development (USAID), the Inter-American Development Bank, and the World Bank produced a set of common methodological guidelines for the four agencies that has made it possible for them to use a similar approach to the detailed study of these areas. These methodological guidelines were used in 1993 to conduct analyses of the processes of investment in the environment and health in Brazil, Colombia, El Salvador, and Honduras.

Another important methodological development has been the health futures approach, which PAHO is incorporating through its participation in a coordinating committee on the subject, under the aegis of the Monitoring, Evaluation, and Projection Methodology Unit of the World Health Organization.

b. *Sectoral Financing*

Target:

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

In this area it was considered important to examine alternative means of financing and the implications thereof in terms of their contribution to the reduction of inequities in the distribution of the benefits of health services and in more effective use of resources.

With cooperation from the World Bank's Economic Development Institute, four subregional seminars on health economics and financing were held in the cities of Brasília, Bridgetown, Cuernavaca, and San José. These seminars included

theoretical and practical discussion of the most important current issues in the management of the economic and financial dimensions of health and health services. The participants 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. The purpose of the seminars was not only to familiarize the participants with the most recent trends in the area, but also to lay the foundation for carrying out monitoring and development activities at the national and intercountry level.

These seminars had a multiplier effect, spawning a number of activities at the national level and leading directly to the creation of five national health economics associations. More recently, also through cooperation between PAHO/WHO and IDA/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, whose demand for economic-financial analysis applied to the health sector is growing exponentially, but without parallel growth in their resources.

A seminar on health financing during the crisis and structural adjustment was held with a view to comparing the experiences of several countries during the second half of the 1980s and beginning of 1990s. In addition, a study was carried out on the use of emergency and social investment funds in seven countries of the Region (Bolivia, Costa Rica, Guatemala, Honduras, Jamaica, Nicaragua, and Peru). Such funds have constituted the principal source of financing for the implementation of social policy in the countries of Latin America and the Caribbean.

c. *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 Countries, 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.**

In 1988, the XXXIII Meeting of the Directing Council of PAHO adopted Resolution XV, which defined the development of local health systems as the best sectoral reorganization strategy for achieving greater efficiency and equity in health care. Five years after this decision, the countries have made significant headway in improving the organization and management of health services, despite the financial constraints affecting health institutions.

The most salient feature of 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 (see Box 5).

Twenty countries have reported that structural adjustment in the health sector has had an impact on the quality and quantity of health care services.

The process of decentralization, which has progressed significantly, was accompanied by changes in the central agencies that manage and administer health services. In 12 countries reorganization of health systems has been initiated, with 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. In other countries this change began prior to 1988.

The restructuring of the State and the process of health sector adjustment are being accompanied by the formulation and implementation of projects with financing from international lending institutions and bilateral cooperation agencies. This has helped to mitigate the negative impact of adjustment measures, both through programs to channel investment into infrastructure and, especially, through institutional strengthening aimed at achieving better levels of efficiency.

In seven countries special funds have been created for the allocation of government financing specifically to the social sectors. These funds--which have generally been labeled social emergency, development, or social investment funds--have been used to finance health-sector activities such as investment in critical areas or programs designed to provide health care coverage to disadvantaged populations.

The modernization of the State has required an additional effort to develop and enhance managerial capacity. Emphasis has been placed on institutional development in the framework of State and sectoral reform aimed at decentralization and the improvement of local capacity for management. Reforms have been introduced in the health sector, and considerable progress has been made toward decentralization, especially in the cases of Argentina, Bolivia, Brazil, Colombia, Chile, Ecuador, Peru, and Venezuela. In El Salvador, Honduras, and Nicaragua there has been a deconcentration of administrative systems, and in the countries of the Caribbean, Costa Rica, Cuba, Guatemala, Honduras, and Panama emphasis has been placed on the development of managerial capacity.

In the process of methodological systematization 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 that connection, a conceptual and instrumental framework was drawn up which covered the areas of organizational development, management, administrative decentralization, management information systems, project management, and strengthening of training institutions to support the establishment of local health systems. Under the Central American Health Initiative, PAHO obtained US$ 1.2 million from UNDP and the Central American Emergency Program for a project to consolidate and increase the managerial capacity of health services. Also in that subregion, PAHO collaborated with the countries in developing operational instruments to facilitate the implementation of local strategic administration, including educational materials on the supply system for health sector institutions, which comprises 12 self-instruction modules.

Three basic components are considered essential for information systems to support the management process--data collection, data analysis, and interpretation

in order to identify trends and associations, and to facilitate decision-making. For the most part, the Region of the Americas remains in the first stage, and a number of problems hinder progress in this area. These include incomplete data and the fact that most data are 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 in their local health systems. 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.

Box 5

Trends in the Organization and Operation of the Health Sector During the Quadrennium 1991-1994

- Decentralization
- Adjustment in sectoral financing
- Social emergency funds with action in the health sector
- Reorganization of the Ministries of Health and changes in their roles
- Targeted programs
- Emphasis on managerial development
- Coordination with social security systems
- Greater participation by private entities and NGOs in the delivery of services
- Community participation

d. *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.

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, which is indicative of the low impact of its production on the international scientific community. In addition to being relatively limited, scientific production in the Region is very concentrated: during the period 1973-1984, five countries (Argentina, Brazil, Chile, Mexico, and Venezuela) accounted for nearly 90% of all research findings published in the Region.

In terms of health technology development, Latin America and the Caribbean have a significant infrastructure in place for the development and production of health care materials and equipment. The Region's strongest capacity has traditionally been in the area of biologicals (sera, vaccines, reagents for diagnosis), with at least fifteen production laboratories in nine countries. However, progress has also been made through the Regional System of Vaccines of PAHO (SIREVA) in strengthening infrastructure to improve the quality of the vaccines currently produced and to promote the development of new ones. SIREVA is establishing a regional network for quality control of vaccines with a view to standardizing quality control procedures and technologies. Development in the area of health care equipment has been more recent, but already there are almost 800 companies in the Region manufacturing medical 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 goods and services, including those in the area of health. In the case of some highly prestigious universities, more than 50% of their budgetary resources come from these agreements.

An effort is being made to strengthen technical cooperation among countries as a strategy for furthering technological development in the Region. In the biomedical area, in particular, several cooperation agreements have been signed for joint research, including the one between the Brazil and Argentina on biotechnology, the RIDALC network of cooperation, and others. PAHO is also seeking to promote intercountry collaborative projects through its Research Grants Program. In 1992 work was completed on the development of an AIDS diagnostic kit through a collaborative project involving four institutions in three countries.

Project Convergence, sponsored by PAHO, has supported the development of technology in the Region in eight areas: vaccines; regional health technology information system; training in research and technology management; regulatory harmonization and standardization; marketing and production of hospital and medical instruments and equipment; medicinal plants; sanitation and protection of the environment; and orthoses, prostheses, and rehabilitation. Through meetings held in connection with the Project in the Andean subregion, the Southern Cone, Central America, and the Caribbean, 56 subjects for subregional projects were identified.

e. *Development of Human Resources*

Goals:

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.

In the area of human resources it was proposed that continued emphasis be placed on the formulation of policies on human resources and on planning for human resource development using a strategic approach and taking into account the findings of research on the health work force in order to correct the imbalances between the training and the utilization of personnel.

The targets established for this area complement one another and are aimed at bringing about the development of a human resources policy geared to the needs of the population and the structural changes in the sector. This involves strengthening the capacity to analyze the process of human resource development, which in turn implies achieving a high degree of interinstitutional and intersectoral consensus that links training institutions with institutions that deliver health services.

PAHO has promoted advanced training for the personnel responsible for the development of human resources. Activities in this regard have included information, research, and strategic planning of human resources; development of continuing education to provide ongoing training for personnel already in service, involving the entire Organization, but in particular the fellowships and textbooks programs; support for greater participation by universities in the process of changing the 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. While 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. This is partly because the social background of the educators in institutions that train health professionals, especially in medicine, is

different from that of the existing professionals, and this gap will be even wider in the case of future professionals. The educators present an ideological model of the organization of health care practice that for them is very real, but is unattainable for their students. The students, especially those in medicine and dentistry, are thus influenced by two modalities of practice advocated by their teachers: traditional liberal and autonomous practice, on the one hand, and a technology-dependent model, on the other. It is for this reason that the aspiration expressed some years ago that the process of professional training be adapted to the needs and socio-epidemiological reality of the population has yet to be realized. Efforts to change curricula have been limited to isolated experiments, outside the mainstream of the educational process, which have had no significant impact on the central aspects of the teaching-learning process. In addition, as a result of the fiscal crisis and its impact on the public education system, the salaries of educators are low, and equipment and physical installations are deteriorated, all of which exacerbates the situation.

A process of continuing education is being carried out through the development of educational methodologies geared to the work of health services and articulated with specific priority programs, especially in the areas of management and administration, public health, epidemiology, maternal and child health, and environmental health. Currently, PAHO is reviewing the activities carried out during the last eight years with a view to establishing guidelines for a conceptual and methodological reorientation that will be in line with the socioeconomic and political situations anticipated in the Region during the next decade. Sixteen countries in the Region have been incorporated into this process, the essence of which is the development and promotion of learning by workers in their jobs. The content of the educational process is derived from experiences and problems that have occurred in actual work situations and is based on the needs identified.

A tremendous 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. Many Ministries do not even have accurate figures on their own staffs. Table 1 shows the annual variation in the numbers of physicians and nursing professionals from the previous quadrennium (data from 1988) to the current one (1992). It should be borne in mind that in some cases the variations may be due to errors or differences in the way the figures were calculated in previous publications, as happened with the figures on physicians in Argentina and Guatemala. Apparently the figure was overestimated

in the case of Argentina, and only the staff members of the Ministry were considered for Guatemala. In the case of the countries of the English-speaking Caribbean, the phenomenon of "brain drain" continues, which explains the negative growth in the nursing profession, on which the health care model of these countries is based. An exception to the general rule is Ecuador, which registered a substantial increase in both the number of physicians and the number of professional nurses.

There is no uniformity among the countries with regard to the formulation of policies on human resources, mainly because such policies must necessarily be of an intersectoral nature, since they involve matters relating to health, education, science, technology, and labor. Often 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, since decisions are made outside the health sector. Some countries have tried establishing intersectoral commissions on human resources, which in many cases take responsibility for the formulation of policies. This does not imply that once this type of commission is established the problem is resolved, since often the commissions established cannot fulfill their function, either due to unresolved differences between the parties or to lack of interest on the part of the officials who happen to be in office. The only notable divergence from this pattern is in Cuba, where the development of human resources comes under the Ministry of Health, which gives coherence to the policies formulated.

With regard to the administration of human resources, almost all the countries have made efforts to decentralize health services and thus to decentralize the administration of human resources. The general impression is that the second modality is politically more complicated, especially in public administration. There are countries in which health workers work in units subordinated to the local government, although they continue to be employed (and therefore retain certain rights) by the central government. Although on a small scale, efforts have been made to create flexible modalities of personnel administration that can be adapted to the characteristics of labor markets.

As concerns the participation of international, bilateral, and nongovernmental agencies in the area of human resources development, the projects funded by the international lending institutions seem increasingly to incorporate components related to institutional development with emphasis on human resources development (as in Bolivia, Colombia, Peru). In most cases, the activities are directed toward personnel already in service, so they have limited impact on the development of future professionals. Also worthy of mention are the fellowships and some training-service integration projects sponsored by several bilateral and international agencies.

TABLE 1: Variation in the Number of Professionals Between 1988 AND 1994

SUBREGION / COUNTRY	PHYSICIANS 1992	PHYSICIANS 1988	PHYSICIANS Annual Growth	NURSES 1992	NURSES 1988	NURSES Annual Growth
ANDEAN REGION						
Bolivia	3,392	1,730	11.88%	1,869	891	13.14%
Colombia	36,551	29,353	5.64%	15,251	11,940	6.31%
Ecuador	15,737	9,901	16.70%	5,538	2,771	25.96%
Peru	23,771	20,031	3.48%	19,612	15,748	4 49%
Venezuela	32,616	28,400	2.81%	15,026	14,389	0.87%
SOUTHERN						
Argentina	88,800	96,000	-1.93%	18,000	17,118	5.15%
Chile	15,015	10,087	4.06%	5,653	3,355	5.97%
Paraguay	2,924	2,536	3.62%	1,375	565	24.90%
Uruguay	1,530	5,756	9.07%	1,710	1,500	1.65%
BRAZIL	208,966	169,488	5.37%	57,047	42,347	7 73%
CENTRAL AMERICA						
Costa Rica	4,027	2,539	9.66%	3,021	1,300	9.82%
EL Salvador	4,525	3,200	7.18%	2,655	1,500	12.10%
Guatemala	7,601	2,171	36.79%	3,120	1,225	26.33%
Honduras	3,803	2,666	7.36%	1,352	1,051	5.17%
Nicaragua	1,723	1,942	-2.95%	2,200	1,120	18.39%
Panama	4,131	2,167	7.43%	2,630	2,172	2.15%
MEXICO	149,432	130,000	2.83%	80,760	44,046	12.89%
LATIN CARIBBEAN						
Cuba	46,860	31,299	10.62%	5,474	N/A[1]	-
Haiti	564	887	-10.70%	728	691	1.31%
Dominican Rep.	11,130	7,332	11.00%	1,360	723	17.11%
NON-LATIN CARIBBEAN						
Bahamas	373	187	12.20%	629	944	-4.95%
Barbados	294	225	4.56%	836	944	-2.00%
Jamaica	338	330	0.80%	2,130	1,974	2.57%
Suriname	329	306	0.91%	995	922	1.92%
Trinidad and	911	1,213	-4.01%	2,037	3,346	-5.37%
NORTH AMERICA						
Canada	60,559	57,405	1.80%	262,288	241,759	2.06%
United States	625,661	585,597	1.11%	2,239,816	2,033,000	1.96%

[1] In the case of Cuba, training of nursing personnel in the 1980s.

2. Priorities for the Development of Health Programs

a. *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.

According to 1992 United Nations estimates, the population of Latin America and the Caribbean numbers 457.7 million, while that of North America is 282.7 million. 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%), but they also reveal that there are 86 million people who lack access to safe drinking water. Access to safe drinking water is defined as the ability to obtain uncontaminated water without this taking a disproportionate amount of the time of one person. The criterion generally established for the sector is that the water source should not be more than 200 meters from where the consumer lives.

Access to drinking water varies from country to country. In Haiti and Venezuela, 50% of the urban population has access to drinking water; in Argentina, Belize, Bolivia, Colombia, the Dominican Republic, Ecuador, Guatemala, Honduras, Nicaragua, Peru, Suriname, and Trinidad and Tobago, 70%-90% has access; and in the Bahamas, Barbados, Brazil, Chile, Cuba, El Salvador, Guyana, Jamaica, Mexico, and Uruguay, over 90% of the urban population has access.

As for the rural population, less than 30% in Argentina, Bolivia, El Salvador, Paraguay, and Peru has drinking water; 30%-50% in Chile, the Dominican Republic, Ecuador, Haiti, Jamaica, and Nicaragua; 50%-70% in Belize, Brazil, Guatemala, Honduras, Mexico, Suriname, and Venezuela; and over 70% in the Bahamas, Barbados, Colombia, Cuba, Guyana, and Trinidad and Tobago.

Despite the fact that Latin America and the Caribbean are among the richest areas in the world with regard to the availability of water, there is a shortage of uncontaminated water for certain segments of the population. This scarcity is the result of lack of adequate water treatment and waste disposal facilities, lack of basic sanitation, and improper agricultural practices. Water supplies are being increasingly contaminated by wastewater, waste products, heavy metals, pesticides, solvents, refuse, and chemical substances.

Quality control of water for human consumption is carried out only in cities of more than 100,000 inhabitants. In smaller communities no quality control exists. 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 for drinking water quality. Some countries such as Chile, Cuba, and Costa Rica have drafted national reports that provide this information, but most of the countries have no data in this regard. Some states of Brazil and Mexico have produced status reports, but data at the national level are not available. The countries of Central America, as part of the PROAGUA project, are in the process of collecting, analyzing, and documenting information on water quality.

Most of the countries have adopted national standards for drinking water quality, and some of the countries have recently enacted laws that set comprehensive water quality standards. One example is Mexico, which enacted the National Water Law in 1992 and is currently in the process of drafting the corresponding regulations. Some countries of the Caribbean have not established their own standards for drinking water quality but have adopted the WHO standards.

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 waste disposal.

The percentage of population covered by sanitation services differs from one country to the next. From 30% to 50% of the urban population of the Haiti has sanitation services; in Bolivia, Ecuador, Peru, Suriname, Trinidad and Tobago, and Venezuela, the proportion ranges from 50% to 70%; in Belize, Brazil, Colombia, the Dominican Republic, Guatemala, Guyana, Jamaica, and Mexico, it is between 70% and 90%; and for Argentina, the Bahamas, Barbados, Chile, Cuba, El Salvador, Honduras, and Uruguay, it is over 90%. With regard to the rural population, less than 30% in Argentina, Belize, Bolivia, Chile, Colombia, Haiti, Mexico, and Peru has sanitation services; from 30% to 50% in Brazil, the Dominican Republic, Ecuador, Guyana, Honduras, and Suriname; from 50% to 70% in Cuba, El Salvador, Guatemala, Jamaica, Paraguay, Trinidad and Tobago, and Venezuela; and over 70% of the rural populations of the Bahamas and Barbados.

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%. The remaining 100 million inhabitants of the Region do not have solid waste collection systems. Cuba, Chile, Trinidad and Tobago, and Barbados are the countries that have the highest national coverage. Colombia and Bolivia are developing plans and programs which, if they are as successful as expected, will increase coverage substantially. In order to fully cover refuse collection needs, it is estimated that around 6,000 collector vehicles need to be produced or imported per year, at an approximate cost of US$ 600 million. An accelerated trend toward "private concessions" in 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. Recycling is a way to relieve the problem of lack of infrastructure for collection and final disposal, since it makes it possible to diminish the quantity of refuse and, at the same time, conserve natural resources. In the last 30 years more than 20 solid waste recycling centers have been installed in the Region. These facilities were designed to produce fertilizer or compost to enrich the soil. However, 90% of them have been closed as a result of the failure to conduct adequate preliminary studies to determine the market for the resulting product. Colombia has implemented, with good results, a recycling program that addresses the most important aspects of this problem.

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. By way of comparison, the water losses of companies in countries with well-run water supply systems are in the 10%-20% range. The economic

crisis, 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, Mexico and the countries of Central America, Belize, Panama, and the Dominican Republic have developed programs for the efficient use of water. However, it is not sufficient to control the quality of water for human consumption or to implement programs for efficient water use; it is also necessary for people to stop wasting water. In all the countries of the Region, PAHO is encouraging the institutions that supply water to develop mass communication campaigns to ensure that the community uses water more efficiently. Although most of the water supply institutions acknowledge the need to encourage consumers to use water efficiently, it is estimated that only 50% of these institutions are conducting information campaigns to that end. Most of the countries of the Region have recognized that water supply and sanitation require, in addition to technical solutions, community participation in the study, analysis, and solution of problems. With that objective in mind, Brazil, Mexico, the countries of Central America and the Andean Countries have established programs of mass communication on efficient use of this resource.

With respect to the mass communication activities conducted directly by the PAHO/WHO Representative Offices in the countries, those of the mass communication units created in the PWR Offices in Peru and Costa Rica are particularly noteworthy. These units have achieved active interaction with the mass media (press and TV) for the dissemination of special messages, programs, and/or supplements devoted to health education and environmental health. In the case of Peru, this interaction has produced very positive results during the cholera epidemic, which began in the country in 1991.

PAHO/WHO also provided support for water quality monitoring and control programs, utilizing techniques for treatment of drinking water with high soluble matter content. The Organization continued to promote the development and use of appropriate technologies, in particular those for collection of waste with vehicles and manual sanitary landfills.

The priorities for the period of 1991-2000 emanate from the Declaration of Puerto Rico, which contains recommendations on the preparation of national plans for efficient water use, quality control, sanitation in high-risk areas, sanitary disposal of excreta and wastewater, and strengthening of institutional and human resources.

Since 1990 at least three countries (Argentina, Costa Rica, and Paraguay) have enacted legislation on environmental impact assessment, and most of the countries

in the Region have revised their environmental legislation in the following areas: environmental pollution (Argentina, Ecuador, Panama, Paraguay, Saint Lucia, and the United States of America); urban sanitation (Belize, Bolivia, Grenada, Saint Vincent and the Grenadines, Turks and Caicos); air quality control (Chile and Mexico); creation of education programs (Colombia, Costa Rica, Ecuador, and Panama).

Several countries have endeavored to formulate appropriate environmental health plans and programs and advise local authorities on the formulation of policies on the environment (Brazil, Chile, Colombia, Costa Rica, Cuba, El Salvador, and Guatemala). In the Caribbean, the Turks and Caicos Islands in 1992 created a council on public health and the environment, and St. Vincent and the Grenadines, in 1991, established an environmental health council, which is responsible for advising the Ministry of Health on environmental issues.

The importance attached to the environment is also reflected in the structures of the legislatures and parliaments of the Region. Several countries have established legislative commissions to address matters relating to the environment: Argentina, Brazil, Chile, Colombia, El Salvador, Honduras, Mexico, Panama, Paraguay, and Venezuela. The Latin American Parliament and the Andean Parliament have also established commissions on the environment.

Since the 1990s several factors have influenced the nature of legislation on health and the environment in the Region. The increase in popular participation, a result of the revitalization of democratic institutions that began in the last decade, has led to the inclusion in the constitutional provisions enacted since 1990 of legal measures permitting the effective incorporation of such participation. In some countries, under the constitution the people, individually and collectively, are entitled to certain "diffuse and collective rights," one of which is the protection of the environment (Brazil, Colombia, Paraguay). In Brazil legal action was taken to repair damages caused to the environment and other collective interests, and in Canada the community, interest groups, and industry have actively cooperated with the three levels of government in the formulation of plans of action on health and the environment.

At the international level, the United Nations Conference on Environment and Development (UNCED) called for the enactment of appropriate legislation to incorporate, in accord with the reality of each country, environmental concerns into development policies, as well as the establishment of effective judicial and administrative mechanisms to ensure compliance with such legislation at the national, state, municipal, and local levels.

The process of integration that is taking place in the Region should also be recognized as a factor in health legislation. The Regional Conference on Water Supply and Sanitation (1990), which evaluated the achievements made during the International Drinking Water Supply and Sanitation Decade (1981-1990), noted significant increases in coverage, as well as conceptual and operational progress favorable to the future development of services. In the area of the environmental law, an agreement establishing the Central American Commission on Environment and Development (CCAD) was signed in 1991. Integration agreements such as common markets and free trade areas (the Southern Common Market (MERCOSUR) and the North American Free Trade Agreement (NAFTA), for example) are important from an environmental health standpoint, since they offer the possibility for reviewing existing standards and adapting them to new realities. In addition, integration processes create the opportunity for the establishment of more efficient control mechanisms than those currently in effect. For example, the North American Agreement on Cooperation for the Environment, which complements NAFTA, is aimed at promoting sustainable development through cooperation among the parties and the development of policies of mutual support with regard to the environment and economics. In addition, the Agreement seeks to promote cooperation for the development and strengthening of legislation in the area.

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. The Regional Program on Environmental Health collaborated with the World Bank and IDB in formulating and implementing regional and national projects, and with the World Bank and the Government of the Netherlands on the design and preparation of a computerized model for assessing the environmental impact of investment projects. Environmental impact assessments are widely practiced in most of the developed countries, but have only recently begun to be performed in the Region. Numerous international agencies now insist on such assessments. Although some countries of the Region, including Brazil, Mexico, Chile, Bolivia, Colombia and Peru, have established their own requirements for these evaluations, most still have considerable work to do in this regard.

PAHO/WHO promoted and participated in numerous interprogram activities aimed at ensuring and facilitating the implementation of environmental interventions at the local level. With a view to stepping up the introduction of environmental services in local communities, a proposal was prepared for a specialized methodology for the development of local environmental profiles (Argentina, the Dominican Republic, Ecuador, Guatemala, Mexico). The Organization continued to disseminate standards and methodologies for the evaluation of health hazards associated with exposure to dangerous chemical substances and pesticides, and

provided support to the countries for the establishment of standards and the regulation of the air and water quality. It also continued to promote systems for wastewater treatment and reuse as an appropriate technology that will make it possible to raise the currently low levels of water treatment. The use of this technology is expected to reduce health hazards.

The cholera epidemic has shown that the priority PAHO/WHO assigns to drinking water quality is warranted. The Regional Program on Environmental Health prepared and distributed technical documents and supported the countries in planning and carrying out measures designed to impact on the environment. The Program also participated in the production, publication, and dissemination of guidelines, criteria, and educational materials on risk assessment and epidemiological surveillance. The activities carried out in 1992 included promotion of the information network and production of several specific guides and catalogs. Several countries, including Argentina, Brazil, Chile, Cuba, Mexico, and Peru, have continued to carry out activities with a view to organizing local networks. During the year six courses were offered in environmental epidemiology, and these courses have served as one of the principal mechanisms for the promotion of the network. Special attention continued to be given to the training of human resources as a part of the effort to strengthen institutional capacity. Short courses were offered, attracting a total of more 10,000 participants, and support continued to be provided for undergraduate and graduate-level professional training programs.

At the regional level, several activities were carried out for the purpose of providing the basic elements for improving teaching and research on sanitary and environmental engineering, and in order to promote cooperation between teaching institutions.

In the area of solid waste, at the regional and subregional levels the Organization continued to employ the strategy of promoting exchanges and cooperation between countries and the formation of civil associations of institutions and people involved in urban sanitation. In regard to human resources development, several courses and seminars were offered.

In 1991, the Region of the Americas had 64 regular programs for professional education in sanitary and/or environmental engineering, offered by 46 universities in 11 countries. Of these programs, 23 were at the undergraduate level, and 41 were graduate-level programs.

Of the 23 undergraduate programs, 14 awarded degrees in sanitary engineering or environmental engineering, while the other 9 awarded degrees in civil

engineering with specialization in sanitary engineering. As for the graduate-level programs, six were doctoral programs, 28 master's degree programs, and 7 programs for specialization in sanitary and/or environmental engineering. PAHO has provided technical cooperation and has supported the creation of most of these programs. During 1991 and 1992 the Organization promoted and supported cooperation between the universities offering these programs, the revision and/or updating of their curricula, and the identification of priority areas for research.

With a view to promoting and facilitating the execution of specific activities in this area, the establishment of an Inter-American Association of Professors of Sanitary Engineering was promoted, and the group was formed in November 1991 during a meeting of Schools of Sanitary Engineering organized with support from PAHO. Advisory services were also provided for curriculum development to three universities seeking to establish programs in environmental engineering, two of which inaugurated master's degree programs in 1993.

In 1991, PAHO, through its Pan American Center for Human Ecology and Health (ECO), provided support for 33 events on environmental topics, which were attended by a total of 936 participants. In 1992, there were 29 such events, with 869 participants. Several of these events had to do with the issue of risk and environmental impact assessment. During this period, ECO has also given technical support to institutions that offer regular specialization courses in epidemiology and environmental toxicology in Brazil, Cuba, and Mexico.

In the area of food safety, January 1992 marked the initiation of the activities of the Pan American Institute for Food Protection and Zoonoses (INPPAZ), created in November 1991, under an agreement between PAHO and the Government of Argentina. Only a few countries have instituted comprehensive food safety programs thus far. In Latin America and Caribbean, seven countries had such programs in 1990. In 1991, two more countries established comprehensive food safety programs, and in 1992, the total of countries with programs rose to ten.

The cholera epidemic, which began in Peru in January 1991 and has spread to almost all the countries in Latin America, has promoted greater awareness of the role food plays in the transmission of disease. In the campaign against cholera, PAHO prepared and widely distributed a comprehensive document titled "Risk of Cholera Transmission from Food" and carried out studies of *Vibrio cholerae* contamination in food sold on the streets in La Paz, Bolivia, and Lima, Peru. In collaboration with the United States Food and Drug Administration (FDA), the United Nations Food and Agriculture Organization (FAO), the United States Centers for Disease Control (CDC), and the United States Agency for International Development (USAID), PAHO developed four international courses

on microbiological analysis of *Vibrio cholerae* in food, which were given in Argentina, Mexico, Trinidad and Tobago, and Venezuela.

In the framework of economic integration, FAO, PAHO, and WHO held a technical consultation meeting in Buenos Aires, Argentina, in order to analyze issues relating to food safety, including the imposition of non-tariff barriers on food products, and to formulate technical recommendations to serve as a basis for the countries' policies on safeguards against the risk of cholera transmission in the marketing and consumption of foods.

In 1990 work was begun on the establishment of a Latin American network of laboratories for food analysis. In 1991, only six countries in Latin America and the Caribbean were conducting epidemiological surveillance of food-borne diseases (FBDs); in 1992 four more began to do so.

In 1992, a guide for epidemiological surveillance of food-borne diseases was prepared and distributed to all focal points in the countries who will be in charge of the collection and analysis of data on FBDs. The system will be implemented on a trial basis in various places in eight countries, including touristic cities.

In order to gradually overcome the enormous deficit existing in health service infrastructure, evaluation of the 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 shortages that have been accumulating in these areas for decades (see Box 6).

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 third 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 advance 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, set in motion, and coordinate the activities carried out by the Organization as a whole to implement the Plan.

Box 6

Investing in the Environment and Health--the PIAS

The Regional Plan for Investment in the Environment and Health (PIAS) basically proposes that approximately US$ 216,000 million be invested throughout the Region over the next 12 years. Seventy percent of that amount would come from national sources and 30% would 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 would 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 would 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.

b. *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.

The nutrition situation in the countries of the Americas is conditioned by diverse social, economic, and political factors, which influence the availability and consumption of food. The economic crisis that began in the 1980s has reduced the real income and purchasing power of the population in the vast majority of the countries.

The nutritional status of a population is generally assessed on the basis of anthropometric indicators determined through surveys or by analyzing data collected by food and nutrition monitoring systems in the countries. Unfortunately, only a few countries produce reliable periodic reports. The lack of uniformity in the information available--a result of the diversity of sources utilized, the time periods considered, the different classification criteria applied, and the different reference values used--hinders comparison and makes it difficult to obtain an accurate picture of the overall nutrition situation in the Region (see Table 2).

Using the classification criteria recommended by WHO, which are based on the tables developed by the United States National Center for Health Statistics (according to which any value falling below -2 standard deviations from the median weight or height for a given age is considered to indicate malnutrition), the prevalence of malnutrition as measured by weight-for-height is relatively low, ranging from 0.4% in Cuba to 6.3% in Mexico. However, when malnutrition is measured by weight-for-age, the prevalence ranges from 0.8% in Chile to 38.5% in Guatemala. With regard to the prevalence of low height-for-age, an analysis of 14 countries in the Region has shown that the highest rates are found in Bolivia, Guatemala, Ecuador, and Peru, where at least one out of every three children under the age of 5 shows significant growth retardation. Although height-for-age figures do not reflect present nutritional status, they are a good indicator of general health status and of nutritional and economic history. The indicator that shows the lowest average prevalence of malnutrition for all the countries is weight-for-height (see Table 2). A UNICEF study carried out in 1990 estimated the average prevalence of nutrition deficits in Latin America and Caribbean at 13.8% when calculated on the basis of weight-for-age, 27.7% based on the indicator height-for-age, and 1.3% based on weight-for-height.

As for the target of making significant progress toward the elimination of vitamin A and iodine deficiency and reducing the prevalence of iron deficiency anemia, the information available indicates that numerous countries have strengthened their iodine deficiency control programs, and considerable technological progress has been made, as reflected by the fact that other, more sensitive indicators than the presence of goiter are now being considered--for example, measurements of iodine

TABLE 2: Nutritional status according to weight-for-height[a], weight-for-age[b] and height-for-age[c] (children <5 years of age), endemic goiter[d], anemia among pregnant women[e], and serum retinol levels[f] (vitamin a)

COUNTRY	W/H (a)	W/A (b)	H/A (c)	GOITER % (d)	ANEMIA AMONG PREGNANT WOMEN % (e)	VIT. A % (f)
Argentina	0.8			0.8 - 3(2)	27 - 60(2)	
Bahamas		2.1(1)				
Bolivia	2.2(1)	11.7(1)	38.3(1)	20.9	36.41(2)	11.3
Brazil	2.0(1)	7.0(1)	15.4(1)	18.2 - 47.5(2)	21(2)	13.2 - 48.8(2)
Chile		0.8		9.1 - 13.5(2)	20(2)	
Colombia	2.9(1)	10.1(1)	16.6(1)	13.0 - 52(2)		
Costa Rica		2.8	27.6		28.3	1.8
Cuba	0.4 - 0.9			3.3 - 11.3(2)	20 - 25	
Dominica		4.2			24.7	
Dominican Republic	2.3(1)	12.5(1)	20.8(1)		24.7	19.6
Ecuador		16.5(1)	34.6(1)	36	60	14.1
El Salvador	2.3(1)		29.9(1)	25	12.3	36
Grenada		8.0			62.9	
Guatemala	1.4(1)	38.5(1)	59.7(1)	20.4		21.6
Guyana		24.3				
Haiti					39(2)	
Honduras		20.6(1)	25.1(1)	8.8		17.5
Jamaica		6.9			61.6(2)	
Mexico	6.3(1)	13.9(1)	22.3(1)	6.0(2)		25.9 - 32(2)
Nicaragua	2.3	10.9	21.9	3.9		
Panama				13.2		6
Paraguay	0.4(1)	4.2(1)	20.3(1)	49	13 - 44(2)	
Peru	1.4	10.4	35.2	25 - 38	48(2)	14.1 - 32.8(2)
Saint Kitts and Nevis		7.5				
Saint Lucia		8.0				
Suriname					31(2)	
Saint Vincent		6.2			53(2)	
Trinidad and Tobago		9.9				
Uruguay	1.9	6.5	14.6	<1(2)	25(2)	
Venezuela	7.2	10.4	15.8	58.5(2)	18(2)	

(1) Countrywide surveys.
(2) Studies of specific areas.
(f) Percentage of cases with serum retinol levels of <20 mcg/dl
Source of Data: Doc. 93.2 HPN/PAHO. Updated May 1993.

content of urine in communities. On the basis of this indicator and monitoring of the iodization of salt, numerous countries in the Region are developing surveillance systems that will make it possible to more accurately determine the prevalence of iodine deficiency. However, the cut-offs for determining at what point this deficiency becomes a public health problem are still being defined. Iodine deficiency disorders tend to be concentrated in certain geographical areas of Argentina, Bolivia, Brazil, Chile, Colombia, Cuba, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay, and Venezuela. All the countries of Latin America, except Cuba and the Dominican Republic, have legislation in effect with regard to the iodization of salt.

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 of such programs is limited and compliance is low. Few countries have programs for the enrichment of food with iron.

Vitamin A deficiency is defined as serum retinol levels of under 20 mcg/dl. The problem occurs in specific, socioeconomically deprived geographical areas in the following countries: Bolivia, Brazil, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Panama, and Peru. 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 an 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 used only for local programming of interventions. The groups at highest risk for nutritional deficiencies have been identified in numerous countries through maps of impoverished areas, using various indicators (unmet basic needs, height surveys of schoolchildren, household surveys). In many of the countries in which malnutrition has been reduced to moderate levels there continue to be tremendous differences, not revealed by the figures, between geographic regions and strata of the population. It is therefore of utmost importance to implement effective nutrition monitoring systems in order to facilitate the collection of disaggregated

data, which will serve to identify depressed areas so that they can then be targeted by appropriate interventions.

c. *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.

With regard to 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), it is noted that this target has not been embraced expressly by most of the Member Countries, with very few exceptions (Canada, the United States, Mexico). In most cases, some intersectoral activities relating to health promotion and risk prevention have been planned in the context of programs of chronic degenerative disease control. Although such programs, or variants, exist in Brazil, Chile, Costa Rica, Cuba, Mexico, Panama, Uruguay, and Venezuela, their emphasis has been more on the formulation of standards for curative management of the diseases than on prevention. In other countries, the governments have stated their intention of initiating health promotion activities (Argentina, Barbados, Colombia, Costa Rica, Chile, and Uruguay), but there is no information to indicate that these statements have been translated into concrete programs.

The intersectoral activities most closely attuned to the spirit of this target are the projects carried out under the "healthy communities" initiative. Projects of this type have been initiated in Zacatecas (Mexico), Cienfuegos (Cuba), Manizales (Colombia), Baruta and El Hatillo (Venezuela) and Valdivia (Chile), and another is to be initiated in Ciudad Quesada (Costa Rica). Two of these projects have made baseline measurements of the prevalence of risk factors for NCD and a third will do so shortly. These projects are ongoing and are at various stages of completion.

In the plan of action for attaining the targets established under this priority, it was considered important to strengthen the capacity for analyzing and monitoring the magnitude, distribution, and determinants of risk factors in order to raise awareness of the problem, both among the general public and in decision-making circles. However, these measurements have been heterogeneous and very sporadic in Latin America and the Caribbean. The prevalences of risk factors found are not comparable among themselves, and because they are single measurements in most cases, they do not make it possible to assess trends. Hence, there is a need to facilitate systematic measurement of the prevalence of risk factors. In response to this need, the Regional Program on Health Promotion is preparing a conceptual document that is intended to serve as a guide for the development of positive indicators of health and well-being, which should enable the countries of the Region to have, in the relatively near future, suitably comparable and reliable information.

According to the report *Tobacco or Health: Situation in the Americas* most of the countries of the Region have initiated efforts to prevent and control smoking, whether through legislation, education, individual support. Several strides have been made in this area, notable among them the prohibition of smoking on commercial airlines flights in some countries and the imposition of restrictions on smoking in health institutions. However, for the same reasons cited above, there are not yet sufficient recent and reliable data to make it possible to draw a comparison between countries or accurately assess trends in the Region.

d. *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.

Thirty-two countries (69.5% of the total number) identified this area as a priority 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.

At the time the SOPPs were drafted, tuberculosis, leprosy, yaws, pinta, malaria, dengue, onchocerciasis, and Chagas' disease were identified as diseases susceptible to control or elimination from the Region. In addition, the countries and the Organization committed themselves to continue with the activities aimed at interrupting the transmission of indigenous wild poliovirus and eradicating urban rabies, virtually eliminating neonatal tetanus, reducing mortality from measles, and reducing animal morbidity from foot-and-mouth disease. With regard to onchocerciasis, the data available from areas in which the disease is endemic are from 1990, and a follow-up analysis for the period covered by the SOPPs is therefore impossible.

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. However, when the situation is examined on a country-by-country basis it becomes apparent that while the prevalence has shown a downward trend it continues to be very high, especially in Brazil (12.95), Bolivia (4.82), Colombia (4.77) Venezuela (4.13), and Paraguay (2.83). In fulfillment of resolutions of the World Health Assembly and the Directing Council of PAHO, a conference on leprosy control in the Americas was held in Mexico. At that meeting 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. These strategies and plans would include the following activities: reinforcement of the political commitment to eliminate the disease; stratification of the problem and strengthening of health infrastructure at the national and regional levels; establishment of goals, including intermediate goals; and mobilization of national and international resources.

In 1990, 70 cases of pinta in Mexico and the existence of foci in Brazil and Venezuela were reported. In 1992, only the existence of foci was reported in those countries. There were 78 cases of yaws 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 problem and a threat to public health. This situation 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. Several countries with serious tuberculosis problems--

among them Bolivia, Guatemala, Honduras, Nicaragua, and Peru--in recent years have attempted to obtain up-to-date and reliable morbidity statistics. The Government of Peru has declared tuberculosis one the priority diseases at the national level, and the presidents of the health commissions of Peru and Bolivia have made known their interest in collaborating with and supporting the tuberculosis control program. The Meeting of Ministers of Health of Central America (RESSCA) has also included tuberculosis among the diseases of priority interest. Several countries have made significant progress in implementing control programs, although this has not been the case in countries such as Brazil and Mexico. In those countries, despite the efforts made, control programs have not had any great impact on the epidemiological situation, which continues to be severe, and many cases of the disease continue to exist. Four countries have registered reductions of approximately 7% in morbidity among contagious cases. A rapid reduction of the problem could be expected if this trend were to be maintained. Three more countries could easily join this group, but 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 data available are from 1982-1985. The Regional activities coordinated by PAHO were aimed at developing national capabilities for the elimination of the vector and the development of infrastructure to control blood used for transfusions. Efforts in this area included the development of integrated programs for the elimination of *Triatoma infestans*, promotion of technical cooperation between countries for vector control and the prevention of transmission through blood transfusions, and the enactment and enforcement of legislation designed to regulate the use of human blood.

In the framework of the Southern Cone Initiative, in 1991 the Ministers of Health of Argentina, Brazil, Bolivia, Chile, Paraguay, and Uruguay adopted a resolution on zoonosis control that called for the creation of an intergovernmental commission on Chagas' disease. PAHO was named secretariat of the commission, which was charged with developing a program and subregional plan of action for eliminating *T. infestans* in dwellings and interrupting transmission of *Trypanosoma cruzi* through blood transfusion. The countries participating in the initiative prepared their national programs for 1992-1995 and, thanks to the initiative for the development of a subregional plan of action, the activities were implemented, even though there had not been any significant contribution of external resources. Among these activities were: the intensification of Argentina's program, which paved the way for the adoption of semiannual cycles of operation and testing of alternative surveillance techniques; administrative restructuring in Bolivia, within new legal frameworks and with the negotiation of new financing schemes; the

continuation of activities under way in Brazil, including priority activities to combat *Triatoma infestans*; and the negotiation of supplementary sources of funding in Uruguay, with consideration of a draft law that would impose a regressive tax on the marketing of toxic agrochemicals.

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 in Brazil, Colombia, Ecuador, El Salvador, Honduras, Guatemala, Nicaragua, Panama, Uruguay, and the countries of the Caribbean. The measures to control dengue in the countries are geared toward control of *Aedes* with a view to interrupting transmission. In this regard, two extreme situations are noted in the Region. Some countries have been successful in their control efforts, including Panama, which achieved its objectives through community participation, and Chile and Uruguay, which have effective surveillance systems that prevent colonization by the vector. In other countries, however, the epidemiological situation remains worrisome, despite their efforts. In Colombia there was a significant reduction in the number of cases of type 1 dengue during the period 1990-1992, from 17,389 cases in 1990 to 1,115 in 1992; in Barbados the number decreased from 236 in 1990 to 4 in 1992. In Guatemala there were 5,757 in 1990, 10,968 in 1991, and 1,268 in 1992. Nicaragua experienced a substantial reduction in the number of cases between 1990 and 1991, from 4,137 to 1,885. Mexico had a similar situation, going from 14,485 cases in 1990 to 5,863 in 1991. However, during 1992 these two countries saw an increase in cases, with 4,936 cases reported in Nicaragua and 11,348 in Mexico. Between 1990 and 1992 the number of cases of hemorrhagic dengue increased from 31 to 493.

The practice of epidemiological stratification in malaria control efforts has not been readily adopted owing to the fact the managers responsible for health actions normally expect to receive and implement standardized procedures, rather than general principles of a basic strategy that can and must be adapted to local situations. In order to apply this strategy it is necessary to define the characteristics and determinants of malaria at the local level. In particular, it is essential to identify those features of the disease which would be susceptible to control measures and to develop indicators for monitoring the relative prevalence of the factors that determine local transmission. Three major advances have been made in this regard: (1) regionalization of numerators and denominators in the systems for epidemiological surveillance of malaria in Brazil, Colombia, Costa Rica, Mexico, Panama, Peru, and Venezuela, which will facilitate all future analysis and decision-making in regard to local malaria control action; (2) incorporation of ecological elements into the epidemiological analysis carried out

under malaria prevention and control programs, which will make it possible to predict where the disease is liable to spread epidemically; and (3) application of the epidemiological risk approach in efforts to solve the malaria problem at the local level.

Progress has been made in integrating malaria diagnosis and treatment services--which is essential for reducing the interval between suspicion and treatment of the infection--in Belize, Colombia, El Salvador, French Guiana, Guyana, Honduras, Nicaragua, Panama, and Suriname. However, Argentina, Bolivia, Brazil, the Dominican Republic, Ecuador, Guatemala, Haiti, Mexico, Paraguay, Peru, and Venezuela continue to experience difficulties in integrating this specialized service into general health services, which hinders the detection and treatment of suspected and confirmed cases and places a heavy burden on the specialized service, thus preventing the development of prevention and control activities at the local level. Hence, the malaria situation in the Region continues to be severe, with 39% of the population living in ecological conditions propitious for transmission of the disease. In 1991 a total of 1,148,000 parasitologically confirmed cases were reported, which represents an increase in morbidity with respect to 1990. The rate in malarious areas in that year was 375 cases per 100,000 population and rose to 409 in 1991. These figures reveal that the epidemiological situation of malaria has grown steadily worse since 1974, when morbidity was 134 cases per 100,000 population.

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. In the areas that have implemented control programs, the annual incidence has fallen from 13-20 animals affected per 1,000 head to about 1 animal per 1,000 head in the last two years. General morbidity declined from 2%-3% to 0.5%. Uruguay has not reported any cases since late 1991 and has been recognized as a country that this free of foot-and-mouth disease with vaccination. The disease-free areas (North America, Central America, the Caribbean, French Guiana, Guyana, Panama, and Suriname) have remained disease-free.

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. The actions necessary for the elimination of urban rabies from the Hemisphere are continuing,

but it has not been possible to attain the target of elimination proposed under this program priority.

Two years have passed since the last report was received in the Region of a case of poliomyelitis confirmed by isolation of wild poliovirus. The last confirmed case occurred in August 1991. The criteria for certifying the eradication of polio approved by the International Certification Commission on Polio Eradication (ICCPE) are: verification of the absence of virologically confirmed indigenous poliomyelitis cases in the Americas for a period of at least 3 years under circumstances of adequate surveillance; verification of the absence of detectable wild polioviruses from communities as determined by testing of stools from normal children and, where appropriate, testing of wastewater from high-risk populations; on-site evaluation by national certification commissions composed of knowledgeable local persons and outside experts; and establishment of appropriate measures to deal with the potential importation of cases. The effort to certify the Region of the Americas as a region free from indigenous wild poliovirus continues. In this effort emphasis is being placed on active surveillance of acute flaccid paralysis (AFP) and wild poliovirus, active AFP case-finding in areas in which of surveillance is considered deficient, and documentation of mass vaccination campaigns in high-risk areas.

With regard to measles, the overall incidence in the Americas has continued to decline and the periods between epidemics have grown longer. Under the recent measles elimination initiative in the English-speaking Caribbean, several countries carried out one-month mass vaccination campaigns and were successful in interrupting transmission. The initiative followed the Cuban model of conducting an intensive mass vaccine campaign in order to immunize all children between 1 and 14 years of age. After the campaign, immunization coverage levels are maintained by vaccinating successive cohorts of 1-year-old children and carrying out aggressive surveillance in order to detect any new cases and institute control measures immediately. The Central American countries have adopted similar strategies, and at the summit meeting held in October 1991, the Presidents of the Central American countries adopted a resolution calling for the elimination of measles from Central America by 1997. In 1992 Brazil and Chile launched mass campaigns aimed at eliminating measles, also applying the Cuban strategy. In the Region the number of measles cases decreased 59% between the 1990 and 1992 (from 237,553 to 99,423).

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 30% (from 1,208 to 850).

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 has seriously hampered efforts to respond to the most basic needs of the population (see Table 3).

e. *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.**

The 46 countries of the Region have made maternal and child health a priority in their policies and programs, and have also attached importance to technical cooperation in this area. This should help to attain the targets established by the Member Countries, which are basically concerned with infant mortality, maternal mortality, and mortality from diarrheal diseases and acute respiratory infections in children under 5. Generally speaking, the lack of reliable information with regard to the indicators selected has been a frequent obstacle for assessing the progress made at the regional and national levels.

Table 3: Cholera in the Americas Reported Cases and Deaths by Country

COUNTRY	TOTAL CASES	ATTACK RATE/1000	TOTAL DEATHS	CFR(%)
SOUTH AMERICA				
Argentina	2,080	0.06	34	1.63
Bolivia	10,134	1.27	254	251
Brazil	56,286	0.35	607	1.08
Chile	32	<0.01	0	0
Colombia	230	<0.01	4	1.74
Ecuador	6,833	0.60	72	1.05
French Guiana	2	0.03	0	0
Guyana	66	0.08	2	3.03
Paraguay	3	<0.01	0	0
Peru	71,448	3.12	575	0.80
Suriname	0	<0.01	0	0
Venezuela	409	0.02	10	2.44
MEXICO AND CENTRAL AMERICA				
Belize	135	0.69	3	2.22
Costa Rica	14	<0.01	0	0
El Salvador	6,573	1.16	14	0.21
Guatemala	30,604	3.04	306	100
Honduras	4,007	0.71	103	257
Mexico	10,712	0.11	193	1.80
Nicaragua	6,631	155	220	3.32
Panama	42	0.02	4	9.52
USA	18	<0.01	0	0
TOTAL	206,259		2,401	1.16

This report reflects country information received by PAHO as of December 1993.
Source: Ministries of Health in the countries; PAHO/HMP/CDD
CFR: Case fatality rate = number of deaths from a disease (as percentage)
number of cases of that disease
Attack rate = Reported cases/1,000 population

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 Fund, which are very close to the figures reported to PAHO 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, accurate information is not available on the true magnitude of the problem, and there are substantial differences in the quality of the information collected on the reproductive health of women in the various countries of the Region. In addition to the deficiencies of the 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 does include 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, on the basis of the information available, that significant headway has been made in this area. Maternal mortality has been falling by 5.7% a year, so that if action in this area were stepped up, it would be possible to attain the proposed target.

To that end, the Regional Plan of Action for the Reduction of Maternal Mortality in the Americas was submitted to the XXIII Pan American Sanitary Conference, which adopted it through Resolution XVII. The Plan proposes a broad effort at social mobilization around the goal of improving the health of women, and calls for the mobilization of national and international resources for the implementation of health promotion activities, the expansion and improvement of health services, and effective participation by the population. The goals of the Plan and its principal lines of action were endorsed by the countries at the Meeting to Assess Progress toward Attainment of the Goals of the World Summit for Children (Brasilia, Brazil, 1991) and at subregional and interagency meetings on safe motherhood, held in Guatemala in 1992 and in Santa Cruz, Bolivia, in 1993. The

Plan has also served as a basis for the formulation of national plans for the reduction of maternal mortality.

Of the 17 countries that have reported their progress in reducing maternal mortality, with the exception of the Bahamas, Bolivia, and Chile, all have formulated a National Plan for the Reduction of Maternal Mortality. In the case of Bolivia, Chile, the Dominican Republic, and Ecuador, targets were set and the Plan was incorporated as a component of the Maternal and Child Health Program. In countries with a federal system of government, some states or *municipios* reinforced the Plan through the enactment of specific legislation. More than 70% of the countries that submitted information 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 g to 10% by 1994, since reliable, up-to-date information is available only for Chile, Costa Rica, Cuba, and Uruguay, which have already attained the target. 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.

On the basis of available data concerning morbidity and mortality it can be affirmed that important advances have been made; however, the trend registered in recent years indicates that in order to attain the proposed targets it will be necessary not only to sustain but to redouble the efforts put forth to date.

f. *Workers' Health*

Targets:

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.

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 (85%) of Latin America national committees or councils have been formed with the participation of various sectors. In the same percentage of countries National Plans for the Development of Worker's Health were prepared; of these, in 50% (eight) the plans are being implemented and in 15% (three) national funds have been allotted. The countries of the English-speaking Caribbean, in keeping with the general commitment, have initiated the preparation or adjustment of national plans.

In eight countries (five in 1991 and three in 1992) graduate courses in workers' health have been launched. PAHO/WHO cooperates directly with 22 of the 32 programs with which it maintains connections.

Dissemination of information increased in 90% of the countries. The activities planned involved various sectors, intersectoral groups, and information campaigns via television, radio, press, publications, posters, and commemorative stamps. Several Latin American multicountry and national congresses, seminars, courses, and workshops were also held. Mexico, for example, in 1992 held more than 500 events organized by the social security system, universities, the Ministry of Health, and the Ministry of Labor. Colombia held 160 events, some organized through intersectoral committees by the Ministry of Health, the Ministry of Labor, the social security system, NGOs, and workers' organizations. The PAHO/WHO Representative Offices organized (or provided support for) 39 events which were attended by 2,210 participants. PAHO/WHO Headquarters participated or sponsored 20 competitions and other activities such as seminars and courses, which were attended by a total of 2,325 participants. 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 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, many of which call for the formation of national intersectoral groups. In addition to governmental institutions, the commercial sector, workers, and NGOs have been involved in efforts in this area. Various programs have been placed under the authority of interinstitutional groups, with participation by the government, the public and private commercial sectors, workers's associations, universities, and NGOs. At the regional level, the ministries of health, labor, agriculture, and education have produced resolutions on workers' health, advocating widespread collaboration and

support for the lines of action established by PAHO/WHO. Lawmakers in the Region have also issued declarations in this regard.

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.

At the Andean level, labor organizations have given special attention to the issue of workers' health, in particular at a subregional meeting attended by representatives of all workers' organizations that have been formed in the various countries through joint efforts.

In the Andean, Central American, and Southern Cone subregions, a meeting was held that brought together representatives of the governments, lawmakers, and representatives of workers and employers, who, together with representatives of PAHO, ILO, NGOs, universities, and other experts, discussed the National Plans in order to define the course of action to be taken and the strategies to be employed for their implementation.

PAHO prepared and disseminated information and guidelines to facilitate the task of the national groups charged with developing, reviewing, and adjusting the national plans. The Organization also provided advisory services to various of these national committees or councils and increased interagency collaboration at the regional and national levels.

g. 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.

Drug dependency is a growing problem in the countries of the Region, especially in urban areas. It attacks the adolescent and young adult population in particular, giving rise to in chronic conditions, job absenteeism, school drop-out, personality disorders, and a variety of social and cultural problems.

In the early part of the decade it was recognized that it was necessary to increase epidemiological knowledge of the problem in order to be able to better determine the high-risk groups toward which sectoral and intersectoral prevention and control efforts should be directed. This knowledge would make it possible, in addition, to move forward in the design and implementation of policies and programs aimed at combating drug dependency, mainly through health promotion activities and specific preventive measures.

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%).

With regard to the target of developing a database in all the countries of the Region on the magnitude, type, consequences, and trends of abuse of psychoactive substances among different social groups, nine countries are currently conducting epidemiological surveillance programs in this area (Colombia, Costa Rica, the Dominican Republic, El Salvador, Guatemala, Honduras, Mexico, and Panama). The Regional Epidemiological Surveillance System is linked to the Uniform Statistics System of the Inter-American Drug Abuse Control Commission (CICAD) of the 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 specific cities and population groups. During 1991 and 1992, household surveys and several studies on specific populations (students, street kids) were carried out in Belize, Bolivia, Colombia (2 surveys), Costa Rica, the Dominican Republic, El Salvador, Guatemala, Haiti, Mexico, Panama, and Paraguay.

In terms of activities carried out with a view to attaining the targets, meetings with advisory groups on epidemiological surveillance were held in order to revise and update instruments and methodologies for monitoring drug abuse. A meeting of the Regional Advisory Group on Preventive Research was held in order to propose guidelines and protocols for research. Three training courses were also offered in biostatistics and epidemiological surveillance of drug dependency for Central America and the Andean subregion. PAHO is collaborating in a project sponsored by WHO and the National Institute on Drug Abuse (NIDA) of the United States to review data collection instruments through collaborating centers

such as the Mexican Institute of Psychiatry and the Addiction Research Foundation of Toronto.

With respect to the mobilization of resources for this area, the United Nations Fund for Drug Abuse Control (UNFDAC) has given funds for the implementation of the drug abuse control program in Colombia and has provided support for a training workshop in the epidemiology of drug addiction in the Andean Subregion. The United States Bureau of International Narcotic Matters contributed additional financial resources for continuation of a monitoring study in Central America.

With regard to the development and strengthening of the services for the prevention and control of drug addiction and the rehabilitation of drug addicts, through the approaches of community participation and support, the Regional Program for Health Promotion collaborated with the Program on Drug Dependency of WHO in Geneva and with the Department of Mental Health of Johns Hopkins University in the implementation of a project to develop minimum standards for the treatment of drug dependency. The Program also prepared a proposal for training in the treatment of drug dependency for students and workers in the health and related sciences to be submitted to the XIV working session of CICAD/OAS.

PAHO participates as a technical resource on the Inter-American Council for Education, Science, and Culture (CIECC) of the OAS and CICAD/OAS in the Central America Program on Preventive Education, which involves the ministries of health and education of the countries. In addition, a project is being launched 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. This project includes activities of planning, training, national programming, evaluation, and demonstration programs.

In order to strengthen the leadership of the health sector in the formulation of policies, directives, and national programs to reduce the demand for psychoactive substances, most of the countries (90%) have created national intersectoral commissions, composed of representatives of the minister, deputy minister, or secretary of health, for the standardization and programming of prevention, control, and treatment activities. Some countries have established secretariats or subcommittees for the reduction of demand under the leadership of the health and/or education ministries.

h. *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.

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 in the Region who are currently infected with human immunodeficiency virus (HIV) is around 2.5 million--1 million in North America and 1.5 million in Latin America and Caribbean. Provision of information about how to avoid becoming infected, promotion of condom use, treatment of other sexually transmitted diseases, and reduction of HIV transmission through blood continue to be the most effective means of curbing the spread of the disease (see Table 7).

In recent years, in more and more countries an important change in the epidemic has been noted: whereas before AIDS 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. Although HIV is transmitted primarily through sexual contact, preliminary data on seroprevalence reveal that intravenous drug use is an increasingly frequent route of transmission in various countries. In some communities of Argentina, Brazil, and Uruguay, it is estimated that more than 50% of intravenous drug users may be infected.

In general, the incidence of sexual transmission of AIDS in Latin America appears to have stabilized; from 17.3 per 1,000,000 population in 1990 it rose to 20.4 in 1991 and then decreased to 18.5 in 1992. In the Caribbean, on the other hand, sexual transmission of AIDS increased, from 52.4 to 82.1 to 93.6 in the same years. In the United States the rates were 107.7 in 1990, 110.8 in 1991, and 110.9 in 1992. In Brazil, the incidence was 26.3, 32.6, and 28.3 in the same years. Mexico registered a 67% increase in sexual transmission, with the incidence rising from 15.5 in 1990 to 22.8 in 1991; a slight reduction was observed in 1992, when the rate was 22.0.

In the Andean Area the incidence of sexual transmission of AIDS has tended to decrease during the period, with rates dropping from 10.0 in 1990 to 7.8 in 1991 and 5.4 in 1992. The largest reductions in the subregion were registered in Colombia and Venezuela.

Between 1990 and 1992, in all the countries of the Americas the incidence of HIV transmission through blood transfusion and blood products remained relatively stable. In the Andean Area the incidence declined to around 0.2 per 1,000,000 population, with the greatest reductions occurring in Ecuador (0.4 in 1990, 0 in 1991 and 1992) and Venezuela (0.9 in 1990, 0.7 in 1991, and 0.3 in 1992). In the Southern Cone, the incidence increased during the period, rising from 3.5 in 1990 to 4.9 in 1992. In the Caribbean, the rate remained stable, with a slight reduction in 1991 and 1992 (0.4 and 0.3, respectively). In Central America, the rates declined from 1.2 in 1990 to 0.5 in 1992.

With regard to the target of strengthening comprehensive care of 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.

As for the organization of national programs for the control and prevention of AIDS, almost all the countries have implemented integrated programs aimed at controlling both AIDS and other sexually transmitted diseases. In 9 countries (19.5%) AIDS and STD control activities are coordinated with those of the national tuberculosis control program. In addition, the PAHO Regional Programs on AIDS and Maternal and Child Health are collaborating on a project in which they are carrying out joint activities at the country level.

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

As concerns the target of strengthening regional capacity for basic, clinical, epidemiological, and behavioral research to support the development of programs for AIDS prevention and control, reports from the countries indicate that as of 1991 a total of 561 research projects on AIDS had been carried out in Latin America and the Caribbean, distributed in the following areas: epidemiology, 216; basic sciences, 44; clinical studies, 132; social, behavioral, and intervention studies, 169.

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. An intercountry program for the development of a laboratory test for the diagnosis of HIV is currently being carried out with the support of the PAHO Program on Research and Technological Development. The participating countries are Argentina, Brazil, and Mexico.

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.

COUNTRY	GOVERNMENT	INTERNATIONAL	OTHER
	%	%	%
Costa Rica	21	56	23
Cuba	98	2	–
El Salvador	32	43	25
Honduras	45	37	18
Nicaragua	33	43	24
Panama	43	42	15

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

Box 7

Spending on AIDS and AIDS Prevention

According to the World Bank's *World Development Report 1992 - Investment in Health*, current annual spending worldwide for the prevention of AIDS amounts to some US$ 1,500 million a year. Of this amount, perhaps less than US$ 200 million are spent in the developing countries, which account for 85% of all the infections.

According to a WHO study for the Global Program on AIDS, it would cost between US$ 1,500 million and US$ 2,900 million a year to ensure comprehensive AIDS and STD prevention services for all the developing countries. That would mean increasing spending by 10-15 times over the current level, but the payoff would be enormous. It is estimated that between 1993 and the year 2000 some 9.5 million new HIV infections in adults could be avoided through such spending--4.2 million in Africa, 4.2 million in Asia, and 1.1 million in Latin America.

IV. CONCLUSION

This report was prepared using as a reference the technical cooperation provided by PAHO, which was analyzed in the framework of the Strategic Orientations and Program Priorities and in light of the challenges faced by the Region. It is hoped that it will serve as a basis for the reorientation of the policies of the Secretariat and that it will be useful for the establishment of the program orientations for the next four-year period.

As was pointed out in the Introduction, this is a report based on contributions from the programs. The objective in drawing up the report was to determine the extent to which the Strategic Orientations have been adopted in national health policies and in the programming of PAHO/WHO technical cooperation with the countries. An effort has also been made to describe the activities carried out with a view to attaining the targets and executing the plans of action established under the Strategic Orientations and Program Priorities. This report therefore does not constitute an evaluation of cooperation programs, or an assessment of health problems or programs of the Ministries of Health, although in some cases it has been necessary to refer to the content or execution of cooperation programs, to changes in or persistence of health problems, or to the activities of the Governments or the Ministries of Health.

The strategic orientation "health in development," in addition to being the point of confluence for all the other orientations and priorities, took on a its own specificity when it was expressed in concrete actions that sought to highlight the importance of health in social policies and underscore its role as a part and a social product of the development process. That role was recognized within political superstructures such as the Ibero-American Summits of Heads of State and Government, the Organization of American States, the subregional Parliaments, and international conferences, among others. As a result, it was possible to obtain the adoption of principles included in the strategic orientations of health promotion, health of women, health and the environment, and food and nutrition. These principles were expressed, for example, in Agenda 21 (the blueprint for action approved by the United Nations Conference on Environment and Development, held in 1992), which reaffirms that health is an integral part of environmentally and socially sustainable development; in the declarations of the Ibero American Summits of Heads of States and Government expressing support for the Regional Plan for Investment in the Environment and Health; and in the regional health priorities established by the Latin American Parliament and the International Conference on Health Promotion, held in Colombia in 1992. It can therefore 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, coupled with 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 unmet needs in terms of the health and well-being of the population--that is, in order to address the huge "sanitary deficit" that continues to exist.

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 and there continue to be gaps that should be filled through advances in decentralization and the development and training of human resources in order to facilitate the identification of high-risk groups requiring priority attention, the control of preventable diseases, and the promotion of lifestyles that reduce the risk factors for chronic noncommunicable diseases.

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 aimed at bringing about the redistribution of wealth as a means of extending coverage and thereby ensuring equity in health. This will continue to be a challenge in the Region, and addressing it may necessitate a reversal of some of the trends toward reduction of the role of the State in order to promote social development. One promising occurrence in this regard is the World Bank's choice of the theme *Investment in Health* for its *World Development Report* for 1993, which proposes an approach to health policy aimed at fostering an environment in which family units will be able to improve their health, public sending on health will increase, and diversity and competence among health care providers will be promoted. Similarly, at the forum on social reform and poverty sponsored by the Inter-American Development Bank (IDB) and the United Nations Development Program (UNDP), the President of the IDB, in his presentation entitled "Economic Reform and Social Reform: An Integrated View," affirmed that "the State has the ultimate responsibility of ensuring reconciliation of economic and social reform."

In the work of the Secretariat and in the countries a number of advances have been registered with regard to the control and elimination of preventable diseases, maternal and child health, food and nutrition, although 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. Although the prevalence of leprosy remains quite high in some countries, the rate has declined in the Region as a whole; the number of dengue cases decreased in most of the countries; foot-and-mouth disease has been eradicated in Chile and large-scale epidemics of the disease no longer occur in the rest of the Region; and while the target of elimination of urban rabies has not yet been attained, the number of cases has been reduced substantially. In contrast to these

successes, however, the prevalence of tuberculosis has remained the same or has declined only slightly, and the incidence of the disease is rising in connection with the spread of HIV infection.

As for malaria, although some progress has been noted in the control activities carried out by the health sector--for example, better integration of diagnostic and treatment services--the situation remains grave, and 39% of the Region's population continues to live in conditions that are ecologically propitious for transmission of the disease. In regard to the vaccine-preventable diseases, it has been almost three years since any reports have been received of confirmed cases of polio caused by wild poliovirus, and efforts are under way to certify the Region of the Americas as a region free from indigenous wild poliovirus. In these efforts, emphasis is being placed on epidemiological surveillance. The global incidence of measles continues to decline and a trend toward lengthening of the period between epidemics has been noted. As concerns neonatal tetanus, the number of cases decreased 30% during the period 1990-1992.

With regard to the nutritional status of children under 5 years of age, the countries that have data available have shown an overall trend toward relative reduction of malnutrition rates, but this trend has not been uniform. Although the rates have decreased, the absolute number of malnourished children has continued to rise, and malnutrition remains a serious problem.

The most significant event of the quadrennium can be said to be the resurgence of cholera in 1991. As of 1993 a cumulative total of 953,387 cases had been reported. The cholera epidemic has made apparent the situation of inequity that persists in the Region.

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 ad the establishment of local health systems, the reorganization of sectoral financing, and the development of human resources.

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 the targets established under the Strategic Orientations and Program Priorities for the next quadrennium should be included among the regular activities of the Technical Units of the Organization through its incorporation into the American Region Planning, Programming, Monitoring, and Evaluation System (AMPES).

BIBLIOGRAPHY

1. Centro Latinoamericano de Demografía. *Boletín Demográfico* 1991; 24(48).

2. Division of Epidemiological Surveillance and Health Situation and Trend Assessment. World Health Organization. *Demographic Data for Health Situation Assessment and Projections*. Geneva: WHO; 1993.

3. Díaz, AR, Ortíz, R, Torres, C. Procesos Económicos, Sociales y Políticos y su Impacto sobre la Salud de las Américas. Document of the Health Policies Program of the Division of Health and Development of the Pan American Health Organization. Washington, D.C.: Organización Panamericana de la Salud; September 1993.

4. Organization for Economic Cooperation and Development. *Geographical Distribution of Financial Flows to Developing Countries*. Paris: OECD; 1992.

5. Pan American Health Organization. *Health Statistics from the Americas, 1992 Edition.* Washington, D.C.: PAHO; 1992.

6. Pan American Health Organization. Implementation of the Strategic Orientations an Program Priorities for the Pan American Health Organization during the Quadrennium 1991-1994 (Document CE107/22). Resolution III of the 107th Meeting of the Executive Committee of the Pan American Health Organization. Washington, D.C.: PAHO; 1991.

7. Pan American Health Organization. *Annual Report of the Director 1991.* Washington, D.C.: PAHO; 1991.

8. Pan American Health Organization. *Annual Report of the Director 1992.* Washington, D.C.: PAHO; 1992.

9. Organización Panamericana de la Salud. Informe Anual del Programa de Desarrollo de Recursos Humanos. Washington, D.C.: OPS; 1992.

10. Klinger, I. Cooperación Internacional en Salud. Washington, D.C.: Organización Panamericana de Salud; August 1993.

11. Organización Panamericana de la Salud. *La Investigación en Salud en América Latina - Estudio de Países Seleccionados*. Washington, D.C.: OPS; 1992. (Publicación Científica 543)

12. Pan American Health Organization. Strategic Orientations and Program Priorities for the Pan American Health Organization during the Quadrennium 1991-1994 (Document CSP23/14). Resolution XIII of the XXIII Pan American Sanitary Conference. Washington, D.C.: PAHO; 1990.

13. Paganini, JM. Los Procesos de Desarrollo de los Sistemas Locales de Salud - Un Análisis de la Situación. Washington, D.C.: Organización Panamericana de la Salud; 1993.

14. Organización Panamericana de la Salud, Programa Ampliado de Inmunización. Plan de Acción para la Certificación de la Erradicación del Poliovirus Salvaje en las Américas. Washington, D.C.: OPS; July 1993.

15. Banco Mundial, Oficina Regional de América Latina y el Caribe. Los Recursos Humanos en América Latina y el Caribe - Prioridades y Medidas a Tomar. Washington D.C.: Banco Mundial; 1993.

16. Organization for Economic Cooperation and Development. *Development Cooperation Report 1991-1992.* Paris: OECD; 1992

17. Restrepo, HE. Las Políticas de Promoción de la Salud en la OPS. Document presented at the International Conference on Health Promotion, Bogota, Colombia, 1992. Washington, D.C.: Organización Panamericana de la Salud; November 1992.

18. Organización Panamericana de la Salud. Sistemas de Información de SILOS (SI-SILOS). Módulo I - Nivel Nacional. Washington, D.C.: OPS; November 1992.