executive committee of the directing council

PAN AMERICAN HEALTH ORGANIZATION

working party of the regional committee

WORLD HEALTH ORGANIZATION

72nd Meeting
Washington, D.C.
July 1974

Provisional Agenda Item 14

CE72/6 (Eng.)
7 June 1974
ORIGINAL: SPANISH

A METHOD OF EVALUATING THE TEN-YEAR HEALTH PLAN

EVALUATION OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS

CONTENT

EXPLANATORY NOTE

The Directing Council of the Pan American Health Organization at its XXI Meeting adopted Resolution XIII in which it requested the Director to convene a working group of personnel responsible for planning and information and of health economists, with a view to designing a method of evaluating the Ten-Year Health Plan for the Americas drawn up by the III Special Meeting of Ministers of Health held at Santiago, Chile, in October 1972.

In compliance with Resolution XIII, the Director convened a Working Group on Evaluation of the Ten-Year Health Plan for the Americas, consisting of eitht planning and information specialists and health economists from various countries of the continent, which met at the Headquarters of the Organization in Washington from 4 to 8 June 1973. The deliberations of the Group culminated in the drafting of a report to the Director (attached) in which, following general remarks on the overall framework for evaluation of the Ten-Year Plan, the Group makes recommendations concerning the desirable characteristics of a method of evaluation, whether at continental or at country level. It also makes recommendations on the organization of country evaluation systems and their harmonization with a view to constituting a continental system.

In the course of its deliberations, and in its recommendations, the Group emphasized the definition and adjustment of country health policies as an indispensable condition together with information requirements; the difference in focus of evaluation at continental and national levels; the on-going nature of the evaluation process and feedback into the regular health activities; the role of planning units and participation of the health system at all levels; the training of personnel in evaluation methods and practices, etc. With regard to the role of the Organization, the Group not only urges that it be assigned the responsibility for carrying out the evaluation of the Ten-Year Plan at the continental level; it also points out the need for the Organization to promote the adoption of the evaluation processes in the various countries, advising them and cooperating with them in all relevant matters.

The Group recommends that the evaluation of the Ten-Year Plan should be carried out at three points in time: initial evaluation in 1974, intermediate evaluation in 1977, and final evaluation in 1981. At the same time it expresses the wish to see the countries ultimately make annual evaluations of all their programs Finally, it suggests that the Organization work out the method to be used at the continental level, selecting the indicators most suitable for the purpose and defining them operatively to avoid ambiguity.

Pursuant to the recommendations of the Working Group, the Organization has prepared the attached Scheme for the Evaluation of the Ten-Year Health Plan for the Americas, consisting of a set of forms for obtaining from the countries the information necessary to establish indicators for each of the areas included in the Ten-Year Plan with a view to carrying out an initial evaluation at continental level in 1974. The set of forms is accompanied by guidelines or instructions for completing them, giving a series of definitions of each of the indicators used, their main features and the way to obtain and handle them.

1. REPORT OF THE WORKING GROUP

PAN AMERICAN HEALTH ORGANIZATION

WORKING GROUP ON EVALUATION OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS

WORLD HEALTH ORGANIZATION

WASHINGTON, D.C., 4-8 JUNE 1973

REPORT TO THE DIRECTOR

INDEX

1. PARTICIPANTS

Argentina	
Dr. Antonio González	Chief, Planning Unit CONADE Section of Argentina
Brazil	
Dr. Roberto Carvalho Cardozo	Advisor Secretariat of Health of Brazil
Canada	
Mr. H. L. Laframboise	Director-General Health Planning Branch Department of National Health and Welfare of Canada
Colombia	
Dr. Himbad Gartner (Rapporteur)	Chief, Planning Unit Ministry of Public Health of Colombia
Ecuador	
Dr. Oswaldo Egas	Chief, Planning Office Ministry of Public Health of Ecuador
El Salvador	
Dr. Roberto de J. Badía	Director, Health Services Planning Ministry of Public Health and Welfare Assistance of El Salvador
Mexico	
Dr. Carlos García Alvarez	Chief, Planning and Evaluation Department Secretariat of Health and Welfare of Mexico

United States of America

Mr. M. Allen Pond (Moderator)	Associate Dean Graduate School of Public Health University of Pittsburgh

PAHO Secretariat

Dr. José Luis García Gutiérrez	Chief, Department of Special Technical Services
Dr. Juan José Barrenechea	Chief, Planning and Evaluation Unit
Dr. Raúl Vargas	Chief, Research Division Pan American Center for Health Planning

2. INTRODUCTION

In helping to formulate national programs and projects, the Ten-Year Public Health Plan of the Charter of Punta del Este (adopted in 1961) was successful in promoting a consensus among the countries of the Region on the role played by health and the health sector in the process of economic and social development, in promoting joint efforts, and in demonstrating that the countries derive far greater benefits, visible as solid improvements in the peoples' health conditions, when these conditions of consensus and joint action prevail.

The Ten-Year Plan was examined at the first two special meetings of the Continent's ministers of health. It was evaluated on three occasions by the simple process of comparing goals with achievements, as revealed by the information furnished by the countries themselves.

The Third Special Meeting of Minister of Health, held at Santiago, Chile in October 1972, conclused its deliberations by proposing a second Ten-Year Health Plan for the Americas, based on the role to be played by the health sector in the activities envisioned for the Second United Nations Development Decade. The second Ten-Year Plan, along with other recommendations of the III Special Meeting of Ministers, was incorporated in the Organization's policies by resolution of the Governing Council.

When one examines the contents of the Ten-Year Plan with a knowledge of the process which led to its formulation, one notes the evolution and the progress that have taken place in the conceptual structure now guiding health activities in the countries of the Continent. For example, the Plan clearly establishes the need to view the health sector as a whole, with its internal and external relationships, but with this global view not engendering neglect of consideration of the subsystems within the sector. There is also a clear concern both for the objectives in the health field and for the tools needed to achieve them while maintaining equilibrium between efficiency and social justice. Profiting from each country's greater knowledge, information, and experience, acquired over the last decade, on its problems and means of solving them, the new Plan is significantly more precise in its objectives and in the strategies it proposes for meeting them.

The Ten-Year Plan drawn up by the Ministers and their technical staffs serves as a guide for orienting the programs and activities of the countries which conceived it and of the Organization. It proposes general objectives and strategies relating to practically all major aspects of national health systems and health problems, in the framework of a national health policy consistent with the level of economic and social development. Defining such a policy, weighing the possibilities for

action in each country, and selecting priorities for achievement of the established goals, are prerequisites for the formulation and fulfillment of national plans.

The intense activity of the countries in drawing up the Ten-Year Plan for the Americas is continuing with the formulation of national policies, the establishment of goals, the selection of priorities, and the designing of strategies. The next steps, therefore, are implementation and evaluation.

On the latter subject -evaluation- the Organization's Governing Council, at its XXI Meeting, adopted Resolution XIII, a pertinent part of which reads as follows:

"Request the Director of the PASB to call together, as soon as possible, a work group composed of planning and information authorities and health economists to design an evaluation system adaptable to the conditions of the various countries and sufficiently flexible to provide comparable results, making possible a continent-wide evaluation of accomplishments during the decade."

Pursuant to this mandate, the Director called a meeting of eight specialists in health planning, information, and economics from various countries of the Continent. The group met at the Organization's headquarters in Washington from June 4-8, 1973, to discuss, and to make recommendations upon, the method to be used and systems to be established by the countries and by the Organization.

Several preliminary studies prepared by PAHO staff for the meeting were used as reference documents. The "Discussion Guide," presented as a suggestion to the group, was accepted and, after amndment, included in the group's final report. The "Guide for Analysis and Incorporation of the Goals of the Ten-Year Health Plan for the Americas in National Health Policies and Adjustment of Quadrennial Country-PAHO Projections" (Appendix I) was also available to the group and is being used by the countries. The Organization's preliminary study on "Classification and Analysis of the Goals of the Ten-Year Health Plan for the Americas" (Appendix II) was also offered for the group's consideration, as was "Considerations relating to the Selection of Priorities as a Component of the Decision-Making Process" (Appendix III). Other documents used were the "Basic Reference Document of the III Special Meeting of Ministers of Health for the Americas" and the "Ten-Year Health Plan for the Americas," which had been approved by that ministerial meeting.

The group opened its deliberations after being welcomed by the Director of the PASB, who pointed out the importance of evaluating the Ten-Year Plan and the need for a simple method, easily applicable in

the various countries, and for a system that could be effectively used by existing facilities both in the countries and in the Organization.

Mr. Allen Pond was chosen as Moderator and Dr. Himbad Gartner as Rapporteur of the group. Discussion centered upon the three subjects suggested by the Organization's Secretariat and according to the agenda it had proposed, which the work group accepted. Item I, "Purposes and Characteristics of Evaluation of the Ten-Year Plan for the Americas," was discussed for three hours on the first day of the meeting. More time was devoted to Item II, "Recommendations on Elaboration of a Method of Evaluation," which was discussed during the latter part of the first day and during the second and third days. In view of the length of time spent on this subject, a subgroup was appointed to draft a resolution for the group's consideration; and editing committee, which worked outside the meeting hours, was also appointed. Six hours were devoted to Item III, "Recommendations on the Organization and Operation of the Evaluation System;" a special drafting subgroup was appointed for this item as well.

A draft of the final report was prepared by a drafting committee which met in the afternoon and evening of the next-to-the-last day. It was discussed and approved with minor modification in the morning of the last day. After the Moderator reviewed the meeting orally for the Director of the PASB, the Director gave his closing words of thanks, and the meeting was adjourned.

3. WORK GROUP REPORT

3.1 OVERALL FRAMEWORK FOR EVALUATION OF THE TEN-YEAR PLAN

The members of the Work Group made a series of observations on the status of the countries' decision-making and planning processes, evaluation practices, and the role of information systems in evaluation. This discussion led to the identification of factors that should be taken into account in organizing systems for evaluating the Ten-Year Health Plan for the Americas:

-As the Ten-Year Plan makes clear, its execution requires that each country establish policies, or adjust existing policies, so as to incorporate the goals in each pertinent section of the Plan, to provide for the identification of priority areas, and to state the strategies for achieving the proposed goals. In evaluating progress toward these goals at the national level, indicators based on information that is both simple and homogeneous in nature must be used. In most areas,

the Plan suggests indicators for evaluating its implementation. In other areas, however, criteria for making qualitative or quantitative comparisons will have to be found; this applies particularly to the development of administrative, planning, and information processes in the national health sectors.

-Despite the shortcomings in the information systems of the national health sectors, they may be able to provide sufficient information to assess the implementation of national and continental goals and strategies in the terms in which the Ten-Year Plan expresses them. It is possible and advisable to seek the greatest development of those systems, so as to improve the processes of evaluation and control, and, hence, the establishment and adjustment of policies and the processes of decision-making at all levels.

-In deciding how to evaluate the Plan, the current availability of information in the countries, as well as the information which will become available as national information systems are improved, should be considered. It is important to improve the use of available information on mortality, in-hospital morbidity, resources (availability, preparation, and use), and production and productivity, as well as information on health services organization, so as to improve the systems of decision-making, planning, and control.

-The same area categories should be used in evaluation as those into which the Ten-Year Health Plan for the Americas is divided.

In light of these and other considerations, the group adopted the following recommendations on the purposes and characteristics of evaluation of the Ten-Year Health Plan for the Americas:

-The evaluation system should focus on estimating the effort applied and change achieved in each country, as regards the resources, process, and production of the health system, as well as its effects in bringing about a higher level of health and a positive attitude on the part of participants in the process. The information obtained through the evaluation should be fed back into the system and serve as a foundation for the adjustments needed for planning and devising strategies to pursue the goals and purposes of the Ten-Year Plan at the continental level.

-The goals and purposes of the Ten-Year Health Plan for the Americas should be considered a point of reference and guidance for the goals and purposes selected for each government's health plan. The consistency and interrelationship of national and continental goals should be examined. To facilitate this examination, the goals and purposes should be studied and classified, bearing in mind that some of them can be measured and assessed only if certain operational criteria exist in advance.

-Achievement of the Ten-Year Health Plan for the Americas should be evaluated as a function of the number of countries and proportion of the population of the Americas which has achieved or surpassed the goals and carried out the stipulations of the Plan.

-Given the structure and concept of the Ten-Year Health Plan for the Americas, the evaluation must include an analysis of the national strategies formulated to implement the goals and targets of the Plan, as well as the analysis of the extent to which they are in fact implemented. Hence, the design of the system for evaluating the Ten-Year Plan should facilitate the evaluation by each country of the progress toward its goals and of implementation of its programs and strategies, with the comparability necessary to permit assessment of achievements at the continental level in the 1971-1980 period. In addition, the final evaluation of the Plan should make it possible to draw up recommendations on areas of continental priority at lines of strategy for modifying the situation in those areas during the following decade.

-At the national level, the evaluation system should also serve to improve the information systems that feed the processes of policy-making, planning, scheduling, and budgeting, as well as the supervision of implementation.

-It is deemed advisable for the countries to define the critical, high-priority programs in each problem area and to focus available resources on those programs, thus promoting accomplishment of their objectives and assuring the effort necessary to improve their administration and programming and the information system for their evaluation and control.

3.2 RECOMMENDATIONS ON ELABORATION OF A METHOD OF EVALUATION

The method of evaluation is affected by the very purposes of the evaluation, already stated; by the structure and form of expression of the goals of the Ten-Year Plan, which cannot be evaluated in terms different from those in which it is expressed; by the manner in which the various countries incorporate the goals of the Ten-Year Plan in their own policies and plans; by the time available for the initial and subsequent evaluations; and by the information available to the countries for each area of the Plan.

For evaluation purposed, it is suggested that PAHO urge the countries to define their health policies and to incorporate in them the goals and provisions of the Ten-Year Plan before the first evaluation effort takes place, which, according to the recommendation, would be 1974.

The evaluation proposed for 1974 is to be the start of the process, assessing the situation of the countries and of the Continent as of 1971 in relation to the goals of the Ten-Year Plan. Further, it is to verify the inclusion of these goals and purposes in their health policies and plans, indicating the national strategies adopted to achieve them.

The way in which the countries incorporate the goals of the Ten-Year Plan in their policies will determine the evaluation system at the continental level. It is therefore recommended:

-That the countries incorporate these goals prior to the date set for the first continent-wide evaluation.

-Evaluation should be considered a constantly on-going process within the countries and a process taking place at defined periods at the continental level, for the purpose of comparing the observed situation with the planned situation, of explaining the differences found, and of using these data to reformulate and adjust the plans.

Consequently, it is recommended that annual evaluations, coinciding with the budget cycle, be conducted in the countries. It will then be possible to make timely corrections in the implementation of the plans, to have feedback into the planning process and to improve it, and to evaluate the impact on the level and structure of community health.

-To practice and apply the evaluation method proposed, and to obtain the information needed for the initial evaluation, it would be useful to make use of the system of Quadrennial Country-PAHO Projections. It would also be advisable for the countries to adjust their Quadrennial Projections, or to draw them up if they have not yet done so, as they incorporate the goals and provisions of the Ten-Year Plan.

-So that all countries may have the same understanding of the proposed evaluation method, it is suggested that PAHO prepare a glossary of operating definitions of the terms used.

-In order to develop homogeneous, well-defined channels of information at the continental level, it is recommended that the attention of the countries be directed at obtaining information in the following areas:

-People exposed to the risk of illness and death, with particular attention to avoidable risks.

-Coverage of services

-Program areas:

Services to persons
Environmental sanitation programs

-Complementary services

-Infrastructure development:

Sector organization and administration:

Organization
Planning
Information
Research

Resources:

Human
Physical
Financial
Technological

Legal aspects

These areas should be examined in relation to intra-sector and extra-sector limitations.

3.2.1. Characteristics of the Analytical Method at the Continental Level*

-It is recommended that the following broad guidelines be considered in preparing the definitive, detailed design of an evaluation method.

-The continental analysis should focus on the progress of each country, using the goals proposed in the Ten-Year Health Plan for the Americas as the point of reference.

-Since the analysis of the state of the Continent as a result of the Ten-Year Plan will be based on an analysis of each country's effort to promote the desired national change, the evaluation should include a study of national strategies, so that operationally valid conclusions and recommendations may be drawn.

---

*The national efforts should follow the guidelines adopted for the continental level so that analysis at that level is feasible; but this should not prevent each country from designing an analytical plan appropriate to its needs.

-In view of the short time available for each evaluation, the rigidity of the evaluation deadlines, and the need to reduce operating costs, the analysis should be based on information that is already available and common to all or the great majority of the countries. Special research to obtain information should be kept to an absolute minimum.

-The shortage of resources and the limitations of technology and time make it necessary that simple, easily conducted procedures, feasible in all the countries, be selected and recommended. Further, it is recommended that the countries and PAHO apply new methods facilitating the procurement of the basic information needed to nourish the processes of decision-making, planning, evaluation, and supervision.

3.2.1.1 Time and Content of Evaluation at the Continental Level

-Initial Evaluation (1974)*

The basic purpose of this evaluation is to examine the gap between the situation in the countries in 1971 (considered to be the initial year of the period covered by the Ten-Year Health Plan for the Americas) and that which is sought for 1980.

This evaluation should look at the level and structure of health and the organization, resources, and operation of the countries' health systems in 1971, and at the changes which each country hopes to achieve in these areas by 1980. Additionally, it should determine how the countries are incorporating the goals and provisions of the Ten-Year Health Plan for the Americas in their own health policies. Examination of the latter aspect is vital, for it will permit adjustment of the system and method of continent-wide evaluation to the limitations initially imposed by the form and content of national health policies.

Therefore, the contents of the initial evaluation should include:

-The number and percentage of countries that have examined the goals and provisions of the Ten-Year Plan for the Continent and formally incorporated them in their national health policies.

---

*Evaluation of the 1971 situation will be made in 1974 because it is assumed that all the countries will be in possession of the necessary information by that time.

-The number and percentage of countries that have made explicit their national health strategies for achieving the proposed goals and purposes.

-The number and percentage of countries that have established intermediate goals for the 1971-1977 period.

-The number and percentage of countries (and of the population involved) that have set goals lesser than, equal to, or greater than those indicated in the Ten-Year Plan:

-Identification of the goals and purposes;

-Quantification and ordering of these goals in relation to the Ten-Year Plan;

-Analysis and categorization of the discrepancies.

-Analysis of the distance between the initial (1971) situation and the national goal or objective proposed for 1980. This analysis should be conducted by goal or objective and by country, specifying the percentage of the total population of the Americas involved.

-Analysis by country of the consistency between each established goal or objective and the strategy set for achieving it.

-Summary of the situation of the health sectors in the Americas in 1971. Number and percentage of the population affected, by goal and by country.

-Outline of the conomic and social situation of the countries of the Americas in 1971.

-Intermediate Evaluation (1977)

The purpose of the evaluation at this intermediate point is to obtain some indication of the pace at which it is hoped to achieve the goals set, as well as of the sequence and intensity of the strategies designed to achieve them.

The major elements of this evaluation will be analyses of progress toward the goals set for 1977 (in countries which set such goals) and of the performance of the strategies designed for the 1971-1977 period.

-Final Evaluation (1981)

The fundamental aim of this evaluation is to examine progress toward the goals and objectives established by the countries for 1980,

which is considered the last year of the period covered by the Ten-Year Health Plan for the Americas.

This evaluation should focus on the changes achieved in each country by the efforts it has made. Change will be measured between the starting point in 1971 and the situation as of 1980, in relation to the objective established by the country for the latter year. Examination of the strategies initially set to pursue the objectives of change and of the modifications made during the period is also regarded as fundamental.

On the basis of the final evaluation in 1981, it should be possible to draw up recommendations on priority areas for the Continent and lines of strategy for modifying conditions in those areas in the following decade.

Therefore, the following should be among the components of this evaluation:

-The number and percentage of countries (and the percentage of the population of the Americas involved) that have achieved the national goals and purposes set for 1980.

-The number and percentage of countries (and the percentage of the population of the Americas involved) that have achieved or surpassed the goals and objectives of the Ten-Year Health Plan for the Americas.

-Analysis and categorization of the limitations internal and external to the national health sectors which affected the chances of achieving the goals proposed.

-Analysis by goal and country of the changes achieved during the 1971-1980 period (number and percentage of the Continent's population affected by the change).

-Analysis of variations in the strategies initially set, by goal or objective and by country.

-Review of the situation in the national health sectors in 1980. Number and percentage of the population affected, by goal and by country, and a comparison of the situation in 1980 with what existed in 1971.

-Outline of the economic and social situation of the countries of the Americas in 1980, comparing it with the 1971 situation.

-Comparative description of the evolution of indicators in the health sector and of the countries' socio-economic indicators in the 1971-1980 period.

-Suggestion for defining objectives and lines of strategy for the 1981-1990 period.

3.2.1.2 Work Sheet Components for the Analysis at the Continental Level

To facilitate the work of evaluation, the group suggests a list of items for inclusion in the basic work sheets for conducting the analysis at the continental level, along with a chart summarizing the comparisons which might be made.

Item No.	Item	Remarks
(1)	Country	
(2)	Population (number)	As of the year of the evaluation
(3)	Population (percentage of total population of the Americas)	
(4)	Goal of the Ten-Year Health Plan for the Americas	*
(5)	Situation of the country in 1971	*
(6)	National goal for 1977	*
(7)	National goal for 1980	*
(8)	Change desired by 1977	Based on (6) and (5)
(9)	Change desired by 1980	Based on (7) and (5) May be the same as the entry for (7)
(10)	Change desired if the country had accepted the goal of the Ten-Year Plan	Based on (4) and (5) May be the same as the entry for (4)

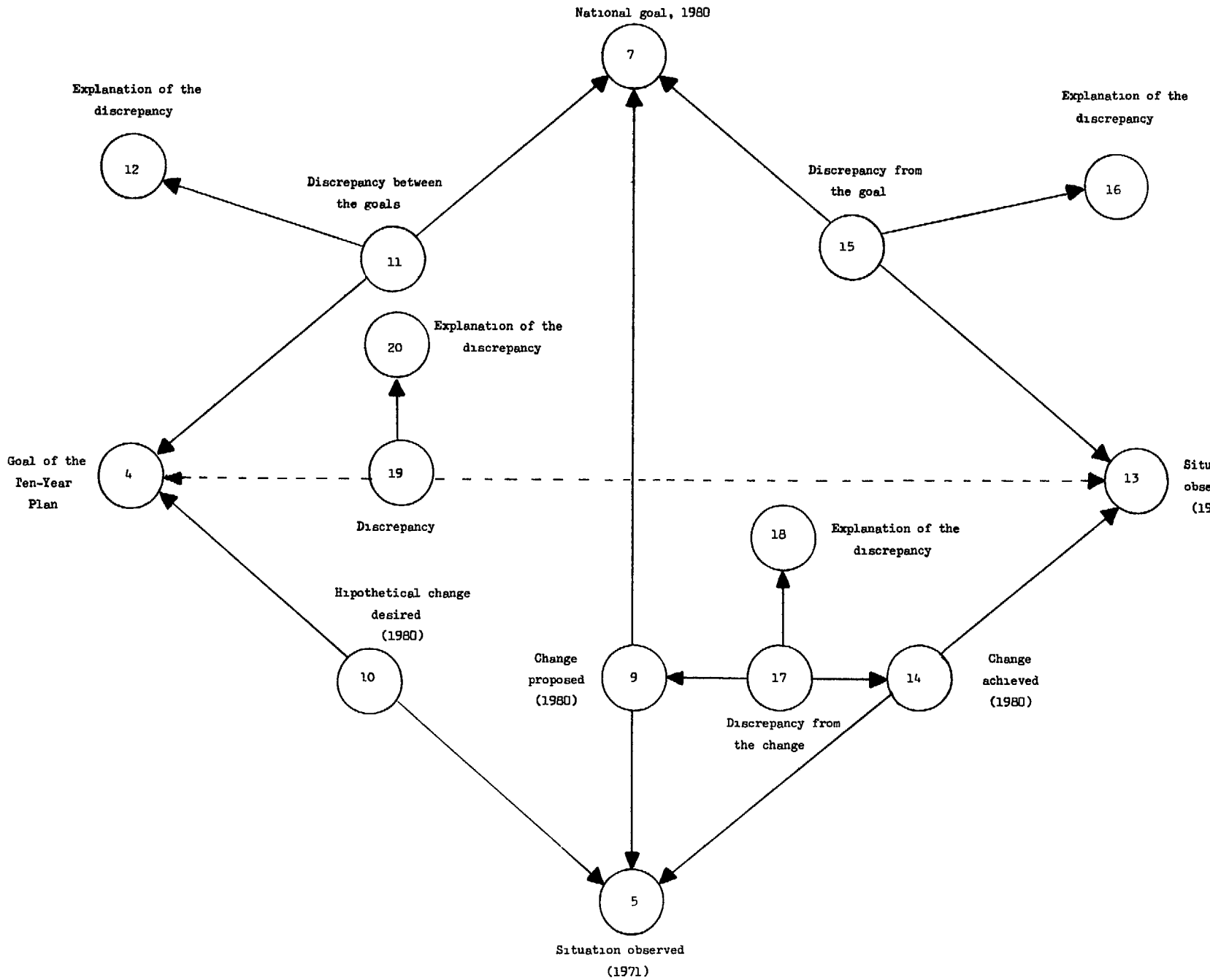
*Based on the information provided by the countries when they incorporate the goals of the Ten-Year Health Plan for the Americas in their national health policies and adjustment of the Quadrennial Projections.

Item No.	Item	Remarks
(11)	Discrepancy between goals of the Ten-Year and national plans for 1980	Based on (4) and (7)
(12)	Explanation of discrepancy indicated in (11)	Logical analysis
(13)	Situation observed in 1980	Data to be collected
(14)	Change observed in 1980	Based on (13) and (5)
(15)	Discrepancy between the national goal for 1980 and the actual situation then	Based on (7) and (13)
(16)	Explanation of discrepancy indicated in (15)	Logical analysis
(17)	Discrepancy between desired and actual change in 1980	Based on (9) and (14)
(18)	Explanation of discrepancy indicated in (17)	Logical analysis
(19)	Discrepancy between goal of Ten-Year Plan and national situation in 1980	Based on (4) and (13)
(20)	Explanation of discrepancy indicated in (19)	Logical analysis
(21)	Discrepancy between the change desired if the country had accepted the goal of the Ten-Year Plan and the change observed in 1980	Data from (10) and (14)
(22)	Explanation of discrepancy indicated in (21)	Logical analysis
(23)	National strategy proposed for 1977	*
(24)	National strategy proposed for 1980	*
(25)	National strategy observed in 1977	Data to be collected
(26)	National strategy observed in 1980	Data to be collected
(27)	Explanation of discrepancies between (24) and (26)	Logical analysis

*Based on the information provided by the countries when they incorporate the goals of the Ten-Year Health Plan for the Americas in their national health policies and adjustment of the Quadrennial Projections.

COMPONENTS OF ANALYSIS FOR EVALUATION AT THE CONTINENTAL LEVEL

(Final Evaluation - 1980)



There are two formulations of different origin for each goal or purpose. They may or may not coincide:

-That expressed in the Ten-Year Health Plan for the Americas.

-That established by each country.

They must both be examined to determine:

-The discrepancies between the situations (and/or changes) desired and those observed.

-The explanation for those discrepancies.

The examination may be by means of comparisons between absolute or relative numbers or between rigorously defined qualitative factors. The type of examination decided upon will depend basically on the way in which each goal is expressed.

3.2.1.3 Items for the Continental Analyses by Country

-Level and structure of health and the health sector situation

(1) Initial situation (1971)
(2) Situation observed in 1980
(3) Situation desired in 1980
(4) Analysis of discrepancies between (2) and (3)

-Socio-economic situation

(1) Initial situation (1971)
(2) Situation observed in 1980

As an example, the group offers a tentative list of socio-economic indicators which fulfill the requirements of being available in most countries of the Americas and which have demonstrated their relevance to the definition of socio-economic profiles:

OVERALL INDICATOR

(1) Live expectancy at birth

HEALTH INDICATORS

(2) Mortality rate, age 1-4
(3) Percentage of death from infectious and parasitic diseases

(4) Inhabitants per physician
(5) Inhabitants per hospital bed

ENVIRONMENTAL INDICATORS

(6) Percentage of population in localities of over 20,000
(7) Percentage of population supplied with water
(8) Calories per capita
(9) Grams per day of protein per capita

EDUCATIONAL INDICATORS (level and structure)

(10) Percentage of literates
(11) Percentage of primary school enrollment, population aged 5-14
(12) Percentage of secondary and vocational school enrollment, population aged 15-19
(13) Percentage of university enrollment, population aged 20-29

ECONOMIC INDICATORS (level and structure)

(14) GNP per capita
(15) Percentage of GNP generated by secondary sector
(16) Population employed in the sector
(17) Sectoral productivity

DEMOGRAPHIC INDICATORS (structure)

(18) Percentage of population under 15 years old
(19) Percentage of population over 55
(20) Rate of population growth
(21) Rate of fertility

OTHER FACTORS

-Population (in thousands)

-Territorial area (including interior waters) (in thousands of square kilometers)

-Land farmed (in thousands of square kilometers)

-Population density per square kilometer

-Ratio of farmed area to total area

-Population per farmed square kilometer

-Percentage of surface that is arable

3.2.2 Characteristics of Analytical Method at the Country Level

The method of evaluation designed by each country should be capable of supplying the continent-wide evaluation method and meeting all its conditions.

At the national level, it is recommended that the contents of the evaluation in each country be such as to permit:

-Analysis of problem areas, critical programs, and priorities.

-Analysis of the activities conducted, with a view to utilizing the information gathered to adjust national goals and strategies, considering the funds and other resources available.

-Explanation of discrepancies and progress in relation to the goals set.

In evaluating the progress toward a goal, one should keep the following steps in mind:

-Compare the goal with the situation achieved.

-Explain why the goal was or was not achieved.

-Feed this information back into the system and start another cycle.

It is recommended that PAHO suggest to the countries that the explanation of discrepancies and achievements should be based on an analysis of the nature of the goal and of the strategies used to pursue it. Hence, the countries should consider both the procedure by which it was adopted and the factors of feasibility, viability, degree of definition, degree of consistency, and degree of dependence on the achievement of other goals.

The operational treatment of the goals and purposes of the Ten-Year Health Plan for the Americas should follow the classification given on page 7. This would facilitate an examination of the consistency and interrelationships of the goals and purposes established by each country.

For certain goals and purposes of the Ten-Year Health Plan for the Americas, the countries will have to identify additional operational criteria by which to measure or estimate their fulfillment.

Though each country must retain the flexibility it needs in working through the process of incorporating the goals of the continental Ten-Year Plan in its health policies, the Group deems it advisable for each country to follow, to the extent it may consider appropriate, the procedure suggested for this purpose in the Guide furnished by PAHO* in order to facilitate the process and assure the comparability necessary to the continent-wide evaluation.

3.3 ORGANIZATION OF THE EVALUATION SYSTEM

In the spirit of the Recommendations of the Third Special Meeting of Ministers of Health of the Americas and the Resolutions of the Governing Council of the Organization, the chief purpose of the evaluation system is to strengthen the national mechanisms for continously observing and assessing efforts to achieve the goals established by the countries themselves in their health plans. It is designed also to produce results which can be made uniform at the continental level so as to permit evaluation of the progress made during the decade.

Organization of the systems should be based on the principle that evaluation is an essential component of the planning process. As such, it cannot be divorced from the process. Whatever structure the countries may have to conduct the process, evaluation must be an integral part of the administrative and planning process.

The conduct of evaluation has been deficient in the countries: the methods used have been inadequate, there has been a shortage of trained personnel, and feedback of the results into the process has been inadequate.

On these grounds, and considering the current state of evaluation in the countries and the resources which they and PAHO may have available for the development of evaluation systems on the Continent, the Group makes the following recommendations:

3.3.1 At the Country Level

-Develop and strengthen the evaluation function as a component of the information, evaluation, supervision, and decision-making systems which are required by national administrative and planning processes.

---

*"Guide for Analysis and Incorporation of the Goals of the Ten-Year Health Plan for the Americas in National Health Policies and Adjustment of Quadrennial Country-PAHO Projections".

-To this end, maximize the use of currently available resources, improve their organization and, if necessary, create additional resources consistent with the country's abilities and capacity.

-The evaluation function should be coordinated and advised by the planning units, making certain that all levels of the health system's structure participate.

-Despite the individual characteristics reflecting the peculiarities and needs of each country, the national evaluation systems should have certain common characteristics, stemming from the use of basically shared methods and procedures, so that their results may be made compatible for continental purposes.

-The training of personnel in the methods, organization, and operation of evaluation systems is an urgent need if the process is to become widely and effectively used beginning in 1974. The organization of short courses essentially operational in nature, is deemed advisable. Within the limits of its capacity, PAHO should participate in these initial efforts when requested by the countries.

-Similarly, in the basic courses in health services administration, and particularly the planning courses, that are conducted in the countries, special stress must be placed on the concepts and methods of evaluation, viewed as an integral part of the information, evaluation, decision-making, and supervision process.

3.3.2 At the Continental Level

PAHO has an important role to play in the continental evaluation system. It is therefore recommended:

-That it serves as a clearing house for information from all countries and coordinate the establishment and development of the continental evaluation system at its central point.

-That its field officials participate in the processes of collaboration, consultation, and coordination between the national planning system and Headquarters.

-That it plan the implementation of the evaluation system, bearing in mind the need to conduct the following activities:

-Informing the governments and other interested institutions of the characteristics of the evaluation system that is proposed.

-Drawing up an instruction manual succinctly describing the purpose and manner of organizing the evaluation system. Drawing up a glossary of the terms used in the manual.

-Creating the patterns of computation, forms of presentation, printed forms, etc., for the proper functioning of the continental evaluation system.

-Drawing a schedule for establishment of the system.

-Maintaining contact with the countries so as to consult as needed while their systems are being established.

-Analysing the information supplied by the countries to the continental level, and publishing the results.

-Developing and advising on training programs in the subject.

-Promote, assist, and conduct research on methods in the field of evaluation.

ANNEX

GUIDELINES FOR THE ANALYSIS AND INCORPORATION OF THE GOALS OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS IN THE NATIONAL HEALTH POLICIES AND ADJUSTMENT OF THE COUNTRY-PAHO QUADRENNIAL PROJECTIONS

Index

I. NATIONAL HEALTH POLICY

1. BACKGROUND

The Third Special Meeting of Ministers of Health of the Americas (Santiago, Chile, October 1972), the basic purpose of which was to draw up the Ten-Year Health Plan for the Americas for the period 1971-80 (see Anexx I) resolved "To consider, as a basic requirement for achieving the goals under the plan,[1/] the definition in each individual country of the health policy, in the light of its economic and social development, specifying clearly the objectives and structural changes necessary to achieve them".

The decision to perfect the national health policies as effective instruments for the implementation of the Ten-Year Health Plan for the Americas and its corollary of evaluating the common efforts and measuring their results, generate in their turn the need to establish a procedure for analysis and reformulation of those policies which is common for all the countries, yet sufficiently flexible to take into account the characteristics and needs peculiar to each one.

2. SOME ELEMENTS TO BE CONSIDERED WHEN FORMULATING A NATIONAL HEALTH POLICY

To facilitate understanding of these guidelines an operational definition of policy is adopted and certain of its components

---

1/ The Ten-Year Health Plan for the Americas

are enumerated. Thus, a POLICY is considered as an:

> Ordered and coherent set of aims of a general nature, which orient the carrying out of actions or the creation of favorable situations for the solving of the problems which have to be overcome in the light of a desired situation for a given period.

Such general aims as arise from analysis of the differences between the present situation and the situation desired for a given future are set forth.

In the case of a sectoral policy, the analysis of the discrepancies between the present and the desired situation will be conditioned by the goals of the overall national development policy (explicit or implicit) and will lead to identification of the sector's problems. Once the problems are identified, those considered to have priority will be selected, which will entail analysis of the possible solutions for each of them. The analysis of the possible solutions --which includes that of the technological alternatives-- constitutes a link between the policy and the formulation of the strategies needed for its application.

Study of the internal and external constraints which affect the health system is essential for evaluation of the viability and feasibility of the proposed changes and their subsequent solutions

The precise definition of the situation which it is desired to achieve within a given time, the identification and ranking in order of importance of the problems and the selection of the possible solutions constitute the very essence of policy formulation. They therefore form the initial and essential stage of a process which triggers off a sequence of decisions which concludes with the programming of the

specific activities and investments required for bringing about the desired change. In other words, the clear and precise definition of a National Health Policy is a vital prerequisite for setting in motion a process of sectoral planning and its formal embodiment in a Health Plan.

3. PURPOSES AND CONSTRAINTS

3.1 The specific purposes of these guidelines can be summed up as follows:

- To facilitate the analysis of the goals of the Ten-Year Health Plan for the Americas and review of the national health policies in the light of that analysis and of the national development policies.

- To facilitate estimation of the contribution expected from each country for the fulfillment of the Ten-Year Health Plan for the Americas.

- To facilitate the systematic evaluation of the Ten-Year Health Plan for the Americas.

- To facilitate the adjustment of the Country/PAHO Quadrennial Projections to the national health policies.

3.2 From these goals is derived the need for establish a common procedure for the analysis, as well as a common basis with that of the Ten-Year Plan for the definition of categories, indicators, etc., to be used in each country.

3.3 The following criteria condition and the preparation of these guidelines:

- Time available for completing the analysis of the goals of the Ten-Year Health Plan for the Americas and updating of the national policies:

  Completion of this process is a matter of urgency, as it is an essential prerequisite for the practical application of the changes envisaged which, according to the approved Ten-Year Plan, have to produce the expected results within the period ending in 1980.

- Present availability of information and resources:

  The evaluation of the availability of resources and information for this process, bearing in mind the urgency as noted, means that the setting up of complex procedures and research in depth will not be possible.

3.4 Because of their form, application of these guidelines is restricted exclusively to certain operational aspects of the analysis of the goals of the Ten-Year Plan, their incorporation into the national health policies, and to the subsequent adjustment of the Quadrennial Projections to the joint Country and PAHO activities.

II. SCHEME FOR THE ANALYSIS OF NATIONAL HEALTH POLICIES AND THEIR ADJUSTMENT IN THE LIGHT OF THE TEN-YEAR PLAN FOR THE AMERICAS

1. BASIC CONVENTIONS AND ASSUMPTIONS

1.1 At the Third Meeting of Ministers (Santiago, Chile, October 1972) the governments undertook to carry out the Ten-Year Health Plan agreed upon at that meeting, and to evaluate it at regular intervals. (See Annex I and Annex III, under 3).

1.2 All the countries possess a national health policy, either expressed explicitly in a health plan, the Quadrennial Projections or in some other set of documents, or simply being implemented on a de facto basis.

1.3 The tools for analysis (categories, definitions, indicators, goals, etc.) and adjustment currently used for the updating or reformulation of the national policies must be the same as those set forth in the Ten-Year Plan for the Americas. Nevertheless, individual countries may split up the categories and indicators used in the Plan and/or include other items, as dictated by their requirements, for the formulation of their particular health policies.

1.4 The targets which each government fixes for the ten-year period must be expressed in national averages, but both the analysis and the adjustment of the national health policy can be performed and expressed in regional terms, in accordance with the characteristics of the country and with the requirements imposed by its national development plan.

1.5 The level or depth of the analysis and the extent of the adjustment will extend, at least, to the general goals for the solving of the country's health problems and their classification by order of priority and will include the main strategic elements.

2. GENERAL STRUCTURE OF THE SCHEME (See **Chart 1,** page 15)

This scheme was based on the items making up the Ten-Year Health Plan for the Americas and those included in the Quadrennial Projections prepared for 22 countries and territories of the Americas. In line with the Ten-Year Plan, these components were grouped in the following areas:

Area 1: General Goal

1 Life expectancy at birth (see Annex I, point III, pp. 8)

Area 2: Main Goal

Coverage of services (see Annex I, Goals I.1, pp. 2)

Area 3: Program Areas

3.1 Services to individuals (see Annex I, Goals I.1.1 through I.1.4, pp. 2 and 3)

3.2 Environmental sanitation (see Annex I, I.2.1 through I.2.11, pp 4 through 5)

Area 4: Supporting Services (see Annex III, Goals I.3, pp. 5)

Area 5: Infrastructure Development

5.1 Development of the organization and sectoral administration (see Annex I, II.1 through II.4, pp. 6)

5.2 Development of resources (see Annex I, II.5 through II.9, pp. 6 through 8)

Once the Plan components were grouped in the above areas, the chief (or primary) interrelationships between them were defined, as shown by the vectors in the Scheme (see Table 1).

The constraints (or factors) which condition the areas and their interrelationships were grouped into two large areas:

Area 6: Internal health sector or intrasectoral constraints 2/.

Area 7: Constraints that are external to the sector or extrasectoral 2/.

2/ Intrasectoral (or internal) constraints are considered to be those over which the Health Sector has control, within certain limits, as regards removing or overcoming the obstacles involved and the achievement of the purposes or goals the Sector sets itself.

Extrasectoral (or external) constraints are considered to be those over which the Health Sector does not have control, as their removal requires decisions which come under the competence of other sectors or of the social system as a whole.

Analysis of the internal and external constraints is the key for the evaluation of the feasibility and viability of the proposed changes which comprise a policy and are the essence of the strategies which have to be formulated to implement it.

3. SEQUENCE OF THE ANALYSIS AND ADJUSTMENT SCHEME (Table 1)

The analysis of the above-described components is based fundamentally on the play between the objectives and goals which the country wishes to achieve --compared with the aims of the Ten-Year Health Plan for the Americas and the present situation of the country making the analysis-- and the requirements in terms of resources and organization which those aims presume. Both the goals and the requirements for achieving them are conditioned or limited by the internal and external constraints peculiar to the Health Sectors of the individual countries.

The carrying out of the analysis also presumes that use will be made of the method of successive approximations, with a final adjustment stage to achieve the necessary consistency between the aims.

3.1 First Approximation:

3.1.1 Life expectancy at birth (Table 1, Area 1)

The goals proposed by the Ten-Year Health Plan for the Americas will be compared with the present situation of the country and with the previously defined proposed change. It will be estimated what level life expectancy at birth could reach in 1980 if it is decided to change certain components of the mortality structure with an intensity and at a rate considered feasible. Such a decision conditions, as a first approximation, the priorities and goals of certain of the components of Area 3.

3.1.2 Coverage of Services (Table 1, Area 2)

For analysis of this area it is first necessary to prepare definitions of the levels of service (minimum, basic and

specialized), in terms of installations, characteristics of the main human resources, functions or types of care to be produced by these units, and potential coverage of each type of service, depending on the national definition of the accessibility of the communities.

Once the above definitions have been prepared, the present position of the country, in terms of national coverage, will be compared with the Ten-Year Plan goals, according to the levels defined. In the first instance priorities will be fixed for coverage goals by level of service: minimum, basic and specialized. A rough estimate will be made of the requirements implied by these goals as regards direct services (Table 1, Area 5.2), demand for supplementary services (Table 1, Area 6) and exigencies in the sectoral organization and administration (Table 1, Area 5.1)

At this stage the first analysis of the internal (Table 1, Area 6) and external (Table 1, Area 7) constraints will be made with a view to obtaining a preliminary estimate of the feasibility and viability of the goals fixed in this first approximation.

3.1.3 Program Areas

The analysis of these areas will be based fundamentally on comparison of the present position of the country with the goals of the Ten-Year Plan for the Americas and the position it wants to reach. The goals as regards services to individuals will be expressed in terms of level and structure of mortality and morbility and population coverage; those relating mainly to environmental improvement will be defined mainly in terms of coverage. In certain countries of given levels of development the requirements in terms of change in specific mortality derived from the general goal set forth (life expectancy), can be effective means

for determining the order of priority of the specific program areas.

In this first approximation the possible solutions for the specific problems considered to have priority must be analyzed and the infrastructure requirements these solutions set must be estimated. An initial evaluation of the internal and external constraints these set for the feasibility and viability of the solutions proposed will also have to be made at this juncture. One of the fundamental constraints for the definition of priorities and goals in Area 3 is formed by the priorities and goals already fixed for Area 2. In this first approximation, the constraints determined for Areas 2 and 5 (mainly 5.2) will make it possible to orient the preliminary selection of alternative technologies for the possible solving of the specific problems considered to have priority.

3.1.4 Complementary Services

The analysis of this area must be centered on the estimating of the feasibility of meeting the requirements, or demands, presumed, in terms of supplementary resources, by the coverage goals for final services and the specific program areas consider to have priority in a first approximation.

3.1.5 Infrastructure Development

In this area the analysis has to be made in three different but necessarily complementary levels:

- In the first level the present position of the country must be analyzed in each of the categories making up the area and it must be compared with the exigencies (or requirements in terms of resources and their organization) arising from the priorities and goals fixed as a first approximation for Areas

2 and 3. It will be endeavored to estimate the critical resources (human, financial, economic, technological) and the sectoral and institutional organization that will be most suitable, in the light of the coverage goals, the program area goals and the supplementary services and production functions (combination of resources according to a given technology) already defined on a first approximation basis. In essence, the aim will be to evaluate the possibility of forming additional resources and/or reorienting the use and combination of resources presently available. The purpose will be to estimate the feasibility of the goals proposed and/or to obtain data to guide decisions on changing the order of priority, the intensity and rate of change, or regarding the selection of other alternatives.

- In the second level the requirements in terms of resources imposed by the decisions taken concerning development of the sectoral organization and its administration will have to be analyzed. Then, in their turn, the organization and administrative requirements arising from the need for efficiency in the use and formation of the resources necessary for achievement of the goals will have to be analyzed.

- In the third level the analysis will be focused on comparison of:

  (1) The manpower training and availability goals and the aims for development and perfecting of the Sector's organization and administration as derived from the national priorities and goals for Areas 2 and 3, with

  (2) the manpower training and availability goals and the aims of the organization and administration as set forth in Ten-Year Health Plan for the Americas.

In the first two levels referred to, the analysis of the sectoral constraints is particularly important because they are determining factors for the feasibility and viability of the goals adopted. In this area, as in that of the complementary services, a selection of priorities is not required as for the coverage areas (2) or the program areas (3. (3.1 and 3.2), since they constitute requirements for the achievement of the purposes and goals in those areas.

In terms of very rough estimates, this analysis makes it possible to obtain sufficient data for preliminary decisions to be taken regarding:

.1. Life expectancy at birth which it is desired to reach in 1980.

.2. Coverage goals for integral services for the period, classified by type of service and technology.

.3. Order of priority and goals for specific program areas.

.4. Goals for reorganization of supplementary services to meet the requirements deriving from 1, 2 and 3.

.5. Changes and improvement of the sectoral and institutional organization and administration necessary for achieving the goals adopted.

.6. Goals in terms of training of additional manpower for the achievement of 1, 2, 3, 4, and 5.

.7. Strategy lines for achieving the goals set.

3.2 Second Approximation

Analysis of this second approximation must center around study of:

3.2.1 Consistency between the goals set for each area of analysis and consistency between these areas.

3.2.2 Feasibility and viability of those goals in the light of the internal and external constraints.

3.2.3 Overall and specific consistency of the goals with the national development policy.

3.3 Final Adjustment

These are the factors to be considered in proceeding to the final adjustment of the goals in each of the areas and the definition of the general considerations which condition formulation of the strategies for achievement of the purposes and changes decided upon.

3.4 Results Expected

It is considered that this analysis scheme should make it possible to obtain:

3.4.1 Consistency in the adjustment of the national health policy in terms of changes envisaged and national priorities with the national development policy and the Ten-Year Health Plan for the Americas as regards:

- Level and structure of health
- Supply of services
- Training of national manpower
- Organization and national administration of the sector's resources

- Guidelines for definition of strategies and their translation into programs of activities.

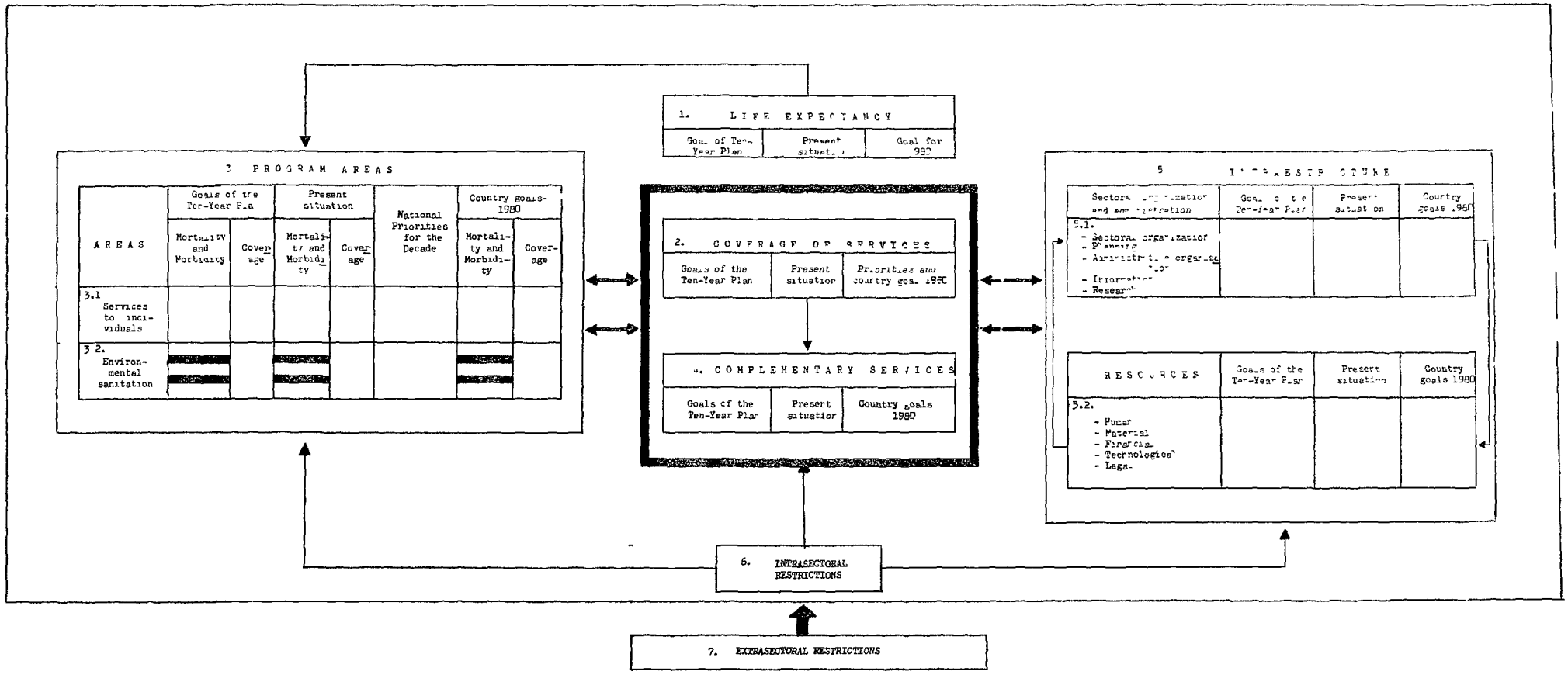
3.4.2 Determination of the contribution toward the implementation of the Ten-Year Health Plan for the Americas expected from each country.

3.4.3 Determination of the national data necessary for systematic evaluation of the Ten-Year Plan for the Americas.

3.4.4 Adjustment of the Country/PAHO Quadrennial Projections to the national health policies and subsequent reprogramming of the joint Country/PAHO activities.

CHART c 1

DIAGRAM FOR THE ANALYSIS AND INCORPORATION OF THE GOALS OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS IN NATIONAL HEALTH POLICIES



III. PROCEDURE

1. SOME PRELIMINARY CLARIFICATIONS

With a view to facilitating systematic application of the analysis scheme proposed under II, a set of work tables and some instructions for their use are given below.

The procedure suggested is based on the assumption that the Quadrennial Projections drawn up by the countries of the Americas Region and adjusted in 1971 will be used. This will allow the harmonization of these projections with the decisions taken regarding adjustment of the national health policies in the light of the Ten-Year Health Plan for the Americas.*

Presentation of the procedure in table form was adopted to facilitate description and understanding of its components, and also of the national and regional analysis needed for the evaluation of the Regional Health Plan for the Americas, to which the governments have committed themselves.

---

* The countries which have not prepared Quadrennial Projections (1971 Revision) will have to produce the information needed for columns 2 and 3 of the procedure from the data available in various official documents and/or by estimating those not obtainable from such sources.

2. DESCRIPTION OF THE PROCEDURE

2.1 Table 1

Area 1: GENERAL GOAL: LIFE EXPECTANCY AT BIRTH (See Annexes I and II).

This table will have to be the first to be made up, and will have to be adjusted if necessary in a second approximation.

Column 1: The life expectancy at birth proposed by the Ten-Year Health Plan for the Americas, for the area corresponding to the particular country, is to be entered here.

Column 2: The estimated life expectancy for the country at the time of the revision of the Quadrennial Projections (1971) is to be entered here. Those countries which have not prepared Quadrennial Projections should enter the figure closest to 1971 that they have available.

Column 3: The life expectancy at birth fixed as the goal for 1980 in the Change Hypothesis Section of the Quadrennial Projections (1100 Series) is to be entered here. Countries which have not fixed this estimate in either their national plans or in the Quadrennial Projections or any other official document should do so on this occasion.

Column 4: The national goal for 1980 resulting from analysis of the likelihood of the country achieving or exceeding the goals proposed in the Ten-Year Health Plan for the Americas should go here. Countries which have already exceeded this goal should estimate the higher goal which they consider they could achieve.

Column 5: Any discrepancy, either way, between the goal proposed in the Ten-Year Plan and that adopted by the country should be explained here. This explanation can be given in terms of observed national trends, expected changes in overall and/or sectoral socio-economic development, etc.

Column 6: In this column it should be stated how the country expects to achieve the goal fixed, and in which age groups and through control of which specific causes of mortality it is expected to obtain the increase in life expectancy at birth. It is particularly important that this strategy be set out explicitly, as it can command the priorities and intensity of action in the specific program areas directly connected with the strategy, and fix requirements as regards coverage and infrastructure, especially in countries with less developed health structures.

2.2 TABLE 2

AREA 2: COVERAGE OF MINIMUM, BASIC AND SPECIALIZED SERVICES

This table should be completed after Table 1, in the first approximation.

Column 1: The goals of the Ten-Year Health Plan for the Americas as regards coverage of minimum, basic and specialized services (see Annexes I and II) should be copied here.

Column 2: A summary should be given here of the present national situation regarding coverage for each of the types of services in which the goals of the Ten-Year Plan are expressed (column 1). The data defining this situation should be

the closest to 1971, if available. It is vitally important that explicit details be given concerning existing obstacles which determine the present coverage, both those intrinsic to the health sector and those due to the particular level of socio-economic development of the country concerned (internal and external constraints).

This information corresponds to that given in the Quadrennial Projections under the analysis by areas chapter, Sections 1, 2 and 3.

Column 3: The salient features of the policy, objectives and goals fixed for the period 1970-80, regarding expansion of the coverage of services (as set out in Section 4 of the Quadrennial Projections for 1971) should be stated here. Also, the aims, objectives or goals designed to minimize the obstacles to expansion of the coverage, as described in column 2, in relation to internal and external constraints, should be entered here.

Columns 4 and 5: The goals in terms of coverage of minimum, basic and specialized services which the government thinks it can achieve by 1980 (column 5) should be entered here, together with the priorities decided upon in terms of quantity and time for each of these types of services. In column 4 the proportion which it is expected to achieve by 1977 of the goals fixed for 1980 should be included. The purpose of column 4 is to present data prior to the analysis of the progress toward the goals fixed for 1980 with regard to starting point (coverages observed in 1971 -- column 2) for the preliminary appraisal proposed for 1978.

The data required in columns 4 and 5 require prior definition: type of services and accessibility, as expressed in the "analysis scheme" (Chapter II, page 8 , 3.1.2) together with a very thorough analysis of the requirements for removing the internal and external restrictions.

Column 6: The same considerations as under column 5, Area 1 (Table 1).

Columns 7 and 8: In these columns explicit details must be given regarding how it is expected to achieve the national goals given under columns 4 and 5. It is essential to state the main lines of action designed to overcome the internal and external constraints indicated in column 2. The strategy will have to be spelled out for each analysis period: 1971-77 and 1978-80.

It is important to take into account that both the priorities and the goals fixed for 1980 and the estimates for 1977 as regards coverage of minimum, basic and specialized services, together with the strategy fixed for reaching a certain life expectancy, commit or condition the goals and strategies of the other areas included in the analysis.

2.3 TABLE 3

AREA 3: PROGRAM AREAS

The layout of Tables 3.1 and 3.2 is identical, so the instructions given apply equally to both of them.

Column 1: As in Table 2, the goals of the Ten-Year Health Plan for the Americas are to be copied here, following the classification and order as in Annex II (columns 1 and 2). All the goals included in the Plan are to be entered here. Those which

are not considered to have priority on account of the characteristics of the country, and which are accordingly disregarded, must also be entered.

Columns 2 and 3: The same considerations as for Areas 1 and 2.

Columns 4 and 5: The same considerations as for Areas 1 and 2. In the particular case of the goals for the program areas 3.1 and 3.2, special account must be taken of the conditions or requirment both as regards priorities and the scope of the specific goals, imposed on these by the decisions taken in Areas 1 and 2. In their turn, the goals decided upon will impose requirements on Areas 4, 5.1 and 5.2.

Column 6: The same considerations as for Tables 1 and 2. It should include an explanation of why the country does not assign priority to the goals excluded.

Columns 7 and 8: The same considerations as for Tables 1 and 2. It must be borne in mind that, as with the goals proposed, these strategies laid down in Tables 1 and 2.

2.4 TABLE 4

AREA 4: COMPLEMENTARY SERVICES COVERAGE

This table should be completed after Tables 2, 3.1 and 3.2 in the first approximation.

Column 1: As in the preceding tables, the goals of the Ten-Year Health Plan for the Americas are to be copied here, following the order given in Annex II (columns 1 and 2).

Columns 2 and 3: Same instructions as for the preceding tables.

Columns 4 and 5: The goals in terms of coverage of complementary services are to be entered here.

Their essential nature as support to the final services, which is their function by definition, makes it necessary that the national goals fixed for the complementary services be consistent with those decided upon for Areas 2, 3.1 and 3.2. Any factor which may become apparent, in the first approximation, that would make it impossible to maintain this consistency will render it essential to revise the goals fixed for Areas 2, 3.1 and 3.2, or else to modify, in a second approximation, the requirements of these as regards the type of supplementary services required.

Column 6: Any discrepancies between the national goals adopted (columns 4 and 5) and those proposed in the Ten-Year Plan (column 1) must be explained in the light not only of columns 2 and 3 but also, and fundamentally, in that of the estimated requirements which Areas 2, 3.1 and 3.2 (coverage of minimum, basic and specialized services, services to individuals and environmental sanitation) impose on the supplementary services.

Columns 7 and 8: The same instructions as for Areas 2, 3.1 and 3.2. In the particular case of complementary services it must be taken into consideration that the strategies defined are conditioned as regards content and time of application by the strategies fixed in Tables 2, 3.1 and 3.2. The analysis of the possible solutions for the restrictions noted in the area of supplementary services could lead, in a second approximation, to

revision and adjustment of the strategies selected for Areas 2, 3.1 and 3.2.

2.5 AREA 5: DEVELOPMENT OF THE INFRASTRUCTURE

TABLE 5.1: SECTORAL ORGANIZATION AND ADMINISTRATION

This table should be completed after Tables 2, 3.1, 3.2 and 4, in the first approximation.

Column 1: As for Tables 3.1 and 3.2.

Column 2: A summary of the present national position for each of the items included in column 1 should be given here. It is particular important that explicit details be given regarding the existing obstacles, both those intrinsic to the sector (internal constraints) and those connected with the particular national organization and administration, especially in the public sector (external constraints).

Column 3: The salient features should be stated here of the policy, objectives and goals fixed for the period 1970-80, as given in Section 4 of the 1971 revision of the Quadrennial Projections, referring to the items in column 1, including the plans and actions designed to help remove the constraints noted in column 2.

Columns 4 and 5: In these columns should be marked the change goals that it is hoped to achieve by 1980 and 1977. The fixing of these goals makes it necessary to estimate carefully the type of organization and administration required by the goals and strategy set for Areas 2, 3.1, 3.2 and 4. Special

attention should also be given to the possibility of removing the constraints noted in column 2. The form in which the goals of the Ten-Year Health Plan for the Americas are expressed in this area (5.1) also renders essential additional definitions, for each of them, that will provide specific details concerning the requirements or conditions to be satisfied in order that these goals may be considered achieved. Precise definition of these criteria is indispensable for evaluation of the goals fixed.

Column 6: The explanation of any discrepancy must be based mainly in the analysis of the requirements imposed by the decisions adopted in regard to Areas 2, 3.1, 3.2 and 4.

Columns 7 and 8: Definition of the strategies for removing the internal and external constraints is fundamental for the completing of this column.

TABLE 5.2: DEVELOPMENT OF RESOURCES

This table has to be made up after the others because the data to go in it depend on the requirements in terms of resources which result from the proposals set out in the other areas. Analysis of the extent to which these requirements can be satisfied is the first approximation toward evaluation of the feasibility of those proposals.

Column 1: Same instructions as for Tables 3.1 and 3.2.

Columns 2 and 3: Same instructions as for Table 2.

Columns 4 and 5: The setting of goals depends entirely on the requirements in terms of resources imposed by the national goals set for Areas 2, 3.1, 3.2, 4 and 5.1. Analysis of whether or not it is possible to meet these requirements is a major factor for the possible adjustment of goals and strategies in those areas, to be effected in a second approximation.

Column 6: The explanation of any discrepancy must be based mainly on the analysis of the requirements imposed by the decisions adopted in regard to Areas 2, 3.1, 3.2, 4 and 5.1.

Columns 7 and 8: Definition of strategies is also conditioned as to content and time of application by the resources required in Areas 2, 3.1, 3.2, 4 and 5.

Once the first approximation is completed the tables will be analyzed and such adjustments as are necessary to ensure the internal consistency of the proposals in each area and also that the proposals for all the areas are consistent among themselves will be made.

Table 1

AREA 1: GENERAL GOAL: LIFE EXPECTANCY AT BIRTH

Ten-Year Health Plan for the Americas GENERAL GOAL LIFE EXPECTANCY AT BIRTH	~~QUADRENNIAL~~ ~~PROJECTIONS~~ 1971 REVISION COUNTRY: HYPOTHESIS OF CHANGE (1100 Series)		ADJUSTMENT TO NATIONAL GOAL (column 3), in light of the Ten-Year Health Plan for the Americas for 1980 (Column 1)	EXPLANATION OF the discrepancies between columns 4 and 3	STRATEGY FOR ACHIEVING the national goal set in column 4
	Present position	Goal fixed for 1980			
(1)	(2)	(3)	(4)	(5)	(6)

Table 2

AREA 2: COVERAGE OF MINIMUM, BASIC AND SPECIALIZED SERVICES

Ten-Year Health Plan for the Americas COVERAGE GOALS FOR MINIMUM, BASIC AND SPECIALIZED SERVICES	QUADRENNIAL PROJECTIONS ~~1971 REVISION~~ COUNTRY: ANALYSIS BY AREAS		SELECTION OF PRIORITIES * AND ADJUSTMENT OF THE NATIONAL GOALS (column 3) in the light of the present position (column 2) and the goals of the Ten-Year Health Plan for the Americas for 1980 (Column 1)		EXPLANATION OF THE DISCREPANCIES between Columns 1 and 5 This analysis should take into consideration that stated in columns 2 and 3	NATIONAL STRATEGY FOR achieving the objectives and targets stated in columns 4 and 5 in the light of the internal and external constraints. *	
	Sections 1, 2, 3	Section 4	OBJECTIVES AND GOALS				
	Present position	Policy, aims and goals set for 1970-80	Estimate 1977	1980		1977	1980
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)

(*) See "Some Considerations on the Selection of Priorities as a Factor in Decision-Making".

Table 3.1

AREA 3: PROGRAM AREAS

3.1: SERVICES TO INDIVIDUALS

Ten-Year Health Plan for the Americas PROGRAM AREAS GOALS FOR SERVICES TO INDIVIDUALS	QUADRENNIAL PROJECTIONS 1971 REVISION COUNTRY ANALYSIS BY AREAS		SELECTION OF PRIORITIES * AND ADJUSTMENT OF THE NATIONAL GOALS (column 3) in the light of the present position (column 2) and the goals and strategies set for Coverage of Services and Life Expectancy.		EXPLANATION OF THE DISCREPANCIES between Columns 1 and 5 This Analysis should take into consideration that stated in columns 2 and 3	NATIONAL STRATEGY FOR achieving the objectives and targets stated in columns 4 and 5 in the light of the internal and external constraints. *	
	Sections 1, 2, 3	Section 4	OBJECTIVES AND GOALS				
	Present position	Policy, aims and goals set for 1970-80	Estimate 1977	1980		1977	1980
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)

(*) See "Some Considerations on the Selection of Priorities as a Factor in Decision-Making".

Table 3.2

AREA 3: PROGRAM AREAS

3.2: Environmental SANITATION

Ten-Year Health Plan for the Americas PROGRAM AREAS ENVIRONMENTAL SANITATION GOALS	QUADRENNIAL PROJECTIONS 1971 REVISION COUNTRY ANALYSIS BY AREAS		SELECTION OF PRIORITIES* AND ADJUSTMENT OF THE NATIONAL GOALS (column 3) in the light of the present position (column 2) and the goals and strategies set for Coverage of Services and Life Expectancy		EXPLANATION OF THE DISCREPANCIES between Columns 1 and 5 This Analysis should take into consideration that stated in columns 2 and 3	NATIONAL STRATEGY FOR achieving the objectives and targets stated in columns 4 and 5 in the light of the internal and external constraints.*	
	Sections 1, 2, 3	Section 4	OBJECTIVES AND GOALS				
	Present position	Policy, aims and goals set for 1970-80	Estimate 1977	1980		1977	1980
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)

(*) See "Some Considerations on the Selection of Priorities as a Factor in Decision-Making".

Table 4

AREA 4: SUPPORTING SERVICES COVERAGE

Ten-Year Health Plan for the Americas	QUADRENNIAL PROJECTIONS 1971 REVISION COUNTRY: ANALYSIS BY AREAS		ADJUSTMENT OF THE GOALS (column 3) in the light of the national goals set for Services Coverage (Area 2) and Priority Program Areas (Areas 3.1 and 3.2)		EXPLANATION OF THE DISCREPANCIES between Columns 1 and 5 This analysis should take into consideration that stated in columns 2 and 3	NATIONAL STRATEGY FOR achieving the objectives and goals stated in columns 4 and 5	
	Sections 1, 2, 3	Section 4	OBJECTIVES AND GOALS				
	Present position	Policy, aims and goals set for 1970-80	Estimate 1977	1980		1977	1980
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)

Table 5.1

AREA 5: DEVELOPMENT OF THE INFRASTRUCTURE

5.1: SECTORAL ORGANIZATION AND ADMINISTRATION

Ten-Year Health Plan for the Americas INFRASTRUCTURE DEVELOPMENT GOALS SECTORAL ORGANIZATION AND ADMINISTRATION	QUADRENNIAL PROJECTIONS 1971 REVISION COUNTRY: ANALYSIS BY AREAS		ADJUSTMENT OF THE NATIONAL GOALS (column 3) in the light of the present position (column 2) and the goals and strategies set for Services Coverage, Program Areas and Supporting Services		EXPLANATION OF THE DISCREPANCIES between Columns 1 and 5 This analysis should take into consideration that stated in columns 2 and 3	NATIONAL STRATEGY FOR achieving the objectives and targets stated in columns 4 and 5 in the light of the internal and external constraints.*	
	Sections 1, 2, 3	Section 4	OBJECTIVES AND GOALS				
	Present position	Policy, aims and goals set for 1970-80	Estimate 1977	1980		1977	1980
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)

(*) See "Some Considerations on the Selection of Priorities as a Factor in Decision-Making".

Table 5.2

AREA 5: DEVELOPMENT OF THE INFRASTRUCTURE

5.2: DEVELOPMENT OF RESOURCES

Ten-Year Health Plan for the Americas INFRASTRUCTURE DEVELOPMENT GOALS RESOURCES AND LEGAL ASPECTS	QUADRENNIAL PROJECTIONS 1971 REVISION COUNTRY: ANALYSIS BY AREAS		ADJUSTMENT OF THE NATIONAL GOALS (column3) in the light of the present position (column 2) and the goals and strategies set for Services Coverage, Program Areas, Supporting Services and Sectoral Organization and Administration		EXPLANATION OF THE DISCREPANCIES between Columns 1 and 5 This analysis should take into consideration that stated in columns 2 and 3	NATIONAL STRATEGY FOR achieving the objectives and targets stated in columns 4 and 5 in the light of the internal and external constraints.*	
	Selections 1, 2, 3	Section 4	OBJECTIVES AND GOALS				
	Present position	Policy, aims and goals set for 1970-80	Estimate 1977	1980		1977	1980
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)

(*) See "Some Considerations on the Selection of Priorities as a Factor in Decision-Making

PART I

GOALS OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS FOR THE PERIOD 1971-80

The III Special Meeting of Ministers of Health of the Americas:

BEARING IN MIND:

That the General Assembly proclaimed the 1970's as the Second United Nations Development Decade, beginning on 1 January 1971, and simultaneously adopted an International Development Strategy for the Decade;

That the objectives of the Ten-Year Health Plan contained in the Charter of Punta del Este have been achieved to a considerable extent, and that the 1960's yielded valuable experience on the ways and means for the solution of health problems, as well as a better knowledge of the dynamics of health and disease in the Americas;

That "the mutual relationship between health, economic development, living standards, and well being" has been more clearly recognized;

That the ecological concept of health has been generally accepted as a continuing process of adaptation of human beings to their environment, which they can either damage or enhance;

Bearing in mind also the expected trends in socioeconomic development and in the planning processes in the Hemisphere;

CONSIDERING:

That the general view of the problems in the light of the experience gained indicates that major health efforts must be devoted to the consolidation of the existing services and to their extension so as to ensure the provision of comprehensive health care to communities not yet covered, in both rural and urban areas;

That programming for the decade should bear in mind that the increase in the population by 1980 is estimated at 24% in the Hemisphere and 33% in Latin America and the Caribbean area;

That some of the health problems contributing most to mortality and morbidity can be prevented or controlled by simple and economical techniques applied through the organization and operation of effective health systems endowed with adequate funds;

That there is an awareness of the need for plans and programs to be formulated not for isolated problems but on the basis of a careful selection of priorities, a clear definition of objectives, the application of efficient standards and techniques and the development of evaluation and information schemes within a single system of program articulation and institutional coordination;

That there should be close association between Ministries of Health and universities for the reform of teaching in the health sciences, designed to bring it more into line with the situation of the countries of the Continent.

That the imbalance between needs and human, physical, and financial resources makes it imperative to obtain the highest possible yield from existing resources, and at the same time to seek new patterns for the delivery of health services and sectoral financing;

That in order to provide comprehensive medical care, investment of national funds and external capital must inevitably be increased;

That health planning must be integrated into economic and social development planning from the preinvestment stage, particular attention being paid to regional development, whether national or international;

That as in the past decade the attainment of the objectives established will depend in each country on its particular characteristics, possibilities and experience, and that health progress in the Region will therefore appear as a great mosaic of national achievements in accordance with each country's economic and social development policies;

RESOLVES:

To recommend to the Governments the following goals for the Ten-Year Health Plan covering the period 1971-1980:

To consider, as a basic requirement for achieving the goals under the plan, the definition in each individual country of the health policy, in the light of its economic and social development, specifying clearly the objectives and structural changes necessary to achieve them.

I. PROGRAM OF SERVICES

1. SERVICES TO INDIVIDUALS

EXTENSION OF COVERAGE, INCLUDING MINIMUM COMPREHENSIVE SERVICES, TO ALL THE POPULATION LIVING IN ACCESIBLE COMMUNITIES OF LESS THAN 2,000 INHABITANTS, AND PROVISION OF BASIC AND SPECIALIZED SERVICES TO THE REST OF THE POPULATION, BY MEANS OF A REGIONALIZED HEALTH SYSTEM, PRIORITY BEING GIVEN TO THE FOLLOWING:

1.1 Communicable Diseases:

- Maintain smallpox eradication;
- Reduce mortality from measles, whooping cough and tetanus to 1.0, 1.0 and 0.5 respectively per 100,000 inhabitants;
- Reduce morbility from diphtheria and poliomyelitis to rates of 1.0 and 0.1 respectively per 100,000 inhabitants;
- Reduce mortality from tuberculosis by not less than 50%;
- Reduce the rates of mortality from enteric diseases by 50%;
- Cut down the incidence of venereal diseases, especially gonorrhea and syphilis, and eradicate yaws and pinta;

- Cut down the incidence of leprosy, typhus, schistosomiasis, on oncocercosis, Chagas'disease and jungle yellow fever, and keep plague under control;

- Eradicate malaria in areas where there are good prospects of reaching this goal, involving a population of approximately 75 million inhabitants. Maintain eradication where it has already been achieved. Apply in the "problem areas" the new techniques derived from research, and give intensive stimulus to research activities.

- Eradicate Aedes aegypti in the countries and territories still infested, and prevent the penetration of the vector into areas from which it has been eliminated.

1.2 Maternal and child health and family welfare:

- Develop sectoral and promote intersectoral programs with a range of 30-50%.

- Reducing mortality in children under one year of age by 40%, with a range of 30 to 50%.

- Reducing mortality in children from one to four years of age by 60%, with a range of 50 to 70%.

- Reducing maternal mortality by 40%, with a range of 30 to 50%.

- Offering families the opportunity - provided this is not at variance with national policy - to obtain adequate information and services on problems related to fertility and sterility.

1.3 Nutrition:

- Reduce grade III protein-calorie malnutrition in children under five years of age, on a regional average, by 85% and grade II by 30%. In countries where it is feasible, these goals will be separated for children under one year and from one to four years.

- Reduce by 30% the prevalence of nutritional anemias in pregnant women, and that of endemic goiter to less than 10%, eliminating cretinism and hypovitaminosis A in vulnerable groups at an average regional rate of 30%.

1.4 Other areas:

- As far as the availability of resources permits and in accordance with national policies, it is suggested that each country should establish priorities and targets corresponding to chronic diseases, cancer, mental health, dental health, and rehabilitation.

- Pay special attention to the medico-social effects of the growing dissemination in some countries of the use of alcohol and dependency-inducing drugs, and the increase in mental health problems caused inter alia by urbanization and industrialization.

2. ENVIRONMENTAL SANITATION PROGRAMS

2.1 Water Supply and excreta disposal services:

- Provide water services with house connections for 80% of the urban population, or as a minimum, supply half the population at present without services.

- Provide water for 50% of the rural population, or as a minimum, supply 30% of the population at present without services.

- Install sewerage for 70% of the urban population, or as a minimum, reduce by 30% the proportion of the population at present lacking such services.

- Install sewerage systems and other sanitary facilities for the disposal of excreta for 50% of the rural population, or as a minimum, reduce by 30% the number of inhabitants not possessing any adequate facilities.

2.2 Solid waste:

- Establish adequate systems for the collection, transport, treatment and disposal of solid wastes in at least 70% of cities with 20,000 population or more.

2.3 Environmental pollution:

- Establish policies and carry out programs for the control of water, air and soil pollution, noise abatement, etc., in line with basic environmental sanitation and industrial development and urbanization.

2.4 Regional development:

- Ensure the active and systematic participation of the health sector in the formulation and execution of regional, national and multinational development plans.

2.5 Occupational health:

- Ensure protection for 70% of workers exposed to presumed or recognized occupational hazards in countries already having programs fully operating, and 50% in countries which still have not developed programs adequately.

2.6 Animal health and veterinary public health:

- Help to control and eventually eradicate foot-and-mouth disease in South America and prevent the introduction of the disease into the countries free of it.

- Help to reduce the incidence of the most common zoonoses, with special emphasis on rabies, brucellosis, bovine tuberculosis, hydatidosis and equine encephalitis.

2.7 Biologically based food policy:

-Increase the availability and consumption of food through a food and nutrition policy, priority being given to the biological needs of the population.

2.8 Quality control of foodstuffs:

- Reduce human diseases and the economic losses caused by biological, physical and chemical pollution of food and by-products, at the same time maintaining their quality.

2.9 Quality control of drugs:

- Carry out programs in all the countries for the quality control of both nationally produced and imported drugs.

2.10 Control of the use of pesticides:

- Reduce morbidity and mortality caused by the undue use of pesticides.

2.11 Accidents:

- Reduce the proportion of traffic and industrial accidents and of those occurring in the home and in places of recreation and tourist resorts, and thereby reduce the number of deaths and disability cases.

3. SUPPORTING SERVICES:

3.1 Nursing:

- Organize nursing in at least 60% of countries, as a system in which the level of nursing care and the staffing required to meet the health goal of each country are defined.

3.2 Laboratories:

- Extend coverage and organize as "systems" the laboratories responsible for diagnosis, production of biologicals for human and animal use, and maintenance of blood banks needed to support health programs.

3.3 Epidemiological surveillance systems:

- Creation and maintenance of epidemiological surveillance units in accordance with the national organization and regionalization structure of each country, so as to ensure a continuous supply of information on the epidemiological characteristics of health problems and the factors governing them, and thus enable timely action to be taken.

3.4 Health education:

- Organize health education as part of the process of active and informed participation of communities in all action for the prevention and cure of disease.

II. DEVELOPMENT OF THE INFRASTRUCTURE

To ensure the achievement of the proposals under the plan, it is essential:

1. To install and develop in each country a health system adapted to its national peculiarities and determined in the light of the sectoral policy.

2. To establish and expand in each country the health planning process as an integral part of the socioeconomic development plan. To organize systems of information, evaluation and control. To improve health statistics.

3. To undertake research with a view to determining the effects of various alternatives within the sectoral policy and defining methods or techniques calculated to increase the productivity and effectiveness of services. To develop systematic studies on costs and financing.

4. To increase operational capacity at the institutional and sectoral level through:

4.1 Coordination or integration of the State, para-State and private institutions which together make up the health sector.

4.2 Initiation or strengthening of the processes of administrative, sectoral and institutional reform.

4.3 Formulation and execution of programs for services, infrastructure, external assistance and preinvestment studies

4.4 To promote the proper communication among the infrastructures of the various sectors in order to achieve, through coordinated programs, the concentration of intersectoral resources to the high risk population, with the aim of preventing illnesses and deaths.

5. DEVELOPMENT OF HUMAN RESOURCES

5.1 Achieve a regional average of 8 doctors, 2 dentists and 2.2 dental auxiliaries, 4.5 nurses and 14.5 nursing auxiliaries per 10,000 inhabitants, and improve their geographical and institutional distribution.

5.2 Train in the course of the decade a minimum of 18,000 veterinary surgeons and 30,000 animal health auxiliaries.

5.3 Train in the course of the decade a minimum of 360,000 nursing auxiliaries and produce 125,000 nurse graduates, especially at the intermediate level.

5.4 Train 3,200 professionals in the course of the decade in postgraduate programs and 30,000 professionals and technicians in short courses in sanitary engineering and other environmental sciences.

5.5 Train during the decade 300 professional level statisticians; 100 professional medical records officers; 4,000 intermediate-level medical records officers; 250 intermediate-level statisticians and 40,000 statistical auxiliaries.

5.6 Train during the decade 3,000 planners and 3,000 administrators at the professional level; train 1,000 professionals in health information systems.

5.7 Promote development of general medical practice to the extent required by the organization of the services and the goals proposed in the present plan. To promote the necessary changes in order to provide better training on this matter, in accordance with each countries' priorities.

5.8 Set up in at least 11 countries national systems of scientific documentation in the health sciences, linked together among themselves and with the Regional Library of Medicine (BIREME).

5.9 Provide textbooks of high scientific and instructional quality for students of medicine, nursing and other disciplines, in a program to cover 75% of students by 1980.

6. PHYSICAL RESOURCES

6.1 Create within the regionalization systems a series of minimum comprehensive health service units, until a coverage is achieved of one unit per 5,000 inhabitants in localities with less than 2,000 inhabitants; health centers with comprehensive basic minimum services for localities with between 2,000 and 20,000 inhabitants; and institutions with comprehensive basic and specialized services to communities with more than 20,000 inhabitants.

6.2 Increase the installed capacity by 106,000 beds in general hospitals by reorganizing and converting long-stay beds when this is feasible.

6.3 Gradually incorporate specialized medical care services into general hospitals in accordance with levels of care within a regionalization scheme

6.4 Establish systems for maintenance of installations and equipment.

7. FINANCIAL RESOURCES

7.1 Develop financing systems for providing the sector with new sources of funds and ensuring wider collaboration by the community and participation by the health sector in key national development projects.

8. TECHNOLOGICAL RESOURCES

8.1 Develop and utilize health technologies in keeping with the conditions obtaining in each country with a view to increasing the coverage and productivity of the services;

8.2 Organize multinational programs of scientific and technological research.

9. LEGAL ASPECTS

Submit for consideration to the competent bodies of each country the systematization, regulation and adaptation of the legal provisions in force in line with the processes of administrative improvement.

III. LIFE EXPECTANCY AT BIRTH

Establish as a general goal for the decade the following increases in life expectancy at birth:

To develop the sectoral and promote the intersectoral programs in order to:

1. Increase life expectancy at birth by five years in those countries where the present figure is under 65 years.

2. Increase life expectancy at birth by two years in those countries where the present figure is between 65 and 69 years.

In order to obtain a reliable estimation of life expectancy and the progress to be achieved:

1. Improve registration of births and deaths, adopting measures to ensure completeness and more realistic estimates.

2. Develop alternative methods of estimating life expectancy in countries where registration of births and deaths is inadequate.

IV. GENERAL

1. The goals and strategies appearing among the recommendations adopted by the III Special Meeting of Ministers of Health will be regarded as an integral part of the present Ten-Year Health Plan for the Americas, even though they are not specifically included in it.

2. In the light of the studies to be carried out and of the economic and social situation in the countries, each Government will evaluate its possibilities and determine the priorities to be set for attaining the goals of the present Ten-Year Health Plan.

3. To request the Member Governments to quantify the targets included in this document which have not been identified numerically and ask them to transmit information to PAHO in order to establish averages for the Americas.

PART II

CLASSIFICATION AND ANALYSIS OF THE GOALS OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS

(prepared by the Pan American Center for Health Planning)

CLASSIFICATION AND ANALYSIS OF GOALS OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS

(Prepared by the Pan American Center for Health Planning)

ASPECT TO WHICH THE GOALS REFER	GOALS FOR THE TEN-YEAR PLAN	CHARACTERISTICS OF THE GOALS	INITIAL EVALUATION (1974)		CRITERIA FOR ANALYSIS AND EVALUATION OF GOALS
(1)	(2)	(3)	(4)	(5)	(6)
1. LIFE EXPECTANCY AT BIRTH	Increase life expectancy at birth by 5 years for those countries where the present level is less than 65 years, and by 2 years in those countries where the level is between 65 and 69 years.	This is an overall goal reflecting the mortality level. It is established for each country, on the basis of the anticipated feasibility and effectiveness of programs to reduce mortality. Among those playing an important part are programs directed to the most vulnerable population groups and to attack on diseases that are reducible through techniques of prevention and protection.	1. Life expectancy at birth on initiation of program. 2. Goal established by the country. 3. Strategy to achieve the goal. 4. Reasons for variance from regional goal, if any.	1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated their strategies. 3. Consistency with regional goal. 4. Gap between initial situation in 1971 and proposed national goal for 1980.	The quality of vital statistics and the degree of consistency between strategies those of the program areas and of the overall development, in helping to reduce mortality, should be kept in mind. Criteria for analysis and achievement of the goals are needed.
2. COVERAGE OF SERVICES		The goals in this regard are designed to initiate, during the decade, the installation of mechanisms that will make it possible for the health services to achieve maximum coverage of the populations in all countries of the Region.	Definition of overall minimum, basic and specialize services, their consistency with ideas expressed in the Basic Reference Document, Meeting of Ministers, pp.11-14. Definition of "accessibility" criterion adopted by each country.		Achievement of goals for population coverage by systems of services is closely related to certain prerequisites that render the goals viable and feasible, such as: - Definition of policy for development of health services systems. - Planning and programming of activities. - Programming and implementing programs for education, training and utilization of manpower. - Formulation and implementation of plans for plant investment. - Research and experimentation in health technology. - Improvement of systems of administration and their legal bases. - Exploration and incorporation of new funding sources national and international. - Increasing productivity and efficiency of services through sectoral systematization, functional regionalization, decentralization, intersectorial coordination, especially with social security institutions, etc. - Establishing efficient information, decision-making and control systems.
2.1. MINIMUM SERVICES	Expand coverage with minimum integrated services to all inhabitants of accessible communities of less than 2,000 population.	This is a goal that it is hoped all countries can establish, and one that seeks to deliver at least a minimum of medical care to rural populations not now covered. The goal is limited by the criterion of accessibility of the said populations. The goal implies coverage of the population in each country and consolidation of the totals at the Regional level.	1. Population and number of localities with less than 2,000 inhabitants. 2. Accessible population in such localities, according to accessibility definition adopted. 3. Population accessible to delivery of minimum services. 4. Goal established for 1980. 5. Strategies for such purpose.	1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated their strategies. 3. Consistency with regional goal. 4. Gap between initial situation in 1971 and proposed national goal for 1980.	
2.2. BASIC SERVICES	Extend coverage in localities of 2,000 to 20,000 population with minimum integrated health services, complementing such services with delivery of basic services, and extend basic services coverages in localities of 20,000 to 100,000 population to all inhabitants not as yet receiving such services.	It is also anticipated that this goal can be set for all countries, seeking to provide some type of coverage to all inhabitants in localities of 2,000 to 100,000 population. A minimum unit of services is suggested for each 5,000 inhabitants and one of basic services for each 10,000 to 15,000 inhabitants. This goal implies coverage of the population of each country and consolidation of totals at the Regional level.	1. Localities of 2,000 - 100,000 population, according to size. 2. Number of minimum and basic services in the these localities. 3. Goal established for 1980. 4. Strategies formulated.	1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated their strategies. 3. Consistency with regional goal 4. Gap between initial situation in 1971 and proposed national goal for 1980.	

CLASSIFICATION AND ANALYSIS OF GOALS OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS

(Prepared by the Pan American Center for Health Planning)

ASPECT TO WHICH THE GOALS REFER	GOALS FOR THE TEN-YEAR PLAN	CHARACTERISTICS OF THE GOALS	INITIAL EVALUATION (1974)		CRITERIA FOR ANALYSIS AND EVALUATION OF GOALS
			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
2.3. SPECIALIZED SERVICES	Extend basic services coverage to all of the population in localities with more than 100,000 population, and expand the field of specialized activities that are demanded by new problems of urbanization.	This goal is designed to provide basic services coverage to the entire population in localities with more than 100,000 inhabitants and to organize the specialized services. The goal also implies coverage of the population in each country and its consolidation at the regional level.	1. Localities of more than 10,000 inhabitants, in order of size 2. Number of basic and specialized services in such localities. 3. Established goals for 1980. 4. Strategies for achieving such goals	1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated their strategies. 3. Consistency with regional goal. 4. Gap between initial situation in 1971 and proposed national goal for 1980.	Other measures for developing the infrastructure and technical and administrative operating standards.
3. PROGRAM AREAS 3.1. SERVICE TO INDIVIDUALS 3.1.1 Communicable Diseases		All goals related to the communicable diseases are Regional averages and could be adopted by each of the countries in the terms set forth, whenever the problem exists. However, it is to be hoped that those countries in position to exceed the proposed goals will set more ambitious figures for this purpose.	1. Current status of the problem. morbidity and mortality rates, problem eradicated, in attack phase, maintenance, etc. 2. Programs currently in process of development. 3. Goal established for the country in 1980. 4. Strategies for attaining the goal. 5. Variance from regional goal and reasons therefor.	1. Number and percentage of countries that have the problem, and that have established their goals. 2. Number and percentage of countries that have formulated their strategies. 3. Number and percentage of countries that have adopted the regional goal, or higher or lower levels. 4. Gap between the initial situation in 1971 and proposed national goals for 1980.	With exception of the goal of eradication, which is an absolute by definition, all other goals in communicable diseases do not have definable deadlines and must be taken only as indicators of the desired level. Hence it is essential to establish criteria for the evaluation of achievement of the goal. For example, if the country establishes as its goal the reduction of mortality rate of measles to 1.0 per 100,000 inhabitants, could it be said that the goal is achieved if a rate of 1.1 per 100,000 is attained by 1980? What is the permissible deviation and how can appropriate weight be given to projection of the indicator curve in time? Note also that there are goals that do not have an indication of magnitude, such as "control" or "reduction" of incidence. It is necessary, therefore, that criteria for evaluation be studied and established. It is recommended that criteria contained in Chapter IV, (pp. 116-160) of the Basic Reference Document and the recommendations in the Final Report of the Meeting of Ministers, pp. 29-34 be reviewed.
3.1.1.1 Smallpox	Maintenance of eradication				
3.1.1.2 Measles	Reduction of mortality rate to 1.0 per 100,000 inhabitants.				
3.1.1.3 Whooping Cough	Reduction of mortality rate to 1.0 per 100,000 inhabitants.				
3.1.1.4 Tetanus	Reduction of mortality rate to 0.5 per 100,000 inhabitants.				
3.1.1.5 Diphtheria	Reduction of incidence to 1.0 per 100,000 inhabitants.				
3.1.1.6 Poliomyelitis	Reduction of incidence to 0.5 per 100,000 inhabitants				
3.1.1.7 Tuberculosis	Reduction of mortality rate by 50 %				
3.1.1.8 Enteric Infections	Reduction of mortality rate by 50 %				

ASPECT TO WHICH THE GOALS REFER	GOALS FOR THE TEN-YEAR PLAN	CHARACTERISTICS OF THE GOALS	INITIAL EVALUATION (1974)		CRITERIA FOR ANALYSIS AND EVALUATION OF GOALS
			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
3.1.1.9. Yaws and pinta	Eradication				
3.1.1.10. Leprosy, typhus, schistosomiasis, onchocerciasis, Chagas' Disease and jungle yellow fever	Reduction of incidence				
3.1.1.11. Plague	Control				
3.1.1.12. Malaria	Eradicate malaria in areas where the outlook for success is favorable, maintain eradication where it has been attained, encourage research and application of resulting techniques in "problem areas"				
3.1.1.13. Aedes aegypti	Eradication in countries where infestation persists, and prevent reintroduction of the vector where eradication has been achieved.				
3.1.2. Maternal and child health and family welfare	Develop sectoral programs and foster intersectoral programs necessary to:	These are goals for all countries and for each one of the countries.	1. Current infant mortality rates for the 1-4 year age group, and maternal mortality. 2. Programs currently in operation. 3. Goals established for 1980. 4. Reason for variance, if any exist, from regional goals. 5. Strategies for achievement of such goals.	1. Number and percentage of countries that have established goals 2. Number and percentage of countries that have formulated their strategies. 3. Consistency with regional goal. 4. Gap between the initial situation in 1971 and the proposed national goal for 1980.	The degree of compatibility between the goals established in this field and those related to reduction of mortality for communicable diseases or those in other program areas including medical care must be kept in mind. They must have been incorporated in the strategy.
	-Reduce mortality in infants under 1 year by 40%, within a range of 30 to 50%.				
	-Reduce mortality in the 1-4 age group by 60%, within a range of 50 to 70%.				
	-Reduce maternal mortality by 40%, within a range of 30 to 50%.				
	-Provide families with the opportunity to obtain adequate information and services on problems related to fertility and sterility, provided such programs are not contrary to established policy in each country.	This goal is delimited by conditions of the prior existence of a policy definition in the countries that adopt it.	1. National policy with regard to family planning. 2. Programs currently in operation. 3. Goals established for 1980. 4. Strategies formulated.	1. Number and percentage of countries that have adopted a policy. 2. Number of countries that have established goals. 3. Number of countries that have formulated their strategies.	See Basic Reference Document, pp. 162-172 and recommendations of the Meeting of Ministers, pp. 39-42.

CLASSIFICATION AND ANALYSIS OF GOALS OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS

(Prepared by the Pan American Center for Health Planning)

ASPECT TO WHICH THE GOALS REFER	GOALS FOR THE TEN-YEAR PLAN	CHARACTERISTICS OF THE GOALS	INITIAL EVALUATION (1974)		CRITERIA FOR ANALYSIS AND EVALUATION OF GOALS
			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
3.1.3 Nutrition		These are goals for all countries, and for each country. The country goal may not coincide with the percentages for reduction mentioned for the Region.	1. Level of protein-calory malnutrition and prevalence of nutritional anemias in pregnant women. 2. Programs currently in operation. 3. Goals established for 1980. 4. Strategies for achieving the goals.	1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated strategies. 3. Consistency with Regional goals. 4. Gap between the initial situation in 1971 and proposed national goal for 1980.	See Chapter VIII, pp. 173-180 of the Basic Reference Document, Meeting of Ministers, and recommendations on program areas in the Final Report of the said meeting, pp. 42-46 to suggest criteria for analysis and evaluation of goals achievement in the field of nutrition.
3.1.3.1 Protein-calory malnutrition	Reduce the third-grade protein calory malnutrition in children under 5 years, by an average of 85% and second-grade malnutrition by an average of 30% over the region.				
3.1.3.2 Nutritional anemias in pregnant women	Reduce the prevalence of nutritional anemias in pregnant women by 30%.				
3.1.3.3 Endemic goiter	Reduce the prevalence of endemic goiter to less than 10%, eliminating cretinism.	This is a goal for the en entire Region which should be achieved by those countries in which goiter is a health problem.	1. Prevalence of endemic goiter. 2. Programs in operation 3. Goals established for 1980. 4. Proposed strategy.	1. Number and percentage of countries with endemic goiter as a problem, that have established goals. 2. Number of these countries that have formulated strategies. 3. Consistency with regional goal. 4. Gap between initial situation and proposed national goal for 1980	
3.1.3.4 Hipovitaminosis A	Reduce the incidence of hypovitaminosis-A in vulnerable groups by an average of 30% throughout the Region	This goal is expressed as a regional average, which may be established by each one of the countries, after a study of its feasibility.	1. Present situation of the problem. 2. Programs in operation. 3. Goals established for 1980. 4. Proposed strategy.	1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated their strategies. 3. Consistency with regional goal. 4. Gap between initial situation in 1971 and national goal proposed for 1980.	

ASPECT TO WHICH THE GOALS REFER	GOALS FOR THE TEN-YEAR PLAN	CHARACTERISTICS OF THE GOALS	INITIAL EVALUATION (1974)		CRITERIA FOR ANALYSIS AND EVALUATION OF GOALS
			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
3.1.4. Other areas					
3.1.4.1. Chronic diseases, cancer, mental health, dental health, rehabilitation	Establishment of priorities and goals according to the availability of funds and in consonance with national policies.	It can be seen that these goals are established more in the nature of recommendations for all countries than as goals that will have impact on the population with regard to morbidity.	1. Current status of these problems. 2. Policies that have been established. 3. Specific programs in process. 4. Proposed goals for 1980. 5. Assigned priorities. 6. Strategies for achieving the goals.	1. Number and percentage of countries that have established priorities for dealing with each problem. 2. Number and percentage of countries that have established goals. 3. Number and percentage of countries that formulated strategies. 4. Gap between the initial situation in 1971 and the proposed national goal for 1980.	See chapters V, IX and X of the Basic Reference Document, Meeting of Ministers, and recommendations of the Final Report of the same meeting, pp. 37-38 and 46-48.
3.1.4.2. Use of alcohol and drugs, problems of urbanization and industrialization.	Give attention to the medical and social aspects arising from the increase in alcoholism and drug dependance, and increasing mental health problems caused by urbanization and industrialization, among other factors.				
3.2. ENVIRONMENTAL SANITATION		All goals relating to water and sewage disposal are goals for population coverage - urban or rural. They are designed to be adopted by all countries and each country individually and the regional goal is consistent with this purpose.		1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated their strategies. 3. Consistency with the regional goal. 4. Gap between the initial situation in 1971 and proposed national goal for 1980.	See chapter XI, pp. 191-205, of the Basic Reference Document of the Meeting of Ministers.
3.2.1. Water supply and sewage disposal services					
3.2.1.1. For urban population	1. Provide water supply services to the homes of 80% of the urban population and supply such services to at least half of the entire population now without such service. 2. Install sewerage systems to serve 70% of the urban population or, as a minimum, reduce by 30% that portion of the population now without such services.		1. Urban population with and without service, with and without house connections. 2. Programs in progress; proposed and approved investment plans. 3. Goals established for 1980. 4. Strategies.		
3.2.1.2. For rural population	1. Provide potable water to 50% of the rural population or, as a minimum, supply 30% of the population without such service. 2. Install sewerage systems and other sanitary measures for the disposal of human waste for 50% of the rural population, or as a minimum, reduce by 30% the number of inhabitants that do not now have adequate facilities.		1. Rural population with and without service. 2. Programs in progress. 3. Goals established for 1980. 4. Strategies.		

CLASSIFICATION AND ANALYSIS OF GOALS OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS

(Prepared by the Pan American Center for Health Planning)

ASPECT TO WHICH THE GOALS REFER	GOALS FOR THE TEN-YEAR PLAN	CHARACTERISTICS OF THE GOALS	INITIAL EVALUATION (1974)		CRITERIA FOR ANALYSIS AND EVALUATION OF GOALS
			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
3.2.2 Solid Waste	Establish adequate systems for the collection, transportation, treatment and final disposal of solid waste in at least 70% of the cities of 20,000 or more inhabitants.	The goal is coverage of the cities, a goal for the Region that may be adopted by each country.	1. Cities of 20,000 and more inhabitants, with and without adequate systems. 2. Projects in operation or approved for implementation in the future. 3. Goal established for the country. 4. Strategy for its achievement.	1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated their strategies. 3. Consistency with regional goal. 4. Gap between the initial situation in 1971 and the proposed national goal for 1980.	A series of technical criteria should be set up to define when and "adequate" system has been attained. See pp. 200-205 of the Basic Reference Document Meeting of Ministers.
3.2.3 Environmental pollution	Establish policies and carry out programs to control water, air and solid pollution and for noise abatement, compatible with environmental sanitation and industrial development and urbanization.	The goal has no implication of population coverage and is more in the nature of a recommendation that each country give priority attention to the problem.	1. Existing policies and programs. 2. Intersectoral coordination. 3. Level of participation by the health sector. 4. Established goals. 5. Strategies.	1. Number and percentage of countries that have established policies and proposed programs.	See Basic Reference Document pp. 206-212 and recommendations on program areas in the Final Report of the said meeting, pp. 49-52.
3.2.4 Regional development	Assure active and systematic participation of the health sector in formulating regional, national and multinational development plans.	Goal for each country, that is more a recommendation and recognition of the need for participation by the health sector in regional development plans.	1. Regional development plans in process of formulation or in operation. 2. Participation of the health sector in formulation or operation of such plans. 3. Strategy for participation in such plans.	1. Number and percentage of countries with regional development plans. 2. Number and percentage of countries that have formulated strategies for health sector participation in such plans.	See Basic Reference Document pp. 243-249 and recommendations in the Final Report of the said meeting, pp. 54-55. Criteria should be established for evaluation of this goal that would incorporate an assessment of the "degree of participation" of the health sector.
3.2.5 Occupational Health	Obtain protection for 70% of the estimated or known workers exposed to occupational risks in countries that already have programs in operation, and 50% of such workers in countries that have not yet sufficiently developed their programs.	Goal for each country, individually adjusted to the current level of development of their occupational health programs.	1. Labor force and risks to which it is exposed. 2. Programs in operation and populations or risks covered by such programs. 3. Goals established for 1980. 4. Strategies to achieve these goals.	1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated their strategies. 3. Consistency with regional goal. 4. Gap between the initial situation in 1971 and the proposed national goal for 1980.	It would also be appropriate for this goal to set up some evaluation criteria to include a description of the present stage of development of these programs, the level of "protection" afforded, etc. See Basic Reference Document, pp. 224-226 and the Final Report of the Meeting of Ministers, recommendations on program areas, pp. 53-54.

CLASSIFICATION AND ANALYSIS OF GOALS OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS

(Prepared by the Pan American Center for Health Planning)

ASPECT TO WHICH THE GOALS REFER	GOALS FOR THE TEN-YEAR PLAN	CHARACTERISTICS OF THE GOALS	INITIAL EVALUATION (1974)		CRITERIA FOR ANALYSIS AND EVALUATION OF GOALS
			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
3.2.6. Animal health and veterinary public health	Help to control and eventually to eradicate foot-and-mouth disease in South America and to prevent its introduction into presently disease-free areas. Help to reduce the incidence of the most frequently occurring zoonoses, with particular attention to rabies, Brucellosis, bovine tuberculosis, hydatidosis and equine encephalitis.	Goals for each country	1. Current status of foot-and-mouth disease, and of the zoonoses. 2. Programs currently in operation. 3. Goals proposed for 1980. 4. Strategies to achieve these goals.	1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated their strategies. 3. Consistency with regional goal. 4. Gap between the situation in 1971 and proposed national goal for 1980.	These goals also require the establishment of criteria that will define the degree to which each country contributes to control of foot-and-mouth disease or reduction of incidence of the zoonoses. See Basic Reference Document pp. 250-262 and recommendations on program areas, Final Report of the Meeting of Ministers, pp. 55-58.
3.2.7. Food and nutrition policy	Obtain in each country the formulation and implementation of a biologically oriented food and nutrition policy that will make it possible to attain the approved nutrition goals, assuring the availability and consumption of food that meets the nutritional needs of all population groups.	Goals for each country	1. Food policy now in effect and degree to which it meets requirements of the regional goal. 2. Degree of participation by the health sector in formulation of this policy. 3. Strategy to obtain such policy formulation.	1. Number and percentage of countries that do not have an adequate policy, and propose to develop such policy. 2. Number and percentage of countries that have formulated their strategies.	Criteria must be defined to determine when a health policy may be considered formulated, and when such a policy is being implemented.
3.2.8. Quality control of food	Reduce human disease and economic losses caused by biological, physical and chemical contamination of food and food products, at the same time preserving the quality of such foods.	Goal for each country	1. Programs currently in operation. 2. Programs being proposed 3. Strategies.	1. Number and percentage of countries proposing to develop activities. 2. Number and percentage of countries that have formulated strategies.	See Basic Reference Document, pp. 225-230.
3.2.9. Quality control of drugs	Carry out programs in all countries for quality control of drugs, whether nationally produced or imported.	Goals for all countries and for each country.	1. Programs currently being developed. 2. Goals established for 1980. 3. Strategies.	1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated their strategies.	See Basic Reference Document, pp. 231-233 and recommendations of the Final Report, Meeting of Ministers, pp. 64-66.
3.2.10. Control of the use of pesticides	Reduce morbidity and mortality resulting from the indiscriminate use of pesticides.	Goal for all countries	1. Estimate of morbidity and mortality atributable to use of pesticides. 2. Goal established for 1980. 3. Strategy.	1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated their strategies. 3. Gap between the initial situation in 1971 and proposed national goal for 1980.	See Basic Reference Document, pp. 248-251 and recommendations in the Final Report, Meeting of Ministers, pp. 61-62.

ASPECT TO WHICH THE GOALS REFER	GOALS FOR THE TEN-YEAR PLAN	CHARACTERISTICS OF THE GOALS	INITIAL EVALUATION (1974)		CRITERIA FOR ANALYSIS AND EVALUATION OF GOALS
			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
3.2.11 Accident Prevention	Reduce the percentage of traffic and industrial accidents as well as those that occur in the home and in recreational and tourist areas, and thus reduce deaths and disability.	Goal for all countries.	1. Current status of the accident problem. 2. Control program currently in operation. 3. Established goals for 1980. 4. Strategies.	1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated strategies. 3. Gap between the initial situation in 1971 and proposed national goal for 1980.	See Basic Reference Document, pp. 227-230 and recommendations in Final Report of Meeting of Ministers, pp. 64-65.
4. COMPLEMENTARY SERVICES 4.1. NURSING	Organize the nursing profession in 60% of the countries, as a minimum, with a system in which the level of nursing care and staffing needs to achieve the health goals of the country are defined.	The goal implies coverage of the countries.	1. Status of the nursing system at the beginning of the period. 2. Existing development programs in the nursing field. 3. Definition of levels of nursing care to be attained. 4. Established goals for the decade. 5. Strategies formulated.	Number and percentage of countries that have defined their levels of nursing care and adopted a development plan in this field.	Evaluation of this goal requires that criteria be established to define what is understood by a "nursing system." Study Basic Reference Document, pp. 271-277 and recommendations on program areas of the Ten-Year Health Plan for the Americas pp. 65-66.
4.2. LABORATORIES	Expand coverage and organize laboratories as systems with diagnostic functions, production of biologicals for human and animal use and blood banks essential to support the health programs.	This is a goal for all countries and for each country individually.	1. Status of the system in 1971. - Minimum and basic care services, with or without laboratory. - Regionalization and reference system. 2. Status of blood bank. 3. Plans currently being implemented. 4. Established goals for 1980.	Number and percentage of countries that have formulated their plans for development of laboratory systems.	Final evaluation of achievement of this goal requires that operational criteria and definitions be established for what is meant by a "laboratory system." See Basic Reference Document, Meeting of Ministers, pp. 266-270 and recommendations on Program areas in the Ten-Year Health Plan for the Americas, pp. 66-67.

ANNEX II

CLASSIFICATION AND ANALYSIS OF GOALS OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS

(Prepared by the Pan American Center for Health Planning)

ASPECT TO WHICH THE GOALS REFER	GOALS FOR THE TEN-YEAR PLAN	CHARACTERISTICS OF THE GOALS	INITIAL EVALUATION (1974)		CRITERIA FOR ANALYSIS AND EVALUATION OF GOALS
			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
4.3. EPIDEMIOLOGICAL SURVEILLANCE	Create and maintain epidemiological surveillance units, according to the national organization and regional structure of each country, in order to obtain continuing information on the epidemiological characteristics of health problems, and factors that condition them, for the purpose of taking timely action.	This goal must be established for all and each one of the countries.	1. Current status of epidemiological surveillance system. 2. Plans now being implemented for the organization and development of the system. 3. Goals established for 1980. 4. Strategies for their achievement.	Number and percentage of countries that have formulated plans for the development of their epidemiological surveillance systems.	Evaluation of this goal also requires establishment of operational criteria and definitions for the organization and functions of epidemiological surveillance units. See Basic Reference Document, Meeting of Ministers, pp. 263 .
4.4. HEALTH EDUCATION	Organize health education as a part of the process of active and informed participation of the communities in all of the activities designed for the prevention and cure of disease.	This goal is also proposed for all and each one of the countries.	1. Current status of the health education service. 2. Plans currently in process for organization and development of the service. 3. Goals established for 1980. 4. Strategy for achieving such goals.	Number and percentage of countries that have formulated plans to develop their health education services.	Consideration of this goal requires operational criteria and definitions of what constitutes a "health education service" in order to devise mechanisms for evaluating its achievement. See Basic Reference Document, pp. 278-281 and recommendations in the Ten-Year Plan, pp. 69-70.
5. DEVELOPMENT OF INFRASTRUCTURE 5.1. SECTORAL ORGANIZATION AND ADMINISTRATION 5.1.1. Health Systems	Install and develop a health system in each country, appropriate to the national needs.	Goal for each country, that implies a decision with regard to the structure and operation of the most effective system.	1. Current status of the health system; institutional composition, coverage, productivity, policies to which it is subject, directing agency. 2. Plans for organization and development. 3. Proposed strategy.	Number and percentage of countries that propose to organize and develop their systems.	Evaluation of achievement of this goal requires establishment of criteria of "existence" of such a system, and its concordance with the policy directives that set it up. See Basic Reference Document pp. 1-15 and recommendations in the Final Report, Meeting of Ministers, pp. 72-77.

CLASSIFICATION AND ANALYSIS OF GOALS OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS

(Prepared by the Pan American Center for Health Planning)

ASPECT TO WHICH THE GOALS REFER	GOALS FOR THE TEN-YEAR PLAN	CHARACTERISTICS OF THE GOALS	INITIAL EVALUATION (1974)		CRITERIA FOR ANALYSIS AND EVALUATION OF GOALS
			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
5.1.2 Planning	Establish and expand in each country the health planning process, incorporating it into social and economic development plans.	Goals for all and for each one of the countries, leading to the development and refinement of the planning process, of information, evaluation and control systems, and of health statistics.	1. Status of the health planning process. 2. Plans for the expansion and improvement of the process and its goals. 3. Proposed strategies.	Number and percentage of countries that formulated strategies for development and improvement of: 1. The planning process. 2. Information, evaluation and control systems, and 3. Health statistics systems.	Evaluation of this goal requires criteria for determining the status of the planning process and the information, evaluation and control systems, as well as the degree of efficiency of the latter as tools leading to the implementation of the established policy. See Basic Reference Document, pp. 27-56 and recommendations of the Final Report of the Meeting of Ministers, pp. 77-81.
5.1.3 Information, evaluation and control systems	Organize information, evaluation and control systems.		1. Current status of the systems. 2. Plans for their improvement and proposed goals. 3. Strategies for achieving such goals.		
5.1.4 Statistical systems	Improve health statistics.		1. Current status of statistical systems. 2. Goals for their organization and development. 3. Proposed strategies.		
5.1.5 Research	- Make studies to determine the effects of various alternatives in sectoral policy. - Develop methods and techniques to obtain an increase in the productivity and efficacy of services. - Make systematic studies of expenditures and financing.	Goals for all countries and for each country, designed to provide the bases for formulating adequate health policies and developing the required infrastructure for their implementation.	1. Existence of a research program, and subjects to be studied. 2. Plan to promote and implement the proposed research. 3. Strategy for completing such studies.	1. Number and percentage of countries that have formulated a research policy. 2. Number and percentage of countries that have set up research programs on: - sectoral policy - techniques - methodologies, and - financing.	Establishment of criteria for determining priorities in areas to be studied is needed. See Basic Reference Document, pp. 60-64 and recommendations of the Final Report of the Meeting of Ministers, pp. 81-82.

ANNEX II

CLASSIFICATION AND ANALYSIS OF GOALS OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS

(Prepared by the Pan American Center for Health Planning)

ASPECT TO WHICH THE GOALS REFER	GOALS FOR THE TEN-YEAR PLAN	CHARACTERISTICS OF THE GOALS	INITIAL EVALUATION (1974)		CRITERIA FOR ANALYSIS AND EVALUATION OF GOALS
			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
5.1.6. Operating capacity 5.1.6.1. Sectoral Coordination	Coordination or integration of the state, paragovernmental and private institutions that together constitute the health sector.	Goals for all countries, designed to perfect the administrative processes, and overall direction of health systems.	1. Existing coordinating mechanisms and their level of efficiency. 2. Plans for the decade. 3. Strategies.	Number and percentage of countries that have established their goals and strategies.	Establishment of criteria for the evaluation of the level of operating capacity, with indicators of the efficiency, the coordination mechanisms, programming of services and investments, administrative systems, etc. (See reference listed under item 5.1.2. Planning).
5.1.6.2. Administrative reform	Initiate or strengthen the processes of administrative, sectoral and instutional reform.		1. Description of the existing programs for administrative reform. 2. Goals for the decade. 3. Proposed strategies.		
5.1.6.3. Programming	Formulate and carry out programs for services, infrastructure, foreign aid and pre-investment studies.		1. Characteristics of current programs in relation to policies and plans. Levels. 2. Future plans with regard to programming mechanisms. 3. Proposed strategy.		
5.1.6.4. Intersectoral communication	Promote communication among infrastructures of the various sectors, designed to bring about, by menas of coordinated programs, intersectoral concentration of resources to those population groups most exposed to preventable risks of illness and death.		1. Current communication mechanisms and existing coordinated programs. 2. Mechanisms proposed to attain such communication. 3. Proposed strategy.		

CLASSIFICATION AND ANALYSIS OF GOALS OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS

(Prepared by the Pan American Center for Health Planning)

ASPECT TO WHICH THE GOALS REFER	GOALS FOR THE TEN-YEAR PLAN	CHARACTERISTICS OF THE GOALS	INITIAL EVALUATION (1974)		CRITERIA FOR ANALYSIS AND EVALUATION OF GOALS
			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
5.2 RESOURCES DEVELOPMENT 5.2.1 Human Resources 5.2.1.1 Personnel in 1980	Attain a regional average per 10,000 inhabitants of:	All manpower goals are average goals for the Region that should serve as indicator for the establishment of each country goal. It should be kept in mind that in all cases the manpower goals are designed to attain a population coverage level.	1. Current number, and institutional and geographical distribution (1971). 2. Established goal for 1980. 3. Variance from regional goal and reasons therefor. 4 Strategies for achieving the goals	1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated strategies. 3. Consistency with regional goal. 4. Gap between initial situation in 1971 and proposed national goal for 1980.	
- physicians	8.0				
- dentist	2.0				
- dental auxiliaries	4.0				
- nurses	4.5				
- nursing auxiliaries	14.5				
5.2.1.2 Distribution	Improve manpower distribution, geographical and institutional.				
5.2.1. Training	Personnel to be trained in the decade		1. Current number and estimated deficit (1971). 2. Goal for 1980. 3. Variance from regional goal and reasons therefor. 4 Current training programs 5. Proposed training programs. 6. Strategies for implementing the programs.		
- veterinary doctors	1,000				
- animal health auxiliaries	8,000				
- nurse	145,000				
- nursing auxiliaries	60,000				
- sanitary engineers	1,200				
- other professional in sanitation	20,000				
- statistical professional	500				
- medical records professionals	100				
- medical records auxiliaries	4,000				
- statinticians, intermediate level	250				
- auxiliaries in statistics	40,000				
- professionals in planning	3,000				
- professionals in administration	3,000				
- professionals in information systems.	1,000				

ANNEX II

CLASSIFICATION AND ANALYSIS OF GOALS OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS
(Prepared by the Pan American Center for Health Planning)

ASPECT TO WHICH THE GOALS REFER	GOALS FOR THE TEN-YEAR PLAN	CHARACTERISTICS OF THE GOALS	INITIAL EVALUATION (1974)		CRITERIA FOR ANALYSIS AND EVALUATION OF GOALS
			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
5.2.1.4. Practice of Medicine	Strengthen development of general medical practice to the extent required by the organization of the services and the goals proposed in the Ten-Year Plan.	Goal for each country designed to make the practice of the medical profession more satisfying in relation to the goals of the Ten-Year Plan.	1. Relationships at the decision-making level of the sector with the medical profession. 2. Mechanisms for information and participation in decisions. 3. Strategies to encourage and develop the practice of medicine.	Number and percentage of countries that have formulated strategies.	
5.2.1.5. Teaching of Medicine	Promote the necessary reforms to provide maximum training in this field, according to the priorities set forth for each country.	Goal for each country, designed to raise the quality of medical manpower and its adjustment to the health needs of each country.	1. Priorities assigned. 2. Coordination with the Schools of Medicine. 3. Plans for changes in medical education. 4. Strategies for achievement of such goals.	Number and percentage of countries that have formulated strategies.	
5.2.1.6. Scientific Documentation	Create national systems for scientific documentation in the health sciences, in at least 11 countries, interrelated among these countries and with the Regional Library of Medicine (BIREME).	Regional goal.	1. Existing systems. 2. Outlook and plans for organization. 3. Proposed goal. 4. Strategy adopted.	Number and percentage of countries that have decided to set up documentation systems.	
5.2.1.7. Textbooks	Supply high-quality scientific and pedagogical textbooks to students of medicine, nursing, and other disciplines, so as to cover with this program 75% of the students in 1980.	Regional goal.	1. Number of students expected. 2. Existing program and outlook for its development. 3. Proposed goal. 4. Strategy for its achievement.	Number and percentage of countries that have formulated programs for the period, 1971-1980.	

CLASSIFICATION AND ANALYSIS OF GOALS OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS

(Prepared by the Pan American Center for Health Planning)

ASPECT TO WHICH THE GOALS REFER	GOALS FOR THE TEN-YEAR PLAN	CHARACTERISTICS OF THE GOALS	INITIAL EVALUATION (1974)		CRITERIA FOR ANALYSIS AND EVALUATION OF GOALS
			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
5.2.2. Physical Resources 5.2.2.1	Within the systems of regionalization, create minimum integrated health service units, designed to attain coverage of one unit for each 5,000 inhabitants in towns of less than 2,000 population, health centers with integrated minimum and basic services for towns of 2,000 to 20,000 population, and institutions with integrated basic and specialized services to communities of more than 20,000 inhabitants.	Regional goal of population coverage that can be adopted by each country. The goal refers to construction and equipment of installed capacity.	1. Localities, according to population and number of minimum, basic and specialized units operating in each. 2. Investment plan approved projects and projects in operation. 3. Established goal for the country and its consistency with regional goal. 4. Strategies.	1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated their strategies. 3. Consistency with regional goal. 4. Gap between initial situation in 1971 and proposed national goal for 1980.	This goal is an expression in concrete terms of investment in plant construction for delivery of service to which the coverage goals mentioned in 2. "coverage of services", refer.
5.2.2.2	Increase the installed capacity by 106,000 general hospital beds, by remodeling, and conversion of long-stay beds whenever possible.	Goal for the entire Region. Breakdown for each country required.	1. Number of general and long-stay hospital beds. 2. Planned investment. 3. Goal established for the country. 4. Strategy.		See Basic Reference Document, pp. 15-22.
5.2.2.3	Gradually incorporate specialized medical care services into the general hospitals, in consonance with the health care level and within the regionalization system.		1. Country policy applicable to this topic and progress made in its implementation. 2. National goal established for 1980. 3. Strategy.		
5.2.2.4	Establish systems for the maintenance of installations and equipment.	Goal applicable to each country, for coverage of establishments.	1. Status of the systems. 2. Goal established for 1980. 3. Strategy.		See Basic Reference Document, pp. 23-26.

ANNEX II

CLASSIFICATION AND ANALYSIS OF GOALS OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS

(Prepared by the Pan American Center for Health Planning)

ASPECT TO WHICH THE GOALS REFER	GOALS FOR THE TEN-YEAR PLAN	CHARACTERISTICS OF THE GOALS	INITIAL EVALUATION (1974)		CRITERIA FOR ANALYSIS AND EVALUATION OF GOALS
			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
5.2.3. Financial resources	Develop financial systems that will seek out new sources of funds for the sector and ensure fuller cooperation of the community and participation of the health sector in key national development projects.	Goal to be adopted in each country for 1980.	1. Current status of health funding. 2. Financial policy now in effect. 3. Goals with regard to total amount, sources, origin and allotment of funds. 4. Strategies.	1. Number and percentage of countries that have established goals. 2. Number and percentage of countries that have formulated strategies. 3. Consistency with regional goal. 4. Gap between initial situation in 1971 and proposed national goal (1980).	
5.2.4. Technological resources	Develop and utilize techniques adapted to conditions in each country, to increase coverage and productivity of the services.	Goal for each country. This refers in essence to the need to study and experiment with such techniques.	1. Research programs in progress. 2. Proposed plans.	1. Number and percentage of countries that have formulated programs. 2. Number and percentage of countries that have formulated strategies for development of such programs.	
	Organize multinational scientific and technological research programs.	Regional goal.	1. Programs in which the country is now participating. 2. Topics in which the country would be interested.		
5.2.5. Legal aspects	Submit the systematization, regulation and adequacy of legal provisions now in effect to the competent agencies of each country, as a part of process of improving administration.	Goals for each country.	1. Current status of health legislation. 2. Programs now in operation in this area. 3. Established goals. 4. Strategy.	1. Number and percentage of countries that have formulated programs. 2. Number and percentage of countries that have formulated strategies for development of such programs.	See Basic Reference Document, pp. 56-60 and recommendations in the Final Report of the Meeting of Ministers, pp. 95-96.

PART III

RESOLUTION XIII OF THE XXI MEETING OF THE PAHO DIRECTING COUNCIL

RESOLUTION XIII

REPORT ON THE III SPECIAL MEETING OF MINISTERS OF HEALTH AND STEPS NECESSARY TO IMPLEMENT THE DECISIONS ADOPTED

THE DIRECTING COUNCIL,

Having heard the statement by the Director of PASB on the III Meeting of Ministers of Health of the Americas, held in Santiago, Chile, 2-9 October 1972; and

Considering that the recommendations made by the III Meeting of Ministers of Health of the Americas constitute valuable guidelines on the direction to be taken by the programs of the countries during the next decade,

RESOLVES:

1. To incorporate into the Organization's policy the recommendations of the III Meeting of Ministers of Health of the Americas, held in Santiago, 2-9 October 1972.

2. To request the Director of PASB to study the implications of the recommendations of the III Meeting of Ministers of Health, and the consequent modifications of objectives and priorities in the program of the Organization, and to report thereon to the XXII Meeting of the Directing Council.

3. To recommend to the countries that, within their planning process, they identify the priority health problems and establish objectives for each of them in accordance with the manpower, physical, and financial resources available, taking into account the regional health goals.

4. To request the Director of PASB to convene as soon as possible a working group of personnel responsible for planning and information and of health economists, with a view to designing an evaluation system that can be adapted to the unique conditions of the countries and still be flexible enough to give comparable results, which in turn will make possible a continent-wide evaluation of the achievements of the decade.

5. To recommend to PAHO that, in consultation with experts of the countries, general guidelines be drawn up for determining the present financing of health investments and the changes required to carry out the plans and programs envisaged in the Ten-Year Health Plan for the Americas, 1971-1980.

6. To suggest to the health authorities of the countries that they initiate cost studies of their health services and, when they deem it possible, cost-benefit studies, particularly in areas with the largest investment.

7. To recommend to PAHO that it prepare the necessary designs to ensure comparability of the cost studies.

8. To recommend that PASB furnish advisory services to countries requesting them, in all matter relating to the financing of the health sector, for example: the financial analysis of the sector, analysis of health expenditures, programming of investments, management and financing of specific projects and of external credits, so that the countries will gradually come to know what financial resources are earmarked for health and how they are related to the benefits obtained.

(Approved at the sixth plenary session, 12 October 1972)

PART IV

SELECTION OF PRIORITIES AS AN ELEMENT IN THE DECISION-MAKING PROCESS

PURPOSE

The purpose of this paper is to present some thoughts on the nature of the decision-making process in the health sector, a process in which the establishment of priorities plays a fundamental role. It was deliberately decided not to include an in-depth analysis of the procedures and techniques for establishing priorities, but rather to present a very general but systematic discussion of the underlying assumptions and implicit criteria which may be regarded as having substantive importance in this stage of the decision-making process.

1. THE SELECTION OF PRIORITIES AS AN ELEMENT OF THE DECISION-MAKING PROCESS

The identification and selection of the problems to be solved in order to achieve an overall objective are the very essence of the work involved in defining a policy and therefore constitute the initial stage of a process which triggers off the sequence of necessary decisions to attain the desired objective. This sequence includes decision-making with regard to selecting the best solution to the problem, the programming of the activities and investments which these solutions imply and their implementation.

The initial decisions are based on a system of values and cultural norms, on an ideology, and on the requirements of the political, technical and operational systems.

The study of the decision-making process goes back to the beginning of recorded history. However, it was only two decades ago that the analysis of the process of administration and the development of logically constructed mathematical instruments applicable to this process linked again in a formal way the decision-making process with administration. This development had - and continues to have - greater influence on business administration than on public administration. Moreover, in the analysis and development of instruments the primary emphasis continues to be placed on operational aspects rather than on the formulation of policies and of guidelines for their application. During the 1960's a concern with analyzing the decision-making process in the area of public administration began to emerge. Many of the conceptual, methodological and instrumental efforts in this field were in essence merely direct application of decisional techniques in use in private industry to particular cases arising in public administration. This approach poses a number of problems that cannot easily be solved because of the differences in nature of public administration and business administration. In business the processes to be analyzed are relatively simple, the aims and results are easily identifiable and quantifiable, and the inter-relations are less complex and numerous. Public administration, on the other hand, especially in the social sectors, operates in the context of a complex and ill-defined system involving a vast number of inter-relations.

Quantitative instruments proved inadequate for the analysis of processes aimed at achieving higher levels of social well-being, an objective which is difficult to reduce to quantifiable variables and which presupposes cultural values expressed in ideologies.

The realization of this fact is leading to the development of instruments appropriate for the treatment of problems of this type,

the solution of which depends essentially on being able to perform qualitative analyses. The tools of quantitative analysis should be utilized mainly in support of qualitative analysis, in the taking of decisions at the operational level, and in certain aspects of the definition of guidelines.

2. QUALITATIVE AND QUANTITATIVE ANALYSIS

It is proposed that the health sector be defined as a "system composed of a large number of complex elements interrelated in many ways, an ill-defined system in which the relationships among the various components cannot be represented in only one way, but in as many ways as there are points of view and in which each point of view depends on the philosophical and political prism through which the relationship is seen. And that very context in which the system evolves and which stipulates the relationships is itself variable, and its inter-relations with the system are little known."(+) If this definition is accepted, the conclusion is valid that quantitative approaches, used alone, are not effective tools for measuring the realities of the system and do not provide a basis for decision-taking at the stage of defining a policy and the guidelines required for its implementation. It is therefore necessary to resort to a type of systematical analysis, other than quantitative analysis that will bring the elements into a more logical arrangement as a basis for decision.

Figure 1 (see next page) depicts the process for a systematic selection of priorities under this approach.

2.1. Desired versus present situation

A process or a decision to bring about a change can be represented in terms of the distance from a present situation considered unsatisfactory to a situation which it is desired to attain.(++)

In the case of public health it is obvious that both situations are conditioned by the overall frame of reference in a country.

Although the images of the desired situations, overall and sectoral, are not always formally defined, they are always necessarily utilized, either implicitly or explicitly, in evaluating the need for a change from existing situations.

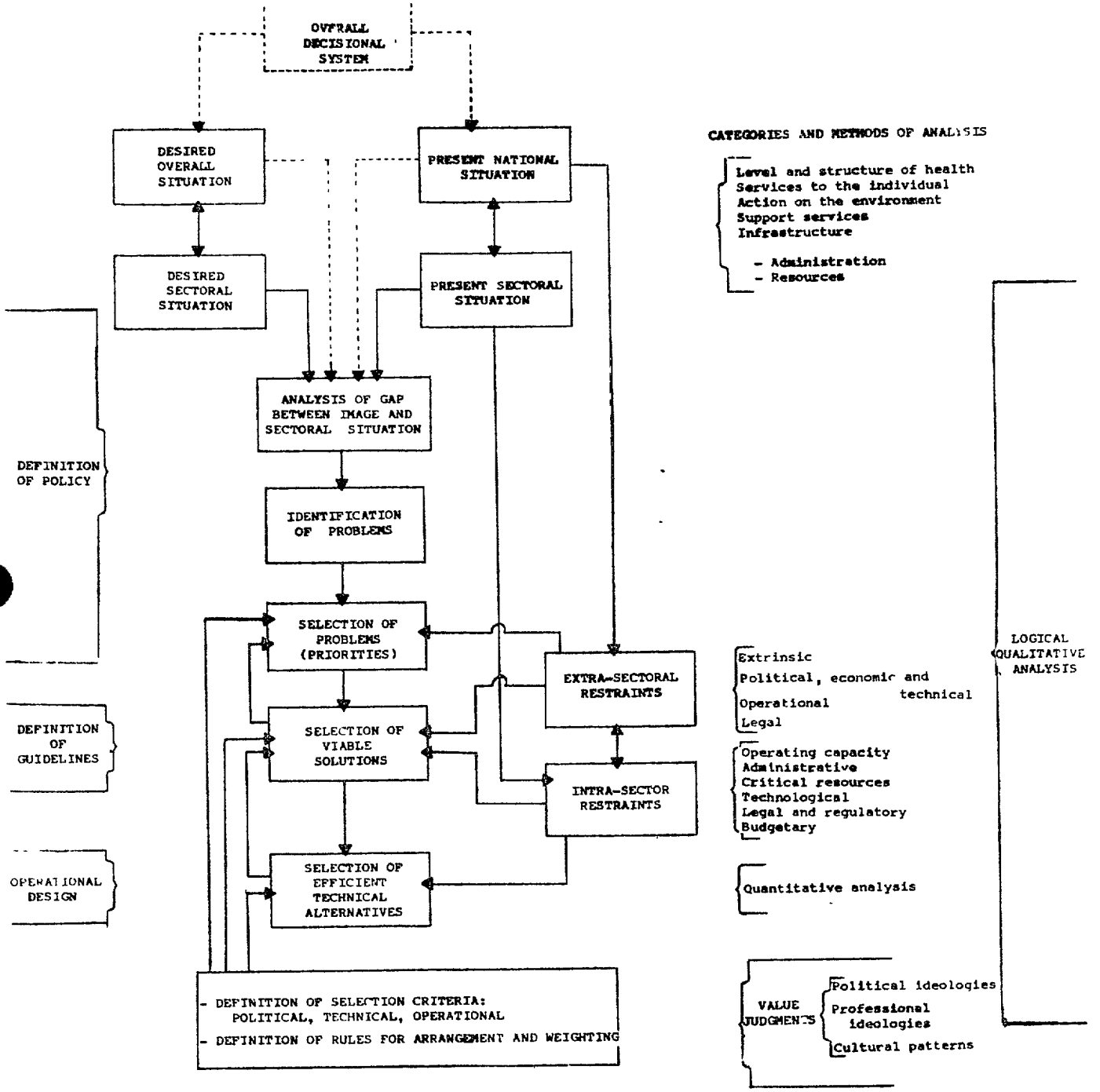
(+) Latin American Center for Medical Care Administration (CLAM). Program for the Development of Models for Medical Experimentation, Buenos Aires, Argentina, 1972.

(++) By desired situation it is meant the type of society, defined in terms of its economic, social and cultural interrelated characteristics which a country proposes to achieve within a given period through a given growth and structural change.

Figure 1

THE SELECTION OF PRIORITIES

IN THE DECISION-MAKING PROCESS



2.2. Identification of problems through analysis of the gap between the desired situation and the present situation in a sector

A comparison of the present situation in a sector with that which it is desired to attain is the basis for determining the existing gap between one and the other. This analysis should permit in an initial approximation the identification of problem situations through the estimation of the gap and the systematic analysis of the obstacles that it would be necessary to overcome in order to attain the desired situation.

The analysis of the sectoral gap must be done in such a way that a very careful account is taken of the overall national framework that shapes the sectoral situation, or at least conditions it within certain parameters.

This analysis is the methodological path leading to the identification of the problem-situations that have to be solved in order to bring about the desired change.

2.3. Selection of problems

The identification of problems is but one of the necessary elements in the decision-making process, since the health sector, like all other sectors of society, faces the classic economic problem of multiple needs versus a scarcity of resources available for possible application to each need. Due to this imbalance between few and relatively unchangeable resources and multiple needs, it is necessary to arrive at an order of priorities in which the problems may be solved through the allocation of combinations of resources. That is, it is necessary to establish priorities among problems.

For many years the efforts of research workers and administrators in the health sector were aimed at finding out a "summary" element with "economic" connotations and "technically rational" characteristics that would enable them to establish priorities.

The experience gained and the progress achieved in the understanding of the nature and the interrelations of social phenomena support the assertion that priorities in the health sector cannot accurately be determined on the basis of a single summary indicator. Health problems have a social connotation as well as economic characteristics, since their solution is a substantive factor in the degree of well-being that a community can achieve.

Recent analyses would seem to provide rather clear evidence that three types of rationality - political, technical and operational - play a part in the decision-making process, the relative influence of each depending on the stage of the process.

If it is accepted that establishing priorities among problems is one of the fundamental aspects in the definition of a policy, it is logical to conclude that political rationality should prevail at this stage over the other two types of rationality, which should support and complement the former (see Figure 2, next page). This conclusion presupposes the need to define political, technical and operational criteria to govern the selection among problems and make it possible to systematize them in some way that will facilitate the decision-making process.

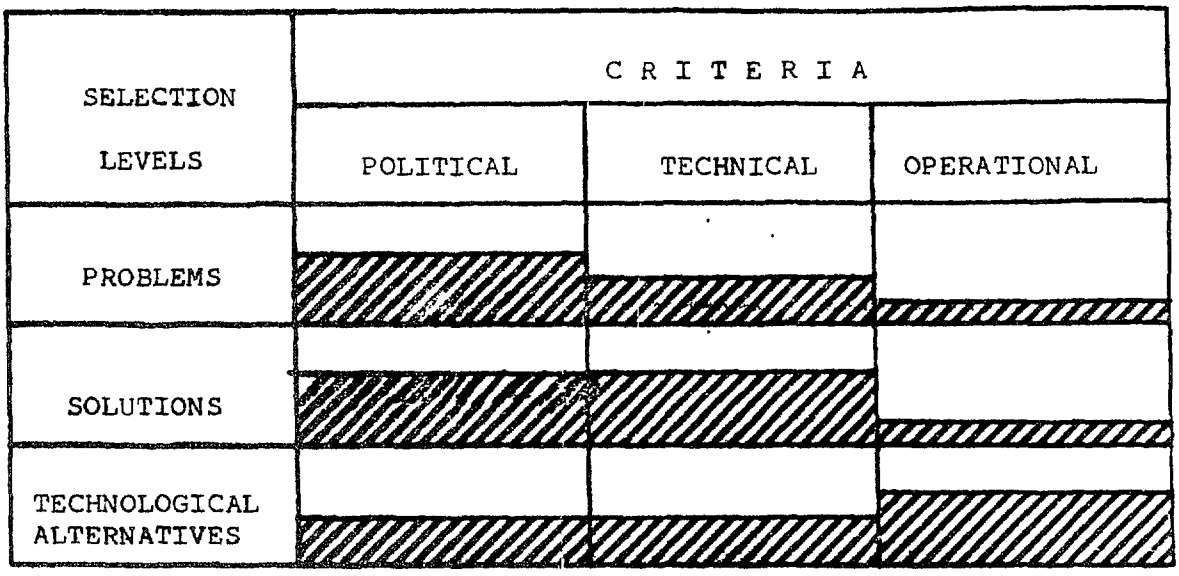
It is proposed that the "political criteria" be regarded as consisting of the entire series of variables which are of concern at the political level of the administrative apparatus responsible for deciding on priorities between problems and among alternative solutions; that "technical criteria" be regarded as referring to these variables that concern the technical level of the administrative apparatus responsible for the programming of decisions, the principal purpose of which is to assure maximum efficiency through efficient solutions; and that "operational criteria" be considered as being the variables which are the responsability of those who carry out the decisions aimed primarily at obtaining the most productive use of resources.

Figure 2

RELATIVE WEIGHT OF THE CRITERIA

FOR SELECTION OF PRIORITIES AT

THE DIFFERENT LEVELS OF THE PROCESS



On this basis it would be possible to construct for each of these types of criteria a subclassification that would facilitate the determination of the weight to be given to each variable in the decision-making process. It is obvious that this subclassification of relevant variables for the decision-making process, in accordance to the types of criteria we have proposed, will differ with the characteristics of the health sector in each country and that, therefore, each decision-planning-implementation system would have to draw up its own classification in the light of national and sectoral characteristics. However, it would seem possible and desirable to establish, by way of illustration, certain sets of variables into broad categories which are sufficiently universal to lend themselves to general use, such as the categories proposed in Figure 3.

It is important to emphasize that the definition and selection of criteria such as these is essentially a matter of value judgments, regardless of the degree of sophistication involved in its formalization and use. These value judgments reflect the political and professional ideologies of those participating in the decision-making process, as well as the cultural patterns influencing the situation in each country.

This proposition is not always accepted as valid. There is still a tendency to speak in terms of a supposed "rationality" as opposed to the "subjectivity" inherent in all value judgment. However, when we call a decision "rational" or "irrational," we are doing so from the standpoint of a given system of values. It is important to recognize that the concept of "rationality" or "irrationality" in decision-making is relative and is based on values and ideologies.

None of the present techniques of quantitative analysis contain the "magic" that will solve all "value" problems inherent to a society and therefore in its health sector. It is therefore necessary to recognize and make explicit the presence of these "values" that influence the establishment of priorities, in order that we may evaluate them and thus bring the necessary realism to decisions.

A system of values is the result of a complex process of relations between cultural patterns and the processes of professional and political socialization. It is hardly necessary to emphasize that in high level political decisions these values are strongly present, but even though less is known of what might be termed "professional ideologies," the analysis of reality shows that these, too, strongly influence the decision-making process.

Public health problems, like those in other social sectors, must be analyzed and evaluated in terms of values and social patterns because these values and patterns, observed or desired, are the point of departure in all social planning.

It would seem important to stress the influence of the political component in the decision-making process because this component is responsive to an ideology or a concept of society that could be closer to reality than the fragmentary vision usually offered by highly specialized technicians. But it is also important to keep in mind that the more criteria are brought to bear on the analysis leading to a decision, the greater is the likelihood that the decision will be correct. This explains the tremendous importance of including technical and operational criteria in the analysis of problem situations at the political level.

Definition of political, technical and operational criteria, regardless of the subclassification adopted, is a necessary prerequisite for the selection of problems (priorities), but it is also essential to confront these criteria with a careful analysis of the extrasectoral restrictions, presumably beyond the control of the decision-making level in the sector. This type of logical analysis may be sufficient for arriving, in a first attempt, at an initial arrangement of problems. However, this arrangement should be reviewed after the possible solutions are analyzed, in order to introduce whatever changes seem advisable in the light of this analysis.

To sum up: the establishment of priorities is one of the fundamental stages in the definition of a policy. At this stage the political criteria predominate and the technical and operational criteria are secondary, although necessary supporting elements. Its analysis is strongly influenced by value judgments which should be made explicit, and it is essentially of a logical and qualitative nature.

2.4 Selection of feasible solutions

In viewof the fact there can be several feasible solutions to a problem, it will be necessary to choose one of those possible solutions as part of the process of decision-making.

It is proposed that the term "solutions" be understood to refer to the possible ways or paths for obtaining a given result. This definition implies that there are a number of possible options. The problem is to decide which of the options are feasible and, of these, which is the most useful. This judgment on feasibility includes the category of desirability. "A dimension of purpose which cannot be ignored is thus introduced. Useful for what and for whom?" (+)

(+) L. A. de Souza, "Los insumos políticos para una estrategia para el desarrollo," ILPES, ECLA, draft, 1971.

It is evident that we are again faced with the question of a value judgement on which a decision at the political level is based. Moreover, "feasibility is not only a problem in the short-term; it must be analyzed over a certain period of time and within the context of a specific experience. The feasibility of a solution is therefore not to be determined solely on the basis of present possibilities" (+) but must be viewed from the perspective of change over the time required to achieve the desired image of a future national society. Otherwise the decision-making process will be confined within the limits of the status quo.

In the selection of feasible solutions, as in the selection of priorities, the political, technical and operational "rationalities" also play a role, but the technical criteria of effectiveness, efficiency and social cost are more influential (see Figure 2, page 6, and Figure 3, next page) and thus technical rationality carries more weight. Here the technical considerations assume equal importance with political ones and it becomes possible to add to the indispensable qualitative analysis the use of some type of instruments of quantitative analysis, provided sufficient information is available on effectiveness, efficiency and social cost.

The selection of feasible solutions is one of the fundamental aspects in the definition of guidelines to be followed in implementing a policy.

As in the case of the selection of problems, the determination of political, technical and operational criteria for selecting solutions must be complemented by analysis of extra-sectoral restrictions over which the sector has no control. Equally important and essential is the analysis of restrictions within the sector, restrictions representing obstacles that can and should be solved through the various solutions offered for the problem, since in this case the sector does have control over them.

It should be kept in mind that the analysis of feasible solutions may lead to a modification of the scheme of priorities between problems as it was determined in the first attempt.

2.5. Selection of technological alternatives

Just as it is possible that there may be a number of solutions to a given problem, it is equally possible that there are various technological alternatives for a given solution and that it will, therefore, be necessary to decide which of the latter is the most efficient for the solution chosen.

(+) L.A. de Souza, "Los insumos políticos para una estrategia para el desarrollo," ILPES, ECLA, draft, 1971.

Figure 3

EXAMPLES OF MAJOR GROUPS OF VARIABLES FOR CRITERIA FOR THE SELECTION OF PRIORITIES AT DIFFERENT LEVELS OF THE PROCESS

LEVELS OF THE PROCESS	CRITERIA		
	POLITICAL	TECHNICAL	OPERATIONAL
PROBLEMS	- Impact on pressure groups - Impact on policies - Social impact	- Technical relevance - Technical possibilities of solution	Administrative relevance
SOLUTIONS	- Impact on pressure groups - Consistency with policies - Relationship to political and technical stages of development	- Effectiveness - Efficiency - Social cost	- Critical resources - Efficiency
TECHNICAL ALTERNATIVES	- Impact on pressure groups - Relationship to stage of political and technical advance	- Efficiency - Social cost	- Critical resources - Administrative requirements - Legal and regulatory requirements - Efficiency - Operating capacity

In the selection of the most efficient technical alternatives, although political criteria are present, the most relevant criteria are the technical and, even more, the operational (see Figure 2, page 6 and Figure 3, page 10).

The nature of a technical alternative is generally such that it lends itself to and indeed requires quantitative analysis, since it frequently involves situations that are well-defined, quantifiable and structured according to relatively simple inter-relations. In this instance of analysis for decision-making, the tools of "operational research" are a valuable adjunct, especially cost-benefit analysis and its by-products, as well as optimizing mathematical models.

It is in this area, which belongs to what might be called the operational sphere, that the investigation and design of instruments is today centered. Most of this methodological arsenal has been specially conceived and designed for the operational microsphere of modern business administration.

Owing to the differences between business and public administration, the application of these instruments to the selection of technical alternatives for the health sector will be possible only if they are suitably adapted.

3. DISCUSSION OF CERTAIN METHODS THAT CAN BE USED IN THE DECISION-MAKING PROCESS

The following discussion deals with certain methods which can be used for measuring qualitative variables and which, judging from experience to date, would seem to constitute highly useful methodological approaches. These methods, if further developed through application, offer excellent prospects for improvement of the decision-making and planning processes.

The discussion will be limited to two methods that we regard as having the greatest potential relevance: Numerical Experimentation Models and the DELPHI Method with its variations.(+)

(+) It is not considered necessary to comment in detail on the quantitative methods, since they are sufficiently well-known and there is abundant literature on them.

NUMERICAL EXPERIMENTATION MODELS(+)

If it is accepted that the health system is open, poorly defined and complex, it would appear valid to apply the following comments to it: (++)

-".... Description of a complex system requires the use of an appropriate language. Verbal language is insufficient because it does not permit a description of the full complexity of the relationship among the components of the system. This requires the formalization of an overall view or model that makes it possible to describe the behavior of those components and their inter-relations.

-"The type of formalization or model selected should be adapted as far as possible to the characteristics we have described in reference to poorly defined systems.

-"Models are appropriate instruments for investigating and describing reality and testing possible changes. By utilizing them it is possible to introduce a greater element of rationality into the management or operation of a system...

-"For a single system there are as many models as there are parameters that can be handled endogeneously. All these models will have a basic common scheme reflecting the undeniable relationship among the variables defining the system.

-"The models thus prepared are not intended to be a tool for arriving at precise quantitative predictions. They are designed to be used in taking qualitative decisions involving a choice among various action alternatives the effects of which can be compared by using the model.

-"At an initial stage it is possible that the greatest usefulness of models of this kind will lie in indicating previously unanticipated pitfalls. This would be done in the following way: one would begin by testing policies similar to those already in use. The results obtained may be used as a basis for comparison. As a second step, new experiments with innovative policies are designed. Some of these policies may yield undesirable results. By comparing a basic experiment with the one yielding the undesirable results, it is possible to arrive at conclusions as to the causes of those results

---

(+) Since 1968 the Pan American Health Planning Center has been carrying out a research program on the formulation of numerical experimentation models, for the use of the Health Sector.

(++) Latin American Center for Medical Administration (CLAM), Program for the Development of Numerical Experimentation Models, Buenos Aires, 1972, and Research Program of the Pan American Center for Health Planning, Santiago, Chile, 1971.

and, consequently, to make a special effort (in reality) so that those results that one wishes to avoid will not come about.

-"However, although these models will not permit a prediction in the traditional sense of a determination, subject to a certain margin of error, of the quantities of each of the variables making up the system, it is still possible to arrive at some type of prediction. For example if various policy experiments lead to results which are approximately the same, it may be considered that the model is predictive in a qualitative sense and even in certain semi-quantitative respects, as when a certain arrangement is consistently predicted.

"Usefulness of the Model

"A model having the characteristics described makes it possible to:

- Select a suitable alternative from among various policies or various strategies for a single policy, by comparing the probable results of applying them.

- Detect, in relation to fields of knowledge which have not been studied in depth thus far:

  (a) Areas whose behavior is not relevant to an explanation of the operation of the system under study;

  (b) Priority areas in which further investigation is needed.

- Predict bottlenecks in the behavior of the system, under given conditions.

- Test, correct and adjust the existing hypothesis on the system, and analyze the characteristics, interrelations and operation of the relevant components thereof.

- Check the formal consistency of hypotheses.

- Facilitate the application of existing methods of planning and programming in the field, by permitting the above possibilities to be brought to bear on such specific fields as financing, investments, human resources, etc."

These models have the drawback that great experience and skill is required in order to formalize them and adapt them to large computers. However, they offer the advantage of facilitating a combination of qualitative with quantitative analysis, a combination which, as noted above, is necessary throughout the decision-making process.

The participation of the various persons composing the decisional levels, technical and operational, of the sectoral system will lead to a number of secondary results which are of fundamental importance for achieving an improved knowledge of health phenomenism and the administration of the sector. These by-products, once formulated, are highly effective tools for checking the probable consequences of policies and strategies and determining key areas in the operation of the system.

The application of these models presupposes a definition of the health system to be analyzed. A clear delimitation of its components and structures is the basic substratum for arriving at an approximation of the qualitative and quantitative relationships between them. Utilization of instruments of this kind makes it possible to identify the major areas in which the system must be adjusted in order to increase its effectiveness and efficiency.

THE DELPHI METHOD

One of the qualitative methods whose use opens up tremendous possibilities for the setting of objectives and the prediction of economic, social and cultural change under different levels of uncertainty and different degrees of sophistication is the Delphi method.(+)

It is designed to make possible the formulation of a group opinion on matters regarding which no precise and adequate information is available.

The Delphi method operates as follows: A group of experts is formed. The group must be composed of persons either directly or indirectly concerned with the problems to be investigated. Each person receives a questionnaire which he must fill out within a given time. The content of the replies is used to modify the original questionnaire and draw up a second one and a summary guide, which are sent to the experts. This system is repeated many times, and anonymity is maintained in each of the events. In this way each participant receives feedback from the ideas of the others and feels free to accept or reject those ideas or to modify or adjust his earlier opinions.

This is a way of averting the rigidity of behavior created by the use of panels of experts faced with the need to provide group opinions.

(+) This method was developed at the Rand Corporation, Santa Monica, California, early in the 1950's and has been extensively used in recent years.

In this way the reply obtained will not be based primarily on an extrapolation of the past. A number of innovative elements will have been generated through the exchange of opinions that comes about each time a new questionnaire is sent.

This method offers the following advantages in the taking of decisions on formulation of policies and strategies:

- It permits the inclusion and treatment of key qualitative variables.

- It fills the gaps in the "formal" information available.

- It requires the participation of a large number of persons from the various decisional levels, technical and operational, so that, by drawing on the experience acquired by them it contributes to the realism of the decision and fosters a positive attitude on the part of the various participants.

- It has great flexibility in terms of the resources and time required.

The method can therefore be adapted readily to the various operative capabilities of the national health systems and to the political requirements of the decisional levels, as far as time is concerned.

However, it calls for considerable imagination and extreme prudence on the part of the analysts responsible for drawing conclusions, and like the numerical experimentation models, it is specific, that is to say, once the exercise is carried out for a given problem in a given space and time, the results cannot be generalized to other similar situations.

The chief drawback in this type of instrument is the basic underlying assumption that the experience and present opinion of the "experts" is valid for a definition of a future change and an assessment of the possibility of bringing it about. This poses the risk that the material on which the judgment at the decisional level is based may be slanted toward a non-change. Nonetheless, instruments such as these may constitute excellent reference material for gauging the possible action-reaction of putting a proposition into effect. In spite of this risk and the relatively brief experience with its use in the health sector, the nature of this sector and the analysis of the possibilities offered by this type of instrument warrant the assumption that the method, if systematically applied, can make a contribution to a gradual improvement of the decision-making process and to sectoral planning in the countries.

Shortage of operational capacity and the pressing demands of politics in the health sectors of the country may make it necessary, at an initial stage, to resort to extreme simplification, but it is to be expected that systematic use of approaches of this type will, through a sustained process of repetition, help to improve not only the decisional and planning process but also the knowledge of the complex sectoral interrelations in health itself and in the administration of resources assigned to the health sector. Important by-products may also be expected in the form of a definition of substantive problems meriting investigation through other methods. The mere fact that the use of these instruments makes it necessary to explicitize, and possible to examine, behavioral variables strongly influencing the possibilities of behavioral change that cannot be weighed through quantitative methods would be sufficient reason for using them systematically.

It should be emphasized once again, however, that regardless of how excellent the available information is, how sensitive and sophisticated are the instruments used, and how expert are the specialists in the handling of these instruments, in the taking of decisions nothing can replace sound judgment and a genuine will to develop a process of change with the object of achieving a clearly defined situation which it is desired to bring into being.

BIBLIOGRAPHY

B. Abel-Smith: "Health Priorities in Developing Countries: The Economist's Contribution". International Journal of Health Services, Vol.2, Nº1, Greemmood Periodicals Co., 1972.

Closter Barnard: Organization and Management - Harvard University Press, Cambridge, Mass., 1948.

M. L. Blum: "Prioriting Setting for Problems, Solutions, and Projects by Means of Selected Criteria". International Journal of Health Services, Vol. 2, Nº1, Greemmood Periodicals Co., 1972.

J. Bronoswski: The Common Sense of Science, Vintage Books, New York.

Centro Panamericano de Planificación de la Salud: "Métodos y Modelos", División de Investigación, 1970.

Ricardo Cibotti y Oscar J. Bardecci: "Un enfoque crítico de la Planificación en América Latina", ILPES, 1971.

Bertham M. Gross: The Managing of Organizations, New York Free Press, 1964. Organization and their Managing, New York Free Press, 1968.

José Medina Echeverría: Filosofía, Educación y Desarrollo, Textos del ILPES, 1965.
La Planeación en las Formas de Racionalidad Cuaderno ILPES, Serie II Nº13.

Naciones Unidas: Interregional Seminar on the Use of Modern Management Techniques in the Public administration of Developing Countries, Wahsington, D.C., 27 de octubre - 6 de noviembre de 1970. Volumen II: Documentos Técnicos ST/TAO/M/52/ADD.1.

A. Rapoport: "Methodology in the Physical, Biological and Social Sciences, Global Systems Dinamics", Charlottsville, 1969 (Vorges, Basel, Müncher, New York, 1970).

A. Schutz: "The Problem of Rationality in the Social World", Economics Chicago, Vol. 10, 1943.

Kuns-Jürjen Seraphin: "Política Económica General: Los Juicios Valorativos para la Política Económica", Apuntes Programa de Capacitación, ILPES, 1965.

Herbert Simon: The New Science of Management Decision, Harper, New York, 1960.

Oscar Varsavski: Modelos Matemáticos y Experimentación Numérica, Buenos Aires, Argentina, 1969.

Sir Geoffrey Vickers: The Art of Judgement, Basic Books, New York, 1965.

2. METHOD OF EVALUATING THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS

CONTENT

Page

2.1. INTRODUCTION

SCHEME FOR THE EVALUATION OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS

The Ten-Year Health Plan for the Americas, drawn up by the III Special Meeting of Ministers of Health of the Americas held at Santiago, Chile, in October 1972, was the final outcome of hard work done by the various countries with a view to coordinating approaches and efforts for the improvement of health in the continent as a whole. This notion of comprehensiveness in regard to the implementation of the Plan is also evident in the content of the proposals it embodies, which include practically all the relevant aspects of health within a framework which indicates clearly the consensus arrived at by the countries in regard to the nature of their health systems, the problems affecting them, and ways and means of solving those problems.

The efforts made by the countries in drawing up the Ten-Year Plan have not stopped. Once the Plan had been formalized and incorporated into the policy of the Pan American Health Organization by a resolution of its Directing Council, the countries took steps to implement the recommendations contained in the Plan, beginning with the formulation or adjustment of their health policies. To this end, many countries found useful, and indeed have made use of, the "Guidelines for the Analysis and Incorporation of the Goals of the Ten-Year Health Plan for the Americas in National Health Policies", prepared by the Organization. A number of countries, in addition to drawing up and adjusting their policies, have adapted the Goals of the Ten-Year Plan as an expression of their own objectives and goals, and have gone on to formulate national strategies to achieve them; and in some cases they have actually programmed the strategies and action over the medium term, and implementation over the short term.

At its Meeting, the Directing Council of the Pan American Health Organization indicated its concern for the need to follow the progress of the Ten-Year Plan and the manner in which its proposals, objectives and goals were to be achieved in the course of time. This concern was expressed in Resolution XIII which requested the Director of PASB to convene a working group "with a view to designing an evaluation system that can be adapted to the unique conditions of the countries and still be flexible enough to give comparable results, which in turn will make possible a continent-wide evaluation of the achievements of the decade". To comply with this mandate, the Director convened such a working group, which met in Washington in June 1973 and produced a report to the Director indicating all the steps necessary for organizing a system and adopting a method of evaluating the Plan at the continental level, as well as making suggestions to the countries for the organization of their own national evaluation systems.

On the basis of the guidelines laid down by the Directing Council and the approach suggested by the Working Group on Evaluation, a methodological scheme was prepared, its general features being as follows:

1. The idea of the scheme is to evaluate the development of the Ten-Year Plan at the continental level. It does not propose to evaluate the national plans, this obviously being the responsibility of the individual countries. However, both the information which will be requested from countries on the basis of the forms drawn up, and many of the concepts, definitions and procedures to be used in the evaluation of the Plan at the continental level, will be useful in organizing national evaluation systems suitably adapted to meet the circumstances of each individual country.

2. In designing the scheme, account was taken of the recommendation of the Working Group on Evaluation of the Ten-Year Plan that it should "facilitate the evaluation by each country of the progress toward its goals and of implementation of its programs and strategies, with the comparability necessary to permit assessment of achievements at the continental level in the 1971-1980 period." When eventually the countries succeed in organizing their national evaluation systems on the basis of uniform concepts, definitions and methods, this will not merely facilitate evaluation at the continental level, it will also provide a feed-back for improving the national systems, at any rate in all areas of the Plan in which the concepts being evaluated apply also at the national level.

3. In accordance with the recommendation of the Working Group on Evaluation of the Ten-Year Health Plan, evaluation will be carried out at three points in time: initial evaluation (scheduled to be made in 1974), intermediate evaluation (1977) and final evaluation (1981). No attempt will be made in any of these phases to weigh the efforts made by each individual country to achieve the goals of the continental Plan; what will be weighed are the efforts made to fulfill those country goals for whose study and establishment the goals of the continental Plan have been used as a point of reference.

4. The purpose of the initial evaluation will be to determine the status or situation of each of the areas embraced by the Ten-Year Plan at the beginning of the period of operation and the degree of participation by countries in implementing it by applying the recommendations on the formulation and adjustment of their health policies and the definition of their own goals and strategies.

5. Intermediate evaluation will be based on the status or situation at that time, but it will also include an assessment of the extent to which the intermediate goals have been achieved and the likelihood of achievement of the final goals of the Ten-Year Plan.

6. The final evaluation will be a typical rounding-off operation, comprising an analysis and explanation of the extent to which it has been possible to achieve the objectives and to reach the goals proposed in the Plan, with a view to securing criteria for making recommendations concerning areas of action for new continental strategies in the forthcoming Ten-Year period.

7. The information to be provided by each of the countries before embarking on the initial evaluation is embodied in a set of forms drawn up for this purpose. Slight changes may be found necessary so that the same set can be used for subsequent evaluations. Any such changes will be introduced once experience has been gained with the initial evaluation.

8. The concepts contained in the forms - except in the case of certain quantitative goals of the Plan - are of a fairly general character reflected in qualitative indicators. The explanation for this is that it is not proposed to evaluate the results of the programs which the countries are carrying out, since this would call for much more specific indicators not relevant for the level of analysis intended.

The Ten-Year Plan covers virtually all the health action areas and hence it might be expected that the volume of information required for its evaluation would be very great. However, the volume has been reduced to the indispensable minimum. It is recommended that the persons who were responsible for the adaptation of the goals of the Ten-Year Plan to national policies should be the same as those detailed to record the information requested of each country. This will smooth out any difficulty likely to arise in the interpretation of the concepts and the scope of the forms. As the Working Group on Evaluation expressed it: The evaluation functions should be coordinated and advised by the planning units, making certain that all levels of the health system's structure participate".

For each of the areas included in the Ten-Year Plan, the indicators chosen are the simplest ones, those which best show, where this is pertinent, the final results achieved on the basis of the action taken, the operational results and in a certain measure the effort made. The definition of such indicators and the method of obtaining them can be found in the instructions accompanying the set of forms and designed to make the significance of the indicators and the way in which they are expressed. It is therefore recommended that the instructions should be read carefully before information is entered on the forms.

Whether the process of evaluating the Ten-Year Plan accomplished its purposes, and a steady improvement is achieved in the continental system, providing a feed-back to the national evaluation systems will depend in large measure on the effort made by the countries themselves

to ensure that uniform information of the highest possible quality is received by the Pan American Sanitary Bureau in good time. In this connection, the Working Group on Evaluation stated that "despite the shortcomings in the information systems of the national health sectors, they may be able to provide sufficient information to assess the implementation of national and continental goals and strategies in the terms in which the Ten-Year Plan expresses them. It is possible and advisable to seek the greatest development of those systems, so as to improve the processes of evaluation and control, and hence, the establishment and adjustment of policies and the processes of decision-making at all levels."

The scheme presented includes a set of forms designed to gather information from the countries regarding indicators used to establish the states of each area of the Ten-Year Health Plan at the moment of initiating its implementation, as well as the determination of goals adopted by the countries for the decade. This set of forms is acompanied by a guideline with instructions for its completion, so as to obtain uniformity of information received from the countries.

Once the feasibility for obtaining the information needed is examined, the method of evaluation will be completed with the description of procedures to be used for the analysis of the indicators at a continental level as well as with the preparation of the final scheme of the continental evaluation system, as recommended by the Working Group on Evaluation of the Ten-Year Health Plan for the Americas.

It is to be hoped that during the second half of 1974, the Pan American Sanitary Bureau will have in its possession information from all the countries so that it can proceed to consolidate it, to make the necessary analyses and to disseminate its findings and thus comply with the Directing Council's mandate.

2.2 COMPILATION OF INFORMATION

2.2.1 FORMS

O. LIFE EXPECTANCY AT BIRTH

Country:_____

Overall goal: life expectancy at birth

Year 1970:_____

Goal for 1980:_____

Specify the strategies designed to increase life expectancy

_____
_____
_____
_____
_____
_____
_____

I. SERVICES TO INDIVIDUALS

A. COVERAGE

1. MINIMUM SERVICES

1.1 National definition of "minimum services" ☐ Not defined ☐ Yes (specify)

1.2 Definition of "elementary care units" ☐ Not defined ☐ Yes (specify)

Potential capacity of the elementary care units _____ persons

1.3 National definition of "accessibility" ☐ Not defined ☐ Yes (specify)

	1971	1974	1977	1980
1.4 Local population in areas with less than 2000 inhabitants, estimated by the middle of each year				
1.5 Population actually or potentially accessible to services				
1.6 Number of elementary care units (existing or planned)				
1.7 Population served by the elementary care units				
1.8 Population served by each elementary unit (average)				
1.9 Accessible population served (%)				

A. COVERAGE (continued)

1. MINIMUM SERVICES (continuation)

1.10 Population in areas with more than 2000 inhabitants, which does not have coverage of any service. Year 1974:_____ Year 1980:_____

1.11 Elementary units planned and population of the localities to be served by them N°. of units_____ Population to be served_____

1.12 Population in areas with more than 2000 inhabitants only covered by the minimum services Year 1974:_____ Year 1980:_____

1.13 Number of elementary units serving this population Year 1974:_____ Year 1980:_____

Observations and comments _____

2. BASIC SERVICES

2.1 National definition of "basic services" ☐ Not defined ☐ Yes (specify)

2.2 Definition of "basic care units" ☐ Not defined ☐ Yes (specify)

Potential capacity of the basic care units:

A. COVERAGE (continued)

2. BASIC SERVICES (continuation)

	1971	1974	1977	1980
2.3 Areas from 2,000 to 20,000 inhabitants				
2.3.1 Total population of the locality				
2.3.2 N° of basic care units serving the population				
2.3.3 Percentage of the population served by the units				
2.3.4 N° of beds of all kinds in the locality				
2.3.5 N° of beds per 10,000 inhabitants				
2.3.6 N° of specialized beds per 100 beds of all kinds				
2.4 Areas from 20,000 to 100,000 inhabitants.				
2.4.1 Total population of the locality				
2.4.2 N° of basic care units serving the population				
2.4.3. Percentage of the population served by the units				
2.4.4 N° of beds of all kinds in the locality				
2.4.5 N° of beds per 10,000 inhabitants				
2.4.6 N° of specialized beds per 100 beds of all kinds				
2.5 Areas from 10,000 inhabitants and more				
2.5.1 Total population of the locality				
2.5.2 N° of basic care units serving the population				
2.5.3 Percentage of the population served by the units				
2.5.4 N° of beds of all kinds in the locality				
2.5.5 N° of beds per 10,000 inhab.				
2.5.6 N° of specialized beds per 100 beds of all kinds				

Observations and comments

B. COMMUNICABLE DISEASES

DISEASE (1)	INDICATOR (2)	REGIONAL GOAL (3)	STATUS IN 1971 (4)	PLANNED FOR 1974 (5)	PLANNED FOR 1977 (6)	GOAL FOR 1980 (7)
1. SMALLPOX It is considered a problem ☐ Yes ☐ No	1.1 Cases for 100,000 inhabitants (incidence)	(erradication)				
	1.2 Primary vaccinations per 1000 inhabitants					
2. MEASLES It is considered a problem ☐ Yes ☐ No	2.1 Deaths per 100,000 inhabitants	Not more than 1 x 100,000 inhabitants				
	2.2 Children under 5 years vaccinated (%)					
3. WHOOPING COUGH It is considered a problem. ☐ Yes ☐ No	3.1 Deaths per 100,000 inhabitants	Not more than 1 x 100,000				
	3.2 Children under 5 yrs. immunized with complete doses of vaccine (%)	80%				
	3.3 Concentration: doses of vaccines administered per child under 5 years (average)					
4. TETANUS It is considered a problem ☐ Yes ☐ No	4.1 Deaths per 100,000 inhabitants	Not more than 1 x 100,000				
	4.2 Children under 5 years immunized with complete doses of vaccine	80%				

B. COMMUNICABLE DISEASES (continued)

DISEASE (1)	INDICATOR (2)	REGIONAL GOAL (3)	STATUS IN 1971 (4)	PLANNED FOR 1974 (5)	PLANNED FOR 1977 (6)	GOAL FOR 1980 (7)
4. TETANUS (cont.)	4.3 Concentration: doses of vaccine administered per child under 5 years (average)					
5. DIPHTHERIA It is considered a problem ☐ Yes ☐ No	5.1 Cases per 100,000 inhabitants (incidence)	Not more than 1 x 100,000				
	5.2 Children under 5 years immunized with complete doses of vaccine	80%				
	5.3 Concentration: doses of vaccine administered per child under 5 years (average)					
6. POLIOMYELITIS It is considered a problem ☐ Yes ☐ No	6.1 Cases per 100,000 inhabitants (incidence)	Not more than 1 x 100,000				
	6.2 Children under 5 years immunized with the complete series of doses	80%				
	6.3 Concentration: doses of vaccine administered per child under 5 years (average)					
7. TUBERCULOSIS It is considered a problem ☐ Yes ☐ No	7.1 Deaths per 100,000 inhabitants	50-65% reduction				
	7.2 Incidence: new cases confirmed bacteriologically, per 100,000 inhabitants					
	7.3 Percentage of children under 5 years vaccinated with BCG	80%				
	7.4 Known cases undergoing treatment	100%				
	7.5 Known cases undergoing ambulatory treatment	90%				
	7.6 Bacilloscopies for the diagnosis of tuberculosis, per 100 first consultations					
	7.7 Tuberculosis hospital beds (% of total beds in the country)					

B. COMMUNICABLE DISEASES (continued)

DISEASE (1)	INDICATOR (2)	REGIONAL GOAL (3)	STATUS IN 1971 (4)	PLANNED FOR 1974 (5)	PLANNED FOR 1977 (6)	GOAL FOR 1980 (7)
8. ENTERIC INFECTIONS It is considered a problem ☐ Yes ☐ No	8.1 Deaths per 100,000 inhabitants	Reduction by 50%				
	8.2 Deaths due to diarrheal diseases per 100,000 children under 5 years					
	8.3 Cases of typhoid and paratyphoid per 100,000 inhabitants					
9. VENEREAL DISEASES It is considered a problem ☐ Yes ☐ No	9.1 Cases of syphilis per 100,000 inhabitants	Reduction				
	9.2 Cases of gonorrhea per 100,000 inhabitants	Reduction				
	9.3 Contacts investigated per 100 contacts declared					
10. YAWS It is considered a problem ☐ Yes ☐ No	Cases per 100,000 inhabitants (incidence)	Eradication				
11. PINTA It is considered a problem ☐ Yes ☐ No	Cases per 100,000 inhabitants (incidence)	Eradication				
12. LEPROSY It is considered a problem ☐ Yes ☐ No	12.1 New cases per 1000 inhabitants (incidence)	Diminution				
	12.2 Sick people per 100,000 inhabitants (incidence)	Diminution				
	12.3 Percentage of infected cases under treatment	100%				

B. COMMUNICABLE DISEASES (continued)

DISEASE (1)	INDICATOR (2)	REGIONAL GOAL (3)	STATUS IN 1971 (4)	PLANNED FOR 1974 (5)	PLANNED FOR 1977 (6)	GOAL FOR 1980 (7)
12. LEPROSY (cont.)	12.4 Percentage of contacts under surveillance and treatment	At least 75%				
13. LOUSE-BORNE TYPHUS It is considered a problem ☐ Yes ☐ No	New cases per 100,000 inhabitants (incidence)	Diminution				
14. SCHISTOSOMIASIS It is considered a problem ☐ Yes ☐ No	Sick people per 100,000 inhabitants (prevalence)	Diminution				
15. ONCHOCERCIASIS It is considered a problem ☐ Yes ☐ No	New cases per 100,000 inhabitants (incidence)	Diminution				
16. CHAGAS' DISEASE It is considered a problem ☐ Yes ☐ No	Sick people per 100,000 inhabitants (prevalence)	Diminution				

B. COMMUNICABLE DISEASES (continued)

DISEASE (1)	INDICATOR (2)	REGIONAL GOAL (3)	STATUS IN 1971 (4)	PLANNED FOR 1974 (5)	PLANNED FOR 1977 (6)	GOAL FOR 1980 (7)
17. JUNGLE YELLOW FEVER It is considered a problem ☐ Yes ☐ No	17.1 Cases per 100,000 inhabitants (incidence)	Reduction to a minimum				
	17.2 Existence of vaccination programs to the exposed population	Constant				
18. PLAGUE It is considered a problem ☐ Yes ☐ No	Cases per 100,000 inhabitants (incidence)	Reduction or elimination				
19. MALARIA It is considered a problem ☐ Yes ☐ No	19.1 Cases per 100,000 inhabitants (incidence)	Eradication				
	19.2 Percentage of the originally malarious area, that is in its maintenance phase	100%				
	19.3 Percentage of the originally malarious area, that is in its consolidation phase	0%				
	19.4 Percentage of the originally malarious area that is in its attack phase	0%				
	19.5 Percentage of the originally malarious area in which no action has been initiated	0%				

B. COMMUNICABLE DISEASES (continued)

DISEASE (1)	INDICATOR (2)	REGIONAL GOAL (3)	STATUS IN 1971 (4)	PLANNED FOR 1974 (5)	PLANNED FOR 1977 (6)	GOAL FOR 1980 (7)
20. AEDES AEGYPTI It is considered a problem ☐ Yes ☐ No	Phase of eradication program: (1) it is not considered; (2) under study; (3) under the attack phase; (4) under the consolidation phase; (5) under the maintenance phase.	Maintenance				

C. MATERNAL AND CHILD HEALTH AND FAMILY WELFARE

AREA (1)	INDICATOR (2)	REGIONAL GOAL (3)	STATUS IN 1971 (4)	PLANNED FOR 1974 (5)	PLANNED FOR 1977 (6)	GOAL FOR 1980 (7)
1. Mortality	1.1 Child mortality: deaths of children under one year per 1000 live births	Reduction by 40%				
	1.2 Mortality, children 1-4 years: deaths per 1000 children of 1-4 years	Reduction by 60%				
	1.3 Maternal mortality: maternal deaths per 1000 live births	Reduction by 40%				
2. Coverage of services	2.1 Percentage of pregnant women undergoing prenatal care	60%				
	2.2 Childbirths with hospital attendance (%)	60-90%				
	2.3 Puerpera under control	60%				
	2.4 Percentage of children of less than one year under supervision	90%				
	2.5 Percentage of children 1-4 years under supervision	50-70%				

C. MATERNAL AND CHILD HEALTH AND FAMILY WELFARE (continued)

3. Intersectoral policy of family, maternity and infant protection	☐ Defined	☐ Not well defined	☐ None	☐ Under consideration to be defined before 1980
4. Intersectoral coordination for carrying out specific programs	☐ Adequate	☐ Partial	☐ Poor	
5. Information and services on problems related to fertility and sterility (where not at variance with national policy)	☐ Provided	☐ Not provided	☐ Initiation or intensification planned	

D. NUTRITION

AREA	INDICATOR	REGIONAL GOAL	STATUS IN 1971	PLANNED FOR 1974	PLANNED FOR 1977	GOAL FOR 1980
1. Protein-calorie malnutrition	1.1 Percentage of children under 5 years suffering from grade II protein-calorie malnutrition	Reduction by 30%(range 10-50%)				
	1.2 Percentage of children under 5 years suffering from grade III protein-calorie malnutrition	Reduction by 85% (range 75-95%)				
2. Nutritional anemias in pregnant women	Percentage of pregnant women suffering from nutritional anemias	Reduction by 30%				
3. Endemic goiter	3.1 Prevalence of goiter (%)	Reduction to under 10%				
	3.2 Prevalence of cretinism	Elimination				
4. Hypovitaminosis A	Prevalence of hypovitaminosis A	Reduction by 30% (range 10-50%)				

D. NUTRITION (continued)					
5. National food and nutrition policy, biologically oriented		☐ Exists	☐ None	☐ Under consideration	☐ Proposed as a goal for 19__
6. Supplementary feeding programs. Coverage of the most vulnerable groups		☐ Yes, sufficient	☐ Yes, but insufficient	☐ No	☐ Proposed as a goal for 19__
7. Iodized salt and iodized oil programs		☐ Yes	☐ No	☐ Under consideration	☐ Proposed as a goal for 19__
8. Technical nutrition units	At central level	☐ Exist	☐ None	☐ Need strengthening	☐ Proposed as a goal for 19__
	At intermediate levels	☐ Exist at all interm. levels	☐ Some exist	☐ None	☐ Need expanding and strengthening ☐ Proposed as a goal for 19__

E. OTHER AREAS

1. CHRONIC DISEASES

Has the country established goals in this area? ☐ No ☐ Yes (specify)

_____
_____
_____
_____
_____

2. CANCER

Has the country established goals in this area? ☐ No ☐ Yes (specify)

_____
_____
_____
_____
_____

2.1 Programs for the detection of uterine cancer ☐ Exist ☐ None ☐ Planned

Annual cytological examinations per 100 women over 20 years of age: 1971: ____%

Envisaged for: 1974: ____% 1977: ____% 1980: ____%

2.2 Programs for the detection of breast cancer ☐ Exist ☐ None ☐ Planned

Examinations carried out each year per 100 women of 20 years or over: 1971: ____%

Envisaged for: 1974: ____% 1977: ____% 1980: ____%

2.3 Percentage of specialized and general hospitals with more than 200 beds which keep a register of tumors

In 1971: ____% Envisaged for 1974: ____% 1977: ____% 1980: ____%

3. MENTAL HEALTH

Has the country established goals in respect of these diseases? ☐ No ☐ Yes (specify)

_____
_____
_____
_____

E. OTHER AREAS (continued)

3. MENTAL HEALTH

3.1 Psychiatric beds per 1000 inhabitants: In 1971: _____ x 1000

Envisaged for 1974:____ x 1000 1977:____x 1000 1980:____x 1000

3.2 Percentage of psychiatric beds in general hospitals: In 1971:____%

Envisaged for 1974:____ % 1977:____% 1980:____%

4. ALCOHOLISM

Has the country established goals for the treatment of this problem? ☐ No ☐ Yes(specify)

_____
_____
_____
_____
_____

5. USE OF DEPENDENCY INDUCING DRUGS

Has the country established goals for the treatment of this problem? ☐ No ☐ Yes(specify)

_____
_____
_____
_____
_____

6. DENTAL HEALTH

Has the country established goals in this field? ☐ No ☐ Yes(specify)

_____
_____
_____
_____
_____

E. OTHER AREAS (continued)

6. DENTAL HEALTH(cont.)

6.1 Programs for the integration of dental health in the light of the various levels of care

☐ Defined ☐ Not well defined ☐ Planned for the period

6.2 Expansion of coverage, priority being given to the care of children

☐ None planned ☐ Planned

6.3 Fluoridation of water in towns of 50,000 inhabitants or more

Number of cities of 50,000 inhabitants or more: In 1971____ In 1980____

Number of cities with water fluoridation: In 1971_____ In 1980_____

II. ENVIRONMENTAL SANITATION PROGRAMS

1. NATIONAL POLICY OF THE ENVIRONMENTAL PRESERVATION AND IMPROVEMENT

1.1 Definition of the policy

☐ Defined ☐ In process of definition ☐ Not defined ☐ Probable year of definition: 19__

Participation by the health sector in the definition of the policy:

☐ Substantial ☐ Slight ☐ None

1.2 Formalization of the policy

☐ By declaration ☐ By law ☐ Not formalized

Organ(s) or institution(s) responsible for conducting the policy:

_____

_____

_____

1.3 Coverage of the policy

1.3.1 Geographic area

☐ Entire country ☐ Part of country ☐ Mixed ☐ Not defined

1.3.2 Institutional

☐ All institutions ☐ Some institutions ☐ Not defined

1.3.3 Program areas

☐ All areas ☐ Certain areas ☐ Not defined

_____

_____

_____

Observations and comments:

2. NATIONAL PLAN OF THE ENVIRONMENTAL PRESERVATION AND DEVELOPMENT

2.1 Formulation of strategies

☐ Formulated ☐ In process of formulation ☐ Not formulated ☐ Planned for year_____

2.2 Areas of coverage of strategies (specify)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

2.3 Programming of strategies

☐ Programmed ☐ Partially programmed or in process ☐ Not programmed ☐ Planned for year _____

2.4 Intersectoral coordination

Assignment of duties and responsibilities to sectors and institutions

☐ Yes ☐ Partial or in process ☐ Not programmed ☐ Planned for year_____

Is there formal mechanism of coordination? ☐ No ☐ Yes (specify)

_____
_____
_____
_____
_____

Observations and comments: (including comments on the functioning of the coordination mechanisms)

3. WATER SUPPLY AND SEWERAGE

3.1 Sub-system diagnosis

3.1.1 Legal and administrative frame

☐ Studied ☐ Being studied ☐ Study planned for 19__

3.1.2 Pre-investment and financing study

☐ Carried out ☐ Under way ☐ Planned for 19__

3.2 Definition of sectoral and institutional jurisdiction

3.2.1 Over the supply of drinking water to urban localities

☐ Defined ☐ Not defined ☐ In process of definition, planned for 19__

Responsibility of the health sector_____

_____

_____

_____

3.2.2 Over the provision of drinking water to rural areas

☐ Defined ☐ Not defined ☐ In process of definition, planned for 19__

Responsibility of the health sector_____

_____

_____

_____

3.2.3 Over the sewerage services for urban localities

☐ Defined ☐ Not defined ☐ In process of definition planned for 19__

Responsibility of the health sector_____

_____

_____

_____

3.2.4 Over the sewerage disposal services in rural areas

☐ Defined ☐ Not defined ☐ In process of definition planned for 19__

Responsibility of the health sector_____

_____

_____

_____

3. WATER SUPPLY AND SEWERAGE (continued)

3.3 Have goals been established in consonance with the goals of the Ten-Year Health Plan for the Americas?

☐ Yes ☐ Partial ☐ No

Did the sectors or institutions responsible for the services participate in establishing these goals?

☐ Yes ☐ Partial ☐ No

3.4 Estimates, forecasts and goals

	INDICATORS (1)	REGIONAL GOAL (2)	STATUS IN 71 (3)	PLANNED FOR 74 (4)	PLANNED FOR 77 (5)	NAT'L GOAL 1980
	Estimated population: Urban					
	Rural					
3.4.1	a) Urban population supplied with water by house connections (%)	80%				
	b) Urban population without drinking water services (%)	Reduction by 50%				
3.4.2	a) Rural population provided with drinking water (%)	50%				
	b) Rural population without water supply services (%)	Reduction by 30%				
3.4.3	a) Urban population with sewerage services (%)	70%				
	b) Urban population without sewerage services (%)	Reduction by 30%				
3.4.4	a) Rural population with sewage disposal services (%)	50%				
	b) Rural population without sewage disposal services (%)	Reduction by 30%				

3.5 Programming of investments

☐ Done ☐ Under way ☐ Not done ☐ Planned for 19__

3.6 Administrative-institutional improvement and development

☐ National level ☐ Regional level ☐ Institutional level ☐ Local level ☐ Planned for 19__

3. WATER SUPPLY AND SEWERAGE (continued)

3.7 Are the goals and programming contained in the overall and/or regional development plans?

☐ Yes ☐ Partial ☐ No

Observations and comments_____

4. COLLECTION AND DISPOSAL OF SOLID WASTE

4.1 Diagnosis of the subsystem

4.1.1 Legal and administrative framework

☐ Studied ☐ Being studied ☐ Study planned for 19__

4.1.2 Preinvestment and financing studies

☐ Carried out ☐ Under way ☐ Planned for 19__

4.2 Goals adopted by the country

Number of cities with 20,000 inhabitants and over: in 1971:_____

in 1980:_____

Number of cities with adequate systems of collection and disposal of solid waste

Number: in 1971:_____ in 1980:_____

Percentage: in 1971:_____% in 1980:_____%

Other goals adopted by the country_____

4.3 Have the goals and plans been incorporated in the Overall Department Plan and/or in regional development plans?

☐ Yes ☐ Partial ☐ No

Observations and comments_____

5. AIR, WATER AND SOIL POLLUTION

5.1 Programs for water pollution control (in operation or planned)

☐ In river basins ☐ In costal waters ☐ In other waters ☐ Do not exist

5.2 Programs for air pollution control

☐ In operation ☐ Planned ☐ Do not exist

Cities with air sampling stations (N°) 1971____ 1974____ 1977____ 1980____

Number of air sampling stations: 1971____ 1974____ 1977____ 1980____

Number of these stations that belong to the Pan American Network for the Measurement of Air Contamination 1971____ 1974____ 1977____ 1980____

5.3 Programs for soil pollution control

☐ In operation ☐ Planned ☐ Do not exist

Observations and comments_____

6. NOISE CONTROL

Is there any technical guidelines and regulations for noise abatement?

☐ Exist and adequate ☐ Incomplete ☐ Being developed ☐ Do not exist

7. REGIONAL DEVELOPMENT PROJECTS

7.1 Does the National Development Plan envisage regionalization?

☐ Yes ☐ No ☐ Number of regions:_____

7.2 Are there plans for regional development? ☐ Yes ☐ No

☐ In progress (Number____) ☐ Planned (Number_____)

7. REGIONAL DEVELOPMENT PROJECTS (continued)

7.3 Participation by the health sector in regional development plans (specify whether active, integrated, at the formulation stage, etc.)

In projects under way: _____

_____

_____

In projects planned: _____

_____

_____

Observations and comments: _____

_____

_____

_____

8. OCCUPATIONAL HEALTH AND INDUSTRIAL HYGIENE:

8.1 Is there any policy governing the protection of the labor force at risk?

☐ Yes ☐ No ☐ Being studied

8.2 Sectoral and institutional responsibility over the occupational health and industrial hygiene (specify)

_____

_____

_____

Are the mechanisms of coordination working out between these sectors?

☐ Yes ☐ Poor ☐ Non-existent

8.3 Programs of occupational health ☐ Exist ☐ Non existent ☐ Planned for year 19__

8.4 Evaluation of the occupational risks and of the exposed population

☐ Done ☐ Partial ☐ Not done ☐ Planned for the year 19__

8.5 Goals and previsions: Population exposed to risk

1971___% 1974___% 1977___% 1980___%

9. ANIMAL HEALTH AND VETERINARY PUBLIC HEALTH. Has the country proposed goals in this field?

☐ No ☐ Yes

9.1 Zoonoses control

DISEASE	INDICATOR	REGIONAL GOAL	STATUS IN 1971	PLANNED FOR 1974	PLANNED FOR 1977	GOAL FOR 1980
9.1.1 CANINE RABIES	a. Prevalence	Eradication in large towns				
	b. Percentage of dogs vaccinated	80%				
	c. Percentage of stray dogs	0%				
9.1.2 BRUCELLOSIS	Prevalence	Eradication in countries having 1% or less. Reduction to under 2% in other countries				
9.1.3 BOVINE TUBERCULOSIS	Prevalence	Eradication in countries having 1% or less. Reduction to under 1% in the rest				
9.1.4 HYDATIDOSIS	a. Prevalence	Reduction				
	b. Abattoirs under supervision	100%				
9.1.5 LEPTOSPIROSIS	Prevalence	Reduction				
9.1.6 EQUINE ENCEPHALITIS	a. Incidence	Reduction				
	b. Equines vaccinated (%)	80%				

9. ANIMAL HEALTH AND VETERINARY PUBLIC HEALTH (continued)

DISEASE	INDICATOR	REGIONAL GOAL	STATUS IN 1971	PLANNED FOR 1974	PLANNED FOR 1977	GOAL FOR 1980
9.1.7 FOOT-AND-MOUTH DISEASE	a. Incidence	Control and eradication				
	b. Phase of the program	Evaluation				
	c. % of disease-free areas	100%				

9.2 Veterinary public health unit in the Ministry of Health, with programs

☐ National level ☐ Regional level ☐ Local level ☐ Non existent ☐ Criation planned for 19___

9.3 Zoonoses control programs in the Ministry of Health ☐ Exist ☐ Non existent ☐ Planned for 19___

Funds destinated to these programs by the Ministry of Health(thousand of dollars)_____

Investment of other sectors for the zoonoses control (thousand of dollars)_____

9.4 Coordination between the ministries of health and agriculture in zoonoses control and foot-and-mouth disease programs

☐ Adequate ☐ Room for improvement ☐ None

9.5 Programs of epidemiological surveillance of zoonoses

☐ Adequate ☐ Room for improvement ☐ Inadequate ☐ Improvement planned

10. CONTROL OF THE USE OF PESTICIDES

Has the country proposed goals in this field? ☐ No ☐ Yes

Annual volume of produced or imported pesticides(ton.)_____

10.1 National legislation on control of the use of pesticides

☐ Adequate ☐ Inadequate ☐ Under consideration; planned for 19__

10.2 Laboratories for the analysis of pesticides

☐ Adequate ☐ Room for improvement ☐ Planned for 19___

10.3 Control programs

☐ Under way ☐ Non-existent ☐ Planned for 19__

11. QUALITY CONTROL OF FOOD

Have goals been proposed in this field? ☐ No ☐ Yes

11.1 National legislation governing quality control of food

☐ Adequate ☐ Inadequate ☐ Planned for 19__

11.2 Bromatological laboratory

☐ Adequate ☐ Inadequate ☐ Planned for 19__

11.3 Food control programs
Food products that are registered and controlled by year(N°.)_____

☐ Under way ☐ Non-existent ☐ Planned for 19__

12. QUALITY CONTROL OF DRUGS

Have goals been proposed? ☐ No ☐ Yes

12. QUALITY CONTROL OF DRUGS (continued)

12.1 Central body for drug control

☐ Exist ☐ Non-existent ☐ Planned for 19__

12.2 Legislation

☐ Adequate ☐ Insufficient ☐ Planned for 19__

12.3 Laboratories for drug analysis and evaluation

☐ Sufficient ☐ Insufficient ☐ Planned for 19__

12.4 Drug evaluation and registration system

☐ Adequate ☐ Inadequate ☐ Planned for 19__

13. ACCIDENT CONTROL

13.1 Deaths from accidents of all kinds, per 100,000 inhabitants

In 1971:_____per 100,000 Estimated for 1974:_____per 100,000

Forecast for 1977:_____ per 100,000 For 1980:_____per 100,000

13.2 Deaths from traffic accidents per 100,000 inhabitants

In 1971:____ per 100,000 Estimated for 1974:_____ per 100,000

Forecast for 1977:_____ per 100,000 For 1980:_____ per 100,000

13.3 National traffic accident control program

☐ Exist ☐ Non-existent ☐ Planned for 19__

13.4 Intersectoral coordination for accident prevention

☐ Adequate ☐ Insufficient ☐ Planned for 19__

III. COMPLEMENTARY SERVICES

A. NURSING

Have national goals been established in connection with nursing, standards for the quality of nursing care, coverage of services, etc.?

☐ No ☐ Yes (specify below)

_____

_____

_____

_____

_____

1. NURSING SYSTEM

1.1 Definition of the functions of nursing for different levels of care

☐ Defined ☐ Partially defined ☐ Not defined ☐ Planned for 19__

1.2 Definition of technical standards for different levels of care

☐ Defined ☐ Partially defined ☐ Not defined ☐ Planned for 19__

1.3 Definition of the type and numbers of nursing staff required

☐ Defined ☐ Partially defined ☐ Not defined ☐ Planned for 19__

1.4 Identification and design of the control information system

☐ Complete ☐ Partial ☐ None ☐ Planned for 19__

2. QUALITY OF NURSING CARE

2.1 Definition of standards of nursing care

2.1.1 In nursing institutions or units

☐ Defined ☐ Partially defined ☐ Not defined ☐ Planned for 19__

2.1.2 In community services

☐ Defined ☐ Partially defined ☐ Not defined ☐ Planned for 19__

A. NURSING (continued)

2. QUALITY OF NURSING CARE (cont.)

2.2 Administrative structuring of nursing services

2.2.1 In nursing institutions or units

☐ Structured ☐ Partially structured ☐ Not structured ☐ Planned for 19__

2.2.2 In community services

☐ Structured ☐ Partially structured ☐ Not structured ☐ Planned for 19__

3. COVERAGE OF NURSING SERVICES

3.1 Preparation of technical-administrative handbooks for the use of auxiliaries

☐ Already exist ☐ Incomplete or in progress ☐ Non-existent ☐ Planned for 19__

3.2 Percentage of auxiliaries who have had training(estimated or forecast)

1971:____% 1974:____% 1977:____% Goal for 1980:____%

3.3 Supervisory activities structured or in operation

☐ Yes ☐ Partial or deficient ☐ None ☐ Planned for 19__

B. LABORATORIES

Have national goals been established in relation to the organization, functioning and improvement of a system of laboratories and blood banks?

☐ No ☐ Yes (specify below)

_____

_____

_____

_____

_____

1. Definition of types of examinations to be undertaken by the different levels of health care

☐ Done ☐ Not done ☐ Planned for 19__

B. LABORATORIES (continued)

2. Elaboration of standards for equipment, personnel and operations for laboratories according to levels of health care

☐ Done ☐ Not done ☐ Planned for 19__

3. Operational rules for regional and national consultation and reference networks

☐ Exist ☐ Do not exist ☐ Planned for 19__

4. Units with a doctor on call permanently which have laboratory services (%)

1971:_____% 1974_____% 1977:_____% Goal for 1980:_____%

5. Organization of networks of blood banks, by levels of care, with central reference banks and in keeping with regionalization of services

☐ In operation ☐ In partial operation ☐ None ☐ Planned for 19__

6. Development of facilities for the preparation and control of biologicals for human and animal use

☐ Plans in operation ☐ No plans ☐ Planned for the year 19__

Is it planned to supply biologicals to other countries? ☐ Yes ☐ No

C. REHABILITATION

Have goals for the decade been set in regard to medical rehabilitation?

☐ No ☐ Yes (specify below)

_____

_____

_____

_____

1. Inclusion of basic rehabilitation services in medical care programs

☐ Included ☐ To a slight extent ☐ None ☐ Expansion planned

D. HEALTH EDUCATION

Have goals been established for the development of health education services?

☐ No ☐ Yes (specify below)

_____

_____

_____

_____

_____

E. EPIDEMIOLOGICAL SURVEILLANCE

Have goals been fixed for the organization, operation and development of epidemiological surveillance systems?

☐ No ☐ Yes (specify below)

_____

_____

_____

_____

_____

1. NATIONAL SYSTEM OF SURVEILLANCE

1.1 Surveillance unit at central level, within the administrative structure

☐ Exist ☐ Being organized ☐ Do not exist ☐ Planned for 19__

1.2 Regional units

☐ In all regions ☐ In some regions ☐ None ☐ Planned for 19__

1.3 Technical standards of functioning

☐ Adequate ☐ Deficient ☐ Being revised ☐ Planned for 19__

1.4 Information system

☐ Eficient ☐ Deficient ☐ Being revised ☐ Planned for 19__

E. EPIDEMIOLOGICAL SURVEILLANCE(continued)

1.5 Geographical coverage

☐ All the country ☐ Part of the country

1.6 Morbidity coverage. Specify only those with surveillance programs in operation.

1.6.1 Communicable diseases_____

1.6.2 Non communicable diseases_____

2. HUMAN RESOURCES

☐ Sufficient ☐ Insufficient ☐ Being trained

3. PARTICIPATION OF THE COMMUNITY

☐ Effective ☐ Poor ☐ Do not exist

IV. PLANNING AND DEVELOPMENT OF THE INFRASTRUCTURE

1. HEALTH SYSTEM

Have goals been established in regard to the structure and functioning of the health service system?

☐ Yes ☐ No

1.1 Definition of the system

☐ Defined ☐ In process of definition ☐ Not defined ☐ Probable year of definition 19__

1.2 Components of the system

☐ Entire sector ☐ Entire public subsector ☐ Part of the public subsector ☐ Not defined

1.3 Type of system

☐ Single ☐ Coordinated ☐ Not defined

1.4 Legal formalization

☐ Formalized ☐ In process of formalization ☐ Not formalized ☐ Probable year of formalization 19__

Observations and comments:

2. HEALTH POLICY

Have goals been established in respect of the formulation, formalization, implementation, etc. of the health policy?

☐ Yes ☐ No

2.1 Definition of the policy

☐ Defined ☐ In process of definition ☐ Not defined ☐ Probable year of definition 19__

2.2 Formalization of the policy

Formalized: ☐ Declaratory ☐ By law

In process of formalization: ☐ Declaratory ☐ By law

☐ Not formalized ☐ Probable year of formalization 19__ ☐ No goals

2.3 Priorities

Does the policy establish priorities? ☐ Yes ☐ No ☐ Policy not defined

2.4 Period covered by the policy: From 19___ to 19__

2.5 Coverage of the policy

2.5.1 Political and administrative

☐ Entire country ☐ Part of the country ☐ Mixed ☐ Not defined

2.5.2 Institutional

☐ All institutions in the sector ☐ Some institutions

2.5.3 Program coverage

☐ All program areas ☐ Some program areas

2. HEALTH POLICY (continued)

2.5 Coverage of the policy (cont.)

2.5.4 Population

☐ No priority groups ☐ Priority groups

Observations and comments:

3. STRATEGIES

Have goals been established in respect of the formulation and implementation of strategies:

☐ Yes ☐ No

3.1 Formulation of strategies

☐ Formulated ☐ In process of formulation ☐ Not formulated ☐ Probable year of formulation 19__

3.2 Coverage of strategies

☐ All policy areas ☐ Some policy areas

3.3 Programming of strategies

☐ Programmed ☐ Partial or under way ☐ Not programmed ☐ Probable year of programming 19__

3.4 Components of strategy programming

3.4.1 Analysis of feasibility

Already made: ☐ For all strategies ☐ For some strategies ☐ None

Planned: ☐ For all strategies ☐ For some strategies ☐ None

3. STRATEGIES (continued)

3.4 (cont.)

3.4.2 Analysis of internal consistency

Done: ☐ Yes ☐ No Planned: ☐ Yes ☐ No

3.4.3 Analysis of consistency with the policy

Done: ☐ Yes ☐ No Planned: ☐ Yes ☐ No

3.4.4 Adjustment of strategies

Done: ☐ Yes ☐ No Planned: ☐ Yes ☐ No

3.4.5 Consolidation of strategies and initiation of programs

Done: ☐ Yes ☐ No Planned: ☐ Yes ☐ No

3.4.6 Formulation of technical and administrative rules

Done: ☐ Yes ☐ No Planned: ☐ Yes ☐ No

3.4.7 Adjustment with executive levels

Done: ☐ Yes ☐ No Planned: ☐ Yes ☐ No

3.5 Content of programming of strategies

3.5.1 Programming of services to persons

Done: ☐ Yes ☐ No Planned: ☐ Yes ☐ No Year 19__

3.5.2 Programming of environmental services

Done: ☐ Yes ☐ No Planned: ☐ Yes ☐ No Year 19__

3.5.3 Programming of community participation

Done: ☐ Yes ☐ No Planned: ☐ Yes ☐ No Year 19__

3. STRATEGIES (continued)

3.5 (cont.)

3.5.4 Programming of investments

Done: ☐ Yes ☐ No Planned: ☐ Yes ☐ No Year 19__

3.5.5 Programming of human resources

Done: ☐ Yes ☐ No Planned: ☐ Yes ☐ No Year 19__

3.5.6 Programming of administrative adequation

Done: ☐ Yes ☐ No Planned: ☐ Yes ☐ No Year 19__

3.5.7 Programming of financing

Done: ☐ Yes ☐ No Planned: ☐ Yes ☐ No Year 19__

3.5.8 Programming of the information-evaluation-control system

Done: ☐ Yes ☐ No Planned: ☐ Yes ☐ No Year 19__

3.5.9 Research programming

Done: ☐ Yes ☐ No Planned: ☐ Yes ☐ No Year 19__

3.5.10 Programming of other areas (specify)

3.6 Short Term Programming

Done: ☐ Yes ☐ No Planned: ☐ Yes ☐ No Year 19__

Participation at local levels: ☐ Yes ☐ No ☐ Partial

4. ADMINISTRATION

Have goals been set for adequating the administration and the functioning of the administrative services?

☐ Yes ☐ No

4.1 Administrative reform

Is there a process of administrative reform of the public sector?

☐ Yes ☐ No ☐ Planned

Does the health sector participate in this process?

☐ Yes ☐ No

Is there a process of administrative reform of the health sector?

☐ Yes ☐ No ☐ Planned, to begin in 19__

4.2 Administrative macro-adequation

Have a sectoral diagnosis and an institutional analysis been made?

☐ Yes ☐ No ☐ Planned to take effect in 19__

Administrative macro-adequation

☐ Yes ☐ No ☐ Under way ☐ Planned, to begin in 19__

4.3 Adequation of the sectoral administration

4.3.1 Intra-institutional restructuring of the Ministry(Secretariat)

☐ Yes ☐ No ☐ Under way ☐ Planned, to begin in 19__

Restructuring of other major institutions of the sector

☐ Yes ☐ No ☐ Under way ☐ Planned, to begin in 19__

4.3.2 Organization of administrative services by operational levels (central, regional, local, etc.)

☐ Yes ☐ No ☐ Under way ☐ Planned, to begin in 19__

4. ADMINISTRATION (continued)

4.3 (cont.)

4.3.3 Regulations

(a) Organic institutional regulations (study and adaptation)

☐ Yes ☐ No ☐ Under way ☐ Planned, to begin in 19__

(b) Other regulations for internal management (study and adaptation)

☐ Yes ☐ No ☐ Under way ☐ Planned, to begin in 19__

4.3.4 Restructuring and adequation of administrative services

(a) Personnel

☐ Yes ☐ No ☐ Under way ☐ Planned, to begin in 19__

(b) Budget

☐ Yes ☐ No ☐ Under way ☐ Planned, to begin in 19__

(c) Accounts

☐ Yes ☐ No ☐ Under way ☐ Planned, to begin in 19__

(d) Supply

☐ Yes ☐ No ☐ Under way ☐ Planned, to begin in 19__

(e) Communications

☐ Yes ☐ No ☐ Under way ☐ Planned, to begin in 19__

(f) Transport

☐ Yes ☐ No ☐ Under way ☐ Planned, to begin in 19__

(g) General services

☐ Yes ☐ No ☐ Under way ☐ Planned, to begin in 19__

4. ADMINISTRATION (continued)
4.3 (cont.) 4.3.5 Preparation and issue of administrative procedure manuals for use at all levels of administration ☐ Yes ☐ No ☐ Under way ☐ Planned for the year 19__
Observations and comments:

5. INFORMATION SYSTEMS

Have goals been established in connection with the organization and functioning of information systems?

☐ Yes ☐ No

5.1 Organization of an information system

☐ Organized ☐ Under way ☐ Planned for 19__ ☐ No plans

5.2 Coverage of the system

Political-administrative	☐ National	☐ Partial	☐ Mixed
Sectoral	☐ Entire sector	☐ Some institutions	☐ Mixed
Program areas	☐ All programs	☐ Some programs	

5.3 Coordination of information systems

Intersectoral	☐ Yes	☐ Partial	☐ No
Interinstitutional	☐ Yes	☐ Partial	☐ No
Between program areas	☐ Yes	☐ Partial	☐ No

5.4 Establishment of information units

☐ At sectoral level ☐ At institutional level (which?)_____ ☐ At program level

5.5 Areas of information covered by the system

	In operation	In process of organization	Goal of the plan	None
5.5.1 Human resources				
(a) Availability	☐	☐	☐	☐
(b) Training	☐	☐	☐	☐
(c) Utilization	☐	☐	☐	☐

5. INFORMATION SYSTEMS (continued)

5.5 (cont.)

	In operation	In process of organization	Goal of the plan	None
5.5.2 Material resources				
(a) Availability	☐	☐	☐	☐
(b) Training	☐	☐	☐	☐
(c) Utilization	☐	☐	☐	☐
5.5.3 Financial resources				
(a) Availability	☐	☐	☐	☐
(b) Utilization	☐	☐	☐	☐
5.5.4 Production of Services	☐	☐	☐	☐
5.5.5 Epidemiological surveillance	☐	☐	☐	☐
5.5.6 Environmental sanitation	☐	☐	☐	☐
5.5.7 Programming and administrative control	☐	☐	☐	☐
5.5.8 Evaluation and control of specific programs (enumerate)				
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

5. INFORMATION SYSTEMS (continued)

5.5 (cont.)

5.5.9 Other areas (specify)	In operation	In process of organization	Goal of the plan	None
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

5.6 Is there a system of regular phased reports for the activities and control of the care units?

☐ Yes ☐ No ☐ Planned for 19__

5.7 Does the information system use electronic computation for data processing?

☐ Yes ☐ No ☐ Planned for 19__

Observations and comments:

6. HEALTH STATISTICS

6.1 Is there a system for registering, collecting, processing, analyzing and publishing the following statistics?

Type	Yes	No	Planned (year)
a) Vital and population	☐	☐	☐ 19__
b) Communicable diseases	☐	☐	☐ 19__
c) Health resources			
Human	☐	☐	☐ 19__
Establishments	☐	☐	☐ 19__
d) Services and care			
Hospitals	☐	☐	☐ 19__
Other establishments	☐	☐	☐ 19__
e) Environmental health	☐	☐	☐ 19__
f) Health investments (financial)	☐	☐	☐ 19__
g) Administrative	☐	☐	☐ 19__
h) Other	☐	☐	☐ 19__

6.2 Is there staff trained to collect, process and analyze the following statistics?

Type	Number		Training planned for:
	Satis-factory	Unsatis-factory	
a) Vital and population			
Professional	☐	☐	19__
Technical	☐	☐	19__
Auxiliary	☐	☐	19__

6. HEALTH STATISTICS (continued)

6.2 (cont.)

	Number Satisfactory	Number Unsatisfactory	Training planned for:
b) Communicable diseases			
Professional	☐	☐	19__
Technical	☐	☐	19__
Auxiliary	☐	☐	19__
c) Health resources			
Human			
Professional	☐	☐	19__
Technical	☐	☐	19__
Establishments			
Professional	☐	☐	19__
Technical	☐	☐	19__
Auxiliary	☐	☐	19__
d) Services and care			
Hospitals			
Professional	☐	☐	19__
Technical	☐	☐	19__
Auxiliary	☐	☐	19__
Other establishments			
Professional	☐	☐	19__
Technical	☐	☐	19__
Auxiliary	☐	☐	19__

6. HEALTH STATISTICS (continued)

6.2 (cont.)

	Number Satisfactory	Number Unsatisfactory	Training planned for:
e) Environmental health			
Professional	☐	☐	19__
Technical	☐	☐	19__
Auxiliary	☐	☐	19__
f) Health investment			
Professional	☐	☐	19__
Technical	☐	☐	19__
Auxiliary	☐	☐	19__
g) Administrative			
Professional	☐	☐	19__
Technical	☐	☐	19__
Auxiliary	☐	☐	19__
h) Other			
Professional	☐	☐	19__
Technical	☐	☐	19__
Auxiliary	☐	☐	19__

6.3 Availability of data

Type	Yes	No	Planned
a) Vital and population	☐ 19__	☐	☐ 19__
b) Communicable diseases	☐ 19__	☐	☐ 19__
c) Health resources	☐ 19__	☐	☐ 19__

6. HEALTH STATISTICS (continued)

6.3 (cont.)

Type	Yes	No	Planned
d) Services and care	☐ 19__	☐	☐ 19__
e) Environmental health	☐ 19__	☐	☐ 19__
f) Health investments	☐ 19__	☐	☐ 19__
g) Administrative	☐ 19__	☐	☐ 19__
h) Other	☐ 19__	☐	☐ 19__

6.4 Coverage of the system	Percentage 1971	Estimated 1980
a) Civil registers		
Births	____	____
Deaths	____	____
b) Communicable diseases	____	____
c) Health resources		
Personnel	____	____
Establishments	____	____
d) Morbidity (hospitalization)	____	____
e) Morbidity (outpatient treatment)	____	____
f) Services and care		
Hospitals	____	____
Other establishments	____	____
g) Environmental health	____	____
h) Other	____	____

6. HEALTH STATISTICS (continued)

6.5 Utilization at national level

	Good	Fair	Poor	Improved use planned
a) Civil registers				
Births	☐	☐	☐	☐
Deaths	☐	☐	☐	☐
b) Communicable diseases	☐	☐	☐	☐
c) Health resources				
Human	☐	☐	☐	☐
Establishments	☐	☐	☐	☐
d) Morbidity (hospitalization)	☐	☐	☐	☐
e) Morbidity (outpatient treatment)	☐	☐	☐	☐
f) Services and care				
Hospitals	☐	☐	☐	☐
Other establishments	☐	☐	☐	☐
g) Environmental health	☐	☐	☐	☐
h) Other	☐	☐	☐	☐

6.6 Coordination of information produced by public and private institutions

	Good	Fair	Poor
a) Vital statistics	☐	☐	☐
b) Communicable diseases	☐	☐	☐
c) Health resources	☐	☐	☐
d) Services and care	☐	☐	☐
e) Environmental health	☐	☐	☐

7. DEVELOPMENT OF HUMAN RESOURCES

Have goals been established for developing human resources under the Ten-Year Health Plan? ☐ Yes ☐ No

7.1 Manpower planning process

7.1.1 Integration with the health planning process

☐ Yes ☐ Partial ☐ No Goal of the Ten-Year Plan ☐ Yes ☐ No

7.1.2 Manpower development plan

☐ In operation ☐ Formulated ☐ No plan Goal of the Ten-Year Plan ☐ Yes ☐ No

7.1.3 Coordination with the national manpower development plan

Is there a national plan? ☐ Yes ☐ No

Is there coordination? ☐ Yes ☐ Partial ☐ No

7.1.4 Participation by the universities in health manpower planning

☐ Yes ☐ Insufficient ☐ No Goal of the Ten-Year Plan ☐ Yes ☐ No

7.2 Manpower training program

7.2.1 Updated inventory of human resources (type, numbers, distribution, and employment)

☐ Exists ☐ Does not exist ☐ Under way ☐ Planned for 19__

7.2.2. Projection of manpower requirements for the expansion of the objectives of the health plan

☐ Made ☐ Not made ☐ Under way ☐ Planned for 19__

7.2.3 Design and utilization of personnel modules to miximize the efficiency of services

Design ☐ Yes ☐ No ☐ Planned for 19__

Utilization: ☐ Yes ☐ No ☐ Planned for 19__

7.2.4 Creation of new categories of personnel

☐ Yes ☐ No ☐ Under Consideration ☐ Planned for 19__

7.2.5 Determination of the productive capacity of personnel training institutions

☐ Done ☐ Not done ☐ Under consideration ☐ Planned for 19__

7. DEVELOPMENT OF HUMAN RESOURCES (continued)

7.2 (cont.)

7.2.6 Determination of the capacity of the country's health services to absorb manpower

☐ Done ☐ Not done ☐ Under consideration ☐ Planned for 19__

7.3 Determination of personnel training goals

Type of Resources	Indicator	Goal Regional Plan	Country Status in 1971	Country Planned in 1974	Country Goal for 1980
Professionals					
Medicine	Physicians per 10,000 inhab.	8			
Dentistry	Dentists per 10,000 inhab.	2			
Nursing	Nurses per 10,000 inhab.	4.5			
Veterinary	Number to be trained	18,000			
Sanitary Engineering	" " " "	3,200			
Statistics	" " " "	300			
Medical Register	" " " "	100			
Planning	" " " "	3,000			
Administration	" " " "	3,000			
Information	" " " "	1,000			
Epidemiology	-				
Psyquiatry	-				
Psyquiatric Nursing	-				
Occupational Therapy	-				
Nutrition	-				
Laboratories	-				
Health Education	-				
Radiology	-				
Others (specify)					
_____					
_____					
_____					
_____					
_____					

7. DEVELOPMENT OF HUMAN RESOURCES (continued)

7.3 (cont.)

Type of Resources	Indicator	Goal Regional Plan	Country		
			Status in 1971	Planned for 1974	Goal for 1980
Intermediate level					
Nursing	-				
Sanitation	-				
Medical registers	Number to be trained	4,000			
Statistics	" " " "	250			
Laboratories	-				
Radiology	-				
Other (specify)					
_____					
_____					
_____					
_____					
_____					
Auxiliares					
Nursing	Auxiliares per 10,000 inhab.	14.5			
Animal health	Number to be trained	30,000			
Statistics	" " " "	40,000			
Laboratories	-				
Radiology	-				
Dentistry	Auxiliares per 10,000 inhab.	2.2			
Other (specify)					
_____					
_____					
_____					
_____					
_____					

8. DEVELOPMENT OF PHYSICAL RESOURCES

Have goals been established for the installation, maintenance, replacement, conversion, etc. of physical resources?

☐ No ☐ Yes (specify)

_____
_____
_____
_____
_____
_____
_____

8.1 Inventory of premises and installations for public health care

☐ None ☐ Not up-to-date ☐ Up dated ☐ Planned for 19__

8.2 Installed capacity development plan

☐ Exists ☐ Does not exist ☐ Planned for 19__

8.2.1 Investment plan

☐ Exists ☐ Does not exist ☐ Series of isolated plans ☐ Planned for the year 19__

8.2.2 Outcome of services plan

☐ Yes ☐ Partially ☐ No ☐ Planned for 19__

8.2.3 Content

☐ New constructions ☐ Rehabilitation of installed capacity ☐ Expansion and conversion

8.3 Installation of premises for the functioning of elementary units

Number of premises functioning in 1971: _____ (100%)

1974: _____ (%) 1977: _____ (%) 1980: _____(%)

8. DEVELOPMENT OF PHYSICAL RESOURCES (continued)

8.4 Installation of beds

8.4.1 General hospital beds. Number available in 1971 _____ (100%)

1974 _____ (%) 1977: _____ (%) 1980: _____ (%)

8.4.2 Specialized hospital beds.

Number available in 1971: _____ (100%) 1974: _____ (%)

1977: _____ (%) 1980: _____ (%)

8.5 Beds for chronic cases used for acute cases

Number of beds for chronic cases in 1971: _____ (100%)

Used for acute cases, up to: 1974: _____ (%)

1977: _____ (%)

1980: _____ (%)

8.6 Maintenance systems

Specialist maintenance staff per 100 beds in hospitals with more than 100 beds

1971 _____ 1974 _____ 1977 _____ 1980 _____

9. FINANCING

9.1 Programs for the analysis of financing and expenditure

☐ In operation ☐ Non-existent ☐ Planned for 19__

9.2 Analysis of production functions

☐ For the sector ☐ For certain institutions ☐ For certain establishments ☐ None

☐ Planned for 19__ (specify) _____

_____

_____

9.3 Budget of current public sector expenditure assigned to the health sector (%)

In 1971: _____% In 1974: _____% Planned for 1977: _____% 1980: _____%

9.4 Community self-help programs

☐ Exist ☐ Do not exist ☐ Are planned for 19__

10. LEGISLATION

Have bills for legislation been drawn up as goals for the Health Plan?

☐ Yes ☐ No

10.1 Compilation and analysis of existing legislation

☐ Yes ☐ No ☐ Under way ☐ Planned for the year 19__

10.2 Has legislation been introduced?

☐ Yes ☐ No ☐ Planned for the year 19__

Observations and comments:

11. RESEARCH

Have proposals been put forward which could be regarded as goals for the Ten-Year Plan in the research area?

☐ Yes ☐ No

11.1 Definition of a research policy for the health sector, in keeping with the health policy and with the national policy for scientific and technological development (if any)

☐ Exists ☐ Does not exist ☐ Under consideration ☐ Goal of the Plan

11.2 Inventory of development research (basic, clinical, epidemiological, administrative and methodological)

☐ Exists ☐ Does not exist ☐ Goal of the Plan

11.3 Design and development of research programs in the defined priority areas of the health policy

☐ Being developed ☐ Non-existent ☐ Goals of the Plan

11.4 Coordination between the various research units and the health service system

☐ Exists ☐ Does not exist ☐ Goals of the Plan

2.2.2 GUIDELINES FOR THE COLLECTION OF INFORMATION

0. LIFE EXPECTANCY AT BIRTH: Overall goals

Life expectancy at birth is the average number of years a newborn child is expected to live, assuming that the population to which the child belongs maintains during the course of his/her life the age-specific mortality situation prevailing at the time of birth. Although expressed in terms of years of life, life expectancy is the resultant of the incidence of mortality in the various age groups within the population. It is calculated on the basis of the age-specific mortality rates. Which like other population variables are closely bound up with virtually all the components of social life within the health ecosystem. Hence life expectancy at birth is regarded as a useful general indicator of development and in particular of the health status of the population, enabling the health sector to concentrate its efforts on reducing the risk of mortality at certain ages from certain diseases.

The strategies for reducing child mortality and malnutrition and the incidence of infectious and parasitic diseases mainly affecting certain age groups can have an appreciable influence in increasing life expectancy at birth.

The regional goal for the ten-year period is to achieve an increase of five years in countries where at the beginning of the period life expectancy was under 65 years and an increase of two years in countries where it was between 65 and 69 years.

Life expectancy at birth should be calculated for 1970, and the figure laid down as a goal for 1980 should be indicated also. In addition, the strategies proposed for achieving the increase should be briefly outlined.

I. SERVICES TO INDIVIDUALS

A. COVERAGE

Coverage of any service means the number of persons who receive or potentially may receive the service if they need it, either in the establishment in which the care unit providing the service usually functions, i.e. by persons going to the unit, or at home or in any other place, i.e. by the unit going to the persons.

The estimation of the coverage of a service may prove very complicated especially if the aim is to obtain very precise figures. Since there is no need for great precision, the Ten-Year Plan uses indirect methods of estimation through the so-called "potential care capacity" which is the number of persons which a care unit can cover in normal circumstances, providing them with the services fixed by existing standards.

One of the most important targets of the Ten-Year Plan is the extension of the coverage of all types of health services. With a view to dealing with this problem in a systematic manner and on the basis of the situation observed in the countries of the region, this target has been broken down into three broad categories of services: minimum, basic, and specialized. These categories reflect a certain growing scale of complexity both of the activities which constitute the service and of the human and technological resources employed to provide it. They also reflect the increasing size of the localities served, following a concept of regionalization of care which facilitates patient referral, supervision and so on.

Many countries have systems organized in this way and also classify their establishments according to definite levels of complexity. Even though the names "minimum", "basic" and "specialized" may not actually be used, the concepts are easily translatable so as to conform to the definitions of the Ten-Year Plan.

Minimum services of integral health care are provided by ELEMENTARY UNITS which are able to provide: out-patient care in cases of emergency to mothers and children under five, including food, nutrition, family and community education for hygienic living; vaccinations; basic environmental sanitation services; primary registration of statistical data; and the referral of patients to more complex units. Such elementary units are manned by auxiliary personnel trained and supervised by higher-level staff. Their maximum capacity is 5,000 inhabitants.

At the moment, the Americas region coverage with minimum services of this kind is close to 90% of the population living in localities between 2,000 and 20,000 inhabitants and less than 20% in localities with under 2,000 inhabitants. It is estimated that localities of more than 20,000 inhabitants are already covered by these services

or other more advanced services. The Ten-Year Health Plan proposes as a regional target to extend the coverage with minimum services to 100% of the population living in localities of between 2,000 and 20,000 inhabitants and to 100% of the accessible population living in localities of less than 2,000 inhabitants.

Basic services are provided by care units which are more complex than the elementary units. They comprise:

- For localities between 2,000 and 20,000 inhabitants, general care of the sick, mostly out-patients; school health; research, diagnosis, treatment and control of communicable diseases; general epidemiological vigilance; laboratory services; community nursing services; registration of statistical information; supervision of smaller units; and referral of patients to more specialized units. The environmental sanitation activities are more complex than in the elementary units. Health units carrying out basic activities have greater installed capacity and more advanced human resources. They have transport facilities and a number of hospital beds for general purposes. They have a capacity for dealing with 10-15,000 inhabitants.

- For localities between 20,000 and 100,000 inhabitants, basic services are the same as those for localities between 2,000 and 20,000 with the added feature of a greater diversification of hospital beds and a greater complexity of health units; they have more extensive facilities for providing environmental sanitation services (water, sewage, food inspection, occupational health, etc.) The localities in which these basic units are situated can also perform administrative health functions as major towns of health areas or regions. The potential coverage of each basic unit of this kind is 15-20,000 persons.

- For localities of more than 100,000 inhabitants the health units fulfill the same functions as those already mentioned, but they also provide additional specialized services and a greater differentiation between out-patient and in-hospital treatment. These units have installations similar to those at the intermediate level (covering 15-20,000 inhabitants) but they also have more advanced supplementary and final services so as to fulfill the functions assigned to them by the central administration. These comprise: central diagnostic laboratories; production and control of biologicals and drugs; training centers for health personnel; specialized centers or institutes for investigation and referral, etc.

It is estimated that at the moment there are 16 countries in the region which have a health center for each 10,000 persons serving localities between 2,000 and 20,000 inhabitants. On the other hand, in another

ten countries there are only 2,200 health centers serving these numbers and they would need 1,000 more centers to attain the coverage of 10,000 persons per center. In localities of more than 20,000 inhabitants it is estimated that at present a potential coverage of 100% has been attained by means of existing health units. It remains merely to achieve a greater rationalization in the siting of these units and in their productivity, and also to extend the coverage of specialized services, according to the needs of each country. For this reason, the regional target is to cover 100% of the population living in localities of between 2,000 and 20,000 inhabitants.

Specialized services are in practice incorporated in the basic care units and they provide a greater variety of treatment according to the type of specific pathology they serve or the type of support activity they perform in the final-care stage. As may be seen from the description of basic services, as the population to be served increases in size, the basic services become more complex and can provide more varied and more specialized treatment.

1. MINIMUM SERVICES

The target of the Ten-Year Plan is to attain a coverage with minimum services of 100% of the accessible population living in localities of less than 2,000 inhabitants. The natural indicator should be the percentage of this population covered by minimum services or a quotient whose calculation requires the determination of (a) the numerator of the population covered and (b) the denominator as the accessible population. The numerator may be obtained by adding the populations of the localities of less than 2,000 inhabitants which have elementary health units, or, if the potential care capacity of the elementary units is known, by the number of elementary units. For the denominator, on the other hand, we need a definition of "accessibility". This may vary considerable from country to country, although general agreement should be possible on the criterion of physical accessibility to a given service. For example, we can take the material possibility, within a given period of time*, of persons needing care gaining access to the unit providing it or for the staff of the unit to bring the care to their home.

This criterion is very useful when it applies to already established units but it cannot be used easily in the case of non-existent units. The installation of a new unit, whatever its location in a rural area, becomes immediately accessible to the population it is designed

* For example, two hours by the normal means of transport in the area.

to serve, a population which, according to the criterion mentioned, was not accessible previously. These considerations make it desirable to distinguish between (a) the population served and automatically accessible; (b) the population not served and potentially accessible through the installation of care units, provided they conform to standards of efficiency previously laid down for such units (for example, whether the minimum population to be covered is 1,000, 500 or 800 persons); and (c) the inaccessible population (considered as such by a decision of the policy-making health body concerned) to which the services cannot be provided without an effort not compatible with the criteria of efficiency or feasibility established.

The estimation of the accessible population i.e. the sum of (a) and (b), requires an analysis of the geographical distribution of the population and the establishment of criteria for determining the accessible population.

To obviate differences between countries as regards the definition of accessibility that may be adopted, another indicator will be used in addition to that based on accessibility. This will be "population served by the elementary unit" and will provide a quick and practical view of the manner in which efforts are being made to achieve greater coverage.

The form must be filled out as follows:

1.1. Definition of "minimum services"

Put an "x" in the appropriate box if a national definition of minimum services exists (or not). If a definition exists, give a brief summary of it. It is possible that the concept of minimum services used in the Ten-Year Plan and described above differs from the national definition. It must be borne in mind that services of this kind are designed mainly for the rural population of a country and hence in all probability they are provided essentially by the State, which is likely to have a clear definition of them (Example: out-patient care of urgent cases, vaccinations, care of pregnant women, etc.)

1.2. Definition of "elementary units"

Put an "x" in the appropriate box if a national definition of "elementary unit" exists (or not). Give a brief indication of the definition and include the number and type of personnel employed in the unit and its most important resources. Indicate also, if the figure has been determined, the number of persons assigned for coverage by the unit. This is known in the Ten-Year Plan as "potential care capacity" and for the elementary unit and the minimum services under the Plan has a maximum of 5,000 persons.

1.3. Definition of "accessibility"

Put an "x" in the appropriate box if a definition of "accesible population" or "inaccessible population" has been adopted (or not). Then state what the definition is.

1.4. Estimated population of localities of less than 2,000 inhabitants

Most of the countries have recent census data. Estimates will have to be made for the years 1971, 1974, 1977 and 1980 (in mid-year). The scattered population must be included if it does not appear in the figures for localities.

1.5. Actual or potential accessible population

If it has been determined that an inaccessible population exists and if it has been defined, it will be possible to subtract the total inaccessible population from the total estimated population (1.4). Estimates will be required for 1971, 1974, 1977 and 1980.

1.6. Number of elementary care units

This is the number of units that were operating in 1971 and in 1974 and the number planned to be operating in 1977 and 1980. In order to determine this number, a list of localities will be necessary, with indication of the size of the population where the elementary units are operating, and a list of localities which will have such units in operation in 1977 and 1980. If a locality has a unit of greater complexity than that defined as an elementary unit, it must be counted as an elementary unit.

1.7. Population served

This is the total population of all the localities where an elementary unit is operating. It is obtained by adding together the populations of the list of localities mentioned in (1.6) and this will give the actual population served in 1971 and 1974 and the population it is planned to serve in 1977 and 1980.

1.8. Population served by each elementary unit

This is an average figure obtained by dividing the population served (1.7) by the number of elementary care units (1.6). This is an indicator of coverage: the smaller the coverage the greater the indicator and vice-versa. The analysis of this indicator must envisage the possibility of determining values situated between "normal" or "optimum" limits, since very high values may indicate low-quality care or a population actually not served whereas very low values may indicate low yields.

1.9. Accessible served population (%)

This is the population served (1.7) divided by the real or potential accessible population (1.5), multiplied by 100. The regional target is to achieve 100%.

2. BASIC AND SPECIALIZED SERVICES

The regional target for coverage with basic services is 100% of the population living in localities with more than 2,000 inhabitants. Generally speaking, it is considered that the population living in localities of more than 20,000 inhabitants has already attained this target coverage; hence, the target relates mainly to the population living in localities of between 2,000 and 20,000 inhabitants.

2.1. Definition of "basic services"

As already mentioned, basic services are defined as being increasingly complex as the size of the localities in which they are situated also increases. Many countries have definitions of the various types of service which its health centers, hospital, etc., provide for the population. It is hereby requested that if such definitions exist they sould be briefly stated.

2.2. Definition of "care units"

Care units providing basic services are establishments of different degrees of complexity which in many countries are described according to their functions. For example, they may be called "Health Center type A, B, C", etc., minumum-care hospitals, general hospitals, regional hospitals, specialized hospitals, etc. It is requested that, if a definition of the different kinds of unit exists, it be given as briefly as possible. A note should also be made of the care capacity of each basic-care unit, if it has been determined.

2.3. Localities of 2,000-20,000 inhabitants

For these localities the following information must be obtained:

2.3.1. Total population living in these localities

This is an estimated which must be obtained for 1971 and 1980.

2.3.2. Number of basic-care units

A note will be made of the number of units as defined in (2.2.).

2.3.3. Percentage of the population served by these units

The total population served will have to be determined first. For 1971 and 1974 this information may be obtained by taking a list of the localities having these units and adding their populations. If a locality has a population greater than the potential care capacity of the unit or units situated in it, only these potential capacities should be added and not the total population of the locality. For 1977 and 1980 the potential capacity of the new units being planned will be added to the population, or, if the information is available, the estimated population of the localities themselves.

2.3.4. Number of beds of all types in these localities

This is the simple total of all the existing hospital beds available in all the care units in 1971 and 1974 and those planned for 1977 and 1980.

2.3.5. Beds per 10,000 inhabitants

This is the ratio between the number of beds (2.3.4.) and the population estimated in (2.3.1.), per 10,000.

2.3.6. Percentage of "specialized" beds

This is an indicator which seeks to give an idea of the degree of specialization of services. It is not easy to measure this degree of specialization without resort to somewhat more complicated techniques than those we wish to use in this evaluation. Hence, we have chosen this rough indicator which is relatively easy to obtain. "Specialized" beds will include all those which are not undifferentiated general beds (such as those in small hospitals) nor beds used for the so-called basic specialties (medicine, surgery, pediatrics and obstetrics) in general hospitals. On the other hand, all beds assigned to clearly defined hospital services such as traumatology, cardiology, urology, opthalmology, etc. will be considered specialized. In hospitals specializing in obstetrics and pediatrics, only the beds that can be identified as belonging to specialized services will be considered as specialized beds.

2.4. Localities of 20,000-100,000 inhabitants

For these localities the following information must be obtained:

2.4.1. Total pupulation living in these localities

This is an estimate that must be obtained for the years 1971, 1974, 1977 and 1980.

2.4.2. Number of basic-care units

A note will be made of the units existing in 1971 and 1974 and those planned for 1977 and 1980.

2.4.3. Percentage of the population served by these units

(See the explanations in (2.3.3.).

2.4.4. Number of beds of all types in these localities

These are the beds available for hospitalization in 1971 and 1974, with the addition of those projected for 1977 and 1980.

2.4.5. Beds per 10,000 inhabitants

This is the ratio between the number of beds (2.4.4.) and the population estimated in (2.4.1.).

2.4.6. Number of specialized beds per 100 beds of all types

This is calculated in the same form as (2.3.6.).

2.5. Localities of 100,000 inhabitants and up

For these localities the following information must be obtained:

2.5.1. Total population living in these localities

This is an estimate which must be obtained for 1971, 1974, 1977 and 1980.

2.5.2. Number of basic-care units

A note will be made of the units existing in 1971 and 1974 and those projected for 1977 and 1980.

2.5.3. Percentage of the population served by these units

The same calculation for (2.3.3.) and (2.4.3.). In general, it is hoped that these populations are 100% covered by basic services.

2.5.4. Number of beds of all types

This is the sum of all the available hospital beds in all the care units existing in these localities in 1971 and 1974 and those projected for 1977 and 1970.

2.5.5. Beds per 10,000 inhabitants

This is the ratio between the number of beds (2.5.4.) and the population estimated in (2.5.1.) per 10,000.

2.5.6. Percentage of "specialized" beds

Calculated in the same way as (2.3.6.).

B. COMMUNICABLE DISEASES

The reduction of morbidity and mortality through the control and eradication of communicable diseases is a major target of the Ten-Year Health Plan for the Americas. The achievement of this target depends on the achievement of other intermediate targets of a general nature, such as the operation of epidemiological surveillance units, the training of human resources, research, the formulation of strategies, programming and so on. These targets are dealt with separately in the areas of infrastructure and general intermediate services of health systems. The overall target also is related to the specific targets for each one of the communicable diseases.

The targets are regional because all the diseases considered constitute risks of some kind in all or some of the countries. Each country must set its own targets for the diseases which are prevalente or which entail risks for its population. For each one of the diseases indicators are proposed. They are not designed as a means of evaluating the specific disease campaigns but of giving a general picture of the projected levels of morbidity and mortality and of the effort planned to attain them. For this purpose minimum indicators for each disease have been chosen. They seek to establish what final results are sought, what operational means are to be used to achieve these results and what the total effort will be. For example, in the case of a disease such as smallpox preventable by vaccination, the target of the Ten-Year Plan is to reduce mortality to a rate of less than 1 per 100,000 inhabitants. This would be a final result. To achieve this target, it is considered necessary to give three doses of DPT vaccine to 80% of children under five. This would be one of the operational means employed. Finally, in order to give three doses to 80% of the children, a total of "x" doses will be required, which is expressed in terms of concentration or as the average number of doses for each child under five.

For each one of the diseases considered, after the name appearing in column (1), there are two boxes where an "x" must be placed depending on whether or not the country has set targets within the Ten-Year Plan either as a result of a health policy decision or because the disease does not exist or does not represent a problem for the country.

Column (2) includes the indicators selected for evaluation and explained below. Column (3) gives the agreed target for the region under the Ten-Year Plan. Of course, there are some indicators for which there are no specific targets under the plan but which are considered necessary for evaluation. Column (4) gives the position of the indicator in 1971, the initial year of the decade covered by the Plan. Probably, all the statistics and information necessary to fill this column are now available.

The last column, (7), will show the target which has been fixed for each one of the indicators in 1980 and which will be the subject of the final evaluation of the Ten-Year Plan. The intermediate columns (5) and (6) are forecasts at intermediate points during the period. These will allow, where necessary, the effort made during the two last three-year stages to be measured.

1. SMALLPOX

The smallpox eradication program initiated in 1967 yielded the results expected because since April 1971 no new cases have been reported in the countries of the continent. The attack phase seems to have been successful but the maintenance phase varies widely, depending on the way in which the national health services are organized and the emphasis each one places on this problem.

1.1. Incidence

The regional target is the maintenance of eradication, i.e. the non-recurrence of smallpox cases. It is assumed that this minimum target will be adopted by each country.

1.2. First vaccinations per 1,000 inhabitants

This is an indicator of the operational results for the maintenance phase of an eradication program. The vaccination programs carried out had a certain coverage, there remaining about 20% non-vaccinated persons, although it is not known whether all this group may not have been vaccinated before. If it is assumed that most of them were not vaccinated and if the children being incorporated into the population are added to them, the number of non-vaccinated persons may be roughly estimated. A maintenance program of eradication would imply mainly the vaccination of this group of the population and hence a useful indicator would be the annual number of first vaccinations per 1,000 inhabitants

which each year must be greater than the birth rate if the aim is to cover not only the population which is added each year but also the older persons who have not been vaccinated.

2. MEASLES

2.1. Deaths per 100,000 inhabitants

The regional target is the reduction of the rate of mortality to not more than 1 per 100,000 inhabitants. Each country will decide on the target for 1980 and will note it down in terms of the rate it expects to achieve. Similarly, each country will obtain the information for 1971, noting it in column (4). If they exist, forecasts of this rate in 1974 and 1977 will be noted in columns (5) and (6) respectively. It is important to point out that the statistics of mortality from measles may be inaccurate in some countries where the medical registration of causes of death is deficient in coverage or quality. Care must be taken to make the necessary corrections to these rates.

2.2. Percentage of children under five vaccinated

The regional target is to vaccinate 80% of the children under five and to maintain this percentage each year. The national target percentage of children vaccinated according to national vaccination standards will be noted in column (7). Column (4) will show how many of these children were vaccinated in 1971. The forecasts for 1974 and 1977, if they exist, will be noted in columns (5) and (6).

3. WHOOPING COUGH

3.1. Death per 100,000 inhabitants

The regional target is to achieve a mortality rate of less than 1 per 100,000 inhabitants. The national mortality rate must be noted in column (7). The rate observed in 1971 will be noted in column (4). If there are forecasts of these rates for 1974 and 1977, these will be noted in columns (5) and (6).

3.2. Percentage of children under five vaccinated with complete doses

The regional target is to vaccinate 80% of children under five and to maintain this percentage every year. Column (7) will show the national target, i.e. the percentage of children under five vaccinated with complete doses according to the national standard and those receiving booster shots. The percentage achieved in 1971 will be shown in column (4) and the forecasts for 1974 and 1977 - if they exist - will be given in columns (4) and (5).

3.3. Concentration

This is the average number of doses given to each child under five. This indicator is obtained by dividing the total number of doses given by the number of children. In certain circumstances this indicator is easier to obtain than (3.2) since it only requires a knowledge of the total doses of vaccine given, whereas indicator (3.2) requires the maintenance of a good vaccination register, which is not always the case.

4. TETANUS

4.1. Deaths per 100,000 inhabitants

The same directions as for whooping cough. See (3.1).

4.2. Percentage of children under five vaccinated with complete doses

The same directions as for whooping cough. See (3.2).

4.3. Concentration

The same directions as for whooping cough. See (3.3).

5. DIPTHERIA

5.1. Incidence: cases per 100,000 inhabitants

The regional target is to achieve an incidence of less than 1 case per 100,000 inhabitants. The national target, if it has been fixed, must be noted in column (7). The incidence of diptheria in 1971 will be annotated in column (4) and forecasts for 1974 and 1977 in columns (5) and (6) respectively.

5.2. Percentage of children under five vaccinated with complete doses

The same directions as for whooping cough. See (3.2).

5.3. Concentration

The same directions as for whooping cough. See (3.3).

6. POLIOMYELITIS

6.1. Incidence: cases per 100,000 inhabitants

The regional target is to bring the level of incidence to below

1 case per 100,000 inhabitants. Directions are the same as those for diphtheria. See (5.1).

6.2. Percentage of children under five vaccinated with complete doses

Same directions as for whooping cough. See (3.2).

6.3. Concentration

Same directions as for whooping cough. See (3.3).

7. TUBERCULOSIS

Generally speaking, tuberculosis is declining. However, the size of this problem can be estimated more accurately only on the basis of mortality data, since there are no reliable data on morbidity or the extent of the infection. For this reason, the Ten-Year Plan has adopted the mortality rate as an indicator of results and has chosen certain other indicators of operational results and of the effort put forward. These may provide a general view of the tuberculosis situation and of the fight against it on the continent based on the consolidation of that situation and activities in each country.

7.1. Deaths per 100,000 inhabitants

The regional target is for each country to reduce the rate of mortality from tuberculosis by percentages between 50% and 65%. Column (4) will show the 1971 rate of mortality from tuberculosis per 100,000 inhabitants. Column (7) will show the target rate for 1980 and the percentage this represents of the 1971 rate.

7.2. Incidence: new cases confirmed bacteriologically per 100,000 inhabitants

There are no regional targets for incidence. However, countries should consider the use of this indicator of morbidity whose greater accuracy will depend on the effort made to carry forward an organized and coordinated program and a good system of surveillance and notification. The 1971 rate will be given in column (4) and the target rate in column (8). Columns (5) and (6) will show the 1974 and 1977 forecasts, if they exist.

7.3. Percentage of minors under 15 vaccinated with BCG

The regional target is a level of 80% of children under 15 vaccinated with BCG and the maintenance of this level one year after it has been attained by vaccination of one-year olds and the high-risk population.

The percentage achieved in 1971 will be noted in column (4), the target for 1980 in column (7) and the 1974 and 1977 estimates, if any, in columns (5) and (6).

7.4. Percentage of known cases under treatment

The regional target is to provide treatment for all known cases of tuberculosis. This target implies the existence of a case register for determining whether patients are under treatment or not. This indicator is an excellent one for revealing operational results since the scope of treatment may be expected to have positive effects on the reduction of the problem. It is also an excellent indicator of the efforts made, because the greater the proportion of cases under treatment, the greater the effort being made to detect and treat them; this indicator is always combined with the indicator reflecting efforts to detect new cases. Put in column (4) the percentage observed or the best possible estimate. The target for 1980 will go in column (7) and the forecasts, if any, for 1974 and 1977 in columns (5) and (6).

7.5. Percentage of known out-patients

The regional target (90%) reflects the aim of changing the emphasis from hospital to out-patient treatment. Note the 1971 position, the 1980 target and the 1974 and 1977 forecasts in the appropriate columns.

7.6. Bacilloscopic examinations for the diagnosis of tuberculosis per 100 consultations

This is also an indicator of effort. The target of the Ten-Year Plan is to give one bacilloscopic examination to 60-75% of persons with respiratory symptoms of more than four weeks' duration. The statistics for hospital morbidity do not easily reveal this information. Hence this indicator has been replaced by another less revealing but easier to obtain: this is the simple total of the bacilloscopies as a percentage of the total number of first-time consultations. This indicator may be obtained more easily when there is an idea of the proportion of consultations for respiratory infections. Countries with more information may study this indicator with a view to a better formulation of their target for 1980. The figure observed in 1971 will be noted in column (4) and the forecasts for 1974 and 1977, if any, in columns (5) and (6).

7.7. Beds in tuberculosis hospitals

This is the proportion (%) which these beds represent of the total beds in the country. The general trend is towards the reduction of the number of beds in these hospitals. Preference is given to out-patient treatment of cases or to their treatment in general hospitals. There is also a tendency to use for general medical care beds formerly set aside for the specialist treatment of tuberculosis. Note the

percentage observed in 1971 in column (4) and any possibility of change as the target for 1980 in column (7). Forecasts for 1974 and 1977 will be noted in columns (5) and (6). The calculation of the target for 1980 and the forecasts for 1974 and 1977 must take into account not only the possibility of reducing the number of beds in tuberculosis hospitals but also the forecasts of new general beds for those years.

8. ENTERIC INFECTIONS

This group of diseases is of great importance for Latin America: they are the main cause of mortality among the infectious and parasitic diseases. This group includes the typhoid and paratyphoid infections and a large number of other types of infection which cause the greatest ravages among children under the general heading of diarrhea. In spite of their importance, the indicators are solely based on the reduction of mortality rates, since the efforts to combat enteric infections are included in targets to be achieved in a series of other fields such as medical care, epidemiological surveillance, water supply and excreta disposal, feeding and nutrition, etc.

8.1. Deaths per 100,000 inhabitants

The regional target is the reduction of mortality from all enteric infections to a rate 50% lower than the 1971 rate. The national target for 1980, the 1971 position and the forecasts for the intermediate years must be noted in the respective columns.

8.2. Deaths from diarrhetic infections among children

No specific regional target has been set for this type of mortality. However, since deaths from this cause are the most frequent of all those originating from enteric diseases, the regional target is no less than a 50% reduction in the mortality rate per 100,000 children under five. Countries will fix the target for 1980 and note it in the appropriate column. The 1971 position and the forecasts for 1974 and 1977, if any, will be noted in the appropriate columns.

8.3. Cases of typhoid and paratyphoid per 100,000 inhabitants

The regional target is also the reduction of the mortality rate by 50%. The target and the national estimates must be noted in the appropriate columns.

9. VENERAL DISEASES

The regional targets are to reduce the incidence of veneral diseases, in particular syphilis and blennorrhagia. This entails plans for developing and improving control programs, epidemiological surveillance, improved laboratory services, health and sexual education and research into control methods. The indicators chosen are as follows:

9.1. Incidence: cases of syphilis per 100,000 inhabitants

The rate observed in 1971, the target proposed for 1980 and forecasts for the intermediate years will be shown in the appropriate columns.

9.2. Incidence: cases of blennorrhagia per 100,000 inhabitants

Same as for syphilis. See (9.1).

9.3. Contacts investigated per 100 contacts declared

This is an indicator of the effort made by the control programs. The figure may be obtained only if there are programs for registering this information or if there are reliable estimates which can be used to establish efficiency targets in the detection of cases among contacts. The estimate of the percentages and the target proposed must be noted in the appropriate columns.

10. YAWS

There are few countries in the region where this disease is still prevalente. The regional target is to eradicate it. The indicator is the incidence or the number of cases per 100,000 inhabitants. Countries having this problem will fix their own target.

11. PINTA

Although the incidence of this disease is decreasing, it still exists, mainly in two countries of the Americas. The regional target is its eradication. The countries where it is still endemic must fix their own targets, in terms of incidence or the number of new cases per 100,000 inhabitants.

12. LEPROSY

Leprosy still persists as a problem in the Americas although in some countries the disease seems to be under control. The recommendations of the Ten-Year Plan stress the improvement and organization of control programs, the development of clinical and rehabilitation services, research and epidemiological vigilance. Besides these general activities, the targets established relate to the following fields in which indicators have been fixed:

12.1. Prevalence: number of sick per 100,000 inhabitants

The regional target is the reduction of prevalence. The countries where this disease is a problem must fix their own targets.

12.2. Incidence: new cases per 100,000 inhabitants

The regional target is also reduction. Each country must fix its own targets.

12.3. Percentage of infectious cases under treatment

The regional target is to provide treatment for 100% of the infectious cases (lepromatoses, dimorphes and indeterminate cases). The calculation of this indicator requires case registration which can provide this type of information in order to establish the base line in 1971 and the target for 1980.

12.4. Percentage of contacts subject to surveillance and treatment

The proposed regional target is to keep under surveillance and treatment at least 75% of the contacts. Each country will fix its own target. Emphasis is again laid on the need for proper registers of patients and active programs for the location and investigation of contacts.

13. LOUSE-BORNE TYPHUS

Louse-borne typhus continues to be an endemic disease in various countries of the Americas. The Ten-Year Plan proposes activities related to epidemiological surveillance in the affected countries, the development of research on vaccines and the resistance of vectors to insecticides and the improvement of laboratory services for the diagnosis of rickets. The only indicator chosen for this disease is the incidence (number of new cases per 100,000 inhabitants) and countries may fix their own targets for reduction.

14. SCHISTOSOMIASIS

There are various countries in the region where this disease is endemic. The recommendations of the Ten-Year Plan stress the need for research to determine more accurately the incidence of this disease, to find drugs to combat it and to establish methods of control and evaluation. The only target proposed is the reduction of its prevalence. The countries affected must fix their own targets in terms of prevalence per 100,000 inhabitants.

15. ONCHOCERCIASIS

This disease is endemic in three countries of the region. The recommendations of the Ten-Year Plan are concerned mainly with better research into control methods and particularly the reduction of sandfly density to levels which preclude transmission. The target proposed is the reduction of incidence (new cases per 100,000 inhabitants).

16. CHAGAS' DISEASE

This disease is widespread in extensive rural areas of the Americas. The recommendations of the Ten-Year Plan stress the organization of control programs and the investigation of methods and procedures for the study of its epidemiological characteristics, the standardization of laboratory techniques and the real evaluation of the problem. The only indicator proposed in that of incidence (new cases per 100,000 inhabitants) and the regional target is reduction of the disease. The countries affected will fix their own targets.

17. JUNGLE YELLOW FEVER

The targets of the Ten-Year Plan relate to the reduction of morbidity and mortality rates by intensifying immunization programs among populations most exposed to risk, i.e. those living in the jungle areas of the enzootic zone and persons entering it. The only indicator adopted is the incidence and the aim is to reduce it to the minimum possible.

18. PLAGUE

The recommendations of the Ten-Year Plan concern epidemiological surveillance in the enzootic areas, the maintenance of control over vectors and rodents and the promotion of research. The only indicator chosen is the incidence and the target is to reduce it and, if possible, eliminate it.

19. MALARIA

The recommendations of the Ten-Year Plan are aimed at avoiding the reintroduction of malaria into areas from which it has been eradicated, eradicating it in areas where there are good prospects of doing so, interrupting transmission in areas where progress has been retarded by financial problems and reducing transmission to a lower level in areas where progress depends on the solution of serious operational and technical problems. The suggested indicators are as follows:

Proportion (%) of malarious area in phases of attack, consolidation and maintenance

The regional target is to achieve eradication over an area containing 90.7% of the population living in the originally malarious zone of the continent and to try to solve the problem for the remaining 9.3% who live in areas where final success depends on the use of better techniques for breaking the chain of transmission and on the satisfactory conclusion of the projected research activities.

20. AEDES AEGYPTI

The Ten-Year Plan aims to eradicate the Aedes aegypti with a view to the efficient prevention and possible elimination of the diseases transmitted by it. The indicator chosen is the state of the campaign. There are five possibilities: not contemplated, under study, attack phase, consolidation phase and maintenance phase. These must be noted in the appropriate column depending on the 1971 situation, the 1974 and 1977 forecasts and the 1980 target.

C. MATERNAL AND CHILD HEALTH AND FAMILY WELFARE

Activities in this area concern mostly medical care for individuals or environmental sanitation measures aimed at preventing sickness and death and promoting health. These are covered by other general programs such as nutrition, control of communicable diseases, environmental sanitation, medical care, immunization, etc. Hence most of the indicators belong to these other areas of activity. However, certain indicators have been chosen as expressing the target of the Ten-Year Plan in terms of country targets. They are contained in form C which must be filled out as follows:

1. MORTALITY

These are indicators of child and maternal mortality i.e. the groups of the population to which the program activities are directed. Their calculation requires for 1971 the vital statistics and the population estimates for children of 1-4 years for that year.

1.1. Infant mortality

The indicator is the rate of infant mortality which is too well known to require emphasis. It is the number of deaths of children under one per 1,000 live births. The only point that needs stressing here is the care which must be employed in taking into account an established but

not adequately quantified fact, namely, that there are serious omissions in the registration of deaths of children under one, especially new-born children, and also in the registration of live births. The accuracy of the registers must therefore be checked, since they have an important influence on the quality of the indicator.

The regional target is a reduction of 40% in the mortality rate. It is suggested that countries should adopt reductions of between 30% and 60% depending on their present level. It is assumed that it will be harder to reduce already low levels and easier to achieve larger reductions in rates that are high. The appropriate columns will show the figure for 1971 which is taken as the base, the rates expected for 1974 and 1977, and the target proposed for 1980, both in terms of mortality rates and percentages of reduction.

1.2. Mortality rate for children aged 1-4

The indicator is the specific mortality rate of this age-group, i.e. the number of deaths of children between 1 and 4 per 1,000 children of this age-group. Establishment of this indicator requires a knowledge of the number of deaths in 1971 of children aged 1-4 and of the estimated population in that age-group. The quality of the registration of deaths and of the population estimates must also be checked.

The regional target is a reduction of 60% by the end of the Plan period, with reductions suggested for countries varying between 50% and 70%. It is considered that the mortality rates for children in this age-group are high throughout the region and can be reduced by strenuous action.

The appropriate columns will show the figure for 1971, the figures expected in 1974 and 1977, and the 1980 target expressed in terms of mortality rates and percentages.

1.3. Maternal mortality

The indicator is the maternal mortality rate i.e. the number of deaths from maternal causes (pregnancy, birth and puerperium) for each thousand live births. A check must be made of the quality of the numerator, i.e. of the maternal deaths which may be affected by the coverage and quality of the medical certification of causes of death.

The regional target is a 40% reduction in the mortality rate, with country targets ranging from 30% to 50%.

As in previous cases, the appropriate columns will show the figure observed for 1971, the base year, the rates expected for 1974 and 1977 and the 1980 target, expressed in terms of the mortality rate itself and the percentage reduction this signifies over the base year.

2. COVERAGE OF SERVICES

The Ten-Year Plan proposes certain operational targets relating to pre-natal, natal, post-natal and child care. These services must be programmed and provided by care units according to technical standards for medical treatment, health education, family protection, nutrition and so on. The coverage indicators and the targets for each one of them are as follows:

2.1. Prenatal care

The indicator for the coverage of prenatal care is the number of pregnant women receiving care (according to a definition of "care") for each 100 live births. The basic for this percentage is roughly equal to the number of pregnant women who completed their pregnancy with a live birth. It is not the total number of pregnant women, which would have to include dead births as well as live births. Sometimes it includes only the number of late fetal deaths; but, for the sake of simplicity of calculation, it is better to take the number of live births which is more accurately recorded.

The regional target is 60% of prenatal care. The 1971 figure, the 1974 and 1977 forecasts and the 1980 national target will go into the appropriate columns.

2.2. Natal care

The regional recommendation is a level of between 60% and 90% of adequate care during birth; adequate care means care in hospitals or clinic, i.e. "institutionalized" care. The indicator entailed in this target is the percentage of births with institutionalized care. Again, the number of births refers only to live births which is much easier to obtain, as was seen in (2.1).

The percentage of births which occurred in hospitals in 1971 must be noted in the appropriate column together with the estimates for 1974 and 1977 and the national target for 1980.

2.3. Post-natal care

The regional recommendation is to achieve a coverage of 60% of post-natal care. Each country must formulate its own target and its own definition of "post-natal care". The suggested indicator is the percentage of mothers who gave birth to live children and who received post-natal care (post-natal care per 100 live births.)

The figures observed in 1971, the forecasts, if any, for 1974 and 1977, and the national target must be given in the appropriate columns.

2.4. Care of children under one

The Ten-Year Plan recommends that 90% of the infant population should be under care. The indicator is the percentage of the population under one year under care. Again, each country must define what a child "under care" is and include them in their registers of infant care.

The denominator is the population of children under one year at mid-year. This population should be calculated by a demographer (who in any case will have to calculate it in order to construct the life tables). A rough estimate may be obtained as follows: in order to estimate the population under one year as of 1 July 1971, add the births which occured in 1970 and 1971 (corrected for underregistration as far as possible); divide this total by two; and subtract 75% of the infant deaths in 1971 and 25% of those in 1970 (also corrected for underregistration as far as possible).

Note the position observed in 1971, the figures expected for 1974 and 1977, and the national target in the appropriate columns.

2.5. Care of children between one and four

The Ten-Year Plan recommends a coverage of 50-70% of this age-group. The indicator is the percentage of children between one and four with coverage of services. Each country must define the type of services it considers pertinent (immunizations, medical care, care of healthy children etc.) and record in its registers the number of children receiving care. The denominator is the population between one and four estimated as of the middle of the year in question.

Each country will fix its targets for 1980, noting the position observed and the expected positions for 1974 and 1977 in the appropriate columns.

3. INTERSECTORAL POLICY

Activities in the field of maternity, child and family welfare require a national policy which necessarily must be intersectoral. This policy must include guarantees of the legal and civil rights of the family, of mothers and children; their economic, social and working protection; their general advancement towards a better life; and their integral medical and health protection. The formulation of such a policy is a recommendation contained in the Ten-Year Plan. An "x" should be marked on the form:

1. If such a policy is already defined, i.e. if it has been formulated and is appropriate for the purposes mentioned;

2. If such a policy is not well defined, i.e. if it covers only certain aspects and not others, or if its formulation is not sufficiently clear to allow its implementation by the interested sectors.

3. If such a policy does not exist.

4. If it is under study and is to be formulated during the Plan period. This eventuality is compatible with those in (2) and (3); in other words, it is possible to have an "x" in columns (4), (2) and (3) at the same time.

4. INTERSECTORAL COORDINATION

As stated before, the activities in this field require an intersectoral policy. However, even if such a policy exists, there remains the problem of its implementation. The more closely coordinated the interested sectors within the framework of specific programs, the more efficient this implementation will be. Even if a national policy has not been clearly formulated, intersectoral coordination of this kind can achieve important results. Typical cases for such coordination are: supplementary feeding programs; child care for working mothers; labor legislation for the protection of mothers and children; health and sexual education and so on.

The form has three boxes in which an "x" will be placed:

1. If existing coordination is adequate (in the opinion of the group supplying the information).

2. Partially adequate, i.e. when there is coordination in certain areas or programs and not in others.

3. Rare, i.e. when such coordination hardly exists.

5. INFORMATION AND SERVICES CONCERNING PROBLEMS OF FERTILITY AND STERILITY

This information is to be supplied by those countries where national policy is not opposed to activities in the field or family planning. An "x" will be marked:

1. If such services are offered.

2. If they are not offered.

3. If their initiation is planned (if they are not now offered) or if they are to be intensified (if they are already offered). An "x" in (3) is compatible with an "x" in (1) or (2).

D. NUTRITION

Indicators of the nutritional state of the population are generally not easy to obtain without resort to special studies or surveys. However, the seriousness of the problem in the region has increasingly revealed the need for a better knowledge of the magnitude of the difficulties and the prospects of solving them. Accordingly, many countries already have a certain general picture of the situation and are taking steps to improve it. In the light of information recently accumulated and studied, the Ten-Year Plan fixed clearly defined targets in various aspects of nutrition. Form D contains the following areas in which information is requested:

1. PROTEIN-CALORIE MALNUTRITION

The targets of the Ten-Year Plan are as follows:

1.1. Second grade protein-calorie malnutrition

This refers only to children under five among whom it is proposed to reduce this malnutrition by 30%, with country reductions varying between 10% and 50% depending on their present position and the progress which is feasible. The indicator is the percentage of children suffering from second grade malnutrition. Countries are requested to estimate second grade protein-calorie malnutrition among children under five for the year 1971, to give their estimates for 1974 and 1977, and to state the target for 1980.

1.2. Third-grade protein-calorie malnutrition

This also refers to children under five among whom it is proposed to reduce this grade of malnutrition to 85% with country reductions suggested between 75% and 95%. The indicator is the percentage of children under five with third-grade protein-calorie malnutrition. We request an estimate of this indicator for 1971, national forecasts for 1974 and 1977, and the 1980 target.

2. NUTRITIONAL ANEMIAS IN PREGNANT WOMEN

The regional target proposed is an 80% reduction in the number of women with nutritional anemias. The indicator is the percentage of pregnant women with nutritional anemias. Countries are requested to give the information available for 1971, the 1974 and 1977 forecasts, and the 1980 target.

3. ENDEMIC GOITER

3.1. Prevalence of goiter

The regional target is reduction to a prevalence below 10%. Each country affected by this problem will fix its own targets. Information is requested concerning the endemic position in 1971, the forecasts for 1974 and 1977 and the target fixed for 1980.

3.2. Cretinism

The regional target is the elimination of cretinism. The indicator is "prevalence" or the number of cretins per 100,000 inhabitants. This information is requested for 1971, with estimates for 1974 and 1977 and the national target for 1980. This target, if it is to be coordinated with that of the Ten-Year Plan, should also be elimination.

4. HYPOVITAMINOSIS "A"

The regional target is a 30% reduction and country targets range from 10% to 50%. The indicator is prevalence on the proportion (%) of cases of hypovitaminosis "A". Information is requested on the position in 1971, the forecasts for 1974 and 1977, and the target fixed for 1980.

5. NATIONAL FEEDING AND NUTRITION POLICY

The Ten-Year Plan recommends the adoption in each country of a biologically oriented national feeding and nutrition policy and, within this framework, the development of coordinated intersectoral programs which can alleviate to some extent the situation in which those countries may find themselves if the slow trends in agricultural development persist as compared with the rate of urbanization and demographic growth.

Information is requested from countries concerning their national feeding and nutrition policy. An "x" should be placed in the appropriate boxes if:

1. There is a policy and it is adequate for the aims set.
2. There is no policy or it is inadequate.
3. It is under study.
4. It is estimated that the policy will be formulated in 19 ....

Responses in boxes (3) and (4) do not exclude responses in any of the others.

6. SUPPLEMENTARY FEEDING PROGRAMS

Information is requested concerning the existence of these programs to supplement the feeding of the most vulnerable groups. Put an "x" in the boxes:

1. If they exist and are adequate.

2. If they exist but are inadequate in coverage.

3. If they do not exist

4. If they are proposed as a target for 19 .....

7. IODIZED SALT AND IODIZED OIL PROGRAMS

Information is requested only concerning the existence or non-existence of these programs. An "x" must be placed in the appropriate box if such programs exist, do not exist, are under study or are expected to be initiated in 19 .....

8. TECHNICAL NUTRITION UNITS

The existence of nutrition units in health services is an indicator of the importance of the nutrition sector within the country's projected activities. According to the Ten-Year Plan, these units must as far as possible be located not only centrally at the ministerial level but also at the intermediate or regional level. If these units exist, an "x" must be placed in the appropriate boxes.

E. OTHER AREAS

1. CHRONIC DISEASES

Information is requested concerning the targets that may have been fixed in this general field. The Ten-Year Plan has fixed only the targets of epidemiological surveillance and research, apart from the satisfaction of the demand for medical care. It must be stated briefly whether the country has fixed targets.

2. CANCER

Information is also sought as to whether the country has fixed targets other than epidemiological surveillance and research and the

satisfaction of the demand for medical care. Under this heading, however, the Ten-Year Plan stresses certain special aspects of the disease which may call for programs of early detection and treatment to reduce their lethality.

2.1. Uterine cancer

Information is requested concerning the existence of regular programs for detecting uterine cancer and the number of cytological examinations carried out per 100 women over 20 in 1971, together with estimates for 1974, 1977 and 1980.

2.2. Breast cancer

Information is also requested concerning the existence of programs for detecting breast cancer and the number of women examined per 100 women over 20 in 1971, together with estimates for 1974, 1977 and 1980.

2.3. Registration of tumors

The existence of tumor registers indicates a genuine interest in the investigation of cancer treatment and epidemiological research. Information is requested concerning the existence of these registers on the basis of the proportion (%) of hospitals specializing in oncology and general hospitals of more than 200 beds which had a tumors register in 1971; also, whether organizational plans exist and whether it is planned to increase the proportion in 1974, 1977 and 1980.

3. MENTAL HEALTH

Information is requested concerning the national targets that may have been fixed, with a brief description of them.

3.1. Psychiatric beds per 1,000 inhabitants

Note the number of psychiatric beds per 1,000 inhabitants in 1971 and the forecasts for 1974, 1977 and 1980.

3.2. Psychiatric beds in general hospitals

Information is requested concerning the percentage of beds in general hospitals assigned to psychiatry in 1971 and the percentage foreseen for 1974, 1977 and 1980. This is an indicator of the trend in psychiatric care in general hospitals.

4. ALCOHOLISM

Brief indications are requested of targets that may have been fixed.

5. USE OF DRUGS

Brief indications are also requested of possible national targets concerning the use of dependency-causing drugs.

6. DENTAL HEALTH

Please state briefly whether the country has fixed targets in the field of dental health.

6.1. Integrated programs

We wish to know whether dental health has been integrated in health programs at the various levels of care established by the country. Put an "x" if:

1. The programs are well defined.

2. They are not well defined.

3. They are to be integrated within the Plan period.

6.2. Priority child care

We wish to know whether the extension of dental coverage is planned so as to give priority to children.

6.3. Fluoridization of water

One recommendation of the Plan is to fluoridize the water in towns of 50,000 inhabitants or more, and, where possible, to develop other fluoridization systems in other areas. Please state the number of towns with more than 50,000 inhabitants in 1971 and 1980 and the number of them which had or will have fluoridized water in those years.

II. ENVIRONMENTAL SANITATION PROGRAMS

The Ten-Year Plan considered environmental sanitation programs within the broader context of the preservation and improvement of the environment in general and did not confine them to the traditional activities usually included within the health sector. Besides objectives and targets within these traditional areas, the Plan advocated national policies which involve intersectoral areas where the objectives and targets represent proposals for coordinated action between the various sectors of national activity. The following are the areas in which the Ten-Year Plan has established proposals and targets.

1. NATIONAL POLICY FOR THE PRESERVATION AND IMPROVEMENT OF THE ENVIRONMENT

The formulation of a national policy which orients activities and shapes decisions in environmental matters is considered essential. This policy must form part of the country's general development policy and the information requested in the forms is designed solely to determine whether such a policy exists or is in the process of formulation. Such a policy should contemplate action proposals for all environmental areas but often will only include some of them, thus reflecting the priorities assigned by Governments.

1.1. Formulation of policy

We wish to know whether a national policy for the preservation and improvement of the environment has been formulated, whether it is in the process of formulation, or whether it has not been formulated. These facts will be established by the insertion of an "x" in the appropriate box. If the policy is in the process of formulation or has not been formulated, we would like to know in what year it is hoped to formulate the policy.

We would also like to know the degree of participation of the health sector in the formulation of the policy. We request an opinion as to whether this participation has been considerable, slight or nonexistent, with an "x" placed in the appropriate box.

1.2. Formalization of the policy

A policy may be considered to be formalized when it is expressed in clear terms at the levels of Government action or when it is invested with the legal requirements needed to facilitate the decision to carry it out. The fact that the policy has been formalized or not is precisely an indicator of the official decision to implement it. An "x" must be placed in the appropriate box if the policy has been formalized by an express decision, if it has been given legal expression, or if it has not not been formalized. If the policy has not been formulated, this section will be left blank.

We would also like to know, if the policy has been formalized, the organ(s) or institution(s) responsible for the activities designed to implement the policy (Ministry of Health, Office of the Secretary for Water Resources, etc.)

1.3. Coverage of the policy

The policy may indicate activities which include various types of coverage. Information is requested concerning three of them:

1.3.1. Geographical coverage

The policy may relate to environmental activities which take place throughout the country or only in some areas or it (regions, political or administrative divisions etc.). Alternatively, activities may be fixed; some aspects may involve the whole country, others only a part of it. An "x" should be placed in the appropriate box to cover any of these eventualities.

1.3.2. Institutional coverage

The policy may involve activities carried out by all the institutions which make up the sector or only some of them; alternatively, the institutional coverage may not be defined. For example, the policy may include activities by the institutions of the Central Government (Ministries), local governments (municipalities), universities, the private sector, etc. Place an "x" in the appropriate box to indicate these cases.

1.3.3. Program converage

The policy may be comprehensive, i.e. it may include all the fields of environmental action or it may be restricted to certain areas. Mark with an "x" the box which covers these eventualities. If the policy relates only to certain areas, specify which ones. The reference areas for this objective are those contemplated in the Ten-Year Plan: water supply; sewage and excreta-disposal services; solid wastes; water, air and soil contamination; control of ionizing radiations; regional environmental development; occupational health and industrial hygiene; animal health; food inspection; use of pesticides and drug control. These areas are not restrictive: others not considered in the Ten-Year Plan may be listed.

2. NATIONAL PLAN FOR THE PRESERVATION AND DEVELOPMENT OF THE ENVIRONMENT

The next logical step in dealing with the environment, once the policy objectives have been formulated, is the preparation of strategies which constitute the National Plan. This Plan will specify the manner in which activities will be developed and the initiation of national programs to implement them. This constitutes a clear indicator of the decision to carry the policy forward. Information is requested on the following topics:

2.1. Formulation of strategies

Place an "x" in the appropriate box depending on whether the strategies have been formulated in all the areas covered by the policy, whether they have been formulated only in certain areas, whether they have not been formulated,at all, or whether they are in the process of formulation and will be completed in 19.....

2.2. Areas in which strategies have been formulated

We would like a list of the fields or areas for which strategies have been formulated. It is not necessary to specify their contents. For example, countries may state "urban water supply", "air contamination" etc., without specifying the action contemplated in these fields.

2.3. Programming of strategies

Once formulated, the strategies require programming. At this point "the initiation of program" takes place and their acceptance by the decision-making bodies presupposes the allocation of resources for their implementation. The programming of strategies in practice constitutes the Plan. Information is requested, by the insertion of an "x" in the appropriate box, of the state of programming: whether all strategies have been programmed, or only some of them, whether the process of programming is under way, or whether there has been no programming.

2.4. Intersectoral coordination

The preservation and improvement of the environment requires intersectoral efforts and activities which have to be coordinated. Firstly, at the top decision-making level, an administrative macrosurvey must be made of the sectors concerned and functions and responsibilities must be assigned to the sectors and institutions. For this purpose, a diagnosis of the sectoral and institutional situation will be required so as to establish clearly the formal coordination mechanisms that must exist in those areas of common interest to the various sectors or institutions.

Place an "x" in the appropriate box if there is a sectoral and institutional allocation of functions and responsibilities; if such an allocation has been made only in some areas of activity; or if the allocation is not clear. Secondly, indicate if there exist(or not) formal coordination mechanisms; if such mechanisms exist only in some areas; or if such mechanisms do not exist. Finally, if such mechanisms exist, state whether they operate efficiently; whether they can be improved; or whether they are not operating at all.

3. WATER SUPPLY AND SEWAGE DISPOSAL SERVICES

The provision of water and sewage disposal services depends on diverse sectoral and institutional activities. In some countries there is confusion between the responsibilities exercised in this field by the health sector, the municipalities, the local governments, public works, the private sector and so on. Investment projects may have many sources and often there is no basic frame of reference for establishing a national plan and a national policy for water and sewage services which incorporates development strategies, defines sectoral and institutional jurisdications and coordinates the activities of the bodies entrusted with the administration of specific programs. Efforts to achieve the formulation of a policy and the preparation of national strategies must begin with a diagnosis of the subsystem, the proposal of alternatives and the determination of feasibility by pre-investment and financial studies. Next follows the formulation and programming of strategies and the programming of investments and finance.

Certain major indicators of this whole process are sought under the headings appearing on the appropriate forms.

3.1. Diagnosis of the subsystem

We would like to know if the legal-administrative framework of the subsystem has been studied and if pre-investment and financial studies have been made. The appropriate boxes (3.1.1) should be filled in to signify whether the legal-administrative framework has been studied, whether it is under study, or whether it is projected, and in what year. Similarly, indicate in (3.1.2) whether pre-investment and financial studies have been made, whether they are under way, or whether they are projected, and in what year.

3.2. Definition of sectoral and institutional jurisdictions

Once the situation has been diagnosed, a decision must be taken to assign responsibilities to sectors and institutions. The jurisdiction of each of them must be defined. Information is requested as to whether such a definition of jurisdiction exists or not, or whether it is in the process of definition. This will be done separately for (3.2.1) water supply to urban localities; for (3.2.2) water supply to rural populations; and for (3.2.3) sewage services for rural localities. In all these cases a brief description is requested of the responsibilities of the health sector.

3.3. National targets in relation to the Health Plan

We would like to know -if national targets have been adopted for water supply and sewage services- whether they have been established with reference to or on the basis of the Ten-Year Plan targets. If they have been so established, place an "x" in the appropriate box. If they have not been so established or so established only partially, reply accordingly.

Moreover, we would like information here concerning the participation in the formulation of national targets of the sectors or institutions responsible for the implementation of the country's water supply and sewage programs. This will serve as an indicator of the operational feasibility of the action taken to achieve the targets.

3.4. Estimates, forecasts and targets

This table has six columns: the first is for the indicator used; the second is for the indicator adopted as the regional target; the third is for the situation of this indicator in 1971; the fourth and fifth are for the 1974 and 1977 forecasts of the indicators; and, finally, the sixth is for the indicator adopted as the national target for 1980.

3.4.1.(a) Percentage of the urban population supplied with water by house connections

The regional target adopted for this indicator is 80%. However, if countries decide not to use this target, an alternative is allowed for 2.4.1.(b). In other words, this line should be left blank if the second alternative is adopted and vice-versa.

3.4.1.(b) Percentage of the urban population without water supply services

The regional target for this indicator, if countries decide to use it instead of the one above, is to reduce this proportion by 50%. If countries decide to use the indicator 3.4.1.(a), this line should remain blank, and vice-versa.

3.4.2.(a) Percentage of the rural population with water supply services

The regional target adopted for this indicator is 50%. However, if countries decide not to use this target, the alternative 3.4.2.(b) is available. This line must be left blank if the second alternative is adopted and vice-versa.

3.4.2.(b) Percentage of the rural population without water supply services

The regional target for this indicator, if countries decide to adopt it instead of the one above, is to reduce the rural population without service by 30%. If countries decide to use the indicator 3.4.2 (a), this line should be left blank and vice-versa.

3.4.3.(a) Percentage of the urban population with sewage services

The regional target adopted for this indicator is 70%. However, if countries decide not to use it, the alternative 3.4.3.(b) is available. In this case, this line should be left blank.

3.4.3.(b) Percentage of the urban population without sewage services

The regional target for this indicator is to reduce it by 30%. However, if countries decide to use the indicator above, 3.4.3.(a), this line should remain blank.

3.4.4.(a) Percentage of the rural population with excreta-disposal services

The regional target for this indicator is 50%. Countries have the alternative of using indicator 3.4.4.(b), in which case this line must be left blank and vice-versa.

3.4.4.(b) Percentage of the population without excreta-disposal services

The regional target for this indicator is a 30% reduction. However, if countries decide to use the indicator 3.4.4.(a), this line should be left blank.

3.5. Investment programming

Investments in water-supply and sewage projects must be programmed in conformity with the programming of the services to be provided, according to the targets and objectives established. An "x" must be placed in the appropriate boxes depending on whether investments have been programmed, are in the process of being programmed, or have not been programmed. In the latter case, if programming is planned, state the year when this is to be done.

3.6. Institutional improvement or development

The institutions responsible for providing water and sewage services often require the adaption and modernization of their administrative apparatus so as to make them more efficient. Information is requested concerning action taken or planned for the

administrative improvement of the entire system, at the national, regional, institutional and local levels, with the insertion of an "x" in the appropriate boxes.

3.7. Relationship with the global development plan or with regional development plans

Place an "x" in the appropriate box if the targets and plans adopted are incorporated within the global plan or regional plans, totally or partially, or not at all.

4. COLLECTION AND DISPOSAL OF SOLID WASTE

The garbage collection and disposal services in the countries of Latin America and the Caribbean are generally the responsibility of the municipal administrations of the communities served. For this reason, these systems possess adequate legal powers. As the major town of the Continent have grown in size beyond communal limits, the problems of garbage disposal have become increasingly acute, especially in the large metropolitan areas. The services have been expanded and improved and it is estimated that about 75% of the urban population has daily garbage collections, although final disposal is very deficient. It is felt that a satisfactory policy of management, administration and finance, together with technical planning, could do much to improve garbage collection and disposal.

The regional target adopted in the Ten-Year Plan is to establish adequate systems for the collection, transportation, treatment and final disposal of solid waste in at least 70% of the towns with 20,000 inhabitants or more.

4.1. Diagnosis of the subsystem

It is considered that the legal and administrative framework within which garbage collection and disposal systems operate should be studied with a view to determining the viability and feasibility of more efficient systems so as to achieve the target of the Ten-Year Plan. Moreover, studies of pre-investment and financing are required to complete the picture and to formulate the strategies necessary to attain the objectives. Under (4.1.1) place an "x" in the appropriate box if the legal and administrative framework has been studied or if it is under study, or indicate the year for which the study is planned. Similarly, under(4.1.2), place an "x" in the appropriate box if pre-investment and financial studies have been carried out or if they are under way, or indicate the year for which they are planned.

4.2. Targets adopted by the country

Indicate whether the country has adopted targets for the establishment of adequate systems of solid-waste collection and disposal.

4.3. Relationship with the global development plan or regional development plans

Place an "x" in the appropriate box if the targets and plans adopted have been incorporated in the global development plan or in the regional development plans, if they have been partially incorporated, or not incorporated at all.

5. AIR, WATER AND SOIL POLLUTION

5.1. Water contamination

Although the information available is not very abundant, there is evidence that the problem is growing worse and that insufficient action has been taken to install sewage treatment plants, especially considering the notable increase in urbanization and industrialization.

The existence of programs for controlling water contamination in catchment areas, coastal waters and other bodies of water, where they are needed because of industrial development and urbanization, has been taken as a very general indicator of the country's interest in this problem, besides the enunciation of a policy for the preservation and improvement of the environment already mentioned in (1.3). Place an "x" in the appropriate box if there are control programs of this type in catchment areas, coastal waters or other bodies of water, or if no such programs have been formulated.

5.2. Air contamination

The problem of air contamination has become increasingly acute, mainly in the large urban and industrial areas of the countries. Here, too, it is thought that the existence of contamination control programs is one of the best indicators of the action which countries can take to combat the problem. The Ten-Year Plan recommends the establishment of control programs in urban areas of more than 500,000 inhabitants and in other cities where industrialization makes this necessary.

Indicate in (5.2) whether there are control programs in operation or projected, or whether there are no programs.

Moreover, if they exist, indicate the number of cities where air-contamination measuring stations were operating in 1971 and those where they are projected for 1974, 1977 and 1980. Also, indicate the total number of measuring stations in 1971 and the number planned for 1974, 1977 and 1980, specifying which of them belong to the Pan American Network for the Measurement of Air Contamination.

5.3. Soil contamination

The soil is becoming increasingly contaminated with chemical, domestic, commercial and industrial products, including pesticides and fertilizers used in agriculture. The Ten-Year Plan recommends the formulation and execution of contamination control programs and, again, this is the best indicator that can be used to judge the interest taken in this problem in the various countries. Place an "x" in the appropriate box indicating whether programs are in operation, projected or not in existence.

6. NOISE CONTROL

In this field information is requested only concerning the existence or not of technical guidelines and regulations for the control of noise.

7. REGIONAL DEVELOPMENT PROJECTS

This question goes beyond the field of environmental sanitation but is placed here because the participation of the health sector in regional development projects began with certain environmental programs, particularly those concerned with the contamination and utilization of water in certain catchment areas. The real importance of this field lies in the possibility of achieving genuine inter-sectoral integration in development planning at the regional level.

Under (7.1) indicate whether the National Development Plan envisages regionalization, and if so, how many regions are involved. Under (7.2) state in how many of these regions there are regional development plans in execution, in elaboration or in the process of formulation. Under (7.3) state whether the health sector has participated actively, and in an integrated way, with the other sectors since the formulation of plans or whether it acted passively, in isolated fashion and/or only in the performance of activities within its competence, both in the plans in execution and those in elaboration.

8. OCCUPATIONAL HEALTH AND INDUSTRIAL HYGIENE

The recommendations of the Ten-Year Plan in this field are as follows: to protect in 1975 at least 40% of the working population exposed to risks and 70% in 1980, in countries which already have occupational health programs in operation; to protect in 1975 at least 25% of the working population exposed to risks and a minimum of 50% in 1980, in countries now ready to initiate occupational health programs.

The following information is requested in order to evaluate the situation in this field:

8.1. Protection policy

A protection policy is needed for the working population exposed to risks. Indicate whether such a policy exists, whether it has not been formulated, or whether it is projected.

8.2. Sectoral and institutional responsibility

Generally, the responsibilities in this field are shared between the health ministries, and the social security departments and the ministries of labor. Responsibilities must be clearly assigned and the coordination machinery between the sectors and institutions concerned must function smoothly. Indicate the sectors or institutions which have primary responsibility and state whether coordination machinery exists and whether it is operating satisfactorily.

8.3. Occupational health programs in operation

Indicate whether occupational health programs are in execution, whether they do not exist, or whether they are planned for the future.

8.4. Evaluation of risks

Any occupational health program requires the evaluation of both the type and the gravity of occupational risks, as well as of the population exposed to them. Indicate in the appropriate box whether such an evaluation has been made totally or partially, whether it has not been made, or if and when it is hoped to make it in the future.

8.5. Targets and forecasts

Indicate the percentage of the working population exposed to risks who were protected in 1971, the estimate for 1974 and 1977 and the target fixed for 1980.

9. ANIMAL HEALTH AND VETERINARY PUBLIC HEALTH

In the first place, information is requested as to whether the country has fixed targets in this field or not. This will be taken as an indicator of the importance assigned to the general problem. Under the Ten-Year Plan it was considered important to establish certain targets, mainly as regards foot-and-mouth disease and some other zoonoses, particularly those which were important economically for the country and some which had important human repercussions. We would also like to know whether the country has proposed targets or not, by the insertion of an "x" in the appropriate box.

9.1. Control of zoonoses

The information required for the evaluation of this area is presented in table 9.1 which has seven columns. The first lists the diseases subject to control. The second give the indicators in terms of which the targets have been proposed. The third indicates the regional targets formulated as recommendations of the Ten-Year Plan. In the fourth insert the situation of the indicator for 1971. In the fifth and sixth give the forecasts -if they exist- estimated for each indicator in 1974 and 1977. And, finally, in the seventh column give the national targets fixed for 1980.

9.1.1. Canine rabies

a. Prevalence: The regional target is the eradication of this disease from the biggest cities of the region. The indicator is the number of rabid dogs per 100,000 dogs.

b. Percentage of vaccinated dogs: This realtes only to the biggest cities. The aim is a level of 80% canine vaccination.

c. Percentage of stray dogs: It is proposed to eliminate them (%).

9.1.2. Brucellosis

This refers to animal brucellosis. The indicator is the prevalence (%) of bovine brucellosis. The target is eradication in countries with less than 1% prevalence, and a reduction to prevalences under 2% in the countries which have this problem.

9.1.3. Bovine tuberculosis

The indicator is the prevalence (%) among cattle. The regional target is eradication in countries which have a prevalence of 1% or less, and the reduction to prevalences of less than 2% in the other countries which face this problem.

9.1.4. Hydatidosis

a. Prevalence: The indicator is the prevalence (%) among sheep. The regional target is the reduction of this prevalence.

b. Inspection of slaughter-houses: The indicator is the percentage of slaughter-houses and public and private places where animals are killed for consumption, which are subject to inspection. The regional target is to make 100% of them subject to inspection.

9.1.5. Leptospirosis

The magnitude of this problem is not accurately known. Hence the Ten-Year Plan recommends that the nature of it should be evaluated and that programs should be carried out for reducing it incidence among human beings and animals. The indicator is simply the presence -or absence- of the disease in animals.

9.1.6. Equine encephalitis

a. Incidence: The indicator is the incidence per 1,000 horses. The regional target is to reduce this incidence.

b. Vaccination: The indicator is the percentage of horses vaccinated. The regional target is to vaccinate 80% of them.

9.1.7. Foot-and-mouth disease

a. Incidence: The indicator is the incidence among cattle. The regional target is eradication.

b. Eradication program: The indicator is the phase reached in the eradication program: attack, consolidation or evaluation. The regional target is that all countries should reach the evaluation phase.

c. Areas free of foot-and-mouth disease: The indicator is the percentage of areas free of foot-and-mouth disease. The regional target is 100%.

9.2. Public veterinary health units

The Ten-Year Plan indicates that ministries of health should develop veterinary public health programs which have well-organized units operating at national, regional and local levels. The indicator is the operation (or not) of such units at these levels. By marking the appropriate boxes in the form, countries should indicate if such units exist or if they are projected.

9.3. Programs for the control of zoonoses

The Ten-Year Plan urges ministries of health to develop programs for the control of zoonoses, coordinated with programs carried out in other sectors. The appropriate boxes should indicate whether the national Ministry of Health is developing such programs, whether they do not exist, or whether they are planned and for what year. An indicator of the size of these programs is the amount of funds allocated to them. Countries are requested to indicate the level of the Ministry of Health's investment in these programs and, as a frame of reference, the level of investment of other sectors in these programs.

9.4. Interministerial coordination

Indicate whether adequate coordination machinery exists between the Ministry of Health and the Ministry of Agriculture for zoonoses control programs.

9.5. Epidemiological surveillance

Indicate whether adequate programs of epidemiological surveillance exist and for what diseases.

10. CONTROL OF THE USE OF PESTICIDES

On the basis of the meager information that exists, it is known that the large quantities of pesticides used, often indiscriminately, are having dangerous effects on the health of human beings, animals and plants, either through the ingestion of contaminated food or through poisoning. The Ten-Year Plan draws attention to the problem and recommends that countries should develop programs for controlling the use of pesticides within their health programs and in coordination with other sectors.

The appropriate box should indicate whether the country has established targets for the action to be taken to combat this problem. We also request information concerning the volume, in tons, of pesticides of all kinds imported or produced in 1971 as an indicator of the scale on which they are used in the country.

Three indicators are considered necessary to reflect the attention being given to this problem: the existence of adequate control legislation; the availability of laboratory services for analysis; and the organization of specific control programs. These indicators are grouped in (10.1), (10.2) and (10.3) where the appropriate boxes must be marked.

11. QUALITY CONTROL OF FOOD

Many countries have problems not only with the amount of food produced but also with deficiencies in food processing, transportation, storage and distribution which increase the risks of destruction, waste and contamination. Similarly, existing rules and regulations are inadequate and are not applied because of deficiencies in the control programs or lack of essential resources.

The Ten-Year Plan indicates as the target the reduction of the human diseases and economic losses caused by the biological, physical and chemical contamination of foodstuffs and their by-products, while at the same time preserving their quality. This target may be achieved satisfactorily as the countries adopt up-to-date legislation, have efficient food registration units and food-analysis laboratories, and develop well-structured registration and control programs.

Indicate first whether the country has established targets in this field or not. Then in (11.1) give an opinion as to whether existing rules and regulations are adequate or inadequate. In (11.2) describe the state of laboratory services for analysis. In (11.3) state whether food control programs exist or not, whether a registration and control unit exists or not, and give an estimate of the number of products registered and controlled each year.

12. QUALITY CONTROL OF DRUGS

This is another problem to which the Ten-Year Health Plan devotes attention and on which it makes recommendations after analyzing the situation in the countries. Most of the national bodies are unable to control the growing number of drugs on the market because they lack the resources to carry forward the necessary microbiological tests and

biological evaluations. The Ten-Year Plan recommends that all countries carry out programs for the quality control of drugs, both domestic and imported. For this purpose, there should be a unified national organization for the control of drugs. Existing rules and regulations should be modernized; there should be laboratories for the analysis and evaluation of drugs; and there should be a dynamic registration system for the periodic evaluation of products and a system for keeping such registration up-to-date.

The evaluation form seeks information, firstly, as to whether the country has established targets or not in this field. Then, in (12.1) indicate whether a unified drug control organization exists and operates adequately, inadequately, or not at all, or whether such an organization does not exist. Indicate also whether such an organization is planned or will begin operating in the future.

In (12.2) give an opinion as to the existing rules and regulations: whether they are adequate, not up-to-date, inadequate or insufficient for the conduct of a control program. Indicate also if there are draft laws or regulations being prepared and the year they are likely to enter into force.

In (12.3) state, as appropriate, whether a laboratory exists or not for the analysis and evaluation of drugs; also whether there are plans for building, expanding or improving such a laboratory and the year of completion. State also whether the laboratory has sufficient equipment and technology for the needs of analysis.

In (12.4) indicate whether there exists or not a system for the registration and periodic evaluation of drugs and whether it operates satisfactorily or not. Indicate also if there are plans to organize or improve such a system and the year in which it is expected to operate.

13. ACCIDENT CONTROL

The problem of accidents in the Americas has been increasing in recent years. This is mainly due to the rise in traffic accidents which are responsible for 40% of accidental deaths and are one of the primary causes of death in general. The Ten-Year Plan takes account of this problem and recommends the implementation of programs to reduce the proportion of traffic and industrial accidents, and also those that occur in the home and in recreation and tourist areas, and, consequently, to reduce deaths and disabilities.

13.1. Mortality from accidents of all kinds

The indicator is the incidence, i.e. the number of annual deaths per 100,000 inhabitants. This information is requested for 1971 with estimates for 1974, 1977 and 1980.

13.2. Mortality from traffic accidents

This aspect of the problem is the most serious and may be tackled by means of prevention campaigns and national programs. The indicator is also the incidence, i.e. the number of annual deaths from traffic accidents per 100,000 inhabitants. This information is requested for 1971 with estimates for 1974, 1977 and 1980.

13.3 National control program for traffic accidents

Indicate whether a national program exists, does not exist, or, if it is being organized, the year in which it will start operating. Also indicate whether intersectoral machinery exists for this program.

III. COMPLEMENTARY SERVICES

A. NURSING

The proposals of the Ten-Year Plan in the field of nursing have three aims: the organization of nursing systems, the improvement of the quality of care, and the extension of coverage. For this purpose, of course, emphasis is laid on the preparation and training of human resources (which are dealt with in the section on the development of infrastructure).

Information is requested as to whether national targets have been established in the nursing field, together with a brief description of them.

1. NURSING SYSTEM

The best indicators of a country's efforts to organize the nursing system are believed to be to those reflecting actions taken to define the functions of nursing, the technical standards, the type and numbers of personnel required, and the information necessary for the control of the system, if it is to function as such. Please mark the appropriate box to indicate whether complete partial or no definitions have been formulated for (1.1) nursing functions at different levels of care; (1.2) the technical standards for different levels of care; (1.3) the type and numbers of personnel required; and

(1.4) the system of information for control. If these aspects have not been defined, we would like to know in what year it is planned to do so.

2. QUALITY OF NURSING CARE

It is considered that the quality of nursing care is satisfactory when the standards of care and the nursing services are well organized and administratively structured both in the units themselves and in the services provided for the community.

2.1 Definition of standards of nursing care

Please indicate if such standards have been defined, partially defined, or not defined, both for care institutions or units such as hospitals, health centers etc. (2.1.1) and for the services provided for the community (2.1.2). In both cases, if such standards have not been defined or if they require additions or modifications, indicate if plans exist for this purpose and the year in which they will probably be implemented.

2.2 Administrative structuring of services

Please indicate if the nursing services have an administrative structure or if this is only partial, both in the care units (2.2.1) and in the services they provide for the community (2.1.2). If such a structure does not exist, indicate whether there is any plan to build such a structure and the year in which this will probably be done.

3. COVERAGE OF NURSING SERVICES

It is considered that the coverage of nursing services depends on the numbers and type of existing personnel, the existence of manuals which clearly indicate the functions of auxiliaries and the implementation of supervisory programs. Accordingly, information is requested on the following aspects:

3.1. Preparation of technical and administrative manuals for the use of auxiliaries

Mark the appropriate box if such manuals exist, if they are incomplete, if they are being prepared, or if they do not exist. If there are plans to prepare them, state the year in which they will be available.

3.2. Percentage of auxiliaries with training

A certain proportion of auxiliaries working in the health services have not been properly trained. Training programs for such staff are considered to be of major importance. Hence we request countries to obtain and note the proportion (%) of auxiliaries who received adequate training in 1971 ("adequate" being defined on the basis of the country standard). Also, please estimate the percentage for 1974 and 1977, as an advance towards the target that may have been fixed for 1980.

3.3. Supervisory activities

Supervisory activities, to be effective, must conform to a certain standard of operation. They must be well structured in all of their operational components. Please indicate if supervision is being exercised in a structured way, if supervision is partial or deficient, or if supervision is not practiced at all. In the latter case, please state if there are any plans for the operation of supervisory activities and in what year they are expected to start.

B. LABORATORIES

The Ten-Year Plan considered the urgent need to solve the many problems facing laboratory services in most countries of the region. The availability of these services is very low for out-patient care and, although between 70% and 95% of hospitals have some form of laboratory, these laboratories operate with serious deficiencies. These arise not only because of faults in their own infrastructure but because there are no well-organized referral systems which function as an organic and functional whole.

The Ten-Year Plan has established the target of broadening the coverage and organizing laboratories as "systems" with diagnostic functions, production of biologicals for human and animal use and blood banks necessary to support health programs.

The information requested in the form concerns the establishment of targets for laboratories and blood banks, with a brief description of these targets.

Below, we set forth certain characteristics which a system of laboratories should have, with a view to adopting them as indicators of the situation.

1. DEFINITION OF THE TYPES OF TESTS TO BE CARRIED OUT FOR DIFFERENT TYPES OF CARE

This definition is essential. It must be formulated by harmonizing the type of health activity at each level of care with the laboratory support this care requires. This implies that laboratory tests will become more and more complex as the level of medical care becomes more advanced and specialized. Mark the appropriate box to indicate whether such a definition has been formulated or not, whether it is projected and, if so, for what year.

2. and 3. ELABORATION OF STANDARDS OF EQUIPMENT, PERSONNEL AND OPERATION OF LABORATORIES ACCORDING TO LEVELS OF CARE

The relationship between the functions which each type of laboratory must perform with the resources it must have is obvious. However, this relationship is not always clearly perceived when it is observed that there are small laboratories with more equipment than they can handle and laboratories serving complex care units which lack the resources to carry out special tests. Clearly, the mere existence of standards of equipment, staff and operation does not imply that such standards are in fact maintained but in any case systematization is essential and even more so if investments are planned. Please state if such standards exist, if they do not exist or if they are planned, and if so, for what year.

4. UNITS STAFFED WITH PERMANENT PHYSICIANS AND ALSO EQUIPPED WITH LABORATORY SERVICE

One very specific recommendation of the Ten-Year Plan is that each care unit staffed with a permanent physician should also be equipped with a minimum laboratory. We request information as to whether units staffed with a permanent physician had laboratory service in 1971. Indicate also whether there are plans in this respect for 1974 and 1977 with estimates of an advance towards the achievement of the target in 1980.

5. ORGANIZATION OF BLOOD BANK NETWORKS

The Ten-Year Plan recommends that blood banks should be organized in networks according to levels of care with central referral banks and regionalized in the same way as the health services. Place a mark in the appropriate box if such networks exist, if they are operating partially of if they do not exist. In the latter case, state whether the networks are planned and for what year.

6. PRODUCTION AND CONTROL OF BIOLOGICALS

The Ten-Year Plan urged countries to develop facilities for the production and control of biologicals for human and veterinarian use, which must be coordinated in order to avoid overlapping. In particular, there is no point in spending money to build and operate laboratories for products which are manufactured in other countries and are easy to obtain. Indicate whether there are plans already in operation, whether the production of biologicals has not been envisaged or, if plans exist, in what year they will be implemented.

C. REHABILITATION

In this area there are no specific targets under the Ten-Year Plan. It merely recommends that basic rehabilitation services should be included in all medical care programs. Indicate whether targets in this field have been established and specify them.

D. HEALTH EDUCATION

The Ten-Year Plan recommends the organization in each country of health education as part of the process of active and informed participation of the communities in all of the activities designed for the prevention and cure of disease. Countries are requested to state whether they have fixed targets in this field and, if so, what they are.

E. EPIDEMIOLOGICAL SURVEILLANCE

The target recommended for the Ten-Year Plan is the establishment and maintenance of epidemiological surveillance units, according to the national organization and regional structure of each country, in order to obtain continuing information on the epidemiological characteristics of health problems, and factors that condition them, for the purpose of taking timely action.

The general recommendation for the establishment of an efficient system of epidemiological surveillance is continually reinforced when each of the diseases, especially the communicable one, is considered. For every one of these there is an explicit recommendation that epidemiological surveillance should be maintained. However, this recommendation is not confined to communicable diseases; it also applies to chronic nutritional diseases, zoonoses, etc. Here, too, observation and surveillance are mentioned as being essential for determining the characteristics of the situation and the factors

conditioning it, and also for carrying out the epidemiological studies especially designed for these fields. In some cases -for example, malaria, smallpox, and other diseases, which have been eradicated or reduced to very low levels of prevalence or incidence, or diseases like cholera which may not exist but are potentially dangerous -the only targets mentioned are epidemiological surveillance.

Indicate the targets which the country has fixed regarding the organization, operation and development of epidemiological surveillance systems and specify what they are.

1. SURVEILLANCE SYSTEM

1.1. Central unit

The Ten-Year Plan recommends that countries establish or organize a central unit that functions efficiently and is responsible for the organization of the national system. It should lay down standards of operation, support the work of the regional units and provide the executive units with the necessary criteria for immediate action both at the national and local level. Mark the appropriate box if such a unit exists, if it is being organized or, if it does not exist, state what plans there are to organize it, and in what year.

1.2. Regional units

These units are situated very close to the immediate action and should exist in all the regions. Sometimes, through lack of human resources and for other reasons, these units only exist in certain regions or do not exist at all in the regions, especially if it is a small country in which the link between the national unit and the executive units is immediate. Give the appropriate response in the appropriate box.

1.3. Technical standards of operation

The sytem must operate according to certain technical standards. Indicate whether such standards are adequate, deficient or in the process of revision, and whether there is a plan to establish new standards or modify existing ones, and, if so, in what year.

1.4. Information system

An epidemiological surveillance system is essentially a system consisting of a constant flow of information. Even if the system has highly sophisticated techniques of analysis and operation,

its efficiency will depend entirely on the efficiency of the information system. State whether the system is efficient, inefficient or under review or whether there is a plan to improve or reorganize it, and when it will be implemented.

1.5. Geographical coverage

State whether the system operates throughout the country or if it is confined to certain geographical areas. Remember that we are dealing with the real coverage of the system and not the desired coverage.

1.6. Morbidity coverage

Again, we wish to know the real operational coverage of the surveillance programs which will culminate in action to combat diseases and with a description of the real situation with respect to them, if no action is required. Indicate the communicable diseases which, by order of priority, are subject to epidemiological surveillance. Give this information also for non-communicable diseases: cardiovascular diseases, cancer, accidents, malnutrition, etc. Include zoonoses in the list of communicable diseases.

2. HUMAN RESOURCES

As in all the fields of action of the health sector, human resources are in short supply. For epidemiological surveillance, these resources are critical. The epidemiologists and professionals who must work in this area require very special qualifications that cannot be easily found. We request information on the availability of human resources: whether they are adequate, inadequate or in the process of being trained. The targets for training this personnel must be noted in the section concerning human resources which may be found further on in the questionnaire in the area concerned with infrastructure.

3. PARTICIPATION OF THE COMMUNITY

Epidemiological surveillance, especially in the case of certain infectious diseases, cannot be practised efficiently unless the community participates in the system of information and in keeping it up to date. This aspect is closely linked with programs of health education and often implies a change in people's attitude towards certain diseases (tuberculosis, leprosy, venereal diseases, for example). Information is requested concerning the participation of the community; if it is effective, if it is conditioned by the type of disease or other causes, or if it is slight.

IV. THE PROCESS OF PLANNING AND THE DEVELOPMENT OF THE INFRASTRUCTURE

The process of planning is a process which affects the health system of a country, changing its present shape to the shape that is desired in the future. Hence, before determining the nature of the process, we must define clearly the nature of the present system, the nature of the system desire in the future and the actions and strategies necessary to achieve this future system.

The Ten-Year Plan foresaw this and stressed the need to initiate and develop in each country a health system suited to national characteristics on the basis of a sectoral policy.

1. HEALTH SYSTEM

This refers to the system which is also called the "health services system" and which is the combination of resources organized in a certain way and intended by society to perform actions designed specifically to provide services to promote, protect and restore health. It is a very general definition and in no way refers solely to health services provided by a Ministry or any institution. Include all the resources assigned to health care, whether public or private. For operational purposes, as will be seen later, the system could be described as "system of State health services", "ministerial system", etc.

We would like to know if countries have established targets of any kind with regard to the structure and operation of the health services system and they should indicate in the appropriate box whether they have done so or not.

1.1. Definition of the system

To define a system means to indicate criteria which make it possible to determine when an element belongs to the system or not. For example, it may be defined by stating that the system is made up of all the institutions which provide medical care or that it includes all the institutions which depend financially on the State, etc. Whatever the criterion, the system must be defined prior to the planning process that is to be incorporated in it. Mark the appropriate box to indicate whether the system has been defined, is being defined or has not been defined. If this is to be done in the future, state the year.

1.2. Components of the system

Indicate whether the system is made up of all the sector, of all the public sector or of part of the public sector. Note that the definition of "sector" is very similar to that of system, although generally the definition of sector is given by the State for administrative purposes. If the components of the system are those of all the sector, then the latter must be very carefully defined. Sometimes the system may be defined for operational purposes as made up only of the public services (including social security, for example) or sometimes as made up only of the services belonging to the Ministry of Health. In the latter case, remember that some activities of the system may cover all the sector (planning, epidemiology, statistics, etc.) while the actual provision of the services concerns only a part of the system.

1.3. Type of system

Generally speaking, countries may have a "single" system, i.e. one depending technically and administratively on a central command or a "coordinated" system, i.e. one consisting of the juxtaposition of different subsystems, obeying decisions adopted in a coordinated manner; the subsystems remain free to adopt their own administration and programming but are directed towards common objectives without duplication of effort. Indicate if a decision has been made concerning the type of system defined.

1.4. Formalization

The system is formalized when it is sanctioned by an act of legal authority or other kind and must be accepted by the community. Indicate in the appropriate box whether the system has been formalized, whether it has not been formalized, or whether formalization is envisaged and for what year.

2. HEALTH POLICY

Indicate if targets have been fixed regarding health policy.

2.1. Definition of policy

Indicate if this has been defined, is being defined or, if not, for what year the definition is planned.

2.2. Formalization of policy

State whether the policy has been formalized by official declaration or law or whether it is being formalized in these terms.

2.3. Priorities

Indicate whether, if the policy has been defined, priorities have been established.

2.4. Period of the policy

If the policy has been defined, note the period of years for which it is designed to run.

2.5. Coverage of the policy

From the administrative point of view, indicate whether the coverage is of all the country or only part of the country, or whether in some aspects it covers all the country but in others only part of the country. From the institutional point of view, indicate in (2.5.2) if the policy covers all the health institutions of the country or only some of them (for example, public sector, Ministry of Health, etc.). In (2.5.3) indicate whether the program coverage is total, i.e. whether it covers all the areas or only some. For this purpose, study the Ten-Year Plan which deals with all the possible areas that the policy can cover. Finally, in (2.5.4) state whether the coverage is of all the country's population or if it is of only certain priority groups.

3. STRATEGIES

Strategies mean the activities to be developed or the situations to be established for the fulfillment of the objectives laid down by the policy. We would like to know first whether targets have been established for the formulation of strategies.

3.1. Formulation of strategies

Indicate whether strategies have been formulated, are being formulated or have not been formulated.

3.2. Coverage of the stragegies

Note whether the strategies cover all the areas of the policy or whether they have been formulated only with respect to certain areas. Remember that a policy without strategies remains merely in the realm of enunciation and that activities which may or may not culminate in the objectives of the policy cannot be oriented, evaluated or controlled.

3.3. Programming of strategies

Once the strategies have been formulated, they must be programmed; i.e. countries must decide with what, how and when the actions must be taken. The programming of the strategies, in the process of health planning, culminates in the initiation of large-scale programs, which practically constitute medium-term planning. This programming includes the general operational elements of the system (administration, information, training of human resources, investments, etc.). It does not include the programming of final activities or services to the population, which must be carried out by the executive units or at least by the regional units.

Note whether the strategies have been programmed, are being programmed or have not been programmed. If programming is planned, state for what year.

3.4. Components of strategy programming

Indicate for each of the components whether programming has taken place or not.

3.4.1. Analysis of feasibility

This is to find out whether the technical, material and administrative means exist for carrying out the strategies.

3.4.2. Analysis of internal consistency

This is to ensure that the means and ends of the strategies are not opposed to each other but rather strengthen and complement each other.

3.4.3. Analysis of consistency with the policy

This is to ascertain whether in the elaboration of the strategies and their programming there was no deviation from the objectives of the policy.

3.4.4. Adjustment of strategies

Once the strategies have been formulated and the analyses conducted, the initial formulation of the strategies must be adjusted. It is assumed that after the analysis and once the programming itself is under way, there will be better criteria than at the beginning for adjusting the strategies originally formulated.

3.4.5. Consolidation of the strategies and initiation of programs

The separately programmed strategies may have and usually do have areas of joint action or use joint resources for their implementation. The strategies should therefore be consolidated in action programs which not only guarantee the achievement of the strategies but also harmonize the means employed so that they are used to the best advantage.

3.4.6. Formulation of technical and administrative standards

A normal component of any program.

3.4.7. Adjustment with executive levels

This is a final adjustment which does not imply substantive changes in the strategies themselves but is essential to make them feasible and/or efficient.

3.5. Content of strategy programming

The strategies programmed may refer to various aspects of the system of health services, some of the strategies being listed under (3.5.1) to (3.5.10). It should be specified whether the programming of these items has been done or not, and if not, whether it is planned and for what year.

3.6. Short-term programming

Short-term programming is the immediately operative programming done at the executive levels, within the framework of strategy programming (medium and long-term). The final expression of this programming takes the form of service and activity goals. It should be indicated whether the programming has been carried out or not, or if it has been planned, for what year. Information is also required on whether there was participation at local level or not, or whether the participation was only partial.

4. ADMINISTRATION

4.1. Administrative reform

Administrative reform in the health sector, designed to increase its operative capacity and enable the administration to

meet the requirements of the sectoral development process, is strongly conditioned by the administrative characteristics of the public sector. Hence the importance of participation by the health sector in the processes of administrative reform of the public sector. Information is therefore requested on the situation of the country in this respect, the degree of participation in this reform by the health sector, and whether the process is occurring in the sector.

The appropriate boxes should be checked to show whether:

a) There is a process of administrative reform of the public sector;

b) The health sector is or has been participating in this process either by encouraging it, assuming leadership in it, backing it, serving as model, etc.;

c) A process has been defined in the health sector or it is planned to institute one.

4.2. Administrative macro-adequation

The diagnoses made of the health sector and its institutional organization in various countries, whether using the modern techniques of systems analysis or well-informed and experienced observation, make it clear that planning efforts and the ordering and systemization of health services are often rendered sterile or are limited by the fact that there is fragmentation of the sector, overlapping of the coverage of the various institutions, wide differences of procedure, productivity, costs, etc., among institutions, and so forth. Sectoral order is a necessary condition which must be achieved before adopting any formulation indicative of the policy for the sector. A prior condition is the establishment of a sectoral diagnosis and an institutional analysis leading to proposals for a policy for administrative macro-adequation and sectoral order.

It should be indicated whether a sectoral diagnosis and an institutional analysis have been made or, if it is planned to make them in what year.

In the event that macro-adequation has been carried out, in whatever form, or if it is under way, this should be indicated by checking the relevant box. If this is not the case, or if it is planned, this should also be indicated, together with the year in which it is hoped to execute it.

4.3. Adequation of the sectoral administration

4.3.1. The health sector has a variety of institutions, the most important being the Ministry or Secretariat of Health and social security institutions. It is desirable to know whether the adequation of the administration of the Ministry has been done or not, whether it is under way, or if it is at the planning stage, in what year it is proposed to carry it out. The same applies to the other more important institutions of the sector.

4.3.2. Regionalization

What is required here is to ascertain whether the administration of the sector has been organized by levels of operation in accordance with a regionalization principle, involving definition of decision-making centers of various types and information and control flows at central, regional and local levels. Regionalization implies an order based on special distribution of methods, norms and procedures in line with the techniques of scientific administration.

4.3.3. Organic institutional regulations

Regulations are an important factor in institutional administrative management. Nevertheless, rules in force do not always follow the lines of alert, up-to-date administration. The introduction of modern techniques of information, administration and control, and the new approaches to country development policies require the adoption of regulations in line with needs, envisaging situations consistent with those of national objectives, in respect both of the sector and of overall development. The review of these regulations and the permanent task of studying them and keeping them up to date constitute an indicator of the drive which the administrative process brings to the general process of development of the sector help achieve the objectives of the policy laid down.

For this reason, information is requested on the status of the study and adaptation of the administrative regulations of the institutions in the sector and other internal management.

4.3.4. Restructuring and adequation of the administrative services

The "administrative services" listed under 4.3.4. cover areas with management techniques and procedures that as a rule have to follow guidelines and general directives laid down by the public administration -in the case of health services, the Ministry of Health or State or para-State institutions- but that also have peculiarities and characteristics of their own arising out of their own organic regulations and the nature of the functions they have to fulfill. The techniques and procedures for handling personnel administration, budgeting, accounts, supply, etc. are advancing hand in hand with the development of new technologies, but in addition, these techniques and procedures must be adapted to the needs of objectives, goals and the relevant strategies and programs for achieving them. It is therefore conceivable that the restructuring and adequation of these administrative services must develop as a continuing process of improvement and adjustment which of itself indicates, as in the case of organic and special regulations, the existence of administrative drive in keeping with that of the process of sectoral development.

It should be indicated under (a) to (g) whether the services mentioned have been or are the object of restructuring and adequation for the efficient administration of the sector.

4.3.5. Preparation and issue of manuals

Administrative procedures imply various levels of detail at different levels of the administration. There should be manuals of procedure for use at all levels. Their vary existence is an indicator of sound administrative practice and of the degree of implementation of programs. Hence it is desirable to have information as to whether they exist and plans for preparing and issuing them.

5. INFORMATION SYSTEMS

The functioning of a health system implies the existence of a network of decisions on the definition of policies, selection of strategies, programming of strategies and activities and their implementation, control and evaluation. This network of decisions goes hand in hand with various systems designed to provide the information necessary for rational decision-making. These systems will vary in structure according to the nature of the information they have to provide; and they should be coordinated and made compatible so that they conform to a general system.

It should be noted that the information is not confined to data, qualitative or quantitative, as in the case of health statistics or budgets or accounts it must extend to the sphere of utilization of the data once they are recorded as an expression of a situation or topic. (This is the basic difference between data and information.)

The planning and introduction of scientific administration into the health sector calls more and more frequently nowadays for the organization of information systems, the use of computer techniques and modern "informatics" in support of decision-making and control processes.

Information is required concerning the goals which the country may have laid down in respect of the organization and functioning of health information systems.

5.1. Organization of an information system

We would like to know whether such a system has been organized, whether it is in the process of organization, or if it has been planned, for what year.

5.2. Coverage of the system

a) Political and administrative

Specify whether the system covers the entire country, or only part of the country, or whether for a given type of information there is national coverage while other types are confined to part of the country.

b) Sectoral

Indicate whether the system covers the entire sector or only certain institutions, or whether on certain points it covers all institutions and on others only some of them.

c) Program areas

Indicate whether all the health programs are covered, or only some.

5.3. Coordination of information systems

The information systems frequently give evidence of overlapping or omissions which can be corrected by means of coordination of systems at the intersectoral or interinstitutional level, or at the level of the programs themselves. Check the respective boxes to show whether coordinations appears to exist, whether it is only partial, or whether it does not exist, either at the intersectoral or interinstitutional or program level.

5.4. Establishment of information units

Indicate whether there are or whether it is hoped to establish information units at sectoral level, at institutional level (Ministry, Social Security, etc.) or at the level of specific programs.

5.5. Areas of information

Indicate whether the areas of information as listed in the form are already in operation, whether they are being organized, or whether their organization is a goal of the health plan.

5.6. Reporting system

Supervision of the activities carried out by the services and infrastructure production units calls for a system of regular, phased reports. The reports should mention the goals fixed for the activities and the results achieved, for the purpose of calculating the gaps and seeking proper explanations, a rough estimates being made in the report itself. The system implies the recording of data, elementary analysis, transmission and a second analysis by the units responsible for control at the various levels established, as a basis for decision-making.

An indication is requested under this heading as to whether such a system of reports exists and functions satisfactorily, whether it exists only for certain activities, or functions within certain limitations, or does not exist at all. In the last instance, indicate whether provision has been made for the functioning of such a system and for what year.

5.7. Computers

Specify whether the system is using electronic computing, and if not whether it is envisaged and for what year.

6. HEALTH STATISTICS

6.1. Statistical systems

Indicate whether there are systems for registration, collection, processing, analysis and publication of the statistic listed under (a) to (h), and if not, whether there is any plan to organize them, and for what year.

6.2. Personnel

Check in appropriate instances whether personnel of the type mentioned exist in sufficient quantity, or whether there is a shortage. In the latter case indicate it by what year it is proposed to train staff or have staff available.

6.3. Availability of the data

Indicate whether the data for each type of statistics listed are available and for what year, or if they are not available, in what year it is proposed to have them available.

6.4. Coverage of the system

For each of the systems listed, estimate the proportion, as a percentage, of coverage of the information furnished in 1971 and the goal expected to be reached by 1980.

6.5. Utilization at national level

Indicate for each of the systems listed the degree of utilization estimated within the country, and proposals for promoting more extensive use.

6.6. Coordination

Coordination among the information-producing bodies in each of the systems listed is good, fair or poor. Indicate what is the situation and whether there is any project in hand to improve the existing coordination mechanisms.

7. DEVELOPMENT OF HUMAN RESOURCES

Generally speaking, there is a marked shortage of manpower in the countries of the region, especially in the light of the changes being made in the sector, which operates not only with the participation of the traditional professions (medical practitioners, dentists, pharmacists) but on the basis of care units made up of personnel whose diversity increases in proportion to the complexity of these care units, services and infrastructure.

No consideration will be given in this section to the area of utilization of human resources, since it is dealt with in other sections of the Ten-Year Plan; on the other hand emphasis is laid on the areas of manpower development, planning and programming and the questions of manpower training.

What is required first and foremost is information on whether the country has established goals for the development of human resources in its health plan.

7.1. Manpower planning process

This process has to develop hand in hand with that of health planning and in the light of the sectoral plans and programs and of the

potential of the personnel training institutions and the manpower development policies of all kinds within the country.

7.1.1. Integration with the health planning process

The manpower planning process must be consistent throughout with that of health planning. Indicate whether there is integration of these processes, whether it is only partial or does not exist, and whether integration has been laid down as one of the goals of the country's plan.

7.1.2. Manpower development plan

Indicate whether there is a manpower development plan in operation, or whether it has merely been formulated, or if none exists, whether its formulation is regarded as one of the goals of the country's plan.

7.1.3. Coordination with the national manpower development plan

Indicate first of all whether there is a national plan for manpower development, and if so, the level of coordination between it and the health manpower development plan.

7.1.4. Participation by the universities

The universities are responsible for the training of health professionals and for the organization of programs for training other technicians working in the sector. It seems obvious that the universities need to participate actively in the planning of human resources required by the sectoral plans. Please indicate whether such participation exists or whether it is inadequate, and if it does not exist, whether it is contemplated as a goal of the national plan.

7.2. Manpower training program

7.2.1. Updated inventory

Indicate whether there is an inventory in which a record is kept of the type, number, distribution and utilization of health manpower, whether it is under way or, if it does not exist, whether there are plans for it and for what year.

7.2.2. Projection of requirements

Indicate whether projections have been made of manpower requirements to attain with the objectives of the national health plan, whether they have not been made, or whether they are under way. If they have not been made, indicate whether there are plans to make them and for what year.

7.2.3. Design and utilization of personnel modules

The recommendations of the Ten-Year Plan include the definition of personnel functions and modules in respect of care, administration and support, with a view to increasing productivity. Indicate whether such modules have been designed and whether they have been used or not or, if it is proposed to formulate them, for what year.

7.2.4. Creation of new categories of personnel

Indicate whether the creation of new categories of personnel for the health services has been considered, or whether any thought has been given to it.

7.2.5. Productive capacity of the training institutions

Indicate whether the productive capacity of institutions for personnel training has been determined, whether it is under consideration or, if it is planned, for what year.

7.2.6. Absorptive capacity of the health service

Indicate whether the capacity of the country's health service to absorb manpower has been determined, whether it is under consideration or, if it is planned, for what year.

7.3. Determination of personnel training goals

Note in respect of each category, professional, intermediate, or auxiliary, the number or rate per 10,000 inhabitants (according to the indicator) existing in 1971, planned for 1974, and as a goal for 1980.

8. DEVELOPMENT OF PHYSICAL RESOURCES

Indicate whether goals have been laid down for the installation, replacement, conversion, maintenance, etc. of premises and equipment constituting the country's installed capacity.

8.1. Inventory of premises and installations

Indicate whether there is an up-to-date inventory of premises and installations for public health care, or if there is none, whether there are plans to produce one and in what year.

8.2. Installed capacity development plan

Indicate as appropriate whether or not there is an installed capacity development plan. If there is none, indicate whether any is planned, and for what year.

Indicate under 8.2.1. whether any investment plan has been structured, whether there is none, or whether it consists only of a series of isolated projects. In the event that there is a project to draw up a plan, indicate the year in which it is hoped to accomplish it.

In the event that an investment plan has been formulated, indicate under 8.2.2. if it is the outcome of a services plan, entirely, or only partially, or if it is planned, for what year. Indicate further under 8.2.3., if there is an investment plan, whether it incorporates the construction of new premises, rehabilitation of the installed capacity, expansion and conversion, equipment and/or maintenance.

8.3. Elementary units

Indicate the number of premises for the functioning of elementary units in operation in 1971 (index equals 100 per cent), the number of premises which it is estimated will be in operation in 1974 and 1977 with the relevant percentage, taking the 1971 figure as 100 per cent the number fixed as a goal for 1980, and the relative percentage in relation to 1971.

8.4. Installation of beds

8.4.1. General hospital beds

Indicate the number of general hospital beds available in 1971 and planned for 1974 and 1977, the goal for 1980, and the percentage represented by these estimates in relation to those existing in 1971 (equals 100 per cent.)

8.4.2. Specialized hospital beds

Indicate the number of specialized beds available in 1971 and estimated for 1974 and 1977, and the goal for 1980, plus the percentage which these figures represent in relation to 1971 (equals 100 per cent.)

8.5. Conversion of chronic case beds

Indicate the number of beds for chronic cases available in 1971, the number it is proposed to convert into beds for acute cases in 1974, 1977 and 1980, and the percentage which the figures represent of the number existing in 1971.

8.6. Maintenance systems

It is estimated that an efficient indicator of the status of maintenance systems is the number of personnel specializing in hospital maintenance per 100 hospitals with more than 100 beds each. This information should be given for the year 1971 and the estimated number for 1974 and 1977, and the target for 1980.

9. FINANCING

9.1. Programs for analysis of financing and expenditure

Indicate whether such programs exist and are in operation or, if they do not exist, whether they are planned and for what year.

9.2. Analyses of production functions

Indicate whether analyses of production functions have been carried out or are under way, and whether they cover the entire sector, certain institutions or only certain establishments. If such analyses have not been made, specify whether it is proposed to made any, in what year and in what fields.

9.3. Budget of current expenditure for the health sector

Indicate what proportion of the current expenditure budget for the public sector was assigned to the health sector in 1971 and 1974, and what is estimated for 1977 and 1980.

9.4. Community self-help programs

Indicate whether such programs exist or, if they do not exist, whether they are planned and for what year.

10. LEGISLATION

Indicate whether legislative bills have been drawn up as goals for the country's plan.

10.1. Compilation and analysis

Indicate whether compilation and analysis of the existing health legislation has been undertaken recently, or whether it is under way.

10.2. Legislative bills

Indicate whether any legislative bills have been introduced or are being processed, or whether it is proposed to formulate any, and in what year.

11. RESEARCH

The Ten-Year Plan includes a series of areas in which it is proposed to undertake research in different fields. Information is required as to the proposals or projects which are research goals under the country's plan.

11.1. Research policy

Indicate whether a research policy has been defined for the health sector in keeping with the health policy and with the national scientific and technological development policy, if any. If no such policy has been defined, indicate whether it is proposed to define one as a goal under the plan.

11.2. Inventory or research

Indicate whether there is an inventory or research under consideration or in operation within the sector, whether concerned with basic, epidemiological, administrative or methodological research.

11.3. Program design and development

Indicate whether research programs have been designed and/or are being carried out in the defined priority areas of the health policy.

11.4. Coordination of research

Indicate whether there is coordination between the various research units and the health service system.

DIRECTING COUNCIL

PAN AMERICAN HEALTH ORGANIZATION

REGIONAL COMMITTEE

WORLD HEALTH ORGANIZATION

XXII Meeting

XXV Meeting

RESOLUTION VI

OBJECTIVES AND PRIORITIES IN THE PROGRAM OF THE ORGANIZATION IN THE LIGHT OF THE RECOMMENDATIONS OF THE III SPECIAL MEETING OF MINISTERS OF HEALTH OF THE AMERICAS

THE DIRECTING COUNCIL,

Having heard the report of the Director on the steps being taken by the countries and the Organization in compliance with the provisions of Resolution XIII of the XXI Meeting of the Directing Council of PAHO (Document CD22/17);

Bearing in mind the position taken by the Ministers of Health to the effect that, if the goals of the Ten-Year Health Plan are to be met, it is essential for each country to define a policy consistent with its economic and social development, clearly specifying the objectives, strategies, and programs for attaining them; and

Considering that, pursuant to Resolution XIII, the Director convened a Working Group on Evaluation of the Ten-Year Health Plan, whose report stated that the process of evaluating the Plan will depend on the way in which the national health policies are defined and that it should reflect the effort made by the countries and the progress achieved in solving their priority health problems,

RESOLVES:

1. To urge Governments to continue, and if possible intensify, the review and formulation of their health policies during the current year, and to draw up and develop their priority programs.

2. To recommend to the Director that he continue to render to the countries the collaboration of PAHO in these activities.

3. To request the Director to put into effect the recommendations concerning studies of costs and financing of the health sector contained in Resolution XIII mentioned above, and that he keep the Governments informed on the results of the programmed activities and on the experience of the countries.

4. To request the Director to take the necessary steps so that the documents relating to evaluation, including those resulting from the experience of the countries until 1 May 1974, be the subject of special consideration during the 72nd Meeting of the Executive Committee, and that countries desiring to do so participate in the discussion by sending observers.

(Approved at the tenth plenary session, held on 15 October 1973)

EXECUTIVE COMMITTEE OF THE DIRECTING COUNCIL

PAN AMERICAN HEALTH ORGANIZATION

WORKING PARTY OF THE REGIONAL COMMITTEE

WORLD HEALTH ORGANIZATION

70th Meeting

70th Meeting

RESOLUTION VII

REPORT ON THE III SPECIAL MEETING OF MINISTERS OF HEALTH AND STEPS NECESSARY TO IMPLEMENT THE DECISIONS ADOPTED

THE EXECUTIVE COMMITTEE,

Having heard the preliminary report of the Director (Document CE70/7) on the steps being taken to implement Resolution XIII of the XXI Meeting of the Directing Council of the Pan American Health Organization;

Considering that it is primarily the responsibility of the countries to adopt the necessary measures to formulate or revise their health policies for the purpose of achieving the goals of the Ten-Year Health Plan for the Americas; and

Bearing in mind that the objectives and priorities of the Organization's program must also reflect the goals of the Ten-Year Health Plan so that it can most effectively assist the Governments to meet these objectives,

RESOLVES:

1. To take note of the preliminary report of the Director (Document CE70/7) on the steps the Organization is taking to implement Resolution XIII of the XXI Meeting of the Directing Council of PAHO.

2. To urge the countries to review their health policies and adjust them to the goals of the Ten-Year Plan, in the light of the national health situation and the resources available, and in line with the requirements of economic and social development.

3. To request the Director to assist the countries in (a) defining their policies and objectives and in establishing a permanent system and appropriate methodology for evaluating the results; and (b) carrying out studies required for the Ten-Year Plan on income, costs, and financing of health services.

4. To request the Director to report to the XXII Meeting of the Directing Council on the progress achieved in this important matter.

(Approved at the tenth plenary session, 27 July 1973)