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SOCIAL SECTOR PARTICIPATION IN THE PROTECTION OF AGRICULTURAL AND LIVESTOCK ECOSYSTEMS

CONTENTS

1. Introduction

This document analyzes the participation of the social sector in the protection of agricultural and livestock ecosystems in the Region of the Americas, with particular reference to the participation of the social sector in the rural development in Venezuela.

2. Rural Population in the Region of the Americas

The current population of Latin America is approximately 467 million. Of these, more than 13.5 million are found in small agricultural production units, forming one of the poorest and most marginalized sectors of the Region.

These rural families occupy only 18% of the total land area. Almost half of these production units have a surface area of fewer than two hectares.

In the area of basic food production, small farmers account for 51% of all corn production, 61% of potatoes, 77% of beans, and 32% of rice.

With regard to employment:

> In Latin America and the Caribbean, employment in nonagricultural activities grew from 44% in 1950 to 67% in 1980 and 74% in 1990. This phenomenon reflects important rural-to-urban migratory processes. However, more than 40 million people in the subregion work in agriculture. The percentage of the economically active population employed in the agricultural sector varies from country to country: in Argentina and Venezuela, it is 10%; in Mexico, 37%; and in Haiti and Honduras more than 50%.*(1)*

> Many factors contribute to the inadequate living and health conditions of agricultural workers: geographical location, which limits access to health and education establishments; lack of security in some areas; precarious dwellings with low basic sanitation coverage; lack of adequate hygiene; incomplete and unbalanced diet, and cohabitation with domestic animals -- factors that contribute to the persistence of endemic diseases such as diarrheal diseases, cholera, Chagas' disease *(2)*, teniasis-cysticercosis, and other zoonoses.

As can be appreciated, this ever-dwindling population constitutes a basic strategic group for food security and the primary economy of Venezuela. Paradoxically, however, it constitutes the least protected group and has the least access to basic services.

The rural population is characterized by:

- limited access to land, which is generally poor in terms of quality and location; and with precarious land-holding rights;

- limited capital resources, aggravated by a lack of access to government farm loans and, hence, production inputs and processes;

- low-yield production processes. The situation is exacerbated because products are frequently of low quality and subject to large losses resulting from inadequate food conservation and marketing;

- labor and management performance, adversely affected by precarious environmental, nutrition, and health conditions;

- solidarity within social groups, but little confidence in community organization. Cooperation in facing problems together is limited and inefficient;

- Poor training impedes the optimal and rational use of available resources.

Similarly, a glance at the current situation of the rural population in Venezuela reveals the following characteristics:

- twenty-six percent of producers are illiterate. if the people with less than a third-grade education are included, some 49% of the total population is semi-literate;

- for 88% of the rural population, the production unit constitutes the principal source of employment. All other activities, such as housework, street vending, and freelance or day work, are secondary;

- forty-five percent of the producers do not belong to any grassroots organization. The rest are affiliated with unions, agrarian centers, credit unions, rural enterprises, service units, and mechanization centers with little legitimacy.

- The most common housing is precarious and consists of a single room; 17% of the population lives on small ranches, and 16% in houses with a medium level of comfort *(3)*.

There has been a pronounced abandonment of the countryside. In 1988, there were an estimated 2.2 million hectares under cultivation; by 1993, this figure was estimated at only 1.7 million, while the total number of people dependent on agriculture decreased from 812,000 to 762,000 as a consequence of the economic measures put in place *(4)*.

In short, the panorama in the region, particularly in Venezuela, shows farmers with little land, rudimentary and inefficient production systems, high unit costs, low yields, and few opportunities for saving or capital formation, no access to credit, and precarious environmental, food, and health conditions.

3. Health Situation of the Rural Population in the Americas

3.1 *Living Condition*

The Region of the Americas is characterized by huge social inequalities and inequities. According to some studies, it is the region with the greatest contrasts in the world. The income of the richest 20% of the population is 20 times greater than that of the poorest 20%. In Asia, for example, this ratio is less than ten to one. These inequalities are expressed both at the international level (when the countries of the Region are compared) and at the national level (when the different social sectors and geographical areas are compared). The inequalities are so significant that their reduction is considered today to be indispensable for the viability and feasibility of economic development plans.

In order to compare the countries of the Region, the living conditions in every country are considered to be related to the level of economic development achieved (which translates into the magnitude of the available resources) and to the predominant model of development (which corresponds to the population's access to basic health and welfare resources). This means that living conditions are related to the level of economic development, and access is related to the cumulative social development in a given country (in addition to other variables).

Using relevant social development variables for health (excluding mortality and morbidity), an Global Indicator of Access to Cumulative Social Development (IGADSA) was constructed. This indicator expresses the cumulative historical access, rather than changes of a cyclical nature. For this purpose, information was used that was available around 1990, under relatively reliable conditions, for a significant number of countries of the Region *(5)*.

The following two tables apply the IGADSA to illustrate the inequities observed among countries of the Region.

Table 1 presents some selected indicators for these countries, according to their IGADSA classification (Table 2). The health services access indicator included in the IGADSA shows a variation among the countries that bears a relation to their level of economic development. In general, the countries grouped as having a greater economic level have also achieved greater access by the population to health systems and services. Over the past few decades there have also been variations in countries within a single grouping (with a similar level of economic development) which reveal differences in the access of populations to health services.

The total estimated Venezuelan population in 1992 was approximately 20,249,000, with a population density of 22.4 inhabitants per square kilometer. Despite growing migration in recent years toward some areas of the Orinoco River basin, the population remains concentrated along the coast and in the Andean area. Of the total population, 17.4% is concentrated in the Caracas metropolitan area and 33.4% in four other states (Zulia, Carabobo, Lara, and Aragua), with a population density in this area of 108.6 inhabitants per square kilometer.

The IGADSA is intended to reflect the degree of access by the population to basic living conditions related to health. However, more interesting than a country's score in relation to others of the Region is the country's profile of indicators in relation to other countries with the same level of economic development.

This index makes it possible to establish, in each of the five country groupings, the existence of prototype scenarios. In other words, the IGADSA makes it possible to establish, within each level of economic development, different typologies according to the degree of access by the population (in non-cyclical terms) to cumulative social development. These typologies express different models of development, especially in their cumulative redistributive nature (Tables 1 and 2). Significant differences in the IGADSA are observed among countries of a single group.

According to the 1990 census, 15.9% of the population lives in rural areas, and 71.5% lives in urban areas with 50,000 inhabitants or more. The population is young, with 13.0% in the age cohort of 0 to 4 years, 24.3% in 5 to 14 years, 20.1% in 15 to 24 years, and only 4.0% in the cohort of 65 years or older.

In Venezuela, several studies have been carried out in recent years on the magnitude of health problems in the country. All of them have shown that living conditions have deteriorated in the country over the past few years: more than in absolute terms, the differences have become more acute among the different social groups. The most recent study divides the population into five groups. It concludes that Group 1, with the best conditions, represents only 1.07% of the population. Group 2,

TABLE 1
HEALTH AND LIVING CONDITIONS
INDICATORS SELECTED BY COUNTRY

COUNTRY	General rate of fertility 1990-1995	Median age 1995	Rural population (percentage) 1995	Percentage of health system access 1990	Population without health system access[1]
GROUP I					
United States of America	2,7	34,2	21,9	99	2,5
Canada	1,78	34,7	23,8	99	0,3
GROUP II					
Barbados	1,80	30,4	52,4	97	0,1
Trinidad and Tobago	2,74	24,0	33,4	97	0,4
GROUP III					
Argentina	2,79	28,0	12,6	92	2,6
Costa Rica	3,14	23,1	47,5	96	0,1
Uruguay	2,33	31,3	9,7	96	0,1
Chile	2,66	26,5	14,1	93	0,9
Colombia	2,67	23,7	27,3	75	8,1
Venezuela	3,12	22,6	7,1	76	4,6
Mexico	3,16	21,7	24,7	77	19,4
Brazil	2,75	24,3	21,3	72	41,7
GROUP IV					
Cuba	1,87	30,1	24,0	99	0,1
Panama	2,87	23,5	45,1	79	0,5
Ecuador	3,62	21,1	39,4	61	4,1
Peru	3,57	22,0	27,8	44	12,1
Paraguay	4,34	20,2	49,3	54	2,0
Dominican Republic	3,34	21,9	35,4	71	2,1
Guatemala	5,36	17,6	58,5	50	4,6
GROUP V					
Nicaragua	5,04	19,7	37,1	69	1,1
El Salvador	4,04	18,8	53,3	59	2,1
Honduras	4,94	18,1	52,3	46	2,8
Bolivia	4,56	19,7	45,6	34	4,7
Haiti	4,79	16,8	68,4	40	3,9

[1] Million of inhabitants
SOURCE: The United Nations Statistics Office and the Health Situation Analysis Program, PAHO

TABLE 2
VALUES OF THE GLOBAL INDICATOR OF ACCESS TO CUMULATIVE SOCIAL DEVELOPMENT (IGADSA), CIRCA 1990, FOR COUNTRIES INCLUDED IN THE STUDY

COUNTRY	Access to the health system	Access to economic resources	Access to the educational system	Access to nutrients	Access to basic sanitation	IGADSA
GROUP I						
United States of America	5	5	5	5	5	5
Canada	5	5	5	5	5	5
GROUP II						
Barbados	5	5	5	5	5	5
Trinidad and Tobago	5	4	4	5	4	4,4
GROUP III						
Argentina	5	4	5	5	5	4,8
Costa Rica	5	5	4	4	5	4,6
Uruguay	5	5	4	4	5	4,5
Chile	3	3	4	2	5	3,8
Colombia	3	3	4	2	5	3,4
Venezuela	3	3	4	2	5	3,4
Mexico	3	3	3	4	3	3,2
Brazil	3	2	2	2	5	2,8
GROUP IV						
Cuba	5	5	4	4	5	4,6
Panama	5	2	4	2	5	3,6
Saint Kitts and Nevis	5	1	5	2	5	3,6
Jamaica	5	2	4	2	4	3,4
Suriname	5	5	3	2	2	3,4
Saint Vincent and the Grenadines	3	1	3	2	5	3,2
Ecuador	1	2	4	1	3	2,6
Peru	1	4	4	1	3	2,6
Paraguay	3	3	3	4	1	2,4
Dominican Republic		2	2	2	3	2,4
Guatemala		1	1	2	3	1,6
GROUP V						
Nicaragua	3	2	2	3	2	2,4
El Salvador	3	4	2	1	1	2,2
Honduras	1	3	2	1	3	2,0
Bolivia	1	2	2	1	2	1,0
Haiti	1	1	1	1	1	1,0

SOURCE: PAHO, Health Situation Analysis Program, 1993.

the middle class, represents 7.09%. Group 3, laborers, constitutes 13.65%; the working poor, Group 4, represent 37.85% of the people; and the most numerous sector of the country, Group 5, lives in critical poverty, and with 40.34% of the population, constitutes more than 8 million of the country's inhabitants. One-third of the fifth group, representing nearly 14% of the total population, lives under conditions of absolute poverty *(6)*.

This situation is directly reflected in the health conditions of different population groups in the country, especially in rural areas and underprivileged urban areas. The percentage of inhabitants with unmet basic needs (UBN) was used to classify the parishes of the country into ten groups. The first group has between 0 and 9% of its population with unmet basic needs; the last group has between 90 and 100%. The existence of large differences in the mortality structure, according to living conditions, was demonstrated *(6)*. Infant mortality is 2.5 times higher in the group with the worst conditions than in the first group. Mortality from communicable diseases is three times higher in the last group, and mortality from perinatal causes is six times higher. Practically all the cases of neonatal tetanus recorded in recent years occurred in groups that had 70% or more of their populations with unmet basic needs.

Mortality from cardiovascular causes, neoplasms, and external and other causes are in comparable ranges, with variations of plus or minus 20%.

These studies demonstrate the need to develop differentiated interventions and plans for priority attention in rural and underprivileged urban areas.

3.2 *Problems of Health and Disease*

Unfortunately, it is not possible to make a thorough comparison of what we refer to in this day and age as health indicators. In fact, the statistics, first begun in the 15th century, are still in their infancy. Yet, we still can draw a profile of the principal sanitary problems in the Region at the close of the 20th century. The following are merely preliminary contributions to this profile.

INEQUITY is considered to be the greatest challenge in the sociosanitary balance in the Region. By inequity we mean not a simple and occasionally desirable inequality, but those inequalities that are unnecessary, unjust, and avoidable. This is not abstract inequity, but specific inequity, in every home, in every town, in every walk of life. Therefore, there is not one kind of inequity, but several: those related to gender and politics, culture and technology; monetary inequity; inequities in access to drinking water; age and diet inequities; urban and rural inequities; inequities that we create today, and those that we have inherited; those that we produce here, those that we import from abroad, and those that are imposed from above; inequity as context and as a problem in

which we understand and articulate several other problems that, taken separately, appear to be insignificant or incomprehensible *(8)*. We will briefly illustrate this assertion.

Nevertheless, in fields in which we have generally advanced, inequities continue to grow more acute. Consider two examples: *infant mortality* and *life expectancy at birth*. In its last *World Development Report*, the World Bank points to the increase in life expectancy and the reduction in infant mortality as two of the achievements of poor countries in the past 40 years. However, few indicators show the increase in inequity throughout the world so clearly.

Infant Mortality. From the cradle of poverty, come hunger, malnutrition, and undernourishment. According to the United Nations Development Program, one out of every three children in poor countries suffers from severe malnutrition. There are an estimated 800 million people who still don't have enough to eat, and an estimated 40,000 children who die every day from malnutrition and preventable disease. In Guatemala, two out of every three rural children are malnourished, while malnutrition affects 40% of Bolivian schoolchildren in rural areas and 25% in urban areas.

Life Expectancy at Birth (LEB). The world average is today 64.7 years, one of the few quantitative indicators that favors women, for whom the average LEB is 66.7 years, while for men it is 62.7. The figure indicates that just because women may live longer, they do not necessarily live better. In almost all countries and socioeconomic strata, living conditions among women are worse than among men. However, the most significant difference is not determined by sex, but by poverty. In addition, in 1990, life expectancy at birth reached 70.1 years in Venezuela, with a higher value of 73.3 years among the female population, while it was 67.0 years for males (MSAS,1992) *(9)*. Nevertheless, it should be pointed out that this is not uniform for the different social groups, since in Groups 1 and 2 the average age at death is estimated at 70 years; in group 3 at 62; in group 4 at 61; and in group 5 at 58 years, thus indicating a 12-year range between the highest social strata and that of extreme poverty *(6)*.

From the same perspective, the issue of ecology today is not a simple question of preferring the color green. It is a problem of interrelations, of interactions between man and nature, man and man, society and society, which are mediated by nature. It is a problem of interrelationships between levels, dimensions, and physical, economic, political, and sociocultural realities. And it is also a problem of equity; of those who have drinking water, clean air, little noise, and a good climate, and those who do not. It is a problem of who pays for the damages, who can exploit natural resources, and how; of who wishes to reduce carbon emissions, and who will order it, or order the shutdown of a polluting factory, or the transport and relocation of nuclear waste.

The relationship between the environment and health has been sufficiently demonstrated and documented. From the eastern cosmogonies and those of pre-Columbian peoples, through the Hippocratic studies, those of Snow on the 19th century cholera epidemic in England, up to the most recent studies on the current epidemic of the same disease, there are many indications that we fall ill and die largely from the way we relate to animals, plants, water, the sun, and the air.

Venezuela is in an advanced phase of demographic transition, and health problems associated with underdevelopment coexist alongside characteristics of industrialized countries. This is because the population structure consists mainly of young people who have a growing life expectancy. However, an important percentage of the population continues to subsist under bad living conditions.

In analyzing mortality *(9)*, the leading cause of death in the 1-to-4-year age group is accidents (23.4% of the diagnosed deaths in 1988), closely followed by acute respiratory infections and diarrheal diseases. In the 5-to-14 age group, accidents were a more frequent cause (41.5% of the diagnosed deaths in 1988). In 1988, deaths from external causes in general represented 65.9% of diagnosed deaths in the 15-to-24 age group (76.5% of them male).

Continuing the analysis, Table 3 presents the specific estimated mortality rates for six major causes (per 100,000 population), according to living conditions. The rates for communicable diseases and for perinatal causes practically triple from the first to the fifth group. In Group 1 (the best living conditions) these two combined causes represent only one-third of the rate for cardiovascular diseases (50.2% and 150.3%,respectively). However, in Goup 5 (the worst living conditions), they almost reach the cardiovascular rate (144.8% and 156.0%, respectively). It is important to note that the rates decline only for the external causes group. For all other groups, they either increase (almost triple for the two groups indicated) or they remain practically constant, with a slight reduction in the intermediate groups.

The morbidity data are generally limited, with low coverage for the entire country and for specific population groups and problems. The Ministry of Health and Social Welfare, through its different bureaus and divisions, is practically the only source of data. Other public and, especially, private sector institutions do not report data or do so only partially. Previous estimates that the public sector covered 90% of the population appear not to be confirmed. According to the results of the social survey for 1991, only 54.4% of the population 10 years of age or older with acute diseases or injuries that required attention, went to an ambulatory facility or public hospital, 34.0% was attended in private clinics, and the remaining 11.6% sought some other type of care. Moreover, 33.6% of the same population of 10 years or older did not request care for different reasons.

TABLE 3
MORTALITY PER 100,000 POPULATION BY MAJOR TYPES OF CAUSES, ACCORDING TO LIVING CONDITIONS, 1989

Types of Causes	Strata according to percentage of population with Unmet Basic Needs (UBN)					
	0% a 19%	20 % a 39 %	40 % 59 %	60 % a 79 %	80 % a 100 %	Total of the country
Communicable	32.7	47.3	56.8	88.2	92.8	55.9
Neoplasms	76.2	60.7	57.7	58.6	63.3	61.1
Cardiovascular	150.3	127.1	127.2	144.7	156.0	132.8
Perinatal period	17.5	34.9	43.6	49.2	52.0	38.5
Other Causes	97.5	96.8	100.0	110.5	111.3	100.2
External Causes	55.8	51.6	44.8	45.0	42.1	48.6

The years from 1985 to 1993 have witnessed the return of diseases that had not been seen (cholera) or of new epidemic outbreaks of diseases that had been absent for several years (dengue), and the resurgence of others that had almost been brought under control (malaria). To a great extent, this reflects the deterioration in living conditions among broad sectors of the population.

3.3 *Local Services*

Pronounced inequity in access to services can be more easily observed among underprivileged urban populations and scattered rural ones, whose health problems derive from the usual pathology of poverty, a situation that is combined with problems of violence and environmental degradation *(10)*.

Until now, health services and social services in general have not accomplished all that they should, as indicated by their inability to take decisive action and the low level of satisfaction of users' needs. The health sector underutilizes 25% of its budget, while more than a third of the population does not have access to health services. The quality of activities is deficient, and there is a growing dehumanization in the relationship

of services to the community, which translates into high mortality and an increase in the prevalence of preventable diseases.

The social policy in many of our countries has been characterized by a lack of focus in health care programs and the concentration of resources in areas that usually have little impact on the satisfaction of collective needs. This situation obviously presents significant inequalities.

In 1985, Venezuela invested 40% more per capita in the social sectors than Costa Rica and twice the amount invested by Chile. All three countries suffered the impact of the recession of the 1980s. However, the negative effects on the well-being of children have turned out to be substantially greater in Venezuela.

A central problem in the 1990s was the fact that strategies for services were not in line with the needs of the population, nor with resources available. In education, most of the budget goes to the university sector, which is out of reach for the most disadvantaged. In health, resources are directed toward curative medicine and the hospital sector, at the expense of preventive interventions. Nonsalaried people are excluded from the benefits of the social security system. Public sector nutrition expenditures virtually do not reach the most vulnerable. These inequalities take on greater significance if we acknowledge that resources for social policy have been allocated and distributed primarily from the central level of government.

Another particular danger has been brought on by the decline in real spending on priority sectors and programs, which has affected the expansion of coverage (e.g., preventive programs) and contributed to a deterioration in quality (e.g., basic education).

In the case of Venezuela, the five most important institutions of the health sector are in the public subsector: the Ministry of Health and Social Welfare (MSAS), the Venezuelan Institute of Social Security (IVSS), the Government of the Federal District (GDF), the Institute of Social Welfare of the Ministry of Education (ME), and Military Health (SM).

The activities carried out by the MSAS, in absolute numbers, have fallen in recent years, possibly as a reflection of the crisis, just as public sector coverage in general has dropped in the past few years. By the mid-1980s, coverage was believed to be approximately 90%. Currently, we speak empirically of 60% coverage. According to the 1991 social survey, in response to the question regarding the type of service used by persons 10 years old or older with acute diseases or injuries that required attention, 34.0% answered that they had been seen at a "private clinic", 54.4% in an ambulatory facility or a public hospital, and the remainder in other types of facilities, such as medical services in the workplace and pharmacies. Of the total persons 10 years or older

with injuries or acute diseases, 33.6% had not requested care of any kind. Of these, 17.7% stated they did not due to a "lack of resources" and 5.6% because "they do not like the public service *(11)*."

In addition to the above, the phenomenon of competition and competitiveness has grown in most of the countries of Latin America and the Caribbean and has promoted more productive organizational schemes and performance. Government institutions are also being affected by this new wave which, among the state reforms promoted by international organizations, encourages the transfer of the tasks of administration and the delivery of goods and services handled by governments in previous decades to private groups *(11)*.

In recent years, the consensus has grown throughout the Region that there is a need for introducing changes into the health sector. In several forums that analyzed the situation, the conviction emerged that it is necessary to expand health program coverage to important population groups. Social security agencies, duly reformed, are viewed as systems that are capable of playing important roles in the satisfaction of those needs. This represents a hope and a challenge to strengthen the mechanisms of interinstitutional coordination in the health sector.

Within this overall framework, the economic and social reality of the countries demands new approaches to meet the goal of health for all. The responsibilities of the health and social security institutions should be more clearly defined. Growing private sector participation in the delivery of services demands better coordination with public entities, which cannot transfer their responsibility to oversee the system and to maintain the solidarity, universality, equity, efficiency, and effectiveness of health services.

4. Social Sector Participation and Intersectoral Development Activities from a Strategic Approach

4.1 *Analysis of an experience: comprehensive rural development project*

According to the Minister of Education of Venezuela, in the document "Education and Peace" *(13)*, two clearly differentiated patterns coexist in the Venezuelan educational system: a pattern of excellence and a pattern of deficit, a statement that holds true for the social sector in general.

This situation especially affects children and young people, with great differences between urban and rural populations. The pattern of excellence is very pronounced in the urban area where greater access is found, in contrast to the rural area, where there is a pronounced pattern of deficit.

The challenge of breaking out of these patterns of inequity can only be met with different development strategies that, in the case of agriculture, education, and health, allow the traditional services of public institutions to be concentrated in centers that encourage the empowerment of rural communities to improve their living conditions. This also means exchanging the classical scheme of attention to pathology and survival for a scheme to promote healthy lifestyles and living conditions. Such a shift can only take place through joint action that promotes comprehensive development under an integrated and integrating plan of action that strategically combines efforts to develop the ability to live better.

The new comprehensive health approach leads to service delivery that is more equitable, universal, humane, and democratic. Health protection and promotion also require substantial intrasectoral and extrasectoral coordination. Such coordination must help to achieve sustainable comprehensive development, which means that it is necessary to formulate and implement a legal framework and effective mechanisms of intersectoral coordination among the fields of economics and finance, trade and industry, housing, sports and recreation, education and culture, and public food programs, particularly with respect to the relationship between poverty and disease, and to establish a close correlation between social equity and equity in health based on the democratization of knowledge, information, and practices. This model demands a comprehensive analysis of the health situation in order to identify problem areas and orient development through a comprehensive approach and the appropriate use of existing resources in a given population area, which is not just a geographic territory, but a demographic, socioeconomic, epidemiological, and political one as well.

The modernization of the State will make such efforts viable, through the structural and functional transformation of its organizations to help to meet the needs of the population.

Advances are being made possible through a process of strategic management, which prioritizes policy-making, confrontation and negotiation between the players, the development of technical capability, and conscious community participation. The Comprehensive Rural Development Process is found in three municipios (Pío Tamayo, Moroturo, and Quibor) in Lara State, Venezuela. The process is operating from a sustainable development approach, based on a close interrelationship between economic efficiency and social equity with environmental preservation, in order to ensure stable and diversified growth in the production of goods and services for the continuting satisfaction of human needs.

The process was based on the potential of each of the local inhabitants and institutions, offering opportunities to different population groups so that an educational process that raised their consciousness would be used to develop productive capacities,

organize people to practice empowerment, and promote health through mutual and collective action. People would take over the analysis and solution of the problems that affect them, and they would do this with the support of local and national government guarantors of social and human rights and a sympathetic and just private sector.

There is a need for social policies, implemented through the process, to go beyond the regulatory framework of distributive justice. This approach does not view development solely in terms of improvements in productive parameters or health indicators. Rather, development is understood as an improvement of the people, by the people, and for the people, both within the institutions and, particularly, among the population which is the source of legitimacy and the raison d'etre of development. In short, this is a type of development aimed at being more not just having more *(13)*.

The principal objectives were defined as:

- establishment of development models that prioritize the population as the agent of the process;

- improvement of living conditions as a fundamental strategy;

- achievement of participatory democracy;

- incorporation of women as agents of change in the family and community structure.

To achieve the proposed objectives, we should consider the process of decentralization that is currently taking place in Venezuela and that is increasing the importance of many players who determine the orientation of development processes at the level of the State and the municipio. They are integrating technical, political, and administrative aspects where people live and in their areas of common interest, benefits, and mutual obligations *(14)* and prioritizing health promotion and the quality of life. This allows the field of health to contribute to social well-being and to comprehensive development, which are prerequisites for realizing the full creative and productive potential of the population, transcending the traditional approach centered on disease and death.

Using this health and development approach, the participation of PAHO and other international cooperation agencies and organizations must take into account the presence of new participants who act as counterparts and whose operations extend beyond the realm of the traditional field of cooperation, challenging these agencies to democratize their practices and make them flexible, and making it possible to approach local and regional experiences with solidarity and respect.

Through a series of local interinstitutional workshops, a first attempt was made to identify and describe the characteristics of the development process. They include:

Strategic Characteristics. From the beginning, the strategic approach was used in the planning of activities. Problems were approached using a comprehensive concept that corresponded to a strategy that integrates multiple players, articulating social needs and employing a common approach to improve living conditions.

Intersectoral Characteristics. Considering the preponderant role of the state and local levels, the Process becomes one of support for human resource development and the development of strategies through interinstitutional and intersectoral coordination, which on the basis of common objectives are voluntarily and consensually linked. This linkage is attempted through horizontal or nonhierarchical communication, in which the leadership processes constitute the guiding, broadly participatory, democratic element.

Participatory Characteristics. To the extent that a work methodology based on full participation is used, the critical role of the individual will be strengthened and promoted. This is because, upon becoming an active agent in the process, the individual will consciously take over his or her own situation and will creatively attempt to apply mechanisms to transform it. Participation will also strengthen decentralization as an instrument for the redistribution of power and the democratization of civil society and its institutions. It implies the access of the people involved to decision-making authority, which means the democratization of power structures.

Unique Characteristics of Each Community. Participation as a fundamental element of the process is indispensable for knowing how to differentiate the unique social problems of each community, which require different solutions.

Promotion of Women. From the gender perspective, it is recognized that women have historically been divested of opportunities to act as agents of development and health, in particular. The Comprehensive Rural Development Process makes it possible to reappraise women from a comprehensive perspective, incorporating their capacity to transform, create, and educate.

Project Formulation. Projects have been formulated using the logical framework methodology, with the participation of representative groups from the communities as well as institutions. This formulation has taken place within the framework of a broader process of identifying a vision of the future, situational analysis, the identification, explanation, and prioritization of problems, strategy design, and project implementation with monitoring and evaluation mechanisms.

Self-Sustainability and Co-management. Self-sustainability of the process and the projects should be achieved so that communities or grassroots organizations will, after a time, no longer need an external cash flow to continue operating. In the ideal situation, it is hoped that technical assistance services will also be paid for. Community and institutional resources and decision-making, in particular, are subjects of ongoing negotiation between communities and institutions.

Local Strategic Administration. This is the effective and efficient way to relate the social and health problems and needs of different groups in a locality or region to institutional knowledge and resources in a manner that allows priorities to be defined and many real options for action to be considered and which allocates resources and leads the process to a resolution of the problem. The purpose of this administrative model is to promote consensus, to reconcile interests, to coordinate efforts, and to forge consensus around common goals for everyone. It cannot be divorced from the context and goal of contributing to the democratization of the State and of society.

4.2 *Achievements of the process*

Field visits were carried out, as were interviews with managers, representatives, and technicians of state institutions, and community members. Three strategic planning workshops were held with technical personnel from institutions and communities initially identified as participants in the process.

On the basis of these consultations, a general idea of the regional context was outlined and the processes to restructure the state apparatus were identified. These processes have involved budget cuts and decentralization with little interinstitutional coordination, which has led to a duplication of efforts, unhealthy competition, and a lack of cooperation and support for some projects that are technically feasible, but not politically or financially viable.

These general conditions, along with the acute national economic crisis, have had a negative impact on the motivation of technicians and promoters, who have had little training and few refresher courses, and have called attention to a consequent loss of **legitimacy** among the institutions.

Lara State has great productive potential in terms of human resources, and there exists a basic belief in the innate capacity of campesinos and a strong desire to see people grow in their self-determination and self-fulfillment. With this perspective, some state institutions such as the State Unit for Agricultural and Livestock Development (UEDA) of the Ministry of Agriculture and Animal Husbandry (UEDA), the Agriculture and Livestock Health Service (SASA), and the Ministry of Health and Social Welfare (MSAS), in coordination with the Pan American Health Organization (PAHO), have

designed and implemented a Proposal for Comprehensive Rural Development that is economically and ecologically sustainable, socially acceptable, and has a high degree of community participation as a fundamental characteristic.

A series of workshops have been held with the following objectives:

- to standardize the concepts of comprehensive development and strategic planning;
- to reconcile interests in designing a target situation or common goal;
- to perform a situational analysis through a general analysis, with prioritization of the issues and players at the institutional and community levels;
- to create a group of promoters of the planning process with community outreach;
- to create a first draft of a plan for institutional development and strengthening.

The next step, which lent legitimacy to the entire planning process, was to hold workshops around issues with the communities and to design projects using the logical framework methodology. Currently, at the demand of the communities and from the need to **achieve quick and demonstrable** results, some of the short-term, low-cost, and highly efficient activities have been carried out even while revisions are still being made and medium- and long-term designs are being completed.

The field visits have demonstrated interinstitutional coordination, the high potential of productive resources, the physical infrastructure and that of organizations capable of providing needed support for the educational process inherent in every sustainable development project. In addition, a considerable ability to enlist support is being developed by the government institutions. Most importantly, communities now wish to have a leading role in any effort or project undertaken.

Several communities were selected for visits, on the basis of criteria related to access, strategic location, organizational base, health conditions, productive potential, and institutional presence. These criteria made it possible in one of the planning workshops to select Sanare initially, and later, Moroturo and Quibor.

Each of those areas has its own agro-ecological conditions and agricultural and livestock potential, but they have in common an environmental degradation problem resulting from the improper use of agricultural chemicals, poor soil management, and the presence of development institutions.

Pío Tamayo Parish (whose capital is Sanare) displays a strong organizational and motivational foundation, that has a potential for replication and is capable of providing the support and training necessary for future extension workers or promoters and producers in the area. Its level of rural development requires more advanced support, institutional development, and income-generating activities, such as revolving credit programs and women's organizations.

The work performed during 1994 was done at the institutional level and at the level of the selected community and of communities that were candidates for imminent participation in this Proposal.

4.3 *At the institutional level*

In the workshops, several entities that work in development at the state level were identified, in addition to the Ministry of Agriculture and Animal Husbandry and the Ministry of Health and Social Welfare. These are:

- Universidad Centro Occidental Lisandro Alvarado;
- Ministry of Education;
- Government of Lara State;
- National Fund for Agricultural and Livestock Research;
- "Vecinos" schools;
- Agricultural and Livestock Credit Institute;
- Ministry of the Family;
- Environmental Quality Project for the Quibor Valley;

For a preliminary analysis of the situation inside the institutions, in 1994, the drafting of an initial plan for institutional strengthening and development was established as a work objective. This process is currently being resumed now that project activities in the communities have begun.

These work efforts have revealed the deep commitment of the personnel in the institutions to achieving true human resource development, as well as greater contact and interinstitutional exchange, especially with the communities, where the reestablishment of institutional legitimacy takes place.

At this early time, the target institutional situation can be summarized as follows: "An institution should have a well-defined mission and policies, constant and close contact with other institutions, and have appropriate personnel, who are properly trained, up-to-date, remunerated, placed, and endowed to help to achieve social well-being."

It was agreed that the ultimate consequences of the entire problem is the failure to achieve community well-being, which spells a loss of legitimacy for institutions that fail to contribute to the goal for which they were created.

The following strategies were defined to build viability:

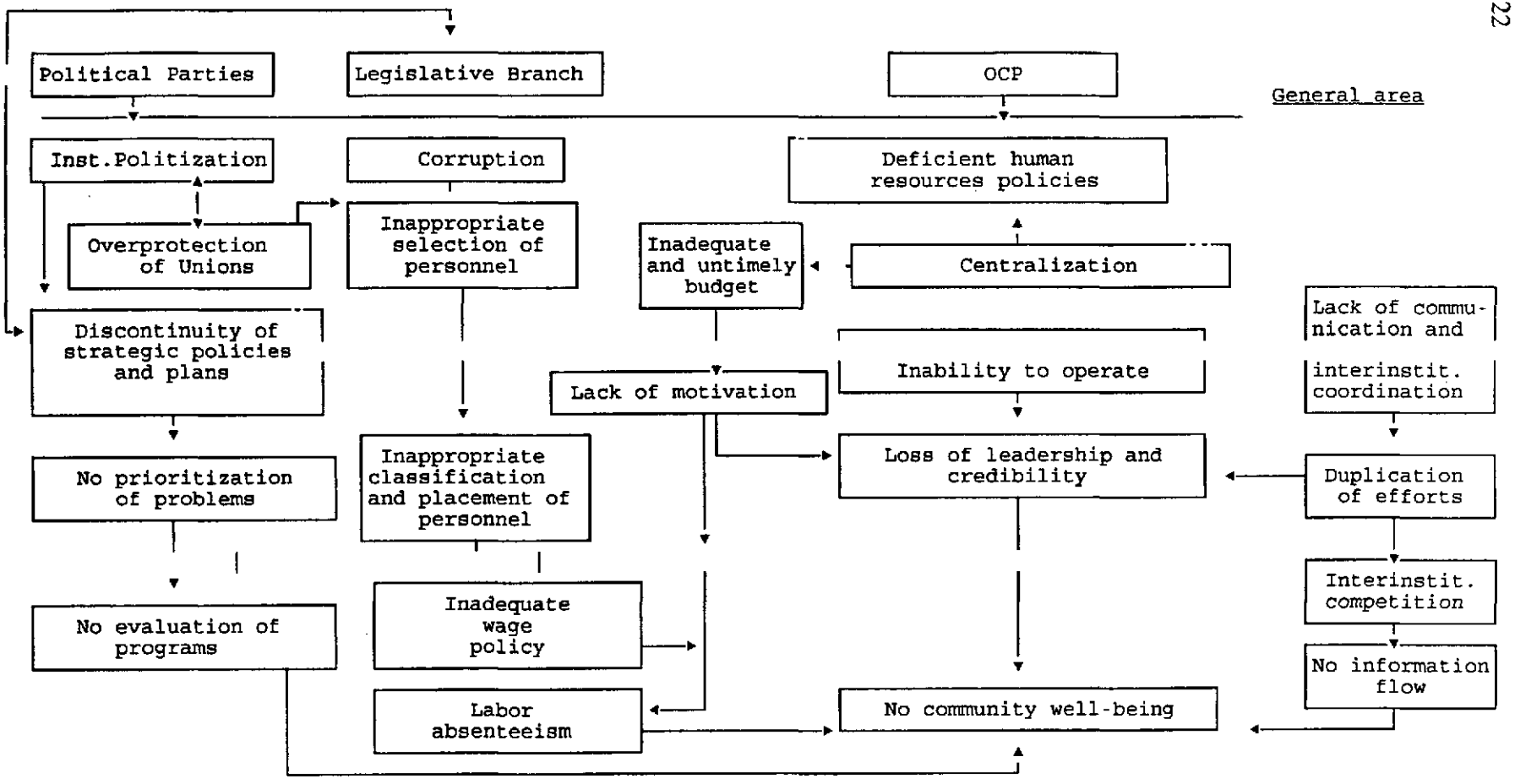
- facilitating the development of policies to upgrade personnel (training, distribution and performance analysis, incentives);

- promoting action at the local level to achieve effective policies that have continuity and make rational use of personnel management.

In addition to improving aptitudes, it is necessary, in the projection toward community work, to achieve a change in technical attitudes, through additional training in extension (or promotion) techniques for sustainable development, as well as participatory methodology and strategic planning.

The change in technical attitudes not only holds benefits for the community, but also frequently engenders a multiplier effect. It also influences its immediate environment and the institution itself. This change has begun within the individual and the future is being built today.

FLOW CHART OF PROBLEMS (1st Approximation)



Opportunity for Legitimization

4.4 *At the community level*

The work began with participatory workshops on issues and planning with municipal representatives and representatives from the communities of Sanare and Moroturo (Santa Inés). Problems were prioritized (see network of Problems on page ..), and as part of a learning process, a set of operations (projects and programs, inter alia) was designed entirely at the community level, with initial institutional support. The work that currently is being carried out by the interinstitutional team consists of refining the conceptualization of goals, outcomes, indicators, and activities, and writing up the work. Once this is accomplished and local and external resources are analyzed, there will be a review of the plenary meetings, and operational plans will be prepared.

It is important to reiterate that some activities have been undertaken, such as courses in micro-agroindustry and livestock activities, and analyses of financing alternatives, the latter of which is a relatively new and undocumented experience in Venezuela.

The immediate requirements of the beneficiaries impose a maximum duration of one year. However, the larger requirements of strategic planning must be borne in mind. Projects will be proposed and accompanied by overarching parallel projects with a three- to five-year time frame, which will conserve the characteristics of the process presented in July 1994. These parallel projects will also include intra- and interinstitutional development based on the results of the three 1994 strategic planning workshops and those that may take place in 1995.

The proposal of the national government was initially made by the Ministries of Health, Agriculture, Education, and the Family, which are involved in joint and participatory activities with the communities. From the beginning, in May 1994, the proposal has enjoyed the support of the Pan American Health Organization, which has also developed a joint strategy for its programs with the different sectors.

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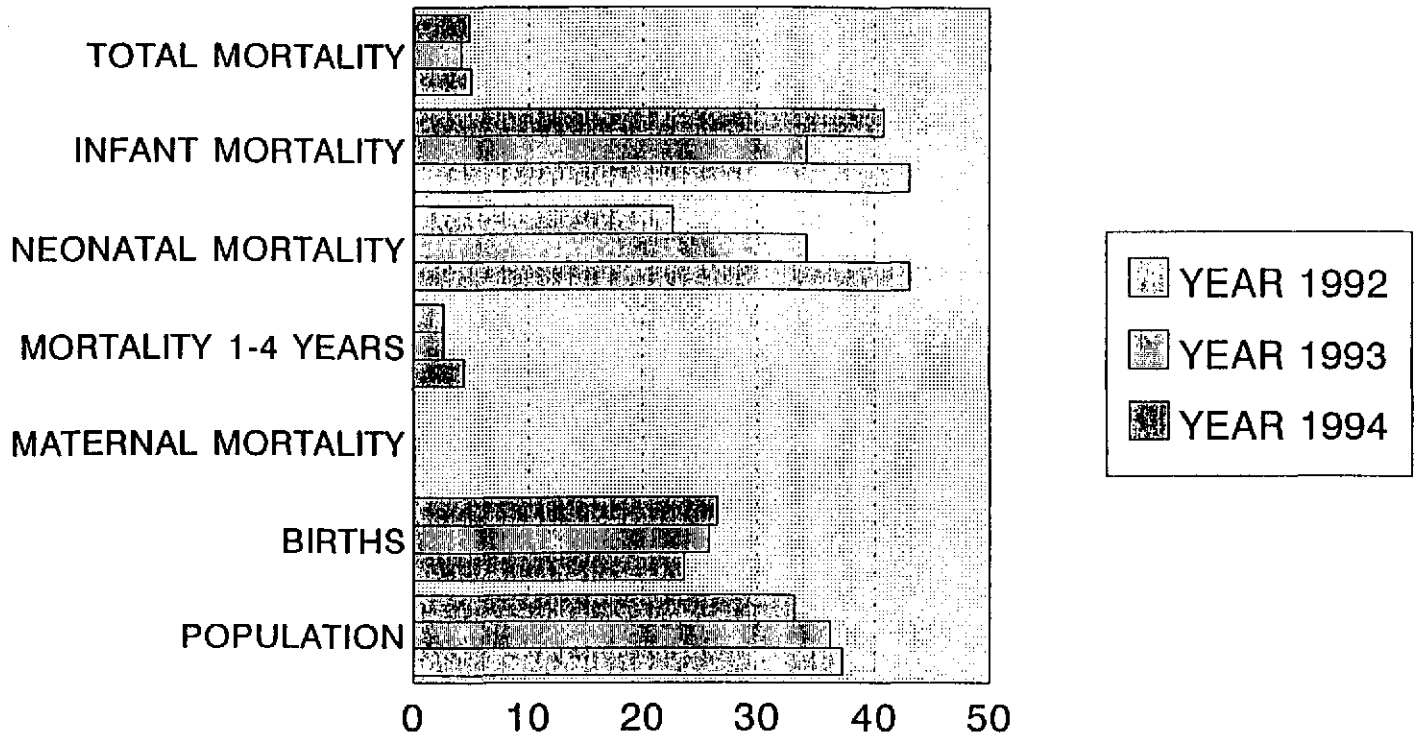
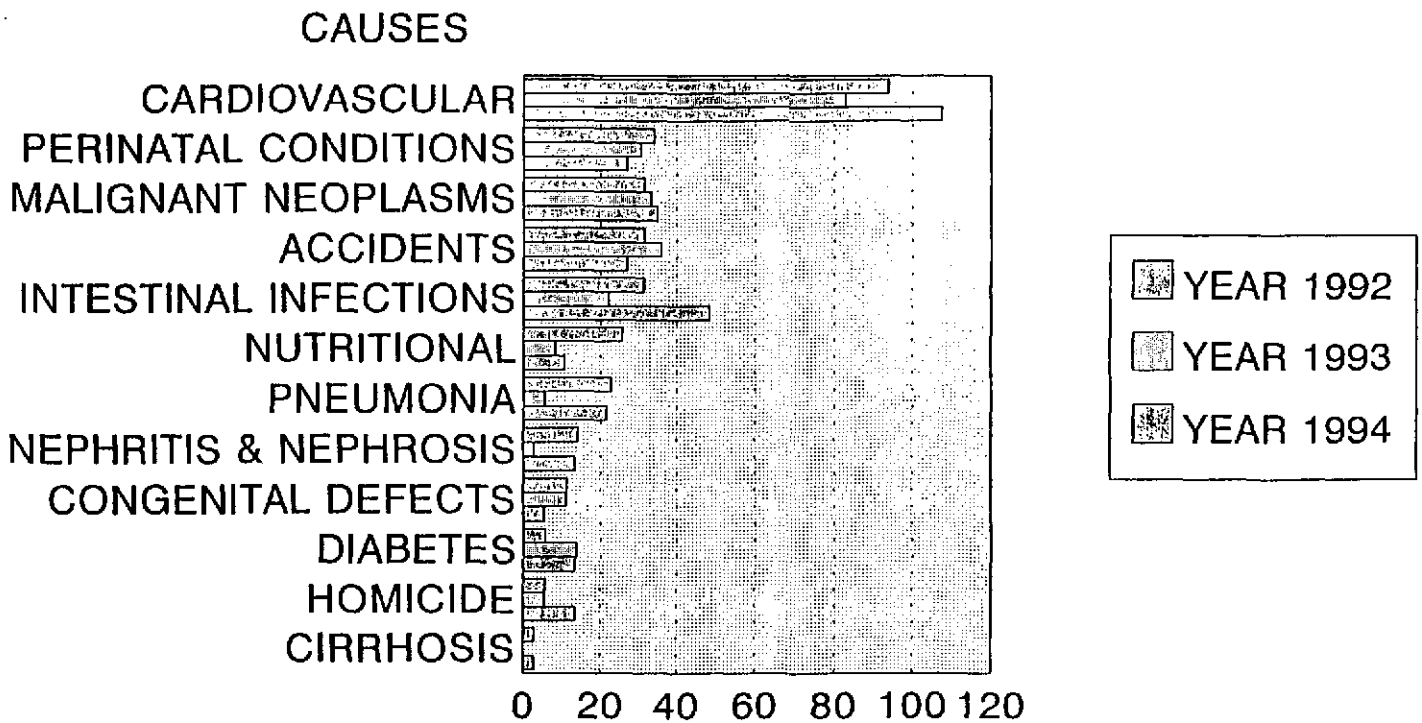
ANNEXES

HEALTH INDICATORS FOR THE SANARE HEALTH DISTRICT, LARA STATE (VENEZUELA) 1992-1994



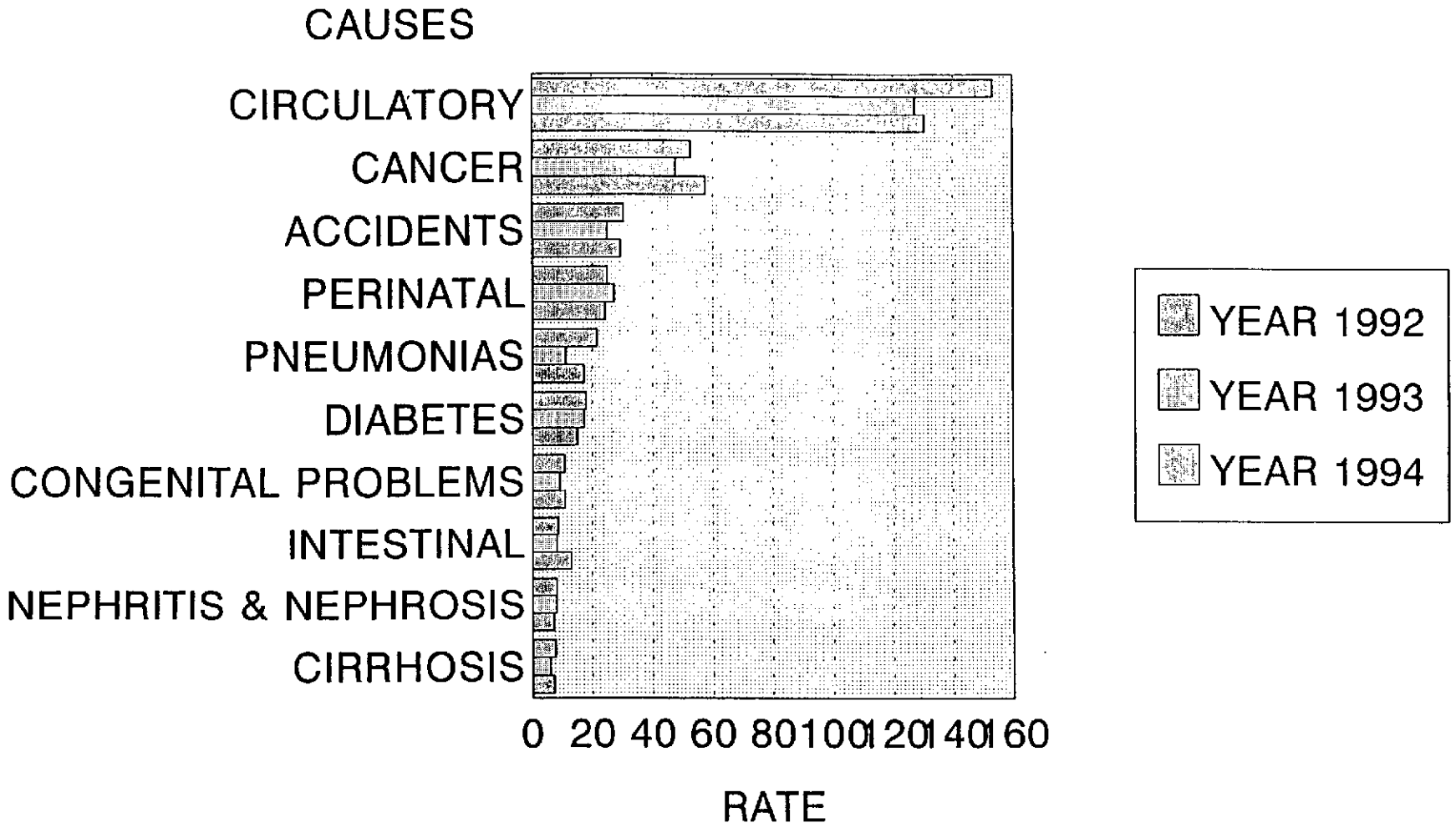
SOURCE: REGIONAL EPIDEMIOLOGY, LARA STATE - VENEZUELA

PRINCIPAL CAUSES OF MORTALITY
DISTRIC OF SANARE, LARA STATE
VENEZUELA - 1992-1994



SOURCE: REGIONAL EPIDEMIOLOGY, LARA STATE, VENEZUELA

TEN PRINCIPAL CAUSES OF MORTALITY
LARA STATE, VENEZUELA - 1992-1994



SOURCE: REGIONAL EPIDEMIOLOGY, LARA STATE, VENEZUELA

COMPREHENSIVE RURAL DEVELOPMENT PROPOSAL
VENEZUELA, 1994 - FUTURE

DEVELOPMENT OF STRATEGIES TO IMPROVE HOUSEHOLD INCOME TO CONTRIBUTE TO THE IMPROVEMENT OF LIVING CONDITIONS

DESIGN AND EXECUTION OF PLANS FOR CONTINUING EDUCATION, COMMUNICATION, AND PROMOTION IN HEALTH

DESIGN AND DEVELOPMENT OF MONITORING AND EVALUATION SYSTEM (HEALTH SITUATION, LIVING CONDITIONS, ACHIEVEMENTS OF THE PROCESS, PROJECT IMPACT...)

DEVELOPMENT OF COMPREHENSIVE, PARTICIPATORY, HUMANE HEALTH CARE MODEL

COMPREHENSIVE RURAL DEVELOPMENT PROCESS - VENEZUELA 1995