



PAN AMERICAN HEALTH ORGANIZATION  
WORLD HEALTH ORGANIZATION



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

The Strategic and Programmatic Orientations (SPO) constitute the policy guidelines for the Pan American Sanitary Bureau (PASB) in each quadrennium. They represent an analysis of conditions and needs in the countries of the Region of the Americas and are directed toward the achievement of the world goal of Health for All. Moreover, they represent the response of the Bureau to the new global policy of Health for All in the Twenty-first Century and the General Program of Work of the World Health Organization.

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

In addition, the most important environmental factors that will have to be addressed to meet the needs of the Region's inhabitants are noted, and there is a description of the SPO that the PASB will focus on in its technical cooperation with the Member States of the Pan American Health Organization during the period 1999-2002. Each SPO represents the Secretariat's specific efforts in search of equity in health during this period.

In this version submitted for the consideration of the 25th Pan American Sanitary Conference, the diagnostic part has been condensed and the Programmatic Orientations added and revised to avoid duplication, in keeping with the suggestions that emerged from the national consultations and the 30th Session of the Subcommittee on Planning and Programming and the 122nd Session of the Executive Committee. Compliance with the current SPO is also discussed, some goals and strategic orientations are more clearly defined, aspects of technical cooperation among countries and health sector reform are emphasized, and adaptations are made to meet the challenges posed by the environment and to take advantage of the opportunities it presents.

The Pan American Sanitary Conference is requested to examine the Strategic and Programmatic Orientations for the PASB for the period 1999-2002, and consider adoption of the resolution (CE122.R4) proposed by the Executive Committee.

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## EXECUTIVE SUMMARY

The Strategic and Programmatic Orientations (SPO) constitute the policy guidelines for the Pan American Sanitary Bureau (PASB) in each quadrennium. They represent an analysis of conditions and needs in the countries of the Region of the Americas and are geared toward achievement of the world goal of Health for All. They also represent the response of PASB to the new global policy of Health for All in the Twenty-first Century and the General Program of Work of the World Health Organization.

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

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

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

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

The document also analyzes the environment, that is, aspects external to health that affect not only the health conditions of the people but also the work of the international organizations and institutions.

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

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

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

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

Further on, it proposes that, bearing in mind the goal of Health for All and assuming that it is achievable, the Secretariat respond with an ongoing effort to seek the highest level of physical, mental, and social well-being for all the inhabitants of the Region,

reducing existing inequities in health until they are eliminated altogether. One of the frameworks for action is the new global policy of Health for All in the Twenty-first Century approved by WHO, which is the outcome of the renewed commitment to the goal of Health for All.

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

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

## 1. Introduction

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

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

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

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

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

## 2. Current Situation<sup>1</sup>

### 2.1 General Situation

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

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

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

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

In the majority of the countries of the Region, the growth of international trade in goods and services in the field of health has had a visible impact on both the public and the

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

private sectors, although up to now this impact in the public sector has been concentrated in the area of goods: equipment, drugs, biologicals, and medical-surgical materials.<sup>2</sup> In the private sector, people who travel in search of medical care and in the procurement of health services from the transnational companies that have established themselves in the countries also express the impact in the volume of expenditures abroad. In the immediate future, telemedicine services will begin to capture a market share in both sectors.

The energizing force is exclusively economic in nature and connected with globalization and the growth of the market. One of the areas where changes in consumption patterns linked with health are visible is food and nutrition, excessive consumption of alcoholic beverages, with the associated traffic accidents, and tobacco use, manifested especially in growing use by women and young people, are also important.<sup>3</sup>

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

The global processes under way in the Region are expected to persist, becoming more patent and widespread.

## **2.2 *Health Situation***

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

Public policies geared toward State modernization and reform and the privatization of essential services in the Region have already found expression in the health sector. Thus, environmental and basic sanitation services, including water supply in urban areas, are in an advanced stage of privatization. Many countries have designed or are carrying out health sector reform, which includes schemes for the decentralization of public health

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

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

services, greater private sector participation in the medical services delivery, and health care financing models.

At the same time, the Region is in the process of a demographic transition marked by changing patterns of morbidity that influence the demand for health care and, hence, the education and training of primary health care workers. Thus, while infectious and re-emerging diseases remain a significant problem in the Region, chronic and noncommunicable diseases are on the rise. This has generated a demand for resources for curative medicine and for promoting healthy behaviors and healthy environments that will facilitate attainment of optimal health and well being, together with healthy aging.

The proportion of the gross domestic product (GDP) allocated to health in the countries has been increasing, growing from 5.7% of the GDP of the Region in 1990 to 7.3% in 1995. This growth has meant higher out-of-pocket expenditures for the population, since public expenditures, which were 43% of total expenditures in 1990, fell to 41.5% in 1995. This has led to an increase in the number of private health care providers, relegating the steering and regulatory role as well as the monitoring of the system to the State, which in most cases has also retained responsibility for providing coverage for the lower-income population. Innovative forms of health insurance, financing, and service delivery are being adopted as a result of these changes.

However, there are still marked differences among the countries. In the upper-income countries, national health expenditure represents more than 10% of GDP—in per capita terms, more than US\$ 1,600 a year. In middle- and lower-income countries, in contrast, this figure is less than \$90 and \$35, respectively, or nearly 6% of GDP. Generally speaking, countries with higher income per capita spend 45 times more on health than lower-income countries.

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

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

under 5 years of age; these diseases claim more lives in countries where the per capita GDP is lower.

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

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

### 2.2.1 *Mortality*

Mortality indicators have improved over the past seven five-year periods for all age groups, with rare exceptions, in every country in the Americas. However, there are enormous disparities among and within the countries, visible in the differential mortality by age group and cause of death in some countries versus other countries with similar levels of economic development, based on per capita income adjusted by the purchasing power of their currency. Mortality in children under 1 year of age has remained stable or fallen slightly in the middle-income countries but remains high and is rising in the lower-income group. A comparison of mortality by age group between countries with similar incomes reveals reducible gaps and preventable deaths.<sup>4</sup>

It can be said that in countries with higher income per capita some 4.7% of deaths could have been prevented in the 45- to 64-year age group, while in the lower-income countries up to 62% of deaths in the population under 65 could have been prevented. This indicates that it still is both possible and necessary to make a deliberate effort to prevent foreseeable death and reduce the differences among age groups and countries. Deliberate investment by the countries, the appropriation of resources, and their effective utilization, together with the establishment of concrete policies and programs aimed at reducing the

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

risk of dying from certain causes in specific population groups, ensure a path toward the reduction or elimination of these gaps and preventable deaths.

Concerning the differentials in the risk of dying among children under 1 year of age, these decreased in all the countries between the periods 1960-1964 and 1990-1994, and only in a very few did the difference with respect to the country with the lowest risk also decrease. Generally speaking, the values for the relative risk of dying before the first year of life in the countries with the lowest risk in the Region showed a certain degree of homogeneity. However, a trend has gradually been emerging in which the countries with the highest risk are worsening and those with the lowest risk are improving.

There are also reducible gaps in mortality from specific causes, which means that the number of deaths from communicable diseases can be reduced. Thus, in children under 1 year of age, up to 80% of deaths could be prevented, in comparison with the countries in which greater achievements have been obtained in the prevention of death from these same causes.

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

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

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

### 2.2.2 *Morbidity*

Great progress has been made in the struggle against disease in the countries of the Region. Poliomyelitis has been eradicated since 1991, tremendous advances have been made in the eradication of measles and neonatal tetanus, the number of episodes of acute diarrheal disease has decreased, and significant reductions in mortality from intestinal infectious diseases and acute respiratory infections have occurred.

The national immunization programs in the Region are having a great impact, reducing morbidity and mortality from vaccine-preventable diseases. Immunization coverage for children under 1 year of age for diphtheria, tetanus, typhoid, poliomyelitis, measles, and tuberculosis is over 80%.

Despite this progress, however, diarrheal diseases, acute respiratory infections, and malnutrition remain the leading causes of death in the population under 5 years of age in most of the medium- and lower-income countries of the Region. The cholera epidemic has become endemic in many of the countries, with more than 1.3 million cases to date, more than 11,500 of them fatal. Chronic undernutrition has replaced acute malnutrition in children, and together with micronutrient deficiencies is characteristic of the nutritional picture in the lower-income countries. Furthermore, the levels of iron deficiency and anemia, as well as vitamin A deficiency, remain high. At the same time, overweight, obesity, and chronic diseases linked with diet have increased with urbanization and changing lifestyles.

In addition, new communicable diseases have emerged in the Region, some diseases thought to be well under control have re-emerged, and the resistance of some infectious organisms to antibiotics has grown.

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

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

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

Malaria has expanded its frontiers, and the high-risk population has increased. Morbidity began to rise steadily in the mid-1970s. It fell 1993, only to rise again in 1994 and 1995, reaching rates more than double those recorded two decades ago.

The Region has acted on the WHO resolution to eliminate leprosy as a public health problem (prevalence below 1 case per 10,000 population) by the year 2000. All countries except Brazil, Colombia, and Paraguay have already reached this goal. There has been more than a 75% reduction in prevalence since the initiative began.

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

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

Dengue has re-emerged as a major health problem in the Region, with more than a quarter of a million cases reported in each of the past three years. The vector, *Aedes aegypti*, is now present in all countries of the Region except Bermuda, Canada, and Chile, and all four serotypes of the virus are circulating widely in the Region.

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

Foot-and-mouth disease has been eradicated from Argentina, Paraguay, and Uruguay and some states in Brazil and Colombia. There has also been a significant reduction in the incidence of human and canine rabies. Most human cases now occur in cities with around 50,000 inhabitants. Meanwhile, the incidence of bat rabies continues its steady rise.

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

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

Every year more than 25,000 women in the Region die from cervical cancer. Diabetes is a growing health problem in the Region, even though its incidence and end results can generally be prevented. Violence is a serious public health problem, and special attention must be paid to programs to prevent injuries.

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

A dual pattern of production, where traditional forms exist side by side with new forms such as biotechnology, microelectronics, automation, and mechanization, is generating a dual morbidity and mortality profile among workers. The old and as yet uncontrolled occupational diseases, such as lead and mercury poisoning, asbestosis, silicosis, occupational deafness, occupational dermatitis, and high accident rates, are still present, together with emerging or re-emerging problems such as malaria, tuberculosis, and zoonoses; at the same time, occupational cancer and asthma are spreading, together with new musculoskeletal, reproductive, and mental health disorders associated with new working conditions and occupational risks, including unemployment and under-employment.

According to WHO, Harvard University, and the World Bank, employment ranks second as the leading cause of years of life with disability in the Region. Estimates put the number of work-related accidents at five million a year—that is, 36 accidents per minute of work.

### **2.3 *Environmental Situation***

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

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

death, disease, and disability and to rank the relative importance of the various environmental factors.

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

Thus, one extremely important problem in the Region is the interior air quality in housing. There is a growing tendency in urban areas to use gas as a household fuel, thus reducing exposure to smoke from cooking or heating. In rural areas, however, the exposure to smoke from the burning of wood or coal is still significant. Estimates indicate that approximately 60% of the total burden of acute respiratory infections (ARI) is related to interior air pollution and other environmental factors.

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

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

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

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

During the Kyoto Conference (5) of December 1997, it was noted that, although the industrialized nations account for only 20% of the world's population, they have produced 90% of the global emissions of carbon into the atmosphere since the beginning of the industrial revolution, and they continue to produce two-thirds of those emissions today.

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

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

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

It is estimated that, out of five million foreseeable workplace accidents, 100,000 deaths occur annually. The total costs associated with these accidents are between 10% and 15% of the regional GDP, not including accidents in the informal sector.

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

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

## 2.4 *Demographic Situation*

The population of the Americas in 1998 is calculated at about 800 million, or 13.5% of the world population (8). By the year 2003 that population will exceed 850 million, but its distribution by country will not change substantially.

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

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

The age structure of the population not only reflects the increase in the population over age 65, with average growth rates in excess of 3% annually, but this trend is expected to continue. Hence, the aging of the population will mean a predominance of this population group.

The working population constitutes from 40% to 60% of the total population of the Region. The economically active population (EAP) was estimated at 357.5 million in 1995 and will reach 399 million by the year 2000. Moreover, it is estimated that 19 million children are part of the Region's work force. By the close of the 1990s, the EAP in Latin America is expected to increase by 25.9% and in North America by 11.1%. If work in the informal sector and work in the home are considered, most of the Region's population is exposed to occupational risks and conditions that, increasingly, are having an adverse impact on health.

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

International migration, much of which resulted from the armed conflicts of the preceding decades, is now mainly work-related. There appears to have been a resurgence in these migratory flows, which has placed significant pressure on the health services of the receiving countries. Everything indicates that, for the time being, there will be no substantive changes in this pattern, either in the national or international area.

## **2.5 *Political Situation***

The frontiers of democracy have expanded considerably in the Hemisphere. Improving the quality of life requires a climate of freedom in which confidence and the assurance of a future characterized by growing equity form part of the system of democratic values. However, the stability and continuity of democracy depends to a great extent on the effectiveness of its institutions and the credibility of the political system among the population (9). This is related to the impact of economic and sectoral policies on governance.

State reform in the Americas varies widely from country to country but basically implies the search for efficiency, responsibility, and participation. These reforms have led to the transfer of some responsibilities to the private sector and local levels, through decentralization processes that have fostered growing participation and given a voice to local governments and regions within the countries. This has had an impact on the development of social policies and social safety systems in the countries. One characteristic today is a change in the autonomy of national governments (10) with respect to the international processes of which they have become part, as well as changes within the State, linked on the one hand to the delegation of its responsibilities in the economic sphere within the framework of expanding market economies, and on the other to the strengthening of civil society.

## **2.6 *Socioeconomic Situation***

During the present decade, the countries have implemented economic policies aimed at the resumption of economic growth. However, they have also put in place models of growth with social equity. There is a significant difference between earlier efforts to obtain a macroeconomic balance and seeking growth with social progress.

A general improvement in the macroeconomic indexes was observed in the last five-year period. The average GDP growth rate was 1.1% in the preceding decade, increasing to 3.1% between 1991 and 1996. In this latter period it ranged from 3.4% to 5.3%. Average GDP per capita in the preceding decade showed 0.9% negative growth, while growth increased from 1.7% to 3.5% between 1991 and 1996 (excluding 1995). At the same time, inflation fell from 887.4% to 19.3%. The analysis of social expenditure is also positive. In a sample of 15 countries, 11 increased their social expenditure between

1990 and 1994, and 7 surpassed the indexes of the 1980s. From 1990 to 1995 per capita social expenditure increased in the Region by nearly 27.5%. It should be noted, moreover, that this progress has been more pronounced in countries that have undertaken more extensive reform processes. However, within this growth greater priority has been given to the education and social security sectors than to health (11).

This is reflected in the marked rise in literacy in the Americas. However, the achievements are mixed: while some countries have reduced illiteracy to 1%, others have rates as high as 57.4% of the general population, with disadvantages for the rural population, the indigenous population, and women in all contexts (12). In addition, there have been quantitative advances in annual school enrollment (13). However, while some countries have achieved 100% enrollment of school-age children, others have achieved only 30%. Also, high repetition and dropout rates, together with low performance levels, can be seen: in 1995, only 66% of the school-age population managed to complete the fourth grade, and the average number of years of schooling for the work force did not exceed six years (14).

Despite the growth in real GDP in Latin America and the Caribbean during the 1990s, the economies have still not reached the levels of the decades prior to the 1980s (15,16,17). Thus, GDP in 14 countries of the subregion in 1996, weighted by population and expressed in 1990 dollars, was lower than that of 1980, with investment constituting the most important component of growth (18). In this regard, the decrease in public investment was substantial (19,20), while direct foreign investment rose from \$6,599 million in 1990 to \$21,288 million in 1995.

At the same time, a real increase of 22% in social expenditure in the subregion was observed. Social expenditure patterns in health have been different: although health expenditure, like all social expenditure, began to grow in 1989, it fell in 1991 and 1992, dropping to 1981 levels. In 1993, it began to rise again, reaching levels in 1995 that were 22% higher (21).

One characteristic of foreign trade in the subregion is the expansion of intraregional trade (22), which is a determinant of the international operations of the health sector. Furthermore, given the impact of the debt burden on the potential availability of goods for the social sector, and the health sector in particular, it should be noted that the debt burden continued to decrease (23).

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

Some 197 million people were living below the poverty line in 1990, a figure that soared to 209 million in 1994; 65% of this population resided in urban areas, although the proportion of poor in the rural population was higher (24). In some countries there was greater poverty than in 1980, notwithstanding the proportional growth of GDP per capita and the reduction in the relative magnitude of poverty in the period 1990-1994. Furthermore, inequality in income distribution has increased in most of the countries of the Region (25). In fact, the share of the richest 10% of households in total income has increased (although it varies from country to country), while that of the poorest 40% has remained stable or declined.

The poor do not belong only to the ranks of the unemployed; they are also found in the formal sector. In 1994, in 7 out of 12 countries in Latin America the percentage of working poor in total wage earners in the private sector, excluding those working in microenterprises, was between 30% and 50%; in three countries it was between 10% and 20%; and in two countries it was between 5% and 6% (26).

Despite the economic recovery, the average annual rate of urban unemployment in Latin America and the Caribbean has been growing without interruption since the late 1980s (27), and the heaviest impact of unemployment has fallen on women and young people (28). This situation has been accompanied by a significant growth in the informal sector.<sup>5</sup> Thus, 84 out of every 100 jobs created in Latin America and the Caribbean during the period 1990-1995 were in the informal sector, making it the principal generator of employment (29). Moreover, there has been a real drop in the purchasing power of wages (30)—even for full-time workers, some 20% to 40% of whom have incomes that are below the minimum threshold required to achieve well-being (31).

Changes in the structure and composition of the work force, the decrease in real household income, together with the changing family structure, oblige women and children to develop survival strategies to deal with poverty, a circumstance reflected in the mass entry of women in the informal sector and the early incorporation of adolescents and children in the work force.

An examination of the findings with respect to poverty, inequalities in income distribution, unemployment, real wages, and wage gaps reveals that economic growth in

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

the Region, especially in Latin America and the Caribbean, has not contributed to an improvement in the serious human underdevelopment that still persists in these societies.

### **3. Challenges and Opportunities for the Quadrennium**

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

Perhaps the most important phenomena today are globalization and the revolution in communications technology. Some of the effects of globalization are related to the strengthening of democracy, the worldwide adoption of a single economic model, the formation of regional and subregional blocs, the changing role of the State, and social participation.

As democracy has gathered strength, expectations have risen and its mechanisms are being transformed. The number of countries with popularly elected mayors has grown from 3 to 17, and the number with some degree of decentralized public spending has grown from 0 to 16 (32). However, this is a gradual process that in some cases is limited to the formal aspects of voting.

In the economic sphere, a homogenization of the macroeconomy has been observed that has resulted in an improvement in the overall economic indexes, without a significant reduction in the inequalities in the distribution of goods and services and access to them or in unemployment and underemployment (33). This growth, characterized by regressive income distribution and unmet needs, has led long-neglected sectors to grow tired of waiting, posing a clear threat to the relative prosperity and progress that have been achieved in recent years (34). This has led to political recognition of the need to concentrate efforts in the social sector, and even to a reorientation of the activities of the international financing institutions, which are intervening increasingly in the social sector.

In trade and hence in the political sphere, globalization is directly reflected as regional integration and, in the Americas, subregional integration. The Free Trade Association of the Americas (FTAA) continues its slow but steady advance, and subregional integration has consolidated. Significant examples in this area are the North American Free Trade Agreement (NAFTA), MERCOSUR, the Andean Integration System, the Central American Integration System (SICA), and the Caribbean Community

(CARICOM). While the principal motive behind these processes is trade, health is an important negotiating factor associated with the environment and sanitation, food protection, the marketing of pharmaceutical products, and the protection of workers and visitors.

In addition, the hemisphere-wide activities launched in 1994 with the Summit of the Americas in Miami have speeded up implementation of the Plan of Action. Here, the collaboration of the various agencies of the Inter-American system, such as PAHO, the Organization of American States (OAS), and the Inter-American Development Bank (IDB), has been significant. The importance of health in this process has been acknowledged. Also in the regional sphere, the Conferences of Wives of Heads of State and Government of the Americas have supported and will continue to support a series of health initiatives (35).

As part of the hemispheric consensus fostered by the Summits of the Americas, PASB has proposed an initiative called "Health Technologies Linking the Americas," which covers vaccines, essential drugs, health information technology, health surveillance systems, and appropriate basic sanitation technologies.

This phenomenon of political linkage transcends regional borders, as in the case of the Ibero-American Summits of Presidents and Heads of State, which on two occasions have included health as a topic for analysis, proposals, and regional initiatives.

Globalization also affects the financial sector, increasing the availability of investment resources in Latin America and the Caribbean. In fact, as a result of a more favorable regulatory framework, between 1990 and 1996 net foreign investment rose from \$6.6 to \$30.8 billion (36).

With respect to State reform, changes in the role of the State have been initiated in nearly every country, although these proposals have rarely been generated with a social development or health perspective in mind and have instead been a reaction by the sector. Such reforms express the degree of complexity needed for negotiating resources in the current and future context. Indeed, in order to obtain financial resources, the health sector must negotiate with the financial sectors, vying with other social sectors in a competition for which the health sector is not always very well prepared.

This is accompanied by the transfer of health functions to the regional (provincial, state, departmental) or local level, which, with some exceptions in the Americas, requires major adjustments and preparation to enable it to assume its new responsibilities and achieve the expected results (37).

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

Far-reaching reform is under way in the multilateral international institutions and the bilateral agencies that provide cooperation for development. In the United Nations system, the reforms are geared toward a more coordinated effort on a global scale and particularly in the countries. Indeed, all of the proposed reforms seek to maintain the dialogue on development (although not necessarily the sectoral dialogue) between the international community and governments through the interagency and national entities providing the respective coordination. It will be difficult for the health sector to carry out this coordination function. The reforms also seek greater interaction with the international financing institutions (38). In the bilateral sphere a trend may be noted toward the decentralization of decision-making on the allocation of development cooperation resources for the country representative offices and local embassies (39). The health sector should develop new skills to make optimum use of these circumstances.

Today's extraordinary technology development has not only achieved unprecedented results, but is increasingly affecting the life of societies and populations. Communication without borders, biotechnology, and telematics are giving rise to fantastic changes in science, culture, and the field of health. In addition to their effects on diagnosis and therapy, they are creating conditions for substantially modifying and homogenizing consumption patterns, forms of behavior, lifestyles, values, and concepts that are having an enormous impact on the health of the population (40). Thus, fostered by globalization, products such as alcohol and tobacco are marketed and consumed, with major repercussions for health.

This has led the national institutions engaged in health technology research and development and the agencies responsible for the design of national science and technology policy to modify their role and mission. These institutions have had to adapt to the new government role and the rise of the private sector, the diversification of internal and external sources of financing, and the establishment and consolidation of new channels for access to and the transfer of scientific and technical know-how. This is particularly true for knowledge regarding the new information technologies, which are distributed unevenly among countries and among groups within the countries.

Thus, it is necessary to incorporate new topics, disciplines, approaches, and methods in health research, in addition to establishing better methods for disseminating

knowledge and the technologies needed to improve the effectiveness and increase the impact of public health practice. One of the new disciplines is bioethics, which has become a growing area of study and concern, given the emergence of new ethical dilemmas stemming from the rapid advances in health science and technology, the ethical dimensions of patients' rights, and the issue of justice in allocating health sector resources.

Thus, the demand for transparency in the management of public affairs has recently emerged. The net effect on the sector is a growing need for States to justify and render an accounting of their work in the field of health to populations that are better informed and better educated about their rights and the level of care they expect.

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

Given the situation described in the preceding chapters, the needs expressed when the strategic orientations and programmatic priorities were adopted for the period 1991-1994 are still present (41). The orientations stressed a gradual decrease in domestic structural obstacles to sustainable human development through a reduction in inequality and priority attention to basic human needs, including health and a frontal attack against extreme poverty.

Just as a change is being discerned in the values system, a moral code of common rights and shared responsibilities is being constructed, based on what is now being termed "global ethics" (42). Among these rights and responsibilities are the right to a secure life, equitable treatment, equal access to information and the common goods of humankind, freedom, consideration of the impact of individual actions on the well-being of others, the promotion of equity (including gender equity), and protection of the interests of future generations through the achievement of sustainable human development.

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

by the countries of the Region, both through their own efforts and in conjunction with the Pan American Health Organization.

Despite the significant achievements chalked up in health, such as the increase in life expectancy and the control of communicable diseases, with the consequent reduction in infant mortality, due mainly to the advances in controlling poliomyelitis, measles, and diphtheria, the three evaluations performed by WHO on the progress toward achieving the goal of Health for All by the Year 2000 indicate that enormous efforts remain to be made, since major population groups do not yet have access to basic health services.

In this regard, the targets and goals established in the SPO for the period 1995-1998 have largely not been met. An evaluation of the degree to which the goals adopted for the period have been met reveals that the disparities in health conditions have not been reduced, universal access to healthy and safe environments and universal coverage of water supply and sanitation services have not been achieved, and unhealthy lifestyles and behaviors persist.<sup>6</sup> These were the terms of reference for the goals to be met in the quadrennium through action by the countries with the cooperation of the Bureau. This situation justifies making a vigorous effort to attain Health for All, as proposed by WHO, continuing the struggle against inequity in health with the same five Strategic Orientations that have already been defined, until these commendable goals are achieved.

#### **4. Response of the Pan American Sanitary Bureau**

Among the fundamental purposes of the Pan American Health Organization are prolonging life, combating disease, and seeking the physical and mental well-being of the population of the Americas by coordinating and promoting the efforts made by the countries. It is also recognized that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief, and economic or social condition (43). On these bases, and recognizing the differences prevailing in health access, coverage, and service delivery among the populations of the Region, the countries have agreed to renew their commitment to attaining the goal of Health for All. The greatest efforts of PASB will be directed primarily toward that goal in the next quadrennium and in those to come until the highest standard degree of physical, mental, and social well-being is attained for all the inhabitants of the Region, reducing and eventually eliminating the inequities presently existing in health.

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<sup>6</sup> For further discussion in this regard, see *Strategic and Programmatic Orientations 1995-1998*. Official Document No. 269, and document CD40/24, 4 August 1997, *Third Evaluation of the Implementation of the Strategy for Health for All by the Year 2000*.

One of the frameworks of action is the new global policy of Health for All in the Twenty-first Century, approved by WHO, which represents the renewal of the goal of HFA and is based on the following values:

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

The new global health policy seeks to attain:

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

#### **4.1 *Regional Goals for the Period***<sup>7</sup>

The Member States of PAHO, through WHO and other international forums, have subscribed to various global commitments to be realized through a combination of national, regional, and global efforts. The assumption of these commitments at the national level corresponds to the sovereign action of the Member States through the formulation of their national policies and plans for development and health. In the regional area they should be expressed in a manner compatible with the development of the Region and with the characteristics, needs, and resources of the countries as a whole. The most important goals are presented for the Region of the Americas, expressed in terms appropriate to conditions in the Hemisphere and the goals to be adopted by the Bureau in its commitment to providing technical cooperation to the countries to assist them in meeting their targets.

##### **4.1.1 *Health Outputs***

- Life expectancy at birth will increase by at least two years in all countries with life expectancy below 70 years in 1998; infant mortality in all countries will decrease by 10%; perinatal mortality will be reduced by 20%; late neonatal mortality will be reduced by 30%; child mortality will be reduced by 40% and will be fewer than 50 per 1,000 live births; maternal mortality will be reduced by 25%; and at least 60% of women aged 15 to 44 years will have access to contraceptives.

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<sup>7</sup> Some of the goals of the new global policy on Health for All in the Twenty-first Century have been adapted to the specific conditions of the Region of the Americas.

- Fewer than 20% of children under 5 years of age in all countries will be stunted; fewer than 10% of newborns will weigh less than 2,500 grams at birth; iodine deficiency diseases will have been eliminated; the prevalence of subclinical vitamin A deficiency in children under 5 years of age will be below 10%; and the prevalence of iron deficiency among women aged 15 to 44 years and pregnant women will be reduced by 30%.
- Elimination of wild poliovirus transmission will be maintained; in all countries measles transmission will have been eliminated; neonatal tetanus incidence will be below 1 per 1,000 live births at the district level (municipal, cantonal, etc.); the prevalence of leprosy will be below 1 per 10,000 inhabitants; the prevalence of endemic dental caries will be reduced by 50%; transmission of human rabies by dogs will have been eliminated; and transmission of Chagas' disease by *Triatoma infestans* will have been eliminated from all countries of the Southern Cone.

#### 4.1.2 *Intersectoral Actions on the Determinants of Health*

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

#### 4.1.3 *Health Policies and Systems*

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

## 4.2 *Strategic and Programmatic Orientations*

During the quadrennium 1995-1998, PAHO established five Strategic and Programmatic Orientations to guide the action of the countries and PASB in establishing national plans and programming actions: Health in Human Development, Health Promotion and Protection, Environmental Protection and Development, Health Systems and Services Development, and Disease Prevention and Control. These five orientations

encompass the natural area of health and are considered to be valid, since the challenge that gave rise to them has still not been overcome. Consequently, they will guide the work of the Secretariat during the quadrennium 1999-2002, focusing more specifically, however, on topics foreseen as the object of efforts in the Region.

#### 4.2.1 *Health in Human Development*

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

- Defining the conceptual aspects related to inequities in health, developing instruments for their measurement and surveillance at the national and regional level, and bolstering the national analytical capacity to document and evaluate inequities in health and their relation to the impact of the structural adjustment programs, globalization/integration processes, and privatization of health activities, among other determinants.
- Supporting studies and research on the health profiles of neglected population groups to orient health interventions with criteria based on the impact that such interventions have on social inequities and health in particular.
- Upgrading the training of human resources in health to enable them to analyze the health situation and living conditions of the various sectors of the population, the prevailing social inequities—in particular those pertaining to health—and their relation to human development.
- Supporting the formation of local, national, subregional, and regional intersectoral networks to assist in policy-making and the preparation of plans, projects, and programs aimed at bridging the gaps in health.
- Promoting systematic research and documentation on the need to invest in health to permit the human capital formation, economic activity, and the development of its potential as a mechanism for redistributing income.

With the object of producing, disseminating, and utilizing public health knowledge and practice in health promotion, health care, and health recovery in order to contribute to sustainable human development and increase the participation of the principal social and political actors in the sector and other sectors of the State and civil society aimed at making health an important item on local, subnational, national, subregional, and regional political agendas, and to formulate health policies, technical cooperation will place emphasis on:

- Disseminating knowledge about the impact of structural, macroeconomic, and social policies on the living conditions and health situation of the population in the Region and contributing to the use of this information within the sector, in the social and economic cabinets, and in meetings of ministers, parliaments, and heads of State.
- Strengthening the capacity of legislative institutions to draft laws that permit the effective participation of social and political actors in the formulation of policies, plans, and programs in health and in the preparation of national human development projects that integrate economic and social policy in a strategy whose common goal is the well-being of the population.
- Developing the capacity to use the gender perspective as a tool for analyzing the impact of globalization on the development process and on structural, macroeconomic, and social policies, with special emphasis on their relation to health.
- Documenting the magnitude of international trade in health capital, goods, and services carried out in the Region.
- Placing discussion and analysis of health in human development on the agendas of the presidential summits and meetings of the governing bodies of the subregional and regional integration processes, encouraging participation in this effort by the ministries of health, agriculture, environment, family, labor, and social development prior to such gatherings.
- Analyzing and documenting the importance of the changes that globalization has produced in the culture of health and, in particular, the impact such changes have had on the health demand of social actors and their support or rejection of health policies.
- Identifying the social and political actors who play an important role in the governance of the health sector, the State, and society, and promote their participation in the debate on ethical issues in health in human development.

The development of public health as a discipline, the research it entails, and the dissemination of the knowledge that it generates requires providing adequate responses to the health needs of the population, particularly the most neglected and excluded groups. For this purpose, technical cooperation will be concentrated specifically on:

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

#### 4.2.2 *Health Promotion and Protection*

Inasmuch as health is the main component of human development, its promotion must of necessity involve a much broader scope of action than that customarily constituted by the health systems and services. Most of the considerations related to the health of populations are based on their living conditions, the satisfaction of their basic needs, the quality of their environment, the culture to which they belong, and their knowledge, attitudes, and practices with regard to health. Given the conditions that still persist in the Region, health promotion and protection is considered a powerful strategy in the concept and practice of public health, as well as the fulcrum of a new paradigm aimed at impacting the determinants of health in general.

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

- Acknowledging the role of health promotion as a tool for empowerment, emphasizing its importance in the regional forums for Presidents and Heads of State and First Ladies of the Region.

- Promoting the formulation of policies, plans, programs, standards, and tools for health promotion.
- Supporting cooperative and operations research through the network of Collaborating Centers.
- Continuing to design and strengthen methodologies and models for the evaluation of programs and interventions in health promotion, the development of environmental initiatives or healthy spaces in schools and municipios, and the consolidation of networks of mayors, health secretariats, and school health associations.
- Developing intersectoral work strategies; mobilizing technical, scientific, political, and financial resources in support of health promotion; and developing technical, political, and social support networks at all levels, including strategic alliances between the Pan American Health Organization and both the international community and the relevant organizations in the countries.
- Promoting the use of social communication in health, especially through the mass media.

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

- Disseminating scientific and technical information on the topic to the greatest number and variety of individuals working in public health in the Region and developing national capabilities for the analysis and use of this information.
- Promoting evaluation of both inputs and processes, as well as the short- and long-term effects of the health promotion strategies, and documenting, analyzing, and disseminating information on the national experiences in health promotion, noting the cost-effectiveness of these strategies compared to curative and rehabilitation activities in health.
- Promoting the adoption of healthy lifestyles and risk prevention through anticipatory behaviors.
- Promoting the use of the life cycle, family cycle, and gender approaches.

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

In order to foster human development and prevent disease throughout the life cycle, priority will be given to cooperation in the following areas:

- Family health and population, which attaches special importance to promoting and assessing growth and development at different ages; this includes programs for adolescent health, reproductive health, and health of the elderly.
- Food and nutrition, with special attention to malnutrition, the fortification of food with micronutrients, breast-feeding, supplementary feeding, nutritional guidelines for the different age groups, and food security.
- Healthy lifestyles and mental health. In particular, preventing the use of tobacco, alcohol, and drugs, domestic violence, and child abuse, including social communication in health for the entire Organization, as well as health education and community participation, an area that involves initiatives to promote healthy schools, healthy municipios, and healthy spaces.

#### 4.2.3 *Environmental Protection and Development*

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

- Promoting the implementation of national strategies for community mobilization and intersectoral coordination on the environment.
- Contributing to human resources education and specialization in environmental epidemiology and toxicology.
- Strengthening the capacity of the ministries of health to exercise leadership and an advisory role in the treatment of environmental health issues in development plans and projects, and developing local capabilities for the operation and maintenance of health systems and services.
- Promoting programs and projects on the effects of the environment on the health of children aimed at identifying and eliminating or minimizing environmental

factors that have a particularly adverse effect on the health of this population due to its greater susceptibility.

- Supporting the promotion and implementation of primary environmental care activities within the context of Health for All to provide environments for communities that promote development through their active participation in the identification of their own needs and in finding solutions.
- Promoting the updating of standards and regulations governing the quality of environmental services and products.
- Promoting the establishment of systems and mechanisms that make it possible to gather, analyze, and utilize data and indicators on the quality of the environment.

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

- Promoting an updating of the legislation and regulations in the field of workers' health.
- Fostering programs for health promotion and disease prevention in occupational health.
- Promoting better health services for the working population.
- Supporting programs aimed at protecting child workers exposed to environmental and occupational risks.

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

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

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

In order to contribute to an improvement in the management of municipal solid waste, given the rapid decentralization and privatization processes, PASB will cooperate in:

- Promoting institutional strengthening and, thus, the regulatory and organizational capacity of the sector.
- Conducting sectoral studies on solid waste management, including hospital waste.
- Identifying investment financing needs and opportunities.

#### 4.2.4 *Health Systems and Services Development*

The technical cooperation of the Secretariat will continue to support sectoral reform processes in the countries of the Region. For this purpose it will provide cooperation in strengthening the sectoral steering role, organizing health systems and services, and financing sectoral activities. To this end, as basic strategies it will employ the systematic and periodic sharing of information on national experiences, the development and dissemination of methodologies and tools to help strengthen institutional capabilities for analysis, policy-making, and the implementation and evaluation of sectoral reform programs; and the establishment of a regional system to monitor the dynamics, contents, and impact of the reforms undertaken.

Concerning the strengthening of the sectoral steering capacity, technical cooperation will focus on:

- Improving the capacity of the sector to develop policies and strategies, draw up master plans, and design concrete proposals for investment in health, as well as coordinating external assistance in an integrated manner.
- Developing the capacity for analyzing the organization and operation of the sector to redefine the role of the central, regional, and local governments in organizing and managing public health and personal health services, within the context of decentralization.
- Establishing health care models that support the reorientation of the services with health promotion and disease prevention criteria that improve the quality and comprehensiveness of the interventions and strengthen the operational and problem-solving capability of the services at the different levels of care.

- Promoting and supporting the development of national quality assurance programs for health services.
- Strengthening the regulatory and operational development of health programs and services in oral health, care for the disabled, eye health, and the health of indigenous peoples.
- Strengthening national and subregional capabilities for planning, managing, and regulating human resources development in the sector.
- Developing performance indicators for health systems and services that contribute to informed decision-making in the sector.
- Supporting subregional and regional mechanisms for the regulatory harmonization of essential drugs and inputs.
- Strengthening and developing programs for the planning, operation, maintenance, and renovation of the physical and technology infrastructure of the health sector.
- Promoting the adoption of safety standards for protection against ionizing radiation and for the safety of radiation sources at the country level.

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

- Developing national, subregional, and regional capabilities for the incorporation and assessment of health technologies.
- Supporting the development of programs to improve the job performance of health workers.
- Promoting a reorientation of education for health professionals and continuing education for workers in the sector, while strengthening institutions and supporting integrated processes in public health education.
- Strengthening institutional capacity in the sector for the development and implementation of information systems for programs and services.
- Promoting the development of programs in telemedicine for greater coverage of the population.
- Strengthening and developing efficient, high quality pharmaceutical services.

- Supporting the development of supply systems to contain costs and increase availability.
- Promoting and developing quality assurance programs in radiation medicine.
- Developing and strengthening public health laboratories and national, subregional, and regional diagnostic laboratory networks.
- Supporting improved safety and quality in blood bank operations.

Concerning the financing of sector activities in the next quadrennium, PASB will advocate technical cooperation activities that permit:

- Improvements in the national capacity to analyze health expenditure and resource allocation based on the criteria of equity, efficiency, and effectiveness.
- Comparative analysis and the dissemination of information on experiences with various forms of payment to providers.

#### 4.2.5 *Disease Prevention and Control*

In order to confront regional challenges and reduce and control disease, health service programs must include components on disease prevention and health promotion. Success will require community participation as well as individual behavioral changes. Sound policies and practices, supported by the scientific evidence must guide such changes.

The Secretariat's technical cooperation in the area of vaccine-preventable diseases will be geared toward:

- Improving the criteria for the adoption of policies governing immunization programs.
- Expanding and improving vaccination carried out by the public and private sectors, including nongovernmental organizations (NGOs).
- Strengthening and supporting national surveillance systems for vaccine-preventable diseases, in conjunction with adequate laboratory support systems, through expansion of the regional network of diagnostic and quality control laboratories.

- Determining the disease burden and ensuring cost-effective inclusion of vaccines against *Haemophilus influenzae*, MR, or MMR in the basic vaccination series.
- Promoting research and development of vaccines, in collaboration with the laboratories of the public sector, ensuring that local vaccine production is economically and technically viable and adheres to good manufacturing practices, as well as national and international norms and standards.
- Promoting the consortium of public laboratories that produce vaccines and the adoption of good manufacturing practices, and continuing the regional certification process for vaccine producers.

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

- Supporting the countries in applied research and the planning and management of programs to combat tropical diseases, infectious diseases, and emerging and re-emerging diseases, including the utilization of new strategies for control and treatment.
- Encouraging the countries to increase the screening of blood and promoting internal and external quality control measures.
- Promoting the application of new techniques to improve regional disease surveillance and developing electronic networks that make it possible to increase the speed with which suspected cases are reported and confirmed.
- Helping the countries to introduce the new International Health Regulations scheduled for adoption by WHO in 1999.
- Disseminating data and knowledge about antimicrobial resistance, promoting the standardization of laboratory testing methods, improving quality control in laboratories, and utilizing the results of antimicrobial resistance tests.
- Helping the countries to focus more specifically on HIV/AIDS-related health issues, such as program management, the safety of the blood supply, and intervention models that foster healthy behaviors and health care, while continuing to promote a broader intersectoral response.
- Promoting surveillance and programs for the control of sexually transmitted diseases.

- Promoting expanded implementation of the global malaria strategy and, given the existence of drug-resistant *Plasmodium falciparum*, a surveillance system to monitor such resistance in the Amazon countries.
- Supporting adoption of the strategy for Integrated Management of Childhood Illness (IMCI), which focuses on acute respiratory infections, diarrheal diseases, malaria, malnutrition, measles, and dengue, in selected countries.

Enormous health gains are possible if there is commitment, evidence-based policies and programs, and adoption of these by communities, individuals, and clinicians. It is important for health organizations to devote human and financial resources so as to benefit from these possibilities. The focus of PASB technical cooperation will be on:

- Establishing a regional network of countries that use an integrated approach to noncommunicable disease control, focusing at first on cardiovascular disease and adapting the model developed in Europe.
- Disseminating information about demonstration projects to reduce mortality from cervical cancer and support countries in adopting a similar approach.
- Supporting countries in developing efficient policies, models, and working partnerships among physicians, laboratories, and treatment facilities; helping cervical cancer control programs to understand women's attitudes and needs; evaluating demonstration projects; and planning their judicious expansion based on the results.
- Assisting countries with implementation of the Declaration of the Americas on Diabetes.
- Documenting the information and resources available to support the programs for injury prevention.
- Establishing regional and national partnerships to set priorities and carrying out activities for the prevention of intentional and unintentional injuries.

Veterinary public health is and will remain a very important area for progress in the countries with respect to food security and food safety. Technical cooperation will therefore be geared toward:

- Preventing new outbreaks of foot-and-mouth disease in the countries that are free of the disease and expanding eradication zones in the Andean countries and northern Brazil, with special attention to border areas.

- Promoting food protection along the lines of action suggested by PASB.
- Promoting rabies prevention activities together with the establishment of a laboratory network in which WHO/PAHO Collaborating Centers would participate.
- Promoting the development of laboratory diagnostic capacity for epidemiological surveillance in the areas at risk for Venezuelan equine encephalitis.
- Promoting the elimination of bovine tuberculosis and brucellosis.
- Supporting the eradication of echinococcus/hydatidosis in the countries of the Southern Cone.

#### **4.3 *Technical Cooperation and International Coordination***

The technical cooperation of the Secretariat of PAHO and its Member States and their coordination of matters pertaining to international health are constitutional responsibilities. For effective technical cooperation in 1999-2002, it is essential to bear in mind that technical cooperation is the principal product of the work of PASB and is based on the priorities of the Member States set forth in the Strategic and Programmatic Orientations of the Organization and approved by those same Member States. Technical cooperation is proposed, carried out, and evaluated in a social, economic, and political environment that is constantly evolving. It is therefore a dependent process subject to ongoing review by PASB.

The policy framework for PASB cooperation is the SPO, which are being defined and approved for the period 1999-2002. This framework is intimately linked with three global influences:

- The Ninth General Program of Work of WHO. Covering the period 1996-2001, and thus currently in force, its orientations include the integration of health and human development in public policy; equitable access to health services; health promotion and protection; and the prevention and control of specific health problems.
- The global policy of Health for All in the Twenty-first Century, which promotes identification of the factors that determine health and action on them, placing health at the center of human development, and fosters the establishment of sustainable health systems that respond to the needs of the people.

These global influences coincide with the SPO, both in their objectives and in their proposed goals, given the situation of the Region of the Americas, its comparative development in health, and its potential for progress with respect to the other WHO regions.

The SPO 1999-2002 will include technical cooperation modalities that offer the best options for addressing the trends and challenges identified. Particular attention will be paid to our understanding of people-centered development, on the one hand, and more effective and efficient cooperation to foster that development, on the other. Considering the changes taking place in society in each country and the reforms in the international system, the growing linkage and interdependence among the countries in different spheres, including health, make it essential to ensure that technical cooperation be consistent with the different policies that participate in and influence development.

The growing presence of institutions and people different from those traditionally involved in health in the national and international sphere justify the incorporation of sufficient flexibility and innovation in the design of technical cooperation to foster the development of practical and effective partnerships that will permit better results to be obtained as a result of cooperation.

The Secretariat understands that technical cooperation is influenced by the criteria and approaches applied to development in general. It attaches special importance to the concept of sustainable development, whose basic characteristics are the formation of human capital, the participation of all sectors (including the private sector), and the protection of the environment—all within the context of equity and social justice. Beyond the traditional “technical” aspects, such as the search for better ways of investigating, teaching, and applying health technologies, the international health agenda of the PASB will take advantage of the influence exerted on health by socioeconomic development, the strengthening of institutional capacity in policy-making, planning and advocacy in health, and the organization of specific programs for a country or group of countries.

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

Some important themes in technical cooperation have been identified as areas requiring special attention in the SPO 1999-2002. This is the result of the ongoing efforts of PASB in rethinking technical cooperation in international health (44):

- Health topics should be linked to the social development and macroeconomic policies of the countries and should include investment in capital, human capital formation, and institutional development.
- Technical cooperation should be based on the priorities identified in and by the countries.
- The growing capacity of the countries to launch health initiatives on their own and administer their own technical cooperation programs should be promoted, opening the way to greater confidence in the knowledge, experience, and resources of the countries.
- Alternative technical cooperation modalities, such as the development of national and international networks, will be adopted and greater technical cooperation among countries promoted.
- Coordination will be sought at all levels through optimization of the managerial capacity of national institutions to build intersectoral consensus and promote multinational programs through joint efforts and resources.
- Maximum advantage will be taken of modern of information and communications technologies to improve the planning, programming, execution, and evaluation of technical cooperation, as well as the coordination and mobilization of resources.

During 1999-2002, PASB will continue its intense promotion of technical cooperation among countries, with special emphasis on Pan American action in health as a powerful cooperation strategy that has proven successful in the past and that will no doubt facilitate regional progress in the complex transition toward the twenty-first century. The Bureau will continue to stress technical cooperation “among countries” and not “among developing countries” to keep from discriminating against any Member State based on its degree of development. Pan Americanism is one of the ruling principles of PASB, and it holds that all the countries of the Americas, regardless of their size or degree of development, can participate in the search for their own health.

For a better understanding of the PASB cooperation strategy, six functional approaches have been identified for classifying program activities in the technical cooperation projects: mobilization of resources (human, financial, physical, political, institutional); dissemination of information; training; development of policies, plans, and standards; promotion of research; and direct technical assistance. Work will continue on completion of the first phase of a study on these approaches to develop better descriptors that more clearly define the expected results of the technical cooperation projects of the

Bureau in the period 1999-2002. In a second phase of the new quadrennium, an impact assessment of the projects in terms of the fulfillment of their goals will be completed.

PASB employs the AMPES system for planning, programming, monitoring, and evaluating technical cooperation through the identification and measurement of the results of cooperation projects. For the period 1999-2002, greater simplification of management processes, greater flexibility, and a more expeditious response to the needs of the countries is envisioned, taking extreme caution to ensure transparency in the use of resources.

The programming of technical cooperation, the foundation of the biennial program budget, focuses on the formulation of national health priorities, the identification of needs for international technical cooperation, and the preparation of technical cooperation projects that PASB will provide, clearly identifying the expected results and defining the indicators for measuring progress. The logical approach for project management will continue to be used, and progress will be made in the development of mechanisms to evaluate technical cooperation.

PASB international cooperation efforts for 1999-2002 will be geared toward strengthening its historic leadership role in international health. Studies conducted by the Bureau (45) reveal a proliferation of institutions and actors who participate not only in technical cooperation but in health activities in general that merit a proactive stance in PASB coordination at several levels: between countries, within countries, and among international organizations (46). PAHO will encourage national governments to take responsibility for coordinating health efforts in their own countries and will help to strengthen this capability, facilitating the necessary coordination among the interested parties in a respectful and innovative manner.

Coordination among countries, particularly for horizontal cooperation, will be encouraged, with a view to strengthening their ability to obtain external resources and stimulating their potential for sharing information and experiences, which is the essence of technical cooperation among countries.

As for coordination at the national level, the Secretariat will make efforts to ensure that the programs of the various international organizations work harmoniously with their respective national counterparts. This coordination will be based on comprehensive national development strategies formulated through a participatory intersectoral process.

PASB will foster coordination among international organizations, ensuring that organizations supporting the same programs and geographical areas apply appropriate policies and strategies, adopting consistent procedures to prevent resources from being wasted and develop complementary orientations that promote Health for All.

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*CE122.R4*

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

*THE 122nd SESSION OF THE EXECUTIVE COMMITTEE,*

Having seen Document CE122/8, which proposes the strategic and programmatic orientations for the Pan American Sanitary Bureau corresponding to the quadrennium 1999–2002,

*RESOLVES:*

To recommend to the 25th Pan American Sanitary Conference the adoption of a resolution along the following lines:

*THE 25th PAN AMERICAN SANITARY CONFERENCE,*

Having seen Document CSP25/8, “Strategic and Programmatic Orientations for the Pan American Sanitary Bureau, 1999–2002”;

Mindful of the constitutional function of the Pan American Sanitary Conference in determining the general policies of the Organization; and

Recognizing the need of the Member States and the Secretariat to channel their efforts and resources toward tasks that improve access to health services and help to ensure effective satisfaction of the health needs of the inhabitants of the Region,

*RESOLVES:*

1. To approve the “Strategic and Programmatic Orientations for the Pan American Sanitary Bureau, 1999–2002” as a basic frame of reference for the strategic planning of the technical cooperation of the Secretariat.

2. To urge the Member States, when formulating their national health policies, to take into account the strategic and programmatic orientations for the Bureau corresponding to the quadrennium 1999–2002.
3. To request the Director to:
  - (a) apply the strategic and programmatic orientations when preparing the biennial program budgets of the Organization during the quadrennium 1999–2002;
  - (b) assess the impact of technical cooperation with the Member States, utilizing the "Strategic and Programmatic Orientations for the Pan American Sanitary Bureau, 1999–2002" as the basic frame of reference, and report the findings of this assessment to the Governing Bodies;
  - (c) disseminate the document "Strategic and Programmatic Orientations for the Pan American Sanitary Bureau, 1999–2002" among the Member States and transmit it to the Director General of WHO for consideration;
  - (d) transmit the aforementioned document to multilateral organizations and the technical cooperation agencies of donor countries that participate in health sector activities of the Member States.

*(Adopted at the fifth meeting,  
24 June 1998)*