

# Chapter 6

## PROSPECTS FOR REGIONAL HEALTH

**T**he countries of the Americas have made significant progress in reducing mortality and morbidity over the past several decades, although inequities persist among and within countries. Both that progress and those inequities are occurring in circumstances of constant flux. Going forward, continuation of that progress and remediation of those inequities will depend on myriad, dynamic factors and trends and on how individuals, populations, governments, and the international community address them.

### Trends that Condition the Future of Health

Health in the Americas over the coming years and decades will take shape as current trends unfold. Three macro trends will prevail, namely those related to the socioeconomic context, the health situation, and the health system response, which explains the structure of the contents—general context, health conditions, and sector response—in both the regional and country volumes of this publication.

**Socioeconomic Trends.** As has been described in the preceding pages, a range of socioeconomic trends—namely those related to the economy, the population, education, the environment, health access, and international aid—impacts the health of the population of the Region. Although the per-capita gross domestic product in Latin America and the Caribbean grew by over 4% from 2001 to 2005 and the numbers of poor are decreasing, 40% of the population (205 million) continue to live in poverty and over 15% (79 million) in extreme poverty. Income and its distribution greatly influence health status.

While the Region's population growth has slowed, an ever-larger portion of that population is over 60. Health systems will need to take account of an aging population's health profile and the implications it will have for the nature and delivery of health services. A second major demographic factor

influencing health is urbanization which, albeit enabling people greater access to social services, also tends to promote unhealthy behaviors—among them, poor nutrition, drug and alcohol abuse, alienation, and violence.

Progress in education in the Americas—while still compromised by inequities in terms of gender, ethnic group, and geographic location—has been characterized by major gains in the past couple of decades. About 94% of the population is literate, and some 95% of boys and girls alike are enrolled in primary education.

Latin America and the Caribbean have attained high overall coverage rates of water supply (91%) and sanitation (77%), although rural areas tend to have less coverage. The major environmental challenges stem from air, water, and soil contamination, the risks of industrialization and unplanned development, and the destructive impact of disasters.

Millions of people in the Region lack health insurance coverage (218 million) and access to health services (over 100 million). This exclusion from health is the result of poverty, marginalization, and various forms of discrimination and stigmatization, which in turn relate to language, informal employment, un- and underemployment, geographic isolation, lack of education and access to information.

A final socioeconomic trend relates to official development aid. Much of that aid is now either going to other regions of the world, resulting in a reduced share for the Americas, or, in the case of bilateral assistance, is targeting specific countries rather than general regional development.

**Health Situation Trends.** Communicable diseases—such as malaria, dengue, tuberculosis, HIV/AIDS, and zoonoses—continue to represent major threats to the health of the population of Latin America and the Caribbean, and certain “neglected” diseases—among them, filariasis, leptospirosis, and Chagas’ disease—disproportionately afflict the region’s poor. Increasingly, however, the leading causes of death and illness in all of the countries of the Americas are noncommunicable chronic diseases—especially cardiovascular diseases, cancer, and diabetes—together with violence, trauma, occupational diseases, and mental illness.

While health indicators have generally improved over the recent past, in large measure as the result of primary care interventions, health inequalities persist. Indigenous groups, women, the poor and uneducated, rural inhabitants, and the elderly are less healthy than other groups in society.

**Health System Trends.** Among the most prevalent trends characterizing health systems in the Region are the segmentation of services, the inadequacy of health financing policies, the poor allocation of health resources, and the emphasis on tertiary and individual health care at the expense of primary and public care. Health sector reforms that began in the 1990s actually weakened the position of health ministries, rendering them less able to

assume sector leadership and to perform their essential health functions.

National health expenditures in Latin America and the Caribbean represented less than 7% of the region’s gross domestic product (about US\$500/capita/year) and comprised two main rubrics: public health expenditures (mostly for government services) and private expenditures (including out-of-pocket expenditures for goods and services).

The health workforce poses a number of problems: in many countries, too few health workers are available for the population’s needs (less than 25 health workers per 10,000 population, which is considered the minimal coverage); those health workers are unevenly distributed; and they have not been adequately trained and developed to meet the health needs of the population. Moreover, meeting those needs in the future will require targeted policies and capital investments in science and technology applied to health.

### Response to Regional Trends: The Health Agenda for the Americas, 2008–2017

As they have many times for over a century, and faced today with the trends and challenges described in the foregoing paragraphs, the countries of the Americas have united once again in their commitment to work together to improve the health of people throughout the Region. Toward that end, they have collectively crafted a “Health Agenda for the Americas, 2008–2017” based on “expected trends and challenges in the decade, and focusing on concrete improvements in the health of the peoples of the Americas.” Approved by delegations of the countries of the Americas to the World Health Assembly (Geneva, May 2007) and launched at the General Assembly of the Organization of American States (Panama City, June 2007), the Health Agenda is a “high-level political instrument” that establishes specific regional public health goals in eight principal “areas of action,” the combined aim of which is to reduce inequalities among and inequities within countries.<sup>1</sup> Those areas of action are summarized below:

**1. Strengthening the national health authority.** Health authorities should secure broad commitment to, and high-level political will in support of, development of the population’s health, for which they need to assure proper governance, effective leadership, and transparent accountability. Towards those ends, national health authorities ought to pursue a number of critical strategies, namely they should: assume the steering role in health; perform essential public health functions; enlist the participation of other sectors, society at large, and communities, with clear delineation of the various parties’ respective roles; strengthen primary health care approaches and address the social determinants of health;

<sup>1</sup>The full version of the Health Agenda is available at [http://www.paho.org/English/DD/PIN/Health\\_Agenda.pdf](http://www.paho.org/English/DD/PIN/Health_Agenda.pdf).

## A Tradition of Regional Health Plans

Among their other major functions, governments set goals for the improvement of their populations' health and, in the context of those goals, assess health conditions and gaps. At any given juncture in a country's history, such an assessment will invariably point to progress both made and pending. In the Americas, countries have worked together for over a century to deal collectively with national and regional health challenges, and for over a half-century their efforts have crystallized in regional health plans. Those health plans are, by definition, blueprints for hemispheric and national action to enhance the health and well-being of the peoples of the Americas.

In 1961, with the Charter of Punta del Este and especially the **Ten-Year Public Health Program** of the Alliance for Progress, countries in the Region, at the highest political level, agree for the first time on a continental program to advance health. That program sets forth the goal "to increase life expectancy at birth by a minimum of five years, and to increase the ability to learn and produce, by improving individual and public health." Toward that end, the program recommends the preparation of national plans and the formulation of a general health policy.

In 1972, the Ministers of Health of the Americas, taking up where the Charter of Punta del Este left off, devise a new **Ten-Year Health Plan for the Americas** that declares health a universal right, recognizes the importance of social participation in decisionmaking, and sets as the principal new goal the extension of health services to unserved and underserved populations "to make it feasible to attain total coverage of the population by the health service system in all the countries of the Region"—thus adumbrating what would become the global aspiration of health for all.

As they had at the outset of the previous two decades, at the beginning of the 1980s the countries of the Region set out to evaluate gains and shortfalls in realizing past health plans for the Americas and to cast a new plan in light of intervening experience. By 1980, most of the countries had defined or confirmed their national strategies to achieve the goal of health for all, in consonance with the Declaration of Alma-Ata iterated in 1978 by the International Conference on Primary Health Care and subsequently adopted by the World Health Assembly in 1979. Those national strategies become the basis for formulating **Regional Strategies for Health for All by the Year 2000**. In the 1990s, there follow a series of regional plans of action and strategic orientations and program priorities.

In the context of that legacy, the **Health Agenda for the Americas, 2008–2017**, is the latest in a series of expressions of the collective will of the countries of the Region.

arrange for legal frameworks that enable proper management of the health system; base decisionmaking on validated evidence; establish reliable information systems for financial management, budgeting, and accounting; and advocate a central role for health as part of the hemispheric development agenda.

**2. Tackling health determinants.** Education, employment, income, and other social factors directly impact health. It follows that gains in health do not depend entirely on the efforts of the health sector; rather, improving the population's health demands action along a number of social fronts and collaboration among many other institutions and sectors—education, agriculture, law enforcement, transportation, and the like. It will be important to assure that national development plans address health determinants and allocate resources to overcome the problems of social exclusion, exposure to risks and violence, unplanned urbanization, and the effects of climate change. Countries will want to maintain and augment health promotion campaigns—especially targeting mothers, children, and families—through proper nutrition and breastfeeding, vaccination, and respiratory and infectious disease prevention and control.

**3. Increasing social protection and access to quality health services.** At present, labor-market uncertainty in the countries of the Region is compromising family incomes and, by extension, social security and access to health care. For families that lack protection, expenditures for health services can be catastrophic. Governments should endorse public policies that protect all their citizens; that assure the population's access to necessary health care services, drugs, and technologies; that deliver comprehensive, effective, and efficient services using referrals and cross-referrals, evidence-based practices, and family/community models of care centered on promoting health and preventing disease; and that regulate private-sector health care so that it contributes to attaining national goals for public health.

**4. Diminishing health inequalities among countries and health inequities within them.** Although regional indicators show that significant gains have been made in the population's health in recent decades, major inequalities persist among countries and profound inequities prevail within them. Those systematically deprived of the benefits of social inclusion—the poor, people with little or no education, rural inhabitants, indigenous

peoples and other ethnic groups, women, and the elderly, among others—experience worse levels of health or are exposed to greater health risks and have less access to health services. Governments need to provide health interventions that respond to the special needs of each group: culturally acceptable health services for indigenous groups that respect their rights as citizens; sexual and reproductive health services for women, from conception through care of the newborn; integrated care of adolescents and young adults that address their development needs, mental health, and tendencies towards risky behaviors; maintenance of the quality of life of the elderly and their participation in self-care; and assurance of health policy and program parity for males and females. International development assistance should target funding activities that contribute to reducing inequities in health.

**5. Reducing the risk and burden of disease.** In every country in the Americas, the epidemiological profile is changing—changes projected to intensify in the years to come—and the health sector needs to adapt its policies and programs accordingly. The prevention and control of communicable diseases continue to be important, and intensive efforts should aim to control and eliminate the “neglected” diseases that tend to disproportionately afflict the poor. At the same time, countries will need to address the leading causes of illness and death: noncommunicable diseases—diabetes, cerebro- and cardiovascular diseases, cancer, etc.—and external causes such as traffic injuries, homicides, and other forms of violence. Toward that end, individuals, the health and education sectors, the media, and society at large should actively promote healthy lifestyles and behavior—principal among them, the availability of healthier foods, better dietary habits, greater physical activity, and the cessation of smoking.

**6. Strengthening the management and development of health workers.** The countries of the Region, including the more developed ones, as well as areas within all of them, are experiencing critical shortages of doctors and nurses. To meet the increasing and changing needs for health workers, governments should base their health workforce policies and plans on evidence regarding those needs; seek equitable distribution of health workers to assure the availability of their services to the most needy; promote working conditions to stem the emigration of health workers; improve health personnel management, and link health worker training to the needs of health services.

**7. Harnessing knowledge, science, and technology.** Research enables countries to better understand the relationship between health determinants and their consequences and to select interventions that are appropriate and effective. The design of health policies and the conduct of health programs should be based on the evidence of state-of-the-art research. Countries should bolster investigation into the nature and scope of social

determinants of health, strengthen research on traditional and complementary medicines, monitor adherence to bioethical principles, and ensure the equitable application of scientific and technological advances.

**8. Strengthening health security.** Individual and collective security throughout the Americas is threatened when pandemics and natural and man-made disasters strike. Migratory movements and unsafe food-trade practices can accelerate disease transmission. Governments must prepare for health emergencies and outbreaks and be ready to provide relief when they occur. To prevent and control the spread of disease within and beyond their borders, countries should assure compliance with the latest iteration of the International Health Regulations. Joint efforts between the health and agriculture sectors should target preventing and controlling zoonotic diseases, including preparations for a potential avian influenza pandemic. And countries should collaborate with international organizations to respond rapidly and effectively to circumstances that threaten health security.

### Perspectives Regarding Action in Health

In their presentation to the international community of the Health Agenda, the Ministers and Secretaries of Health of the countries of the Americas urged “all Governments, civil society, and the international community which contribute to technical cooperation and development financing, to consider this Agenda as a guide and inspiration when developing public policies and implementing actions for health in pursuit of the well-being of the population of the Americas.” In support of that declaration, the Secretariat of the Pan American Health Organization invited a select group of international public health experts to offer their guidance with respect to both the future of health in the Americas and the implementation of the Health Agenda. Specifically, the experts were asked: *“What orientation would you give policy- and decisionmakers regarding implementation of the Health Agenda for the Americas and what prospects for change would you recommend that they take into account?”* What follows are the responses to that twofold question from distinguished leaders with profound experience in international health: George A.O. Alleyne, Stephen Blount and Jay McAuliffe, Paolo Buss, Nils Kastberg, Gustavo Kourí, Sylvie Stachenko, Muthu Subramanian, Ricardo Uauy, and Marijke Velzeboer-Salcedo. Those responses broach a wide array of themes, from epidemiological priorities, to population- and age-group considerations, to health sector and health workforce challenges. Three main themes recur—the need to redress inequities in health, the importance of intersectoral and international cooperation, and the role of information, knowledge, science, and technology in advancing health—and underscore the richness of these perspectives on the future of health in the Americas; those themes are highlighted throughout this chapter (“Recurrent Themes”).

## COMMENTS OF DR. GEORGE A.O. ALLEYNE

In providing policy- and decisionmakers orientation regarding implementation of the Health Agenda for the Americas and prospects for change that they should take into account, I will assume that these individuals represent the same “type” of person, so I will not distinguish between them in my response, referring to them generally as “policymakers”; moreover, I will assume that these are policymakers in the health sector. My response comprises six principal “orientations.”

**Appreciate the nature of public policy and the role of policymakers.** The policy change process needs to be approached with a clear understanding of the political process. As Michael Reich points out in “The Politics of Reforming Health Policies”:

The first skill is to assess the political intentions and actions of stakeholders. Stakeholders include individuals, groups, and organizations that have an interest in a policy and the potential to influence related decisions. . . . In general, political strategies are needed to address four factors that determine the political feasibility of policy change. The four factors are: players, power, position, and perception.

All too frequently policymakers in health are naïve in their belief that, because their cause is noble, their proposals will be instantaneously accepted. Thus, the first orientation that is critical for policymakers, especially new ones, is to be aware of how public policy is formed and of the various stakeholders involved. They must avoid at all costs trying to replace the often very competent technical staff they have at their disposal. One of the grave problems encountered in the health sector is that of the erstwhile health professional who has become a policymaker in the public sector without appreciating that his or her role has changed. Recognition of the basic difference between public policy in general and healthy public policy is a must. It is fine to be able to direct policy in a narrow field of health, but—to the extent that health is determined by many factors outside the traditional health sector—it is important to be clear that healthy public policy, which is critical for achieving much of the Health Agenda, needs a specific set of tools and understanding. The policymaker has to understand that healthy public policy comprises technical, ethical, and political inputs and that all of those inputs must be managed. The tendency in the health sector is to focus exclusively on technical aspects and to ignore the others. No health agenda, no matter how laudable, no matter how technically sound and socially desirable, has any chance of success without a keen appreciation of the nature of public policy and the role of policymakers—factors which, unfortunately, the health organizations that craft such agendas tend not to emphasize sufficiently.

**Acquire the tools to articulate a case for health vis-à-vis other sectors.** The Health Agenda speaks definitively to health in-

equities, the social determinants of health, and the need for the policymaker to make the case that these inequities and determinants merit attention. The first and most important task, however, is to be able to articulate clearly the value of health to all other sectors and thus to society as a whole. The Health Agenda addresses health almost exclusively in terms of the good that health is, which is undoubtedly true. If, however, health policymakers are to argue a case for the appropriate allocation to health, they have to do so not only on the basis of the intrinsic importance of health, but on that of the contribution of the population’s health to all other aspects of national development. It is now abundantly clear that we have hitherto underestimated the value of health to economic welfare. While advocacy of the need to increase social protection and government responsibility for it is ethically correct, as important, if not more so, is the argument that the provision of social protection helps persons and families to avoid falling into a poverty trap or to escape from it—both of which are of critical economic and political significance. More than anecdotal evidence attests to the inadequacy of health sector presentations in fora where decisions are made about resource allocation. This lack of persuasiveness on the part of the health sector results directly in the chronically low allocation to health in the Americas. Thus, the policymaker has to have the tools to argue for the instrumental value of health, and, unless that argument is compellingly made, the Health Agenda will not be adequately resourced and therefore will not fulfill its expectations. We now have the tools to be able to make the case for the role of health in human development, and organizations that advocate for the Health Agenda have a responsibility to arm the health policymaker with those tools.

The policymaker can demonstrate the benefit to be derived from appropriate health interventions, comparing interventions that have the same denominator; for instance, cessation of smoking could be assessed in terms of cost per disability-adjusted life year (DALY) averted or of some measure of health, in the same way that coronary bypass surgery could be, since they both would use the same denominator. In order to compare health interventions with interventions in other sectors, however, the policymaker must be able to present data that show the relative cost-benefit of the health and non-health activity or program. How, for example, might the health policymaker argue to support noncommunicable disease control in the face of competing arguments to build new roads?

In making the vague plea for intersectoral collaboration, which is indeed necessary to address many of the components in the Health Agenda, the policymaker is often placed in the position of a mendicant rather than that of an equal partner seeking the contribution of other sectors to healthy public policy. Noncommunicable diseases, which are highlighted in the Health Agenda, represent an excellent example of the need for healthy public policy and intersectoral collaboration. The tools for the primary prevention and control of many, if not most, of these diseases lie outside the traditional health sector; as examples, the imposition of to-

bacco taxes is usually not in the hands of the health policymaker, and the solutions to an array of health problems require modifications in trade and agricultural policies. Intersectoral involvement in health promotion can only be achieved if the case is made that health has a value beyond the intrinsic or constitutive.

**Emphasize information as a key resource.** It is critical that very careful attention be paid to the collection of appropriate data and, on the basis of those data, the generation of information. The need for data and information will confront the policymaker at every turn, and, indeed, the case for health as set out above can only be made on the basis of reliable data that are collected regularly: the value of the data increases when they are collected on a regular basis with some established periodicity. Evidence now exists of the cost-effectiveness of information as an intervention to ensure good health outcomes. Any serious call for an end to inequities must first be based on a demonstration of inequalities, and the policymaker must understand the difference between these two concepts. The Health Agenda emphasizes health determinants and health inequities and calls for governments to address them. And yet any satisfactory program to address inequity depends on a prior determination of inequalities, their genesis, and their modifiable contributing or risk factors. A call for an end to inequity is hollow without the ability to collect the relevant data and to monitor the results of whatever interventions are applied to modifiable risk factors. The policymaker must be oriented to understand the difference between vertical and horizontal equity—i.e., treating everyone the same or targeting those most in need—as the approaches to redress them are very different. In any case, every approach depends on a good system of knowing what is “upon the people” and of dealing with that knowledge accordingly.

**Establish priorities.** If every problem is addressed at the same time and with the same degree of urgency or priority, chaos will result. It will soon be obvious to the policymaker that change takes place only in response to specific interventions, so it must be clear who is responsible for introducing and monitoring those interventions. The interventions available within the health sector for addressing health determinants, diminishing health inequities, and reducing the risk and burden of disease are of two types—those that address specific problems and those that strengthen the health system—and approaches to both types have their place within the Health Agenda. The policymaker should not, however, get drawn into useless discussion about the relative importance of addressing disease-specific interventions versus applying measures to strengthen the health system. The essential public health functions model shows clearly the need for a dual approach.

Excellent tools are now available to determine the priorities to be addressed in both disease prevention and control and health system governance and toward that end cost-effectiveness analy-

sis can be of critical importance. Thus, for example, the policymaker will be able to determine the opportunity costs of not utilizing a cost-effective intervention to address a disease problem that seriously affects the population. In addition, it will be possible to determine which interventions or programs are of such low cost-effectiveness that their use and continuity should be seriously scrutinized and justified. Notwithstanding, it must be stressed that cost-effectiveness analysis, albeit an essential tool for the policymaker, will be but one of the factors to be taken into account when choosing among priorities. Unfortunately, the policymaker will have to face the reality that for some of the population's health conditions, such as mental health problems, few cost-effective interventions are currently available at the personal level and virtually none are at the population level.

**Be realistic and avoid fantasy.** The policymaker will often be confronted with very attractive schemes designed by very well meaning persons who do not appreciate the nature of emerging social forces, such as globalization and the growing inequality of power and markets. The area of human resources and the health workforce is one such. In this very critical area, a heavy dose of realism is in order regarding a number of issues, included among them that of migration. It is time the health community realized that it is impossible to stop persons from moving freely; by the same token, it is unrealistic to think that developed countries will desist from importing trained health workers or that this traffic can be regulated internationally. More realistic would be an approach that deals with factors over which the policymaker has some control. In like manner, a good measure of realism is needed when confronting the laudable, but often unrealistic aspirations that tend to characterize health agendas in general.

**Be patient.** With regard to the prospects for change that policymakers should take into account, I would urge patience, as the changes that will affect implementation of the Health Agenda are likely to be incremental and evolutionary rather than abrupt. A major change will surely be the growing power and influence of nongovernmental actors within and outside of the state; public health policymakers will have to seek actively a *modus vivendi* with the other nongovernmental state actors. The government or the public sector cannot carry out all the activities necessary for the Health Agenda. The health sector policymaker will need considerable patience and negotiating skill to deal with these new actors. Finally, the policymaker will also need patience in interacting with the changing international architecture, given the growing number of agencies having an interest in health. The local solution is for the policymaker to have the patience and courage to insist on the primacy of the local plan and to convince others to comply with it. The steering role of the policymaker in health will not be restricted to any given agency, rather it extends to all the actors in health at the national level.

In closing, I would merely like to add to this series of orientations an expression of my every hope that the Health Agenda succeeds, as will be evidenced by measurable improvement in the health of the peoples of the Americas.

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## COMMENTS OF DRS. STEPHEN BLOUNT AND JAY MCAULIFFE\*

A fundamental challenge for national health policy- and decisionmakers charged with implementing the Health Agenda for the Americas, 2008–2017, is to effectively transform the proposed “areas of action” into real action. As a starting point, each country will need to establish its own implementation plan. It will also need to regularly apply an objective, user-friendly, and transparent monitoring tool for each area of action—an approach that will document the status quo at the outset and the degree of progress achieved subsequently. The same tool should be used to motivate the appropriate institutions to take the continued actions needed.

**Cross-cutting issues.** Ministries of Health (MOHs) should seek *engagement and partnerships* with other health-related organizations in areas of overlapping interest. While MOHs are best positioned to exercise leadership in the health sector, they are unlikely to possess all the resources needed to be able to fully respond to all of the areas of action. Other governmental agencies, academic institutions, nongovernmental organizations, and businesses in the private sector can assist the MOH in these areas. It requires, however, a commitment from the MOH to support such partnerships, a full understanding by the partner institution of the desired outcomes and a commitment to them, and a set of agreed-upon, well-established terms for the collaboration.

**Tackling health determinants.** While the health sector is limited in its ability to address many determinants of health, such as poverty and education, environmental determinants have a tremendous impact on health in many developing countries and present opportunities for being modified. Collaborations with other sectors—water and sanitation, education, agriculture, and environmental regulation, to name a few—should be encouraged as a means of achieving *healthy environments*.

\*The authors would like to acknowledge the contributions to this text of various colleagues at the United States Centers for Disease Control and Prevention.

**Harnessing knowledge, science, and technology.** To fully understand the health problems that most need to be addressed and the most effective methods for doing so requires establishing an institutional culture within the public health sector that values and demands high-quality information and that develops the capacity to generate it—that is, the pursuit of *applied epidemiology and research*. Policymakers must have staff who can review the health literature and translate the most current research findings into appropriate guidance for country decisionmakers’ use in orienting program plans and implementing health activities. Establishing field epidemiology training programs has been one successful strategy for Ministries of Health to increase their capacity to collect high-quality data and transform them into information and knowledge that are applied to existing program needs. These programs have conducted prompt investigations of disease outbreaks, which are needed to understand such crises and to define the most effective measures to control them. While collection of vital statistics and surveillance data has long been a routine function of Ministries of Health, the incorporation of operational research into their practice is limited and needs to be expanded. As the public health sector increasingly embarks on initiatives to address noncommunicable diseases, establishing an evidence base founded on sound research will be important to the success of new strategies that seek to influence health-related behaviors critical to the advances needed in this area. Research must be used to guide the formulation of health communications and health marketing and to assess the results achieved.

Planning for the assessment and expanded use of new and effective *technologies* in the public health sector is critical; examples include new vaccines, rapid diagnostic kits, geographic information systems, and information technology tools. Decisionmakers in the public health sector must stay abreast of the development of new technologies and be innovative in finding opportunities to apply them to more effectively address priority health problems.

**Strengthening solidarity and health security.** To deal with public health threats and emergencies, an institutional capacity to effectively implement *risk communication* and *social mobilization* interventions is critical. Principles for these interventions and the methods for carrying them out must be incorporated into public health security plans. Whether in response to crises resulting from pandemic influenza, severe outbreaks of unknown etiology, or natural disasters, countries need to have an established capacity to perform risk communication and social mobilization functions when the moment arrives.

In times of crisis, *regional networks* can serve important needs, and their development should be promoted. The network of field epidemiology training programs of Central America is a good case in point: it has assisted individual countries in their response to major natural disasters (e.g., El Salvador’s recent earthquake), toxic exposures (e.g., Panama’s experience with medica-

tions contaminated with diethylene glycol, DEG), and the need to strengthen capacity to respond to an influenza pandemic.

**Reducing the risk and burden of disease.** The Health Agenda for the Americas appropriately recognizes the need to increase efforts to target *noncommunicable diseases* (NCDs). Promoting healthy behaviors and lifestyles contributing to the prevention of NCDs is essential; the public must be advanced from its current stage of awareness of NCDs to a stage of action that modifies behaviors. Countries must strengthen operational research and guidelines for practice in health communication and marketing that assist in identifying the public's needs and preferences for information, products, and resources that support adoption of healthier behaviors. Regular monitoring of the prevalence of key risk behaviors should be adopted to assess the effectiveness of prevention activities.

Policy- and decisionmakers need to give greater emphasis to *injuries* as a public health problem and to extend the focus on this concept beyond “traffic accidents.” WHO estimates for 2002 in Latin America and the Caribbean show that disability-adjusted life year (DALY) rates for injuries typically represent 10-20% of total DALY rates. Recommendations for surveillance systems are available that will provide basic descriptive data regarding injuries and can lead to the identification of opportunities for effective interventions. Collaboration with other sectors—such as transportation and justice—will enhance data collection and the development of interventions.

Care should be taken to assure that the existing commitment to combat *communicable diseases* not diminish. In the case of neglected diseases such as onchocerciasis and lymphatic filariasis, which have programs for elimination in place, countries' commitments need to be reaffirmed and efforts consolidated to achieve this objective. Successful strategies, such as the large-scale distribution of donated ivermectin for lymphatic filariasis, should be widely disseminated. Neglected diseases, which generally affect the most vulnerable or marginalized segments of the population, deserve priority attention to achieve better health equity.

The success of *immunization* programs in the Americas—smallpox and polio eradication, measles elimination, current efforts to eliminate rubella—lays the foundation for the introduction of new vaccines and for the evolution from child to family immunization programs. Supplementary vaccination activities, such as PAHO's Vaccination Week in the Americas, must be supported to reduce inequities and ensure protection for those who lack ready access to health care. Integration of other services during immunization campaigns should be considered when feasible.

**Strengthening the management and development of health workers.** To develop the skills and knowledge of the public health and health care *workforce*, approaches are needed to make education and training accessible in resource- and time-

constrained environments. New ways to provide information and skill-based training to health workers where they live and work will enable them to remain in the communities where they are most needed. The expectation of expanded information and communication technologies, together with other innovations, will play a role in providing opportunities for education and training in health and public health fields to broader audiences.

*Public health training* should be at the core of efforts to improve the management of public health systems—especially in new program areas—and emerging threats. A priority objective for such training should be to support workers who are developing the scientific basis for new interventions and who have responsibility for managing such programs.

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## COMMENTS OF DR. PAOLO BUSS

Any vision of the future of health in the Americas should not focus solely on efforts to strengthen health systems and to improve the quality of health care services. At best, such a focus would perpetuate the regional health situation as it stands, or perhaps something merely somewhat better. Our focus has to be on the central issue underlying the most disturbing problems that confront our countries: the inability of almost one-half of the inhabitants of Latin America and the Caribbean to attain the benefits of human development and, thus, their relegation to an existence of unacceptable inequities.

In Latin America and the Caribbean, progress toward poverty reduction has proceeded at a relatively slow pace, with some 60% of the proposed period (1990–2015) having elapsed and hardly more than 30% of the targeted reduction attained. In the country in the Region that I know best, Brazil, progress has been much greater, with almost 80% of the goal attained, in large measure because effective social projects have been carried out and health

## RECURRENT THEME

**Redressing inequities in health and the right to health**

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—*Paolo Buss*

. . . the concept undergirding everything related to the development of health is that the entire population should have access to health—regardless of economic status, type of employment, race, place of residence, or the like.

—*Gustavo Kouri*

Policymakers will want to assure that commensurate attention is given to achieving greater health equity among those population groups [afrodescendants and indigenous populations] compared to that prevailing among the rest of the population. . . . We should stress ‘coverage’ to indicate the need that health services go beyond ‘access’ and generate demand to ensure coverage.

—*Nils Arne Kastberg*

The policymaker must be oriented to understand the difference between vertical and horizontal equity—i.e., treating everyone the same or targeting those most in need—as the approaches to redress them are very different. In any case, every approach depends on a good system of knowing what is “upon the people” and of dealing with that knowledge accordingly.

—*George Alleyne*

Greater inequality will surely result, unless the regulatory framework presently in place is reexamined to take into account the situation of countries that have serious limitations in resources—limitations that today prohibit their access to the new diagnostic and therapeutic tools that the future will bring.

—*Ricardo Uauy*

Implementation of the Agenda should focus on two objectives: (1) improving the health and well-being of people; and (2) reducing avoidable inequities in health and health care by addressing basic determinants and prerequisites of health.

—*Muthu Subramanian*

As regards efforts to diminish health inequities among and within countries, UNIFEM strongly concurs with the Agenda’s distinction of sexual and reproductive health as a priority issue in the Americas.

—*Marijke Velzeboer-Salcedo*

service coverage has expanded. Notwithstanding, that progress has been compromised by the persistence in the country of large gaps in income, which weaken the bonds of social integration and lower the levels of social capital and political participation.

In that context, and bearing in mind the Millennium Development Goals, it is worth noting that, although three of the eight goals relate to health, the first of them is the eradication of extreme poverty and hunger, without which it is doubtful that progress will be made towards any of the other goals. As a reflec-

tion of that association, the World Health Organization recently called attention to the fact that the poorest countries in the world will have difficulty attaining the MDGs and that in many of them progress, as measured by the respective indicators, has stalled.

In recent decades, the focus on improving health conditions has centered on health system reform, the aim being to assure a social dividend and to contain the increasing costs imposed by economic sectors. It has become obvious, however, that this strictly sectoral approach is insufficient to achieve the universal-

ity, accessibility, and inclusivity in health to which the entire population is entitled.

The health sector crisis is not necessarily a reflection of its irremediable failure or its irreversible deterioration. Rather, the problem lies in a general inability to overcome the status quo, with decisionmakers limiting themselves to their conventional perspective and resisting any involvement in new, potentially more powerful orientations. At the same time, globalization is having significant negative effects that restrict the free political determination of nation states, leading to a form of colonialism that subordinates our countries' development to the influences of foreign trends and policies.

Meanwhile, from a more positive point of view, the gradual acceptance of the concept of social determinants of health and the corresponding increase in health promotion activities will enable more opportunities to improve the quality of life of many population groups in the Region. Among the factors that have the greatest influence on their health is a broad array of social and economic conditions: poverty, injustice, lack of education, lack of social protection, poor nutrition, social exclusion and discrimination, gender discrimination, inadequate housing, urban decay, lack of potable water, violence, and the absence or inadequacy of health care services. The political reorientation of most of the governments in South America should result in greater sensitivity to these conditions and could lead to measures to redress them.

In that context, two important initiatives merit mentioning that could mitigate the negative conditions noted above. Both of these initiatives are based on a renewal of the concept of health as a public good—the objective of public policies crafted with the concerted participation of different segments of the population—as contrasted with the concept of health as a private good, produced in the form of medical care for individuals and governed by the dictates of the marketplace, a concept that informed many of the health reforms carried out in the Region, particularly during the 1990s. The first of these initiatives is social participation, which, as it has spread throughout the Region, has reinforced the value of empowering society as a whole. The second initiative targets the development of effective intersectoral coordination, as a governmental strategy for more cohesive and forceful action based on an open, inclusive dialogue among the social and economic sectors. Both initiatives could contribute to overcoming social constraints in Latin America and the Caribbean, by enabling a new approach to governance wherein all of society, and not just the political powers that be, promotes a collective approach to common, shared objectives.

Allow me to refer, again, to experiences in my country by drawing attention to examples of well-managed interventions, although I am sure that similar examples are underway, with similarly successful outcomes, in other Latin American and Caribbean countries. In Brazil, social participation has made great strides, thanks to a wide network of Municipal Health Councils (*Conselhos Mu-*

*nicipais de Saúde*) that have been integrated in a tripartite scheme along with state and national jurisdictions. Also effective have been the family health program, which today covers 60% of the population and which aims to reach half of the remaining population by the end of this decade, and the HIV/AIDS control program, which has emphasized prevention of the disease, production and free distribution of available medicines to all patients, and comprehensive epidemiological surveillance—an approach that is being adopted in a number of other countries. Finally, immunization and breastfeeding programs have expanded with great results, as have the human milk banks that are widely used in the country.

At the international level, in regional integration summits, the countries of Latin America and the Caribbean can resist global governance and achieve, in a context of regional solidarity, conditions that support local policies; they can join forces to break with the protectionism of more powerful countries; and can cooperate amongst each other to achieve greater self-sufficiency in confronting the demands of human development in general and of health in particular. Convergence of the interests of foreign policy and of health could have a tremendous impact on development, as exemplified by the Framework Convention on Tobacco Control; implementation of the International Health Regulations; the Global Strategy on Diet, Physical Activity, and Health; the probable adoption of the WHO resolution on Intellectual Property Rights; and the development of science and technology in the health field.

Similarly, at the international level, recent promotion of the Decade of Human Resources in Health has served as an important catalyst for implementation, at the international and national levels, of a series of measures that aim to balance the problem of insufficient or poor distribution of health professionals, as well as to reorient the preparation of those professionals to the real needs of the population. The fruits of that initiative are already beginning to have an impact on programs that introduce new theoretical contents in academic training, that diversify the fields of practice of students, and that promote new teaching approaches. These experiences will no doubt influence health actions in our Region and throughout the world. In that respect as well, the program supported by the Inter-American Development Bank to train a critical mass of nursing auxiliaries is noteworthy: a large-scale training methodology has resulted in the addition of 350,000 workers to the health system, and the methodology is now being considered for the training of mid-level technicians.

As these initiatives proceed apace, we will continue to have to live with a number of problems, as the Region still is undergoing an epidemiological transition characterized by the coexistence of the problems of underdevelopment with those of the developed world.

It follows that we will continue to have to depend on large pharmaceutical companies for the procurement of a wide variety of

medicines and supplies, as we have not reached the extent of development in research and technology that would permit us a certain independence—not only in the production of existing medicines but in the production of new drugs that will accompany advances in science. The scant importance that the countries give to intersectoral coordination means that in most of them the health sector is not able to influence technological development.

We will continue to confront increasing problems that result from global warming, especially in the Caribbean and Central America, although the effects of this phenomenon are spreading to other areas. Nonetheless, we can do little beyond recognizing that the cause of global warming stems from environmental degradation not in our countries but in the developed world. No less important is the growing threat of urban violence in Latin America and the Caribbean caused predominantly by drug trafficking and accidents—problems that in some countries have reached alarming proportions.

Meanwhile, we continue to be committed to thwarting the negative influences on the health of our populations and to combating poverty and social exclusion, violence, and environmental degradation. We are likewise committed to a concerted multisectoral approach and to broader social participation, in the hope that, together, we can achieve a brighter future for Latin America and the Caribbean, with greater health and a better quality of life.

**Dr. Paolo Buss**  
**President**  
**Oswaldo Cruz Foundation**  
**Rio de Janeiro, Brazil**

## COMMENTS OF DR. NILS ARNE KASTBERG

UNICEF is pleased with this Health Agenda for the Americas, and with its alignment with the goals of the Millennium Declaration and its strong value focus on human rights, universality, access, and inclusion; on Pan American solidarity; on equity in health; and on participation. And UNICEF particularly welcomes the significant references to children and adolescents in the Agenda. We consider that the work of the Ministries of Health and of the Pan American Health Organization is of fundamental importance for the well-being of children and their mothers in the Region. Within that overall positive perspective, we would like to provide the following complementary orientation to that provided in the Health Strategy to policy- and decisionmakers who will be implementing this Agenda.

**Making the MDGs a reality at the local level to address disparities in health.** The Health Agenda underscores the importance of alignment with the Millennium Declaration and emphasizes the inequalities that need to be addressed. It will be im-

portant, therefore, to establish benchmarks and monitor progress towards achievement of the MDGs—not just as national averages but as expressions of the reality at the local level. The importance of developing measures that disaggregate data in order for public health services to monitor progress and results for the MDGs at the local level is well illustrated by the example in the Agenda, whereby 40% of the municipalities in Latin America and the Caribbean do not reach the immunization goal of routinely vaccinating 95% of children under 1 year of age. The disaggregation of data could help Health Ministries to more forcefully advocate for resources to strengthen health services in the areas where health outcomes are weakest.

**Providing the “people context.”** Policy- and decisionmakers in the health sector will want to give particular attention to the “people context” so that efforts to prevent unhealthy trends can be strengthened. Included among other fundamental considerations of the human geography are: the number of pregnancies and children born, the high number of teenage pregnancies, the number and percentage of children suffering from chronic undernutrition, and the like.

**Addressing violence.** It will be important to give special consideration to the involvement of health in the early detection of intrafamilial violence and to the drama health services face when interacting with other state services responsible for protecting women and children, but who do not live up to their responsibility. The link between violence, sexual abuse, and incest is evidenced by the startling figure that 20% of pregnancies are now among adolescents, and most of those pregnancies are unwanted. PAHO and WHO have been instrumental in contributing to the United Nations Study on Violence against Children, presented to the General Assembly on 11 October 2006. That study estimates that in Latin America and the Caribbean 80,000 persons under 18 years of age die every year as a result of intrafamilial violence. It is critical that attention continue to be given to the reporting of these cases, to follow-up actions that services other than health need to take, to the traumatic situation this presents for health staff to have to witness day after day, often without assistance from other sector services. Increasingly in certain urban settings of the Region, the leading cause of hospitalization of adolescents is injuries caused by violence. Policy- and decisionmakers must make sure that violence of this nature, observed during the day-to-day work of health services, is systematically captured and monitored and that the necessary follow-up action is taken.

**Trends in the health system response: mobilization for health promotion.** Policymakers would benefit from familiarity with examples in countries of the Region of successful health promotion. The UNICEF Brazil Office considers that the 27,000 health promotion teams in that country reach some 70 million

people—an excellent example of mobilization for health. The Vaccination of the Americas campaign promoted by PAHO and supported by UNICEF is another example of mobilization for disease prevention that has reached countless heretofore unreached individuals. Young people could be recruited for health promotion efforts, as another strategy for broadcasting messages that give greater emphasis to preventive, rather than curative, services.

**Afrodescendants and indigenous populations in Latin America.** Afrodescendants in Latin America, who represent some 150 million persons, face similar differences in health indicators in relation to the average population, as do indigenous populations, who number between 40 and 50 million persons. Policy-makers will want to assure that commensurate attention is given to achieving greater health equity among these population groups and compared to that prevailing among the rest of population.

**Chronic undernutrition and the young mother.** Chronic undernutrition was not one of the 48 MDG indicators for MDG1b, Hunger. Through United Nations interagency work and in the 2005 joint United Nations report to the Americas on MDGs, coordinated by ECLAC, the United Nations Regional Directors Team for Latin America and the Caribbean concluded that the chronic undernutrition indicator was the most relevant indicator for our Region to measure progress on MDG1b. In implementing the Health Agenda for the Americas, UNICEF would thus recommend that this issue be given particular attention. We consider that greater focus on the adolescent mother—especially during the nine months before birth and the nine to 36 months after birth—is critical to a number of key health promotion, early detection, and health problem prevention measures. Policymakers will want to make sure that this issue is tackled, to support national programs already underway that target eradicating chronic undernutrition, and to seek national intersectoral action, including access to potable water and sanitation in rural areas, as many countries still have a large proportion of rural populations without access to those services. By 2017 chronic undernutrition should have been eradicated from the Americas.

**Specific suggestions.** It is important to emphasize in regard to HIV/AIDS, the feminization of the pandemic in many countries, the transmission to young women, the need to attain universal access and coverage in the Region, including through pan-American solidarity, the need to reduce mother-to-child transmission to as close to zero as possible. With regard to community involvement in health services, as the Director of PAHO has so appropriately indicated on many occasions, we should stress “coverage” to indicate the need that health services go beyond “access,” and generate demand to ensure coverage. The theme of pan-American solidarity suggests that, in addition to collaboration on common targets, it is important that countries recognize the issue of access

to health across borders, the provision of health staff across borders, and the increase in south-south collaboration beyond the Americas.

Again, UNICEF would like to congratulate PAHO for advancing this Agenda, and will continue to be a close partner in mobilizing society for better health in the Americas!

**Dr. Nils Arne Kastberg**  
**Regional Director**  
**United Nations Children’s Fund**  
**Latin America and the Caribbean Regional Office**

## COMMENTS OF DR. GUSTAVO KOURÍ

The Health Agenda for the Americas, 2008–2017, sets a direction going forward for health throughout the hemisphere. In contemplating the future of health in the Region, it should prove useful to consider the example of Cuba, where the concept undergirding everything related to the development of health is that the entire population should have access to health—regardless of economic status, type of employment, race, place of residence, or the like. In effect, a public health system should be accessible, universal, free, and a force for solidarity. Crucial to realizing those conditions is political will, without which nothing can be achieved.

At the same time, the public health system should have in place excellent services that enable the conduct of high-level, costly studies that will benefit patients. Too often, the quality of public health services is very low, and only in private services can certain studies be carried out.

Public health is based on a preventive rather than a curative principle. Conversely, the private sector requires a lot of patients in order to be profitable; consequently, its thrust is curative, because if the private system doesn’t have patients, it collapses. The problem, as is evident from the Health Agenda for the Americas, is complex. Modifications to the health sector have failed in the Americas, where many of the public health systems have been privatized.

Cuba has a system that is unique in the Americas, and possibly in the world. In addition to having the health indicators of a developed country, it provides cooperation to some 70 countries, where more than 30,000 of its health workers are helping the most needy population groups in those countries. The principle informing Cuba’s health system is not to give away what it cannot use, but, rather, to share what it has.

In addition, because many countries are elaborating comprehensive health plans that include the development of human capital for health, Cuba, as a demonstration of its solidarity with other countries, has established the Latin American Medical School (*Escuela Latinoamericana de Medicina* or ELAM), which is preparing thousands of students from Latin America, other

continents, and even the United States of America. Along similar lines of solidarity, the country works with others to confront epidemics, as is happening in the most recent cases of collaboration, namely with the control of malaria in Gambia and Jamaica.

In its commitment to scientific and technological development, Cuba has produced a number of vaccines, such as that for meningitis B, the country's vaccine being the first in the world against this group of meningococcus; the vaccine against hepatitis B, which has had a tremendous impact on national public health; DPT, which no longer is of commercial interest; the first synthetic vaccine produced in the world, against *Haemophilus influenzae* b; and other vaccines that are being used in the country's health system and which have resulted in vaccine-preventable diseases having little impact on morbidity and mortality in the country, where the population is immunized against 13 diseases. A vaccine has even been developed for cholera, a disease that doesn't exist in Cuba but that does represent a public health threat in other countries, where the vaccine will be made available.

Cuba has made important contributions to the scientific understanding of poliomyelitis, dengue, HIV/AIDS, tuberculosis, and other communicable diseases.

In summary, these gains have been achieved because health is considered a human right, the full and absolute responsibility of the state, and cannot be treated like a marketable good. Moreover, health should be coupled with the development of science and a likewise universal and free education, as health and education go hand in hand.

**Dr. Gustavo Kouri**  
**Instituto "Pedro Kouri"**  
**Havana, Cuba**

## COMMENTS OF DR. SYLVIE STACHENKO

Given what is known about the underlying determinants of both communicable and noncommunicable diseases, and given the clear relationship between health and economic and human development, three high-level orientations to the Health Agenda for the Americas, 2008–2017 are that:

1. Investment in health at the population level implicates the engagement of health and non-health sectors and public and private entities in collaborative relationships;
2. The health of populations and the health system are national assets that serve and underpin other sectors, that investment in health at the levels of the population as well as among individuals can give returns on investment that contribute to economic policy goals within countries and subregionally in the Americas, particularly when investments target populations experiencing relative inequity in health status; and
3. Dealing with the global industry, whose products and practices can compromise the population's health, requires global instruments for health protection.

The evidence is strong that strategic and coordinated investments by various non-health sectors, acting within their traditional domains, can achieve health goals at the same time as the respective non-health sector goals are attained, amounting to protection and improvement in the health of populations.

As for proposals for change, whole-of-government approaches with corresponding executive level whole-of-government governance mechanisms to coordinate action on the underlying determinants of health are the means by which the health of populations and human development become the responsibility of multiple public sectors. Policy- and decisionmakers in the health sector need to seek out the opportunities to engage their national counterparts in other public sectors to, first, raise awareness and, second, instill in non-health sectors the responsibility they hold for disease and for health.

Within the whole-of-government coordinating mechanisms, the role of public health practitioners as the cross-sector stewards of the population's health needs to be elevated, with a corresponding increase in government expenditure for the population/public health components of health systems, and an understanding that non-health sector policy proposals are to be assessed in terms of their potential impact on health status and on the underlying determinants of illness and health disparities.

Given the global nature of certain industries whose products and practices are known to contribute to or cause disease, and given that countries in the Americas have dramatically different, if any, capacities and levers at hand to influence these global industries on which their populations may be dependent, cross-national and subregional initiatives and instruments are needed for industry practices to change for the simultaneous benefit of populations in multiple countries.

Policy- and decisionmakers in public health need to engage with their counterparts in other countries to use their collective voice to draw attention to their common issues and to leverage broader support from the public at large, from national and international agencies and nongovernmental organizations and from sympathetic non-health sectors to create the critical mass of public and political pressure for specific global industries to change their practices and products, such that populations are protected and, where possible, corporate goals are met simultaneously—creating win-win situations.

**Dr. Sylvie Stachenko**  
**Deputy Chief Public Health Officer and**  
**Director, WHO Collaborating Centre on**  
**Chronic Noncommunicable Diseases Policy**  
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## COMMENTS OF DR. MUTHU SUBRAMANIAN

Over the past three decades, since the Global Strategy for Health for All by the Year 2000 was launched in 1977, the Region of the Americas has made significant progress toward improving peoples' health in all the countries of the hemisphere. Relying on primary health care (PHC), inequalities in health levels between and within countries have been reduced and access to all elements of PHC has increased, although the pace of that progress has not been uniform among countries nor among population groups within them. The historical focus on mortality to reflect health status and health policy achievements has led to the assignment of a low priority to non-life threatening diseases, which in turn has resulted in a large part of the gains in life expectancy being accompanied by greater illness and disability; that is, life expectancy in the Region has increased much faster than "healthy life expectancy," understood to mean the number of years that an individual can be expected to live in good health. Generally speaking, the principles underlying the Global Strategy and the primary health care approach have proved their relevance and validity in improving peoples' health and reducing disparities in health levels, although their actual impact has fallen short of their potential. The collective experience gained with implementation of the Strategy and application of the PHC approach to achieve better health for all has contributed to conceptual and operational aspects of public health practice at national, regional, and global levels. Concerns have arisen with the widening disparities—common sources of social tension and unrest—in health status and health care access within countries and with the gap between life expectancies and healthy life expectancies. In that context, effective implementation of the Health Agenda for the Americas, 2008–2017 should ensure that the increases in life span of individuals are accompanied by freedom from additional years of suffering, pain, and disability—thus making longer life a prize, not a penalty.

**Orientation for implementation of the Agenda.** To attain the health outcomes set forth in the Health Agenda, the orientation of policy- and decisionmakers should be to shift away from the emphasis on health care: the focus should be to give all the peoples of the Region a positive sense of health and enable them to make full use of their physical, mental, and emotional capacities and, on that basis, to choose priorities and allocate resources. Such a shift in focus will inspire people to think afresh, to undertake new initiatives, and to work together in innovative ways. It will require a trade-off between increasing life expectancies—through mortality-reduction strategies—and increasing healthy years of life lived by, in addition to improving survival chances, preventing premature morbidity and avoidable disability through healthy ways of living and the elimination or reduction of preventable health risks among individuals and in the environment.

Implementation of the Agenda should focus on two objectives:

1. Improving the health and well-being of people, and
2. Reducing avoidable inequities in health and health care by addressing basic determinants and prerequisites of health.

Furthermore, to achieve and sustain positive health for all the peoples of the Region, sustained action will be required to:

- Add years to life by increasing life expectancy and reducing premature deaths,
- Add life to years by increasing years lived free from ill health, reducing or minimizing the adverse effects of illness and disability, and improving the quality of life through healthy lifestyles as well as healthy physical and social environments, and
- Add health to life by reducing disease and disability.

In policy- and decisionmakers' implementation of the Agenda's focus on lifestyles, the environment, and health care, they should assure the involvement of all levels of society and reach out to all partners and sectors that can influence health.

**Changing scenarios and resulting challenges.** Health development thrives in an environment that recognizes the myriad health benefits to socioeconomic progress and is conducive and receptive to health action being or becoming an integral part of the functions and activities of social and economic sectors. Unlike the political and economic upheavals of the 1980s and 1990s, the 21st century has begun with a favorable environment for health development in the Region, as summarily described in the paragraphs that follow.

**Health systems environment.** The regionalization of *peace* is gathering momentum: there have been no major wars or inter-country conflicts in the Region during the past decade. A new political landscape, more characterized by *democracy*, has been emerging, particularly in Latin America: 2006 proved to be a year of major political transformations with the emergence of democratically elected leaders in a number of Latin American countries. Greater attention is being paid to bolstering regional integration and consolidating democratic institutions. Increasing emphasis is being given to social spending and to achieving social justice, which should enhance people's participation in development—especially in activities aimed at improving their health and well-being.

The global community is increasingly recognizing that national action to improve people's health has global benefits. The Global Health and Foreign Policy Initiative, launched in 2006, aims to broaden the scope of *foreign policy* to include health; a set of actions for raising priority for health in foreign policy has also been outlined in the Agenda for Action (the Oslo Ministerial Declaration). These initiatives augur well for a smooth implementation of the Health Agenda for the Americas.

## RECURRENT THEME

**Promoting intersectoral collaboration and international cooperation in health**

Policy- and decisionmakers in public health need to engage with their counterparts in other countries to use their collective voice to draw attention to their common issues and to leverage broader support from the public at large, from national and international agencies and nongovernmental organizations and from sympathetic non-health sectors to create the critical mass of public and political pressure for specific global industries to change their practices and products, such that populations are protected and, where possible, corporate goals are met simultaneously—creating win-win situations.

—*Sylvie Stachenko*

A major change will surely be the growing power and influence of nongovernmental actors within and outside of the state; public health policymakers will have to seek actively a *modus vivendi* with the other nongovernmental state actors. The government or the public sector cannot carry out all the activities necessary for the Health Agenda. The health sector policymaker will need considerable patience and negotiating skill to deal with these new actors. . . . Intersectoral involvement in health promotion can only be achieved if the case is made that health has a value beyond the intrinsic or constitutive.

—*George Alleyne*

It has become obvious . . . that a strictly health-sector approach is insufficient to achieve the universality, accessibility, and inclusivity in health to which the entire population is entitled. . . . Convergence of the interests of foreign policy and of health could have a tremendous impact of development. . . . We are likewise committed to a concerted multisectoral approach and to broader social participation, in the hope that, together, we can achieve a brighter future for Latin America and the Caribbean, with greater health and a better quality of life.

—*Paolo Buss*

While Ministries of Health are best positioned to exercise leadership in the health sector, they are unlikely to possess all the resources needed to be able to fully respond to all of the areas of action. Other governmental agencies, academic institutions, nongovernmental organizations, and businesses in the private sector can assist the MOH in these areas. . . . In times of crisis, regional networks can serve important needs, and their development should be promoted.

—*Stephen Blount and Jay McAuliffe*

The theme of pan-American solidarity suggests that, in addition to collaboration on common targets, it is important that countries recognize the issue of access to health across borders, the provision of health staff across borders, and the increase in south-south collaboration beyond the Americas.

—*Nils Arne Kastberg*

Health development thrives in an environment that recognizes the myriad health benefits to socioeconomic progress and is conducive and receptive to health action being or becoming an integral part of the functions and activities of social and economic sectors. . . . The implementers of the Health Agenda should address the need to intensify ownership of health and environmental challenges and to assure an awareness of those challenges among the practitioners of disciplines generally less informed of health issues—such as architects, builders, and developers.

—*Muthu Subramanian*

All those who hold stake in the health of the hemisphere should capitalize on the political will in pro of health expressed repeatedly in countless Presidential summits. . . . It is likely that the collective PAHO membership could best contribute by striking strategic partnerships with other regional or international organizations that operate in the Americas.

—*Ricardo Uauy*

Decisionmakers [should] be made aware of the important work being carried out among various sectors, institutions, and United Nations agencies, such as the particularly successful interagency collaboration between PAHO and UNIFEM at the regional, subregional, and country level.

—*Marijke Velzeboer-Salcedo*

In Latin America and the Caribbean, *economic growth* has been solid in recent years and can be expected to continue, albeit perhaps at a slower pace. Domestic demand is becoming a major driver of that growth, with countries' economies less constrained by the vagaries of external demand. Gaps in growth rates among countries have been narrowing lately, resulting in broad-based growth throughout the Region. Greater economic growth is accompanied by decreasing *unemployment*, which has reached its lowest level since the mid-1990s. At the same time, ill-health among the employed is increasingly recognized as a major contributor to less-than-optimal labor productivity. With falling inflation, *real wages* have been increasing as well.

With regard to *literacy*, more than 90% of adults 15 years of age and older in Latin America and the Caribbean are literate, and the gender-gap has been narrowing; among young adults (15–24 years), more than 96% are literate. These young literate people are now making the transition into adulthood in a rapidly changing world with emerging information and communication technologies reshaping their lives and behavior. A priority focus for those implementing the Agenda should be to enable and ensure that these young people practice healthy behavior and that they sustain it over time.

Pre-primary school *enrollment* has become the norm in the Americas. In order not to separate “care” from “education,” intensive efforts, such as Early Childhood Care and Education (ECCE), have been made to expand and improve the early childhood foundation, including good health, hygiene, nutrition, and a nurturing and safe environment that supports children's cognitive and socioemotional well-being. A major challenge for the Health Agenda will be to take advantage of this education-health synergy to carry out health action that can enable children and youth to pursue a harmonious health continuum as they develop and prosper as healthy adults.

The *health of the environment*—healthier food, clean water, and a safe environment—proved to be a huge contributor to better health in the 20th century. More recently, health improvements have also been made through initiatives focusing on children's environmental health and on “built environments”—man-made surroundings that provide the setting for human activity, ranging from large-scale civic surroundings to personal places—focusing not so much on urban tenements but on fragmented and sprawling communities that foster car dependency, inactivity, obesity, loneliness, fossil fuel and resource consumption, and, of course, environmental pollution. The implementers of the Health Agenda should address the need to intensify ownership of health and environmental challenges and to assure an awareness of those challenges among the practitioners of disciplines generally less informed of health issues—such as architects, builders, and developers; moreover, with the aging of the population, many of whose members will live into their 80s and 90s, those practitioners should be made aware of the housing design needs of the elderly. Furthermore, over and above the traditional concerns for safe water, attention should be directed to containing “emerging con-

taminants,” such as residues of pharmaceutical and personal-care products that find their way into rivers from sewage treatment plants and by leaching into groundwater from septic systems, possibly causing harm to human beings.

The 2006 chart of progress toward attainment of the Millennium Development Goals shows that the Americas have met, or are advancing towards meeting, the targets set for 2015 with respect to most of the MDGs, the exceptions being “youth unemployment” and “loss of forest cover”; notwithstanding, disparities in achievement levels within the Region exist. Stubborn poverty seems to have been cracked, and both the number and the percentage of the total population of poor have fallen appreciably in the Americas. The Pan American Health Organization has designated five countries in the Region for urgent and intensified support, due to the intolerable nature of their health situation, poverty level, and indebtedness. In 2006, the Inter-American Development Bank agreed to provide additional resources to meet the MDGs, under a debt-relief package. The United Nations Conference on Trade and Development (UNCTAD) is placing emphasis on a “productive capacity” initiative, that singles out health as a crucial element in the poverty reduction strategy for the least-developed countries, such as Haiti.

Strategic advantage should be taken of these many favorable developments by policy- and decisionmakers charged with implementing the Health Agenda for the Americas over the coming decade.

**Health care systems.** Changes in the *population* in the Americas will have major implications for the planning and training of human resources for health. On the one hand, the elderly population in North America will increase and, by about 2015, will exceed the child population; the working population, however, will continue to grow. On the other hand, in Latin America and the Caribbean the child population is decreasing and is expected to fall below the elderly population by about 2040, around which time the working age population will stop growing. Such a transformation in the population profile will require a balancing of human resources for health to address the changing health care load, with needs for child care decreasing and those for care of the elderly increasing; the health of working adults will also demand greater attention, to ensure that their productivity is not compromised.

The Region is highly *urbanized*, particularly in Latin America and the Caribbean, where in 2005 about 77% lived in cities; the urban proportion is likely to exceed 80% by 2015 and 85% by 2030. In organizing primary health care delivery, those charged with implementing the Health Agenda will need to be cognizant of the challenge of rising urbanization and of a corresponding decrease in rural population growth.

**The health care sector.** Despite the great promise of the PHC movement, two major constraints have inhibited its effectiveness in improving peoples' health, namely:

1. Greater emphasis has been paid to *financing* health services to achieve increased access than to *allocation of resources* to improve health outcomes. All the countries in the Region have achieved the target of at least 5% of GNP allocated to health, but a sufficient proportion of that increase has not gone to accelerating access to primary health care and to services oriented toward better health outcomes.
2. Insufficient emphasis has been given to reorienting and training *human resources for health*, to bridging clinical and public health practices, and to enabling health professionals to function effectively under the new health paradigm of positive health as defined by the Constitution of WHO—not merely the absence of diseases and disabilities—and further fine-tuned by the health for all goal of ensuring that all citizens of the world can lead a socially and economically productive life. The new paradigm implies not only achieving increases in disability-free life expectancy, but also creating physical, cultural, and policy environments that enable individuals who *already* have disabilities (those born with them) that impose restrictions on their functional capabilities to participate in and contribute to society, thereby making their lives worth living. The new paradigm contrasts the old, fragmented, parochial way of addressing population health issues with a bold approach that deals with the interconnectedness of innate factors—genes, age, and sex—and other influences from the social, economic, and physical environment as well as from individual and community behavior and lifestyles. Guiding principles underlying the wholeness of population health will thus lead to new ways of approaching present, emerging, and future population health issues and transform the way the health care community thinks and works.

**Health care delivery.** The Region faces remarkable challenges due to epidemiological and demographic changes, and correspondingly radical changes are needed in the existing health care delivery system. Nor can the system insulate itself from global developments, be they of the economy, trade, or related to health emergencies. The ability to deal with those challenges, however, depends on what happens at the local and national levels. The difference that health care delivery makes over the coming decades should stem primarily from greater emphasis on living long *and* leading a healthy life, not on mere survival.

The eight elements of the primary health care package outlined in the Declaration of Alma-Ata should be revisited and revised to reflect the current health situation. Under each of those elements, medical and especially public health evidence-based interventions should be deconstructed and then reconstructed around an integrated PHC delivery framework to improve the health of people, individually and collectively. Such a revised PHC package should be given overriding health priority and proper support by the health system, which may itself require strength-

ening to ensure health improvement, fair access, effective delivery of appropriate health care, efficiency, sensitivity to individual and community needs, and above all be targeted to attain improved health status. Concepts of sophistication, efficiency, and professionalism must yield to relevance, effectiveness, and acceptability. Advantage should be taken of knowledge and experience gained over the last three decades by the Region and the countries in the application of the PHC approach to health systems development and of recent advances in scientific, technological, biological, and behavioral areas relevant to the enhancement of health.

**Knowledge generation and sharing.** The coming decades will witness at least three revolutions: a biological and technological revolution, a behavioral revolution, and a revolution in health care delivery. The conditions for generating information related to these revolutions and for sharing scientific knowledge are themselves changing, as a consequence of the increased intensity of communication, the growing interface between disciplines, and the tighter interaction between science and technology. Major economic and social implications and ethical consequences are arising from the closer interconnection among scientific discoveries (such as genetic mutation and cloning and their applications), technological know-how, and commercial exploitation as well as between information *per se* and the communication technologies that disseminate it. People have a “right to well-being” by exercising their “right” to scientific knowledge and research, to information on experiences in applying them, and to the results emanating from them. The challenge lies in empowering people and communities with the capability of comprehending scientific information and its relevance to tackling their health issues so that they can participate meaningfully in improving their own health.

Major contributions to prolong life and improve its quality have been made in the Region over the past decades. Yet, further improvement in population health is possible, and many challenges remain. Better understanding of disease processes and of the determinants of individual and community health as well as incredible advances in medical, biological, technological, and related areas are affording possibilities for a quantum leap in population health. For all its successes and aspirations, however, the Americas will not be free from the ravages of ill-health and suffering until all its people are protected and the health of the entire population is promoted. The Health Agenda for the Americas, 2008–2017 addresses the Region’s concerns and, if judiciously implemented, offers the promise of better health for all people throughout the hemisphere in years to come. Are we ready?

**Dr. Muthu Subramanian**  
Former Director, World Health Organization  
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## COMMENTS OF DR. RICARDO UAUY

The Health Agenda for the Americas, 2008–2017, sets forth eight areas of action, each of which is both strategically very important in its own right and potentially a significant contributor to the Agenda’s desired final outcome—namely improving the health of the peoples of the Americas. It would thus be futile to try to discriminate which of these areas is more important or to suggest that other areas, which may be as important, have been ignored. The paragraphs that follow purport merely to contribute to the agenda-setting process that the countries of the Region, collectively, have undertaken.

The Pan American Health Organization—whose membership comprises all the governments in the Region—is clearly in a position to influence the population’s health outcomes in the coming decade. This influence is especially relevant for the worse-off countries: in their case, PAHO’s actions are key to their future health; moreover, PAHO has the opportunity to leverage human and material resources in favor of the worse-off countries within the Region. Even the better-off countries could benefit from a proactive Organization that leads the Region by providing technical stewardship with a common perspective.

All those who hold stake in the health of the hemisphere should capitalize on the political will in pro of health expressed repeatedly in countless Presidential summits (of Heads of State of the Americas, Ibero/Hispano-American, South American, Mercosur, Andean countries, and the like). As a recent example of the existing opportunities, beneficial use could be made of the call by the President of Brazil for “hunger zero”—not only for Brazil but for every country in the Region, thus echoing the oft-expressed will of governments of the Region to put an end to hunger and malnutrition. What could be more energizing, more galvanizing than an appeal to eradicate hunger and malnutrition in all its forms, thereby committing to prevent the deaths of 40,000 children under 5 years of age who today suffer from severe malnutrition and die from preventable infections? Attaining this goal is not an impossible dream: the Region of the Americas has the resources and the skilled professionals to realize it. Other attainable goals arise in the arena of immunizable diseases: just as the member governments of PAHO had their finest moments, in the not-too-distant past, in the eradication of smallpox and poliomyelitis, so too is it now possible for them to contemplate significantly reducing—if not eliminating altogether—measles, tetanus, and diphtheria.

The Health Agenda provides a conceptual framework that integrates these eight areas of action from an overall regional perspective. Together, the countries, through PAHO’s Governing Bodies, should clearly present how this perspective can best orient the actions and policies of individual governments. It bears noting that policy options and the political context will, at the end of the day, determine what actually gets done. That said, the Organization’s ultimate mandate is to serve the people of the Americas, rather than specific governments. The indisputable fact is that,

over the 10-year period that the Agenda covers, most countries will experience changes in governments and even in the guiding political/policy frameworks that orient their actions. To assure that PAHO’s technical cooperation is effective over the long term, the Organization should have a policy framework that transcends a specific political context. PAHO will want to continue engaging technical and community groups that are part of each country’s national leadership so as to be able to support member governments in the design, implementation, and evaluation of the actions proposed by the Agenda. Policymakers will want to consider assigning to each “area of action” a clearly stated goal or set of goals and corresponding indicators, so that 10 years from now it will be possible to evaluate the impact of the Agenda.

Each of the eight areas could be a pillar for the Organization’s technical cooperation over the next decade. While each area has its own relative merit, it will be important to consider where the greatest strengths of the PAHO community lie and what potential value it can add to each of these areas. In several areas, it is likely that the collective PAHO membership could best contribute by striking strategic partnerships with other regional or international organizations that operate in the Americas. To get beyond the Agenda’s lofty goals, good intentions, and, frankly, wishful thinking, national and international health policymakers will want to confront the challenges ahead by giving weight, and meat, to the actions outlined in the Agenda.

The Agenda is well presented in terms of technical background, attempting to cover as comprehensively as possible each of the eight areas. This is clearly a strength, from the standpoint of the analysis. At the same time, however, it should be fully understood that to induce the necessary changes in the present regional health situation, policymakers must assure that effective action is taken.

The concept of aligning the Health Agenda with the MDGs is very good; notwithstanding, the MDGs are clearly insufficient to advance comprehensively the health situation in many of the countries in the Region. PAHO provides an excellent forum for the regional discussion necessary to adapt the MDGs to the regional reality. That discussion among PAHO’s member governments could serve to define how each will contribute to improving health and well-being not only in one country but in all those that have insufficient human and material resources to address their problems alone.

What orientations would one give to policy- and decisionmakers on implementing the Health Agenda for the coming decade (2008–2017)? As indicated in the foregoing paragraphs, policy options should be both ambitious and realistic. The need for critical actions should arise from the people themselves. The only sustainable solution to chronic health problems in the Region, which represent the most burdensome group cause of morbidity and mortality in the hemisphere, is one that starts with the community demands for improved health and well-being through the democratic channels of political participation. In turn, communi-

ties, through their respective governments, could approach PAHO whenever and wherever the cooperation of the Organization is needed. For its part, PAHO should promote the right to health and more equal access to services; should provide the necessary technical support for advocacy, program design, implementation, and evaluation; and should work with the governments to advance health effectively and efficiently. Most important, the Organization should hold itself and others accountable for its adherence to the stated vision and mission that justify PAHO's very existence.

What prospects for change should be taken into account in looking towards the future of health? The Health Agenda reflects reasonably well the expected regional trends, but it fails to sufficiently emphasize the decline in fertility and the dramatic increase in the proportion of older people that is occurring throughout most of the Region. The need to keep people healthy and well for longer than has heretofore been the case will be an imperative in the coming decades. Industrialized countries have become rich before growing older; in contrast, most of the countries in the Americas are becoming older before attaining the necessary wealth to care appropriately for those with age-related limitations.

Finally, the need to contribute to closing health disparities should consider the fact that science and technology, as they are presently being promoted, are forces that most likely will increase rather than decrease inequality among countries. That greater inequality will surely result, unless the regulatory framework presently in place is reexamined to take into account the situation of countries that have serious limitations in resources—limitations that today prohibit their access to the new diagnostic and therapeutic tools that the future will bring.

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## COMMENTS OF DR. MARIJKE VELZEBOER-SALCEDO

The United Nations Development Fund for Women (UNIFEM) congratulates the countries of the Americas for their elaboration of the regional Health Agenda and for explicitly identifying gender equity as one of its guiding principles. An overarching theme of our orientation to policy- and decisionmakers to consider when implementing the Agenda would be that gender equity is central to all its areas of action, in concurrence with the spirit of the Millennium Development Goals:

The Millennium Development Goals acknowledge that women's empowerment and gender equality are prerequisites for devel-

opment, and all the health-related goals require action in this area if they are to be achieved [*emphasis added*]. Women's health is adversely affected by the prevalence among them of poverty, lack of employment, violence and rape, limited power over their sexual and reproductive lives, and lack of influence in decision-making. Expanding access to sexual and reproductive health care is essential. Those working with governments and public health authorities must actively promote a gender perspective in the design and implementation of health policies and programs. Monitoring and evaluation should routinely use sex-disaggregated data.

In that context and with regard to the Agenda's analysis of health trends in the Americas, the exclusion of women is a major issue. It bears noting, as examples of their social exclusion, that a high proportion of women still do not receive trained care at childbirth and do not have access to contraceptive technologies—factors that relate directly to high rates of maternal mortality and adolescent fertility.

One of the principal areas of action set forth in the Health Agenda is strengthening of the national health authority. UNIFEM considers it important, in using the term "participation," to underscore that it should extend to decisionmaking, since the concept of social participation has often been promoted more as a pragmatic instrumental concept for the purpose of rubber-stamping or implementing decisions taken by others. Participation ought to be understood as an exercise in civil rights that influences the processes that affect the common good. In that regard, women should be singled out, since they are, and have always been, more frequently active participants in the execution of community programs, particularly in the health sector, although they continue to be excluded from the formulation, design, and resource allocation phases of those programs.

UNICEF considers that women's empowerment is a key strategy to tackle health determinants—one of the Agenda's eight areas of action. As clarified in the Millennium Declaration, the third MDG, "gender equality and empowerment of women," represents not only an end in itself but also a *sine qua non* for attaining the other seven MDGs. In that context, we applaud the Agenda's specific reference to gender in the section on "tackling health determinants" as a structural determinant of health inequity and suggest that policy- and decisionmakers be made aware of the important work being carried out among various sectors, institutions, and United Nations agencies, such as the particularly successful interagency collaboration between PAHO and UNIFEM at the regional, subregional, and country level.

Implementing the area of action related to harnessing knowledge, science, and technology will require that information for understanding and monitoring health dynamics be routinely disaggregated by sex, age, socioeconomic status, and other socioeconomic variables, in order to identify group-specific needs, assess inequalities, plan responses, and monitor changes. Toward

## RECURRENT THEME

### Grounding health in information, knowledge, science, and technology

The need for data and information will confront the policymaker at every turn, and, indeed, the case for health as set out above can only be made on the basis of reliable data that are collected regularly: the value of the data increases when they are collected on a regular basis with some established periodicity.

—George Alleyne

To fully understand the health problems that most need to be addressed and the most effective methods for doing so requires establishing an institutional culture within the public health sector that values and demands high-quality information and that develops the capacity to generate it—that is, the pursuit of applied epidemiology and research.

—Stephen Blount and Jay McAuliffe

. . . health should be coupled with the development of science and a likewise universal and free education, as health and education go hand in hand. . . . The public health system should have in place excellent services that enable the conduct of high-level, costly studies that will benefit patients. Too often, the quality of public health services is very low, and only in private services can certain studies be carried out.

—Gustavo Kouri

People have a “right to well-being” by exercising their “right” to scientific knowledge and research, to information on experiences in applying them, and to the results emanating from them. The challenge lies in empowering people and communities with the capability of comprehending scientific information and its relevance to tackling their health issues so that they can participate meaningfully in improving their own health.

—Muthu Subramanian

The disaggregation of data could help Health Ministries to more forcefully advocate for resources to strengthen health services in the areas where health outcomes are weakest.

—Nils Arne Kastberg

Planning for the assessment and expanded use of new and effective technologies in the public health sector is critical; examples include new vaccines, rapid diagnostic kits, geographic information systems, and information technology tools. Decisionmakers in the public health sector must stay abreast of the development of new technologies and be innovative in finding opportunities to apply them to more effectively address priority health problems. . . . The success of immunization programs in the Americas—smallpox and polio eradication, measles elimination, current efforts to eliminate rubella—lays the foundation for the introduction of new vaccines and for the evolution from child to family immunization programs.

—Stephen Blount and Jay McAuliffe

Other attainable goals arise in the arena of immunizable diseases: just as the member governments of PAHO had their finest moments, in the not-too-distant past, in the eradication of smallpox and poliomyelitis, so too is it now possible for them to contemplate significantly reducing—if not eliminating altogether—measles, tetanus, and diphtheria.

—Ricardo Uauy

that end and because the availability of gender-sensitive information is indispensable for monitoring progress in gender equality, UNIFEM and PAHO are collaborating on the production and dissemination of basic gender indicators on health and its determinants.

Another area of action focuses on strengthening solidarity and health security. In implementing the Agenda, any effort to deal with violence must take into account the most frequent type of violence, namely that which is gender-based. It is crucial for policy- and decisionmakers to understand that gender-based

violence is not only a public health matter but also a human rights issue that affects one out of three women in the Region.

As regards efforts to diminish health inequities among and within countries, UNIFEM strongly concurs with the Agenda's distinction of sexual and reproductive health as a priority issue in the Americas. We would urge, however, that policymakers not limit the scope of this issue to the maternal sphere. Sexual health must also be emphasized, particularly in the context of the individual's power to make free, informed, responsible, and safe decisions, which will, in turn, contribute to lowering the number of unwanted pregnancies, reducing maternal and child mortality rates, reducing gender-based violence and related health complications, and halting the spread of HIV/AIDS.

Increasing social protection and access to quality health services will indeed require effective dialogue among relevant stakeholders. Because of their role in setting health priorities, those stakeholders should broadly include civil society, particularly women's groups. In applying the concept of collective financing, in addition to the consideration of subsidies across generations and income groups, subsidies that cross over the sexes are also important. In the absence of such subsidies, women carry a heavier health care expenditure load than men, because of women's greater need for health services throughout their lives—a greater need that derives mainly, but not exclusively, from their reproductive function. Moreover, because of the cultural centrality of their role as caregivers and homemakers and their predominance in the informal sector of the economy, women are more frequently deprived of the social protection that comes with full-time employment.

In the context of people working for health, another area of action set out in the Agenda, policymakers will want to bear in mind the issue of unpaid care provided at home. Women continue to carry the main responsibility of caregiving at home, and that care, according to international statistics, accounts for more than 80% of all health care. Because this unpaid work tends to be neither recognized nor valued, women are disadvantaged in terms of available time and the social protection associated with paid work. The health care system cannot keep relying as heavily as it has in the past on this unpaid work: on one hand, the demand for services will increase due to the aging of the population and the related increase in chronic diseases; on the other, the available time for unpaid caregiving is diminishing and will continue to do so, as women increasingly enter the labor force. Human resource policies will have to take these trends into account, particularly when decisions are being made regarding the reduction or expansion of public services. These issues are of particular interest to UNIFEM, because of their impact on gender equality and women's autonomy. We have been collaborating with PAHO and ECLAC towards raising public and government awareness in this respect, and, together, we are spearheading the incorporation of unpaid health care in the system of national accounts, with particular reference to satellite accounts.

We thank the Pan American Health Organization for the opportunity to provide an orientation to policy- and decisionmakers at the local, national, and international levels who will have the challenge of realizing the Health Agenda for the Americas over the coming decade. As we are all stakeholders in the pursuit of the Agenda, we in UNIFEM heartily wish for its every success.

**Dr. Marijke Velzeboer-Salcedo**  
**Chief, Latin America and Caribbean Section**  
**United Nations Development Fund for Women**

### **The Continuing Regional Commitment: Planning for the Future of Health in the Americas**

Inclusion in this edition of *Health in the Americas* of perspectives regarding the future of health and the countries' collective commitment to address its challenges through a common agenda follows a long-standing tradition. Since its inception, the serial publication has stressed the importance of regional health policies and plans for accomplishing health goals throughout the hemisphere. Beginning with the first edition in 1954, every Director of the Pan American Sanitary Bureau has used the publication to link the countries, their regional Organization, and the Secretariat that serves that Organization to the challenge of addressing the future of health in the Americas through collective commitments expressed in regional plans:

The 1954 edition begins with the words of **Fred Lowe Soper** (Director from 1946 to 1958) :

For planning of health programs in the Americas, measurement of the problems is essential. Progress in health work requires basic information regarding the population being served, the health conditions in the countries, and the medical resources and needs. This principle has been recognized by the provisions of the Pan American Sanitary Code and the Constitution of the Pan American Sanitary Organization [*sic*] for the exchange of information regarding the prevention of disease and the preservation of health in the Western Hemisphere. Future progress depends in large part on measurement of the problems by the provision of accurate data for coordinated health planning.

In launching the 1966 edition, **Abraham Horwitz** (Director from 1958 to 1975) notes that:

The Governments of the Americas have agreed to fulfill within the decade beginning in 1962 a series of objectives to prevent disease, to provide timely treatment and rehabilitation for the sick, and to promote well-being. They have recognized planning as the tool for establishing priorities among the health

problems and for allocating resources accordingly, so as to benefit the largest number of people.

**Héctor R. Acuña** (Director from 1975 to 1983) situates the 1978 edition at the mid-point of the Ten-Year Health Plan for the Americas:

It seemed particularly appropriate to focus the analysis on the progress achieved in attaining the goals set forth in the Plan. Likewise, attention is drawn to those areas where increased effort will be required by the countries if these goals are to be met.

**Carlyle Guerra de Macedo** (Director from 1983 to 1995) presents the 1986 edition as documenting:

the progress made by the Member Countries of the Pan American Health Organization toward meeting their collective goal of health for all by the year 2000 . . . and [providing] an overall evaluation of the situation in regard to attainment of that goal by the end of this century.

In his introduction of the 2002 edition, **George A.O. Alleyne** (Director from 1995 to 2003) sets the stage for the pages that followed:

In broad terms, the Region's health situation can be viewed as a reflection of the dual impact of the demographic changes and shifts in epidemiological profiles. It also mirrors the effectiveness of health policies. . . .

For her part, the current Director of the Pan American Health Organization, **Mirta Roses Periago** (2003– ), hopes that this 2007 edition will serve as a reminder that:

behind every number and every statistic is the life of a girl, a boy, a woman, or a man living in some corner of the Region [and that] the 2012 edition of this publication will bring news of the countries' great progress in their common covenant to attain better health and longer, fuller, more fruitful lives for all the peoples of the Americas, especially those who thus far have been excluded from the benefits of development.