

Health Agenda for the Americas 2008–2017

**Text of document distributed at the launching ceremony in Panamá City.
3 June 2007**

The Ministers and Secretaries of Health are pleased to present the Health Agenda for the Americas, 2008-2017 to the international community.

This document was crafted in an iterative process by a Working Group mandated to collect contributions from every country, to prepare a proposal that was submitted to broad consultation in the Region, and to finalize the document, which was approved by the delegations of the countries of the Americas participating in the World Health Assembly, in Geneva, in May 2007.

The consultation was conducted from December 2006 to April 2007. In countries, it included the Ministries or Secretaries of Health and other public and private institutions involved in the design of health policies and health care delivery, academia and civil society. The Agenda also received an enthusiastic response on the part of subregional and regional agencies, as well as the specialized agencies of the United Nations system.

The Working Group, under the presidency of Panama and with the participation of Antigua and Barbuda, Argentina, Canada, Chile, Cuba, and the United States of America, did their best to faithfully report the content of the deliberations, comments and proposals, while maintaining the principles and consistency of the Agenda. The last meeting of the Working Group benefited from participation by high-level officials from the Secretaries of Health of Brazil and Mexico.

Launching of the Health Agenda for the Americas 2008 - 2017
Declaration of the Ministers and Secretaries of Health

We, the undersigned Ministers and Secretaries of Health of the Americas, having assembled in Panama City on the 3rd of June in the year 2007, for the purpose of presenting to the international community the Health Agenda for the Americas, 2008 – 2017, which reflects our countries' intent to work together and in solidarity towards the improvement of the health and the development of our peoples,

Declare:

Our renewed commitment to the principle established in the Constitution of the World Health Organization, which recognizes that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Our commitment to intersectoral action, acknowledging the role of the social determinants of health in public policy making and that exclusion in health is the result of factors both within and beyond the mandates of the National Health Authorities;

Our commitment to dialogue and joint action among all stakeholders at the local, national, subregional and regional levels, in order to promote and accomplish the regional health objectives through the areas of action identified in the Health Agenda for the Americas;

and

Urge 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.

Panama City, 3 June 2007

HEALTH AGENDA FOR THE AMERICAS, 2008–2017

Statement of Intent

1. The Governments of the Region of the Americas jointly establish this Health Agenda to guide the collective action of national and international stakeholders who seek to improve the health of the peoples of this Region over the next decade.
2. The Governments reiterate their commitment to the vision of a Region that is healthier and more equitable with regard to health, addresses health determinants, and shows improved access to individual and collective health goods and services -- a Region where each individual, family, and community has the opportunity to develop to its greatest potential.
3. The Health Agenda for the Americas is a response to the health needs of our people. It reflects the commitment of each country to work together with a regional perspective and with solidarity in support of the development of health in the Region.
4. The Agenda incorporates and complements the global agenda included in the World Health Organization's Eleventh General Program of Work, adopted by the Member States at the 59th World Health Assembly in May of 2006. Moreover, this Agenda is conceived in alignment with the goals of the Millennium Declaration.
5. In accordance with the documents cited in paragraph 4 this Agenda is a high-level political instrument for health. It defines principal areas of action in order to reiterate commitments made by countries in international fora and strengthen the response to effectively realize them.
6. The Agenda will guide the preparation of future national health plans,¹ as appropriate, and the strategic plans of all organizations interested in cooperating for health with the countries of the Americas, including the Pan American Sanitary Bureau. Assessment of progress in the areas of action outlined in this Agenda will be done by evaluating the achievement of goals set in these plans.
7. The Governments of the Americas emphasize the importance of ensuring that stakeholders and institutions working in health will benefit from a concise, flexible, dynamic, and high-level health agenda that guides their actions, facilitates the mobilization of resources, and influences health policies in the Region.

Principles and Values

8. Acknowledging that the Region is heterogeneous, and that our nations and their populations have different needs and sociocultural approaches to improving health, this Agenda respects and adheres to the following principles and values:

9. Human rights, universality, access, and inclusion. The constitution of the World Health Organization states that: “enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition....” In order to make this right a reality, the countries should work toward achieving universality, access, integrity, quality and inclusion in health systems that are available for individuals, families, and communities. Health systems should be accountable to citizens for the achievement of these conditions.

10. Pan American solidarity. Solidarity, defined as collaboration among the countries of the Americas to advance shared interests and responsibilities in order to attain common targets, is an essential condition to overcome the inequities with regard to health and to enhance Pan-American health security during crises, emergencies, and disasters.

11. Equity in health. The search for equity in health is manifested in the effort to eliminate all health inequalities that are avoidable, unjust, and remediable among populations or groups. This search should emphasize the essential need for promoting gender equity in health.²

12. Social participation. The opportunity for all of society to participate in defining and carrying out public health policies and assessing their outcomes is an essential factor in the implementation and success of the Health Agenda.

Situation Analysis and Health Trends in the Americas

(a) *Overview of Socioeconomic Trends in the Region*

13. The Agenda is based on the health trends observed in the Region. Given the significance of the social determinants of health as variables that help to explain the range of health conditions in a region or country,³ it becomes essential to review the principal socioeconomic indicators and trends in the health situation that have informed the Health Agenda for the Americas. In the period 2001–2005, the per capita gross domestic product of Latin America and the Caribbean grew by 4.2%.⁴ The most recent estimates of the Economic Commission for Latin America and the Caribbean (ECLAC) indicate that in 2005, 39.8% of the population in Latin America and the Caribbean lived in poverty (209 million people) and 15.4% of the population (81 million people) lived in extreme poverty or indigence. Projections, carried out by ECLAC, for the year 2006 indicated that the numbers of poor people and of people in a state of extreme poverty were expected to diminish to 205 and 79 million, respectively. Although in recent years there has been some improvement in the distribution of income, the Region continues to be the most inequitable in the world.⁵

14. Inequalities in health bear a close relation to various socioeconomic determinants. In general, life expectancy tends to be longer in wealthier countries than in poorer countries. However, the differences in life expectancy are reduced when income distribution is taken into account: countries that have a more equal distribution of income reach life expectancy levels that are comparable to, and sometimes better than, those of wealthier nations with a more unequal distribution of income.⁶

15. Population growth has slowed in all countries of the Americas;⁷ meanwhile the proportion of people over 60 years of age has progressively increased.⁸ This calls for measures to respond to changes in the epidemiological profile associated with an aging population.

16. Urban areas have grown in all the countries, often with little planning. The growing phenomenon of urbanization, despite allowing people to be closer to health services, may also be associated with widespread adoption of certain consumption patterns and unhealthy lifestyles --poor diet, obesity, lack of physical activity, drug abuse-- deterioration of social support networks, and increase in traumas and violence.

17. Literacy in the Region has increased from 88% of the population in 1980 to 93.7% in 2005, and there have been variable increases in school attendance in most countries. Nevertheless, access to an education continues to be greater for men than for women, especially in rural areas, and the quality of education is clearly differentiated by household income levels. As a result of these disparities, some people have less opportunity to develop healthy behaviors, and have access to quality employment and improved living conditions.

18. The Region's environment has increasingly deteriorated as a result of air and water, and soil contamination. Environmental contamination especially affects the infant population because they are still developing physiologically and neuropsychologically. With regard to water and sanitation coverage, 94% of the population has access to water in the household;⁹ sanitation (excreta and wastewater management) coverage is 86%. The figures are reduced to 91% and 77%, respectively, when only the population of Latin America and the Caribbean is considered, where, moreover, even-greater deficits persist in rural areas.¹⁰ At the same time, countries face the need to control risks associated with industrialization and unplanned development in large cities.

19. Natural and man-made disasters affect the environment and the health status of the population in the Region, and constitute a limiting factor in achieving health sector goals, as well as in the normal functioning of health services. In 2005 alone, for example, hurricanes left 4,598 people dead, seven million people affected, and caused losses valued at over US\$205 billion.¹¹ Economic damages in Central America and the Caribbean were estimated at US\$2.2 billion, demonstrating their vulnerability and the need for prevention and mitigation plans and measures.

20. Exclusion in health in the Region appears to be closely linked with poverty, marginalization, discrimination (cultural, racial, social, and gender), and the stigmatization suffered by people with mental illnesses and special needs. Language, informal employment, unemployment and underemployment, geographic isolation, low education levels, and insufficient information available to potential health systems users are all important factors in exclusion in health. In summary, 218 million people are without protection against the risk of disease because they lack any form of health insurance coverage, and 100 million people lack access to health services due to geographic or economic barriers.¹²

21. Latin America and the Caribbean received US\$6.34 billion in official development aid (ODA) in 2004, only 8% of the worldwide total. At the end of the 1990s the corresponding proportion was approximately 10% and has diminished due to financial reorientation towards other regions. Furthermore, some bilateral partners have decided to suspend support to health in our Region during the coming years, or focus their assistance on a limited number of countries in Latin America and the Caribbean.¹³

(b) *Health Situation Trends in the Region*

22. The regional health panorama is characterized by the coexistence of consequences of communicable diseases with those of chronic-degenerative illnesses, violence, trauma, occupational diseases and mental illness.¹⁴ The latter have replaced communicable diseases as leading causes of death and disease in all of the countries.¹⁵ Among communicable diseases, traditional threats such as malaria persist, threats from new agents (such as HIV/AIDS) have appeared, others (such as tuberculosis) have re-emerged, and changes have occurred in the characteristics of agents whose variants could induce a severe pandemic (such as influenza viruses). Meanwhile, a group of diseases that disproportionately affect developing countries persists, which are a consequence of poverty and generally result in stigma.¹⁶ Although these diseases are preventable and curable, with drugs that are easily administered, controlling them continues to be a challenge.

23. Despite the fact that in recent years there have been overall improvements in most of the principal health indicators,¹⁷ especially when considering national averages, the Region is characterized by large differences among and within countries. Inequalities in health are related to significant differences in geography, age, gender, ethnicity, education level, and income distribution.¹⁸

24. The health conditions of indigenous peoples are consistently worse than those of the non-indigenous population.¹⁹ More than 45 million people in the Region make up the indigenous population, but information systems do not sufficiently elaborate the variables of race and culture, complicating the development of appropriate strategies for health interventions among this important population.

25. Progress in reducing early and avoidable mortality has largely been the result of specific actions by the health sector, mainly in primary care, such as increased

vaccination coverage, family planning, and oral rehydration therapy. Although maternal mortality has declined, the Region still had a rate of 71.9 deaths per 100,000 live births in 2005. This rate rises to 94.5 when only Latin America and the Caribbean are considered, with the highest rate of 523 in Haiti and the lowest of 13.4 in Chile.²⁰ Pregnancies among adolescents, for the most part unwanted, have reached 20% of total pregnancies in many countries, a situation posing evident challenges for these future mothers and fathers and their children. The mortality by cervical cancer, breast cancer, septicemias, malnutrition, and acute respiratory infections –all avoidable causes of death- can be reduced through greater primary health care coverage and effectiveness.

26. In many cases, progress that can be achieved by specific actions of the health system appears to be limited. There is increasing recognition that the risk factors that require intervention and are associated with the principal causes of disease and death are outside the direct control of the health sector. For example, mortality from external causes and from certain illnesses (such as cardiovascular disease, diabetes, chronic obstructive pulmonary disease, and HIV/AIDS) depends to a great extent on living conditions, lifestyles, and behavior. To make headway in reducing the burden of preventable diseases, it is necessary to review and act on the major determinants and risk factors of the principal health problems. This requires analysis of evidence based on international experience that can inform policy decisions as well as strategic partnerships, both intersectoral and interinstitutional, to ensure the effectiveness of interventions.

27. In terms of the contribution of health to a more equitable distribution of wealth, experience shows that interventions that promote the maximum development of children's potential can improve access to productive employment and produce future generations with greater social mobility, which continues to be severely limited in most countries of the Region.^{21, 22} The lack of opportunities is manifested early in childhood; for example, approximately 40% of the municipalities of Latin America and the Caribbean do not reach the goal of vaccinating 95% of children under one year against polio, diphtheria, tetanus, and whooping cough, which means that at least 800,000 children have not been adequately protected against these diseases by that age.²³

(c) Trends in the Health System Response

28. Health systems have not been able to overcome segmentation²⁴ and severe deficiencies in health financing policies. The situation is highly vulnerable, as some countries have extremely low levels of health expenditure; others are excessively dependent on external resources, and in most countries out-of-pocket expenditures continue to rise. All of this predominantly affects the most impoverished populations. In general, the allocation of resources continues to be disconnected from service performance and results. Often, allocation decisions are not based on systematic analysis of the situation and of lessons learned, nor do they take into account cultural diversity. Clinical management is still insufficient and has not made public health actions a priority. The delivery of health services is characterized by the predominance of a curative model centered in hospitals and on individual care, relegating primary care and public health

services to a secondary role. This model lacks mechanisms for coordinating a network of services and does not adequately incorporate health promotion.

29. The health sector reform processes promoted in the 1990s in Latin America and the Caribbean focused on financial and organizational issues, marginalizing essential aspects of public health. These processes undermined the role of the State in key areas, resulting in a steady decline in the ability of the Ministries of Health to exercise their steering role and to develop essential public health functions.

30. Around the year 2005, national health expenditures in Latin America and the Caribbean represented approximately 6.8% of the Region's gross domestic product; this amounts to an annual per capita expenditure of US\$ 500.²⁵ About half of that amount was public health expenditure: expenditure for Ministry of Health services and the services of other units of central and local government institutions, and health service expenditure financed through compulsory premiums to privately administered health funds or social security institutions. The remaining half corresponds to private expenditure, which includes direct out-of-pocket expenditures to purchase health goods and services, and health services obtained through private health insurance arrangements or prepaid medical coverage.²⁶

31. The scarce and poor distribution of health personnel, along with the failure to adapt personnel to actual health needs, is exacerbated by the migration of professionals within countries and by their emigration to wealthier nations. Most countries of the Americas are affected by this phenomenon, which should be addressed at the national level as well as in the context of Inter-American and international frameworks, since a sizable number of countries in the Region do not have the personnel necessary to provide minimum coverage (25 health workers per 10,000 population),²⁷ while other countries have five times the minimum personnel. The distribution of health workers is extremely uneven, illustrated by the fact that urban areas have from 8 to 10 times more doctors than rural areas. Some countries have significant imbalances in the capabilities of available personnel, with very few nurses per physician and an absence of other indispensable professionals. Women occupy almost 70% of the health workforce, but they are the minority in management positions, tend to be paid less, and are the first affected by unemployment. Human resource education continues through traditional modalities that frequently do not encourage the development of leadership and creativity. Planning for the required quantity and quality of human resources is still lacking in the Region.²⁸

32. In Latin America and the Caribbean, investment in science and technology applied to health is characterized by the absence of explicit agendas for needs-driven research that informs policy design, as well as by limited development of financing mechanisms to meet these needs²⁹.

33. The overview of the health determinants, situation, and trends in the Region of the Americas reveals the need to develop strategies to reduce inequalities among and inequities within countries. Those strategies should facilitate continued progress in providing social protection to the population through health systems based on primary

health care and on public policies for good health developed with community participation and implemented by well-informed, respected health authorities. With that perspective, this Agenda identifies eight areas of action. These areas are by definition broad, setting out principles and guidance for countries and the international community without attempting to set priorities, since these will be determined by each country in relation to its own problems and the availability of resources.

Areas of Action: A Health Agenda for the Americas

a) Strengthening the National Health Authority³⁰

34. To improve the health situation, the National Health Authority should strengthen its institutional capacity to exercise its steering role in health, as well as its intersectoral leadership to bring together and guide partners in promoting human development. The Health Authority should foster comprehensive social and community participation and strengthen primary health care to meet national health goals, involving all stakeholders including those in the private sector. At the same time, the National Health Authority should have legal frameworks that support, and allow for auditing of, its management.

35. The exercise of governance, leadership, and accountability is a key element that enables the national health authority to obtain the commitment and political will, at the highest level, needed to strengthen health development. Ministries of Health must fully carry out the essential public health functions³¹ and efficiently perform their role in the guidance, regulation, and management of health systems. A major task is to clarify the respective responsibilities of government, society, and individuals. Evidence-based decision-making strengthens the National Health Authority. The processes for allocating resources and designing policies would benefit from institutionalizing systems of information on expenditures and financing for the health system.

36. The National Health Authority should actively participate in the elaboration of policies aimed at addressing social determinants. Dialogue, coordination, and collaboration between Ministries of Health and Ministries of Finance and Planning should center on forecasting, stability, and continuity in the allocation of financial resources to attain national human development goals.

37. An essential part of the steering role of the National Health Authority is to ensure that the health issues adopted as regional and subregional mandates are incorporated in the hemispheric development agenda. The National Health Authority, in coordination with the sector for foreign affairs and other relevant areas, would thus ensure that health holds a predominant place in development and poverty reduction strategies which, within the global health framework, are discussed in fora such as the Summit of the Americas and the Ibero-American Summit, among others.

38. While encouraging greater investment in health, effective, efficient, and transparent accountability systems should be developed to support the mobilization and proper management of resources. Similarly, National Health Authorities should

strengthen their capacity to plan, manage, and coordinate the use of national resources as well as international health cooperation.

b) Tackling Health Determinants

39. The National Health Authority should advocate for health as a priority on the sustainable human development agenda. Recognition of the role of health determinants and their incorporation in national development plans that adopt lines of work and resources to address them will indicate that this mandate has been fulfilled.

40. The determinants of health should be tackled in order to effectively protect poor, marginalized, and vulnerable populations. This refers to determinants that are related to (a) social exclusion, (b) exposure to risks, (c) unplanned urbanization, and (d) the effects of climate change. This approach requires revision of legislative frameworks, which currently provide adverse incentives for the improvement of health determinants.³²

41. The actions required to tackle most of these determinants are outside the mandate of Ministries of Health and require the involvement of other governmental entities. Consequently, the National Health Authority should expand the arena for public health activities by promoting healthy public policies via interinstitutional consensus-building and intersectoral collaboration.

42. Countries should invest more in health promotion and have policy frameworks that facilitate their development and the achievement of measurable objectives³³. Health services delivery systems should have an intercultural and gender-sensitive approach, in which active social participation is key. This should be supported by strengthening epidemiological surveillance systems through the inclusion of social, behavioral, and lifestyle variables, enabling the evaluation of health promotion interventions. Within the broader concept of human security, concrete intersectoral interventions should be promoted to reduce social and interpersonal violence as well as the personal and community unsafety.

43. Investment in social protection during childhood and in strengthening families should be a priority among the strategies directed toward tackling health determinants. Countries should endeavor to guarantee effective protection for all girls and boys from prenatal-care onward, employing technologies of proven effectiveness.³⁴ Social management of risk by all sectors responsible for public policy is essential for achieving these results. In accordance with the quest for equity, the Health Authority should prioritize and emphasize specific actions to reduce maternal, neonatal, and child mortality in all segments of society. Breastfeeding should be promoted, and actions taken to prevent infections, dehydration, respiratory diseases, and malnutrition and obesity among children as part of the problems of childhood nutrition. Vaccination coverage should be maintained or expanded, along with the gradual introduction of new vaccines and technology when appropriate.

c) *Increasing Social Protection and Access to Quality Health Services*

44. Universality and improved social protection are important issues in the political and academic dialogue regarding sustainable human development in Latin America and the Caribbean³⁵. Attempts are being made to address the uncertainty generated by the labor market and its impact on family incomes, social security coverage, and health care. In this context, public policies should progressively increase the access, financing, and solidarity of social protection systems.

45. Although most countries in the Region have legislation that establishes the public's right to universal health, the reality is that, in many of them, effective coverage is still determined by the availability of financing, without explicit criteria for prioritization in most cases.

46. This reality highlights the need to develop insurance systems that reduce the financial burden on families, protecting them from the risk of falling into poverty due to catastrophic out-of-pocket expenditures, and to try to guarantee the population a set of health services. Given the dilemma posed in prioritizing one service over another, each country should carry out a national dialogue with relevant stakeholders to enable informed decisions that consider epidemiological, economic, equity, financial, and social feasibility criteria.

47. Countries should promote the effective extension of social protection by strengthening: (a) access to services; (b) financial security; (c) solidarity in financing; and (d) dignity and respect for the rights of patients in health care, in accordance with national legislation.³⁶

48. Access to drugs and health technologies is a requirement for effective health interventions. To promote access to drugs, countries should consider: (a) using to the full provisions in trade agreements, including their flexibilities; (b) strengthening the supply system; (c) strengthening regional and sub-regional procurement mechanisms; (d) promoting the rational use of drugs; and e) reducing tariff barriers applied to drugs and health technologies.

49. Emphasizing the primary health care strategy will be crucial to progress toward universal and equitable access to health care in marginalized rural and peri-urban areas, where services are practically nonexistent. These services should be culturally acceptable and adequately incorporate local traditional practices, proven safe, and, to the extent possible, effective. Health systems appropriate for indigenous peoples should be developed and included in national health systems. Strengthening referral and cross-referral systems and improving health information systems at the national and local levels will facilitate the delivery of services in a comprehensive and timely fashion.

50. Improving effective coverage of the population will require more effective and efficient service delivery. This in turn will require the use of evidence in the definition of practices and better managerial capacity in services, while monitoring fulfillment of the

commitment to reorient health services toward models of care that encourage health promotion and disease prevention with a family and community approach. Quality control is a cross-cutting requirement of all health systems and services.

51. With regard to service delivery, the private sector – for-profit and not-for-profit – plays an important role, and should be regulated by the National Health Authority to help achieve national goals for public health.

d) Diminishing Health Inequalities among Countries and Inequities within Them

52. In trying to achieve greater equity, interventions to improve health should prioritize the poorest and most marginalized and vulnerable people. Indigenous peoples and tribal communities, as well as other groups,³⁷ should be a priority. Countries should safeguard these groups' inclusion, their access to culturally acceptable health services, the collection and use of specific data for appropriate decision-making, and the full exercise of their rights as citizens. Health interventions should respond to the specific characteristics of each group.

53. Sexual and reproductive health is a priority issue in the Region. It is imperative to provide women with continuous care that starts prior to conception and continues during pregnancy, childbirth, and puerperium, including care of the newborn. Pregnant women infected with HIV must be provided with delivery conditions in accordance with established protocols to minimize the probability of transmission of the virus to the newborn, who should also be guaranteed a breast-milk substitute during the first six months of life. Access to contraceptives is indispensable for reducing unwanted pregnancies and maternal morbidity and mortality; in addition, some of them prevent sexually transmitted infections, including HIV/AIDS. The role of men in the promotion of sexual and reproductive health should be strengthened to avoid burdening women with exclusive responsibility for this important aspect of human development.

54. With respect to adolescents and young adults, their integrated health care should be expanded, including the promotion of youth development, the diagnosis and treatment of mental illnesses, the prevention of risky behaviors, and the control of problems such as smoking, alcoholism, drug addiction, suicide, unwanted pregnancy, violence, and sexually transmitted infections, including HIV/AIDS.

55. Maintaining the quality of life of elderly people should be part of health programs geared specifically to this age group. Combining economic and food subsidies to accompany these health interventions is key to ensuring that older adults participate in health programs. Educating health workers about elderly care technologies should be a priority and the focus of specific primary health care training programs.

56. The National Health Authority should promote parity among the sexes in the formulation and implementation of health policies and programs. Monitoring and evaluation activities should make systematic use of data disaggregated by sex.

57. The development assistance community should consider aligning its funding with the specific areas of action in this Agenda and the priorities of countries in the Region. The objective is to increase the capacity of the health sector to meet internationally agreed-upon targets and objectives, as well as to reduce inequities which national averages tend to hide.

e) Reducing the Risk and Burden of Disease

58. While efforts continue to control the transmission of infectious diseases, the countries of the Americas should emphasize the prevention and control of non-communicable diseases, which have become the principal cause of morbidity and mortality in the Region. Specific actions should be initiated or strengthened to control diabetes, cardiovascular and cerebrovascular diseases, types of cancer with the greatest incidence, as well as hypertension, dislipidemias, obesity, and physical inactivity. To cover the growing gap in mental health care, policies that include the extension of programs and services need to be developed or updated. Each country will have to target these actions, aimed at reducing risks and burden of disease, by age groups and geographical criteria as needed.

59. The health authority should be highly active in promoting healthy lifestyles and environments. Changes in behavior will only be sustained if they are accompanied by environmental, institutional, and policy changes that truly allow people to choose lifestyles that involve healthy eating habits, physical activity, and not smoking. Collaboration with industry, the media, and other strategic partners is needed to produce and market healthier foods, and with the education sector so that schools set an example of good dietary practices and promote healthy habits.

60. To combat the communicable diseases that continue to affect the populations of the Americas, current actions should be sustained, favorable environments created and innovations introduced. A more intensive effort should be made to control those diseases that disproportionately affect developing countries, principally affect poor populations, and can be eradicated.³⁸

f) Strengthening the Management and Development of Health Workers

61. Governments should collaboratively address these five critical challenges:³⁹ (a) define and implement long-term evidence-based policies and plans to develop the health workforce; (b) find solutions to resolve inequities in the distribution of health workers, assigning more personnel to populations most in need; (c) promote national and international initiatives for developing countries to retain their health workers and avoid personnel deficits; (d) improve personnel management capacity and working conditions in order to get health workers more involved in their institutions' missions; and (e) link training institutions with health services for joint planning to address the needs and profiles of professionals in the future.

62. The working conditions and the health of workers themselves are relevant to retaining trained staff and ensuring the quality of services provided to the population. Emphasis is needed on the training of public health personnel with a multidisciplinary perspective, so that the health workforce's professional profile responds to each country's reality.

63. In terms of knowledge and learning, the following should be undertaken: develop shared technical frameworks; evaluate performance using systems of measurement that are comparable between countries; finance research; and share appropriate evidence-based practices. In policy aspects, it is necessary to: promote ethical methods for the hiring and protection of migrant workers; monitor major migrant flows to safeguard equity and justice; and support fiscal sustainability.

64. The proliferation and diversification of suppliers of services and of skilled human resources necessitates emphasis on the development of accreditation systems and regulatory instruments that aim to guarantee quality. Coordination of work between the National Health Authority, educational entities, service providers and professional associations should be strengthened in order to adapt undergraduate and graduate professional profiles to the needs of health systems.

g) Harnessing Knowledge, Science, and Technology

65. Countries should synthesize, systematically assess, and use knowledge in decision-making to select interventions that are relevant and effective. To fulfill this function in Latin America and the Caribbean, ongoing improvement in the development of the necessary capacities is needed. Moreover, cultivation of local capacity for research and its utilization is necessary.

66. Research should be strengthened to enable a better understanding of the relationship between health determinants and their consequences, to select interventions, and to identify stakeholders that can be partners or can be influenced through public policy.

67. Research on traditional and complementary medicines should be strengthened to identify those that are relevant and effective and can therefore contribute to the population's well-being.

68. Bioethics should be better disseminated and applied in the countries of the Americas to protect the quality of research, respect human dignity, safeguard cultural diversity, and assure the application of knowledge in health, as well as in public health decision-making.

69. All people should benefit from progress and have access to health information and education. Countries need to strengthen their capacity for, and the level of, scientific dissemination; public confidence in research; and the quality of knowledge that supports health actions. The National Health Authority should strengthen its capacity for

information and knowledge management, seek partnerships with those who generate that knowledge, and promote as appropriate financing mechanisms directed at needs-driven research for policy design.

70. The National Health Authority, in exercising its regulatory role, must guarantee the quality, safety, and efficacy of drugs, technologies, and medical supplies. Moreover, it should promote rational use of these products.

71. Health surveillance should be strengthened at the local, national, regional, and global levels. The capacity of local health teams should be strengthened to carry out analytical epidemiological processes that generate scientific data for health planning and that enable the monitoring and evaluation of interventions. Health information should be standardized to facilitate comparison among and within countries, in order to monitor and evaluate progress in achieving health goals.

h) Strengthening Health Security

72. The countries of the Americas should prepare for and take intersectoral measures to address disasters, pandemics, and diseases that affect national, regional, and global health security. The latest iteration of the International Health Regulations (IHR 2005) offer countries opportunities to strengthen public health capacities and to collaborate among themselves. The countries of the Americas should assume the new obligations established in the IHR to prevent and control the spread of disease inside and beyond their borders.⁴⁰

73. Health security requires strategies that are prepared in light of contingencies that exceed national borders, demanding effective and sustainable processes for subregional, regional, and global integration. Joint efforts with the agricultural sector should be strengthened for the prevention and control of zoonotic diseases. Countries should continue modernizing and harmonizing legislation to strengthen the production and marketing of safe food.

74. In confronting circumstances that threaten health security, the countries of the Americas and international organizations should work together with national authorities to respond rapidly and effectively on behalf of the population.

75. The countries of the Americas should develop, as a collaborative public health policy, an exercise in preparation to deal with the potential pandemic influenza. This exercise ought to include every aspect related to the required preparation to confront these diseases at the national, regional and global level.

NOTES AND REFERENCES

- ¹ In countries that have a federal government system, this Agenda will guide the preparation of subnational health plans..
- ² Gender equity is understood to mean the provision of appropriate responses to the particular health needs of men and women.
- ³ World Health Organization Commission on Social Determinants of Health. *Action on the Social Determinants of Health: Learning from Previous Experiences*. WHO, Geneva, 2005.
- ⁴ Economic Commission for Latin America and the Caribbean . *Statistical Yearbook for Latin America and the Caribbean*. ECLAC, Santiago, 2005.
- ⁵ Economic Commission for Latin America and the Caribbean. *Social Panorama of Latin America 2006* LC/G.2326-P/E. December 2006.
- ⁶ At the end of 1990, the gap in life expectancy at birth between the richest and poorest populations was declining, with a difference of 9.8 years (75.6 and 65.8, respectively). In 2000, it was calculated that life expectancy at birth in the countries of the Region ranged from 79.2 to 54.1 years between countries with the longest and shortest life expectancies at birth. Between 1950–55 and 1995–2000, the difference in life expectancy between men and women increased from 3.3 to 5.7 years in Latin America, from 2.7 to 5.2 years in the Caribbean, and from 5.7 to 6.6 years in North America.
- ⁷ Population growth ranges from 0.4% in the non-Latin Caribbean to 2.1% in Central America.
- ⁸ UN Population Division, Department of Economic and Social Affairs. *World Population Ageing 1950–2050*. United Nations, New York, 2002.
- ⁹ This availability, however, does not guarantee certainty of potability, since monitoring of quality varies in the countries of Latin America and the Caribbean.
- ¹⁰ Joint Monitoring Program (PAHO/UNICEF). Information updated to 2004 for MDG target #10 monitoring “Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation.”
- ¹¹ Economic Commission for Latin America and the Caribbean . Preliminary overview of the economies of Latin America and the Caribbean 2005. LC/G.2292-P/I December 2005. The figures include the United States.
- ¹² International Labor Organization/Pan American Health Organization. *Overview of the Exclusion of Social Protection in Health in Latin America and the Caribbean*. Report presented at the ILO Tripartite Regional Meeting with the collaboration of PAHO on “Extension of Social Protection in Health to Excluded Groups in Latin America and the Caribbean” (Mexico, 29 November- 1 December 1999).
- ¹³ German Technical Cooperation Agency (GTZ) and the Norwegian Agency for Development Cooperation (NORAD) have indicated that they will either suspend their assistance to health in the Region in the next few years or that their cooperation will focus on a small number of countries in Latin America and the Caribbean. The Canadian International Development Agency (CIDA) will focus on only five countries in the Region. Other organizations, like USAID, face increasing difficulties in obtaining financing for health programs in the Region.
- ¹⁴ Kohn R, Levav I, Caldas de Almeida JM, Vicente B, Andrade L, Caraveo-Anduaga JJ, Saxena S, Saraceno B. Mental disorders in Latin America and the Caribbean: a public health priority. *Pan American Health Journal of Public Health* 2005; 18 (4/5):229–40: indicates that “the current gap in treatment of mental illnesses in Latin America and the Caribbean continues to be overwhelming and is estimated that the number of people with these illnesses in the Region of the Americas will increase from 114 million in 1990 to 176 million in 2010.”
- ¹⁵ Some authors have coined the term “epidemiological polarization” to refer to this profile of morbidity and mortality.
- ¹⁶ The international community has coined the expression “neglected diseases” to refer to these diseases. In the Americas, these diseases are grouped as follows: (a) in poor neighborhoods: elephantiasis, leprosy, and leptospirosis; (b) in rural areas: snail fever (shistosomiasis), fascioliasis, kala-azar, and cutaneous leishmaniasis, Chagas' disease, cysticercosis, trichinosis, and plague; (c) in some indigenous communities: river blindness (onchocerciasis) and parasitic diseases of the skin (scabies, sand fleas, and fungus); and (d) in the majority of poor populations: ascariasis, hookworm disease, and tricuriosis (helminth infections transmitted through contact with the soil).

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- ¹⁷ In Latin America and the Caribbean, infant mortality in the period from 1980 to 2005 went from 56.6 to 24.8 per 1,000 live births.
- ¹⁸ Economic Commission for Latin America and the Caribbean. *The Millennium Development Goals: A Latin American and Caribbean Perspective*. ECLAC, Santiago, 2005.
- ¹⁹ Pan American Health Organization. Health of the Indigenous Population in the Americas. 138th Session of the Executive Committee, Document CE138/13. PAHO, Washington, D.C., 12 June 2006.
- ²⁰ Pan American Health Organization. *Gender, Health and Development in the Americas - Basic Indicators 2005*. PAHO, Washington, D.C., 2005.
- ²¹ World Bank Office for Argentina, Chile, Paraguay, and Uruguay. *International Evidence on Policies on Early Infancy that Stimulate Child Development and Facilitate Female Integration into the Workforce*. World Bank Working Document 01/06, May 2006.
- ²² P. Bedregal, P. Margozzini, and H. Molina. *Systematic review on the effectiveness and intervention costs of bio-psychosocial childhood development*. PAHO, Washington, D.C., 2002.
- ²³ Annual country reports to the immunization unit in the Pan American Sanitary Bureau via EPI tables/joint reporting forms for PAHO/WHO–UNICEF in the Americas (2005 data).
- ²⁴ Segmentation is the coexistence of subsystems with different mechanisms for financing, affiliation, and provision—“specialized” in accordance with different segments of the population—that are determined by income and economic position. Segmentation occurs, both in terms of provision as well as insurance, in a public subsystem oriented toward the poor—under the social security subsystem, specialized for formal workers and their dependents, and under the private for-profit subsystem, concentrated on the wealthiest segments of the population.
- ²⁵ Dollars adjusted for purchasing power parity (PPP).
- ²⁶ Pan American Health Organization. Health expenditure database, 2006.
- ²⁷ The World Health Organization and the Joint Learning Initiative have proposed using a measure called the “density of human resources in health” comprised of the sum of the indicator available for all the countries: physicians and nurses per 10,000 population. The measurement of density through this method is imperfect, since it does not take into account all other health workers, but it is the only viable measure for global comparisons.
- ²⁸ *Public Health in the Americas* (PAHO/WHO, Washington, D.C., 2002). Analysis of essential public health function number 8 (development and training of human resources in public health) in the measurement exercise developed by PAHO and the CDC in 2000 and 2001 reveals a lack of coordination among Ministries of Health and human resource training centers for planning the number and professional profiles of the people necessary for serving at different levels and structures of health systems in the Region. At the same time, the conclusions of various regional meetings of training centers have pointed out the need to develop the conditions for leadership and capacities to face new problems and solve conflicts among the people who will work in health services. Education methodologies to achieve these capacities should focus on problem solving, rather than the traditional methods based on theoretical teachings that consider students to be passive recipients in the teaching-learning process.
- ²⁹ In accordance with studies sponsored by the Council for Health Research and Development (COHRED), in the Region only three countries showed development of research funds aimed at financing essential health research projects, defined as those intended to provide an evidence base for decisions with regard to health policy.
- ³⁰ In countries that have a federal government system, this includes health authorities at all levels that have policy and programmatic functions and responsibilities.
- ³¹ *Public Health in the Americas* (PAHO/WHO, Washington, D.C., 2002) identifies 11 essential public health functions: (1) monitoring, evaluation, and analysis of health conditions; (2) public health surveillance, research into and control of public health risks and harms; (3) health promotion; (4) citizen participation in health; (5) development of public health policies and the institutional capacity for planning and management; (6) strengthening institutional capacity in public health regulation and enforcement; (7) assessment and promotion of equitable access to necessary health services; (8) development and training of human resources in public health; (9) guaranteeing and improving the quality of individual and collective health services; (10) public health research; and (11) reducing the impact of emergencies and disasters on health.

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- ³² The variables included in this grouping are the following: (a) social exclusion: income, gender, education, ethnic origin, and disability; (b) exposure to risks: poor living and working conditions, unhealthy lifestyles, lack of information, difficulty in accessing food and water, soil, water and air pollution, and contaminated food; (c) unplanned urbanization exacerbates the inadequate water services, sanitation, and housing; and (d) among the consequences of climate change are floods, droughts, and vector-borne diseases, which affect poor population with higher intensity.
- ³³ Jakarta Declaration on Leading Health Promotion into the 21st Century. The Fourth International Conference on Health Promotion: New Players for a New Era - Leading Health Promotion into the 21st Century (Jakarta, 21-25 July 1997).
<http://www.who.int/healthpromotion/conferences/previous/jakarta/declaration/en/>
- ³⁴ Various initiatives carried out in Canada, the United States, Mexico, and other countries of the Region have shown the effectiveness of programs to support families at psychosocial risk through: home visits by health personnel; early developmental stimulation; personal sensitivity in delivery care and other services; development of effective parent-child attachments; resilience; and the prevention of domestic and social violence, substance dependence and early school dropouts.
- ³⁵ Economic Commission for Latin America and the Caribbean: *Shaping the Future of Social Protection: Access, Financing and Solidarity* LC/G.2294(SES.31/3)/I. February 2006
- ³⁶ In this Agenda, these conditions are understood to be: (a) access to services: services necessary for providing health care exist, and people have physical and economic access to them; (b) financial security: health expenditures do not threaten the economic stability of households or the development of family members; (c) solidarity in financing: subsidies exist between generations, groups of different levels of risk, and groups with different income levels; and (d) dignity and respect for the rights of patients in health care: this refers to the quality and provision of care in an environment where the rights and the culture, racial, and socioeconomic characteristics of the patient are respected.
- ³⁷ Among the groups that deserve special attention are immigrants, displaced peoples, inmates, ethnic minorities and people with physical and mental disabilities.
- ³⁸ These diseases are elaborated in note 16.
- ³⁹ Pan American Health Organization and Health Canada. Toronto Call for Action.
www.observatoriorh.org/Toronto/CallAction_eng1.pdf
- ⁴⁰ In view of the International Health Regulations (IHR) entering into effect, WHO member countries are assuming the following obligations: (1) to designate or to establish a national center for the IHR; (2) to strengthen and maintain the ability to detect, notify, and respond rapidly to public health events; (3) To respond to requests for verification of information regarding hazards to public health; (4) to evaluate public health events using decision tools, and notify WHO within 24 hours of all events that constitute a public health emergency of national importance; (5) to provide systemic inspection and control activities in international airports, ports, and designated terrestrial borders to prevent the international spread of diseases; (6) to do everything possible in order to implement measures recommended by WHO; and (7) to collaborate among themselves and with WHO to implement the IHR (2005).