



# HEALTH AGENDA FOR CENTRAL AMERICA AND THE DOMINICAN REPUBLIC

2009-2018



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*United for the Health of Our People*



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## **Health Agenda for Central America and the Dominican Republic**

### **Executive Summary**

The Health Agenda for Central America and the Dominican Republic is a regional policy instrument adopted by the constitutional governments of the region to set strategic priorities and improve the population's health status by strengthening regional social integration; advancing participatory democracy; and guiding and harmonizing the activities of national, regional, and international partners from public, nongovernmental, and private sectors committed to improving the health of the peoples of this region.

In terms of principles and values, the Agenda emphasizes the countries' need to advance the process of social integration as the most appropriate alternative for tackling the old and new challenges for sustainable human development in the region, given the dramatic changes taking place on the international scene. Within the framework of respect for human rights, the Agenda is an instrument to help create the specific conditions needed for populations to exercise their right to health, which includes the commitment of the Central American countries and the Dominican Republic to ensuring universal access, inclusion, and equity in the health systems. The Agenda assumes solidarity among the countries and the participation of society and social organizations as values and prerequisites for ensuring achievement of the expected results; it underscores the need to achieve equality between men and women as a human development goal in itself and as a condition for ensuring the implementation of this Agenda, which is based on respect for ethnic and sociocultural diversity and on recognition that traditional and Western health systems must be coordinated to reduce inequalities in access to health care. The Agenda also recognizes primary health care as the basic strategy for creating equitable health systems with universal coverage and access, using a rights-based approach with an intersectoral and democratic perspective.

The Health Agenda for Central America and the Dominican Republic identifies 10 strategic objectives to guide policy action and serve as the basis for designing the Plan of Action and allocating resources (from both regional and international cooperation sources). The strategic objectives:

1. Strengthen the social integration of Central America and the Dominican Republic by defining and implementing regional health policies
2. Strengthen the steering role of the National Health Authority within the framework of Central American integration
3. Strengthen and extend social protection in health, guaranteeing access to quality health services
4. Reduce inequalities and inequities and social exclusion in health within and among the countries
5. Reduce the risks and burden of communicable and noncommunicable diseases, domestic and social violence, and risks related to the environment and lifestyles
6. Strengthen health workers management and development
7. Promote scientific research, and health science and technology development as well as the use/application of scientific evidence in public health policies
8. Strengthen nutrition and food security and reduce malnutrition with support from the region's specialized institution—the Institute of Nutrition of Central America and Panama (INCAP)
9. Establish mechanisms to increase coverage in the provision of safe drinking water and protect and improve the human environment, with support from the regional entity—the Water and Sanitation Forum for Central American and the Dominican Republic (FOCARD-APS)
10. Reduce the vulnerability to natural disasters, anthropic emergencies, and the effects of climate change

The Agenda is complemented with the respective Plan of Action; it will be in force for the period 2009-2018, and is in alignment with the Health Agenda for the Americas launched by the Ministers of Health of the Americas in June 2007 in Panama, and the Central American Social Strategic Agenda that was approved by the Heads of State and Government of the Central American Integration System on 5 December 2008 in Honduras. The Health Agenda for Central America and the Dominican Republic is the result of a process spearheaded by the national health authorities, including extensive intersectorial consultations in the eight countries as well as consultations with regional entities and stakeholders. The critical path developed was based on the agreements of the XXIII RESSCAD and the XXVII COMISCA Meeting. PAHO/WHO and AECID provided technical and financial support throughout the process.

## I. INTRODUCTION

Integrating Central America and the Dominican Republic calls for the implementation of regional social policies whose objective is sustainable human development based on equity, inclusion, and social justice. An essential contribution for constructing and strengthening regional social policy should come from the field of health, since health is a basic human right, a prerequisite for people to achieve their maximum personal development and the construction of just and democratic societies. This Agenda is a contribution from the field of health to human development in the region.

The Health Agenda for Central America and the Dominican Republic is a regional policy instrument with an integrationist approach that identifies strategic priorities and seeks to strengthen regional social integration, improve the health status of population, advance participatory democracy, and guide and harmonize the activities of national, regional, and international partners in the public, nongovernmental, and private sectors who are committed to improving the health of the peoples of this region.

The need for designing a Health Agenda and Plan of Action for Central America and the Dominican Republic as instruments to strengthen the steering role of the health sector in the region was stated in the regulations of the Council of Central American Health Ministers (COMISCA) approved in 2001. COMISCA is part of the Central American Secretariat for Social Integration (SISCA) of the Central American Integration System (SICA), and its activities are defined in the Declaration of San Salvador, the Tegucigalpa Protocol, and the Central American Social Integration Treaty<sup>1</sup>.

The Health Agenda for Central America and the Dominican Republic is the result of a participative process spearheaded by the countries' health authorities, which appointed a Subregional Technical Commission to draw up the Health Agenda and Plan of Action for Central America and the Dominican Republic (COTESAS) and coordinate the agenda's preparatory phases. There was extensive consultation with different national sectors in the eight countries and with regional entities and social organizations. The development of the critical path was based on the agreements of the XXIII Meeting of the Health Sector of Central America and the Dominican Republic (RESSCAD), held in El Salvador on 11-12 September 2007, and the XXVII COMISCA Meeting, held in Antigua, Guatemala on 7-8 December of that same year. The Pan-American Health Organization/World Health Organization (PAHO/WHO) and the Spanish Agency for International Development Cooperation (AECID) provided technical and financial support to COTESAS throughout the process.

## II. WHY AN AGENDA?

The constitutional governments of the Central American countries and the Dominican Republic have adopted the Health Agenda as a regional policy instrument that complements and is aligned with the Health Agenda for the Americas, launched in Panama on 3 June 2007 by the Ministers of Health of the Americas.

Also, this Health Agenda for Central America and the Dominican Republic is framed within the strengthening of the Central American Social Strategic Agenda that was approved by the Heads of State and Government of the Central American Integration System on 5 December 2008 in San Pedro Sula, Honduras.

The Health Agenda for Central America and the Dominican Republic, jointly designed by the eight countries and based on common public health goals and priorities, seeks to strengthen regional integration, policies, and institutions, guide the regional plan of action in health, and ensure the alignment and harmonization of national and international partners with respect to the stated regional strategic objectives, within the framework of the Millennium Development Goals (MDGs). The Agenda will be in effect for the period 2009-2018 and is complemented with the respective Plan of Action.

*The Health Agenda for Central America and the Dominican Republic seeks to strengthen regional integration, policies, and institutions, guide the regional plan of action in health, and ensure the alignment and harmonization of national and international partners with respect to the stated regional strategic objectives, within the framework of the Millennium Development Goals*

Through a comprehensive regional approach, it will be possible to bolster political capacities, leadership, management, promotion, analysis, monitoring, and evaluation of regional integration institutions. Progress will be made in the definition of common policies and the harmonization of national policies, strategies, standards, and regulatory mechanisms, as well as the implementation of common regulatory systems that will help to develop joint information and epidemiological surveillance systems, common certified laboratories, and regional training institutions; to develop economies of scale for the procurement of drugs and other health products; and to implement systems for technical cooperation among countries in order to develop and strengthen national capabilities in various areas.

The comprehensive regional approach will promote political, academic, and interorganizational networks linked to health practices in order to promote the changes agreed on, help identify problems, and build consensus, negotiation, and the sharing of information on good practices. Likewise, the strategy of cooperation among countries is essential to achieve this, without ruling out opportunities for cooperation with countries outside the region.

### III. PRINCIPLES AND VALUES

The Health Agenda for Central America and the Dominican Republic:

#### **Integration**

Emphasizes the need for the Central American countries and the Dominican Republic to advance the process of social integration as the best alternative for tackling the challenges, old and new, posed by the sustainable human development in the region, given the dramatic changes taking place on the international scene.

#### **Right to the highest attainable level of health**

Within the framework of respect for human rights, the agenda is an instrument for helping create the conditions necessary for the population to exercise its right to the highest attainable level of health, which includes the countries' commitment to ensuring universal access, inclusion, and equity in health systems.

#### **Solidarity Participation**

Promotes solidarity among the countries and the participation of society and social organizations as values and prerequisites for ensuring that this Agenda can achieve the expected results.

#### **Equality between men and women**

Reinforces the need to achieve equality between men and women as a human development goal in itself and as a condition for ensuring the implementation of this Agenda.

#### **Respect for the ethnic and sociocultural diversity**

Is based on respect for the ethnic and sociocultural diversity of the countries in this region and on recognition that the traditional and Western health systems must be coordinated to reduce inequalities in access to health care.

#### **Primary health care**

Recognizes primary health care as the basic strategy for creating equitable health systems with universal coverage and access, using a rights-based approach with an intersectoral democratic perspective.

## IV. CONTEXT

### *a) Socioeconomic and Demographic Trends*

With a population of over 50 million in the eight countries<sup>2</sup>, the region covers an area of 570,360 km<sup>2</sup> and has a population density that varies widely from country to country<sup>3</sup>. The region is in the midst of demographic change; the population continues to grow – although at a slower rate than in the last decade – despite the millions of people who have emigrated outside the region during the past 15 years<sup>4</sup>. Urban development has accelerated in almost all the countries, and 60% of the population currently lives in urban areas, with a relative growth rate of 20% over the past three decades<sup>5</sup>. Central America and the Dominican Republic are part of a region whose population is continually growing and migration is widespread.

The region is unable to retain its people. Emigrants have become the new and most important agents for capturing and transferring financial resources that contribute to the economic sustainability of the majority of the countries; emigration outside the region has become the structural foundation of the economies. A 10% of the population has emigrated outside the region<sup>6</sup>.

In this multiethnic region, Guatemala is the country with the highest proportion of indigenous population, with estimates ranging from 50% to 73%, followed by Honduras, with 11% to 17%, Belize 11%, Panama 5% to 9%, Nicaragua 4% to 7%, Costa Rica less than 2%, and in El Salvador, according to the 2007 Census, 0.2%<sup>7</sup>; the Dominican Republic does not report this information.

The countries' economies have undergone significant changes in the last decade, and all the economies are more open to the influence of the international economy, within the context of a decline in the relative importance of traditional agroexports and the primary sector<sup>8</sup> as a whole, while the tertiary sector – comprised of services, tourism, and trade – has become the most important sector. This is in the context of a certain macroeconomic stability largely due to family remittances<sup>9 10</sup>.

The region has experienced economic growth – the strongest in recent decades. However, the growth of per capita GDP has been moderate and varies widely from country to country. The more affluent countries have experienced greater per-capita GDP growth, which has led to even wider gaps between higher- and lower-income countries<sup>11</sup>.

Poverty and inequality are characteristic of the region. Poverty affects approximately 40% of the inhabitants. The highest poverty rates are in rural areas<sup>12</sup>. The informal sector is the most important source of income for the poor, and the highest levels of informal employment are found in the countries with the greatest inequity<sup>13</sup>. The most recent global assessment of the MDGs commends the Latin American situation, but notes that the rate of poverty reduction is slow and marginal, and that disparities in income are still a major constraint in developing countries. Some of the Central American countries are among the most inequitable in the world<sup>14</sup>.

Every country in the region has steadily improved their human development indicators over the past 30 years, and also their ranking on the Human Development Index since 1990. These development indicators are closely linked to the health profile and its trends. Out of 177 countries<sup>15</sup>, the country with the highest ranking in the region is Costa Rica (48), which is among the countries with a high human development index (in the top 70 countries), while the other seven countries in the region rank among the countries with a medium human development index (71 to 155)<sup>16</sup>.

Literacy rates rose from 83.9% in 1980 to 88.6% in 2004, with school attendance increasing to varying degrees in the majority of the countries. However, boys continue to have greater access to education than girls do, especially in rural areas, and the quality of education depends on family income<sup>17</sup>. Education in this region is also inversely related to infant mortality<sup>18</sup>.

### **b) Health Trends**

Throughout the region, the trend has been for deaths from noncommunicable diseases to exceed those from communicable diseases, although mortality from communicable diseases in Central America and the Dominican Republic is the highest in the Region of the Americas<sup>19</sup>.

The leading causes of death among men are homicides, cirrhosis, traffic accidents, adverse reactions to psychoactive substances (such as alcohol) and external causes, accidental or intentional. The leading causes of death among women are uterine neoplasms, diabetes, cerebrovascular disease, pneumonia, influenza, and ischemic heart disease<sup>20</sup>.

The most recent available data show that, of the total deaths reported, 13.6% are from communicable diseases (influenza 8.6% and intestinal infections 5%)<sup>21</sup>. Influenza/pneumonia is the leading cause of death, with a reported rate of roughly twice that observed in the Region of the Americas. Moreover, intestinal infections are the fourth leading cause of death<sup>22</sup>.

Reported deaths from noncommunicable diseases account for 86.4% of total deaths and can be divided into two major groups: externally caused injuries (8.2%), and chronic degenerative diseases (78.2%), for which the trend is rising. Diabetes rates in this region are relatively low compared to the rest of Latin America and the Caribbean; however, mortality from this disease is much higher among women. Hypertension, ischemic heart diseases, and cardiovascular disease are the most significant in the diseases of the circulatory system and together are among the 10 leading causes of death<sup>23</sup>.

Every year an estimated 32,000 people die from cancer of all types in Central America and the Dominican Republic (49% males and 51% females), with male and female mortality of 95.1 and 89.6 per 100,000 inhabitants, respectively, cancer being one of the five leading causes of death. Also, every year an average of 51,724 new cases are diagnosed (46.3% males and 53.7% female), with a male and female incidence rate of 146.1 and 153.3 per 100,000 inhabitants, respectively. The types of cancer with the highest mortality and incidence rates in Central America are cervical, breast, stomach, and ovarian cancer in women; and prostate, stomach, lung, and colorectal cancer in men. The leading causes of death from cancer in Central America are cervical cancer in women and lung and prostate cancer in men<sup>24</sup>.

Externally caused injuries are the main cause of death in the population group aged 5-60; the principal cause is homicide, followed by motor vehicle accidents<sup>25</sup>. Males are the most affected group; it is estimated that for every female who dies, approximately 5.7 males die. Male mortality is so high that, even though it is the 10th leading cause of death among women, it is the leading cause of death in the total population<sup>26</sup>. Data published in the 2007 editions of PAHO's Basic Indicators and Health in the Americas show that homicide rates in all countries (except Panama) increased significantly. Violence against women is a significant factor in morbidity and mortality in the region; attempts are beginning to be made to correct the currently underreported levels, especially in the case of femicide.

Infant mortality rates in the region range from 9.7 per 100,000 live births in Costa Rica to 39.0 per 100,000 in Guatemala. In the majority of the countries, infant mortality rates are higher than the average for Latin America. Perinatal disorders are the fifth-leading cause of general mortality in Central America, with a rate of 26.4 per 1,000 live births (males 30.6/1,000, females 22.1/1,000), and the leading cause of death among children in Central America and the Dominican Republic.

One of the major challenges in Central America and the Dominican Republic is reducing the high maternal mortality rates<sup>27</sup>. Guatemala, Honduras, Nicaragua, and the Dominican Republic have the highest rates in the Region of the Americas (71.9/100,000 maternal mortality rate). The principal causes of mortality are hemorrhage, preclampsia/eclampsia, obstructed labor, and abortion. In addition to poverty and lack of access to adequate services, other factors are associated with maternal mortality, such as the subordination of women, which prevents them from making their own decisions about their sexual and reproductive health.

Adolescent pregnancy is one of the most significant reproductive health problems in the region, representing over 17% of total pregnancies in women of childbearing age<sup>28</sup>.

In terms of morbidity, among communicable diseases, the main problems are diseases linked to environmental degradation, the lack of basic sanitation combined with poverty, low levels of schooling, and little access to basic services. Over 6% of malaria cases in Latin America and the Caribbean are found in this region. In 2006, Guatemala (57%) and Honduras (21%) together accounted for more than two-thirds of confirmed cases<sup>29</sup>. Dengue represented over 10% of the reported communicable disease cases in Latin America and the Caribbean, with El Salvador (39%) and Costa Rica (21%) accounting for three-quarters of the cases. The estimated prevalence of HIV/AIDS ranges from 0.2% in Nicaragua to 1.02% in the Dominican Republic<sup>30</sup>. The incidence of tuberculosis in 2006 ranged from 12.3 per 100,000 population in Costa Rica to 47.4 per 100,000 in the Dominican Republic; these countries, along with Panama, Honduras and Nicaragua, have incidence rates above the average for Latin America and the Caribbean (38.0 per 100,000 population)<sup>31</sup>.

With regard to nutritional status, low birthweight ranges from 6.8% in Costa Rica to 14.1% in Belize. Chronic malnutrition rates in children under 5 range from 6.1% to 49.3%<sup>32</sup>. The rate of chronic malnutrition in Guatemala exceeds the rates in the Africa and Southeast Asia Regions (43.2 and 41.6%, respectively). The overall rate is 30%, and in the Region of the Americas, 14.2%<sup>33</sup>. In the period 1980-2000, the prevalence of low height-for-age fell in several countries, but the rate of reduction was slow. In Guatemala and Panama, however, there was a slight increase in the most recent

surveys (2002 and 2003, respectively). Low weight-for-age, or overall malnutrition, is one of the MDG indicators in which the Central American countries and the Dominican Republic have consistently shown substantial improvements from 1980 to 2000, but at a lower rate (44%) than that of other Latin American countries<sup>34</sup>. The situation of deficiency disorders, such as iron deficiency anemia in children under 5, is critical, and Guatemala has the higher prevalence (40%). The prevalence of this deficiency is also seen in women aged 15-49, ranging from 8.8% in El Salvador to 51.7% in Belize. Belize has the highest rate of vitamin A deficiency in preschool children (24%)<sup>35</sup>. Malnutrition and nutritional deficiencies continue to be a challenge.

The prevalence of overweight and obesity in children under 5 has risen substantially in the past decade. Around one-third of women aged 15-49 are overweight; in general, this phenomenon is consistently greater in the urban population than in the rural one. The prevalence of obesity in that same group ranges between 13.8% and 21.8%. In the most recent surveys, 3.0% of children under 5 are overweight in Honduras (2001) and 8.6% in the Dominican Republic (2002)<sup>36</sup>.

Smoking continues to be a latent problem. In Costa Rica, 3.0% of adults smoke, and in the Dominican Republic, 13.2%; there is no significant difference in either country between men and women. In Guatemala, the prevalence of smoking is 4.1%, with men clearly predominating (7.7%, vs. 0.9% for women). The prevalence of smoking in young people is significantly higher than in adults, ranging from 13.2% (Panama) to 18.2% (Nicaragua). This data, disaggregated by sex, reveals a trend toward a higher prevalence in men<sup>37</sup>.

### ***c) Trends in the Health System Response***

In the region, the health system response to the health problems of the population is limited, due to problems with financing, organization, and management. Inequality in health care stems from economic, geographical, and sociocultural causes. Health systems in most of the countries are both fragmented and segmented, and a significant percentage of the population does not have any kind of insurance<sup>38</sup>.

In some countries, the scheme of four health care providers predominates: the ministry of health, social security, the for-profit private sector, and traditional healers; in other countries, social security finances, but does not provide, services. The private sector has grown significantly in the past 15 years, with limited supervision or control on the part of the ministries of health. There are other networks of health care providers as well, including those of the armed forces, those financed with presidential social funds, and NGOs contracted to carry out coverage extension programs<sup>39</sup>.

Health information systems in all the countries are under review in order to improve health surveillance and identify strategies to support health policies and programs. The systems rarely provide data disaggregated by sex, age, ethnicity, socioeconomic level, employment, and/or coverage plan, thus limiting the analysis of inequality. The existing information on production, coverage, and quality reveals the limitations of the health systems.

In terms of financing, the Central American countries and the Dominican Republic are quite heterogeneous<sup>40</sup>. Major differences in the levels of national per-capita health expenditure, the relative weight of this expenditure in the gross domestic product (GDP), and the public-private composition of this expenditure reveal major inequalities in access to and the consumption of health products and services by the populations of these countries. In 2006, national health expenditure in the region was estimated at US\$ 9.2 billion. This expenditure represented approximately 7.9% of these countries' GDP, or national health expenditure of US\$ 213 per capita<sup>41</sup>. Public spending on health was approximately US\$ 4.1 billion and accounted for 45% of total expenditure. Private expenditure was estimated at US\$ 5.1 billion and accounted for 55% of national health expenditure<sup>42</sup>. The public sector spent less than one dollar – \$0.85– for each dollar of private spending on health products and services. The inequalities in private spending on health products and services are more pronounced than the inequalities in income distribution in the countries<sup>43</sup>.

In the region, the beneficiary population of social security programs (including disease and maternity) was estimated at 11 million (25% of the population), and the expenditures of all social security institutions came to US\$2.25 billion (accounting for 24% of national health expenditure and 55% of public spending on health). Public spending on health through the ministries of health and all public institutions under the central governments accounted for only 20% of the national health expenditure. External financing is a relatively small part of the annual flow of resources spent on health<sup>44</sup>.

Changes in the level and composition of national health expenditure in recent years (between 2000 and 2006-07) suggest increasing inequalities in access to and the consumption of health products and services by the region's population. During this period, national health expenditure in these countries grew faster than their economic growth. The share of the national health expenditure in GDP rose from around 7.6% in 2000 to 7.9% in 2006/07<sup>45</sup>.

Unlike the market for health products and services in the more developed countries, where public expenditure is the main component of national expenditure, in most countries in this region, the private markets are relatively large.

There are major differences in the region with respect to the public-private mix in national health expenditure. Private expenditure accounted for around 70% of national health expenditure in Guatemala and 75% in the Dominican Republic. The weight of public spending in GDP fell from 3.9% in 2000 to 3.1% in 2006 in this region.

In the countries with the highest levels of public health expenditure as a proportion of GDP (Costa Rica and Panama), private health expenditure represents around 40% of the total national health expenditure. In these countries, social security covers over two-thirds of the population, the health indicators are better, and economic growth rates are higher.

As generally occurs in the Region of the Americas, in Central America and the Dominican Republic health workers are scarce and poorly distributed. The emigration of professionals to more developed countries is a problem in many countries. The Dominican Republic and Costa Rica are the countries with more physicians per 10,000 population (20.0) followed by Nicaragua and Panama (16.4 and

13.8, respectively). Belize and Guatemala (8.5 and 9.7, respectively) are the countries with the fewest physicians per inhabitant<sup>46</sup>. In terms of the available hospital beds per 1,000 population, the Dominican Republic has 2, Panama 1.8, Costa Rica 1.3, while El Salvador and Guatemala have 0.7 per 1,000 population<sup>47</sup>.

In terms of maternal health care provided by trained personnel, Panama reports coverage of 99.9% in prenatal care and 91.9% in delivery care, Costa Rica 91.7% in prenatal care and 94.3% in delivery care, and Belize 99.8% in prenatal care and 90.6% in delivery care. The countries with the least coverage in maternal health are El Salvador (which reports 51.1% in prenatal care and 43.9% in delivery care) and Guatemala (with 79.9% in prenatal care and 31.4% coverage in delivery care)<sup>48</sup>.

Immunization programs have been conducted responsibly. A budget line is available in all the countries for the purchase of vaccines; programs have been implemented with moderate success, helping to reduce the incidence of vaccine-preventable diseases<sup>49</sup>.

Private spending in the drug market grew by 11.28% in the region last year without a corresponding increase in the quantity purchased, a phenomenon that could be explained by the higher prices (which reduce households' purchasing power and the possibility of covering other needs). Six of the ten most-common drugs sold on the private market do not fit the epidemiological profile and indicate the irrational use of drugs and excessive spending by the population on products that do not address their principal health problems. In response to these problems, within the framework of the XXII RESSCAD agreements, the region formulated a policy that is being implemented and strengthened, as the Spanish Agency for International Development Cooperation (AECID) and SISCA have agreed to make it a component of the Regional Health Cooperation Program with Central America and the Dominican Republic<sup>50</sup>.

The Global Fund to Fight AIDS, Tuberculosis, and Malaria is implementing projects to increase coverage with antiretroviral drugs and other drugs for people living with HIV/AIDS in Guatemala, El Salvador, Honduras, Nicaragua, Belize, and the Dominican Republic. This is important assistance for these countries, but its sustainability remains a challenge.

#### ***d) Trends in International Health Cooperation: Alignment and Harmonization of International Cooperation***

The Central American Integration System decided to promote the harmonization and alignment of international cooperation to support its integration and development processes. To this end, in May 2006 it held the Central American Forum on Harmonization and Alignment, called the Vienna Forum, in which the institutional and sectoral cooperation strategies were reviewed, as well as strategies for intersectoral and horizontal cooperation among countries and mechanisms for coordination with international cooperation. An international commitment was made at the forum to support harmonization and alignment mechanisms, make cooperation mechanisms more flexible, and reduce transaction fees and administrative costs.

The region has been building closer ties with the rest of the world and maintaining permanent cooperation forums with different countries<sup>51</sup>. Also, the region has received bilateral cooperation from several countries and cooperation from multilateral agencies and other integration blocs. The region also participates in cooperation schemes with larger geographical areas.

Formulation of the Health Agenda for Central America and the Dominican Republic is a basic step for the alignment of international cooperation, since it is the instrument that will set the political direction and investment priorities. Moreover, representing the commitment to advance toward better living conditions and the possibilities for equitable development in health, it is expected to promote greater investment and to guide national plans and policies, not only in the health sector, but also in all sectors with activities that impact the social determinants of health.

## V. STRATEGIC OBJECTIVES OF THE HEALTH AGENDA FOR CENTRAL AMERICA AND THE DOMINICAN REPUBLIC

### DECALOGUE IN HEALTH

- 1** Strengthen the social integration of Central America and the Dominican Republic by defining and implementing regional health policies
- 2** Strengthen the steering role of the National Health Authority within the framework of Central American integration
- 3** Strengthen and extend social protection in health, guaranteeing access to quality health services
- 4** Reduce inequalities and inequities, and social exclusion in health within and among the countries
- 5** Reduce the risks and burden of communicable and noncommunicable diseases, domestic and social violence, and risks related to the environment and lifestyles
- 6** Strengthen health worker management and development
- 7** Promote scientific research, and health science and technology development as well as the use/application of scientific evidence in public health policies
- 8** Strengthen nutrition and food security and reduce malnutrition with support from the region's specialized institution—the Institute of Nutrition of Central America and Panama (INCAP)
- 9** Establish mechanisms to increase coverage in the provision of safe drinking water and protect and improve the human environment, with support from the regional entity the Water and Sanitation Forum for Central America and the Dominican Republic (FOCARD-APS)
- 10** Reduce the vulnerability to natural disasters, anthropic emergencies, and the effects of climate change

## **STRATEGIC OBJECTIVE 1**

Strengthen the social integration of Central America and the Dominican Republic by defining and implementing regional health policies

In order to strengthen the social integration of Central America and the Dominican Republic, health's position as a linchpin of the regional political agenda should be consolidated with the endorsement of the Presidential summits. The countries must consolidate the political, legal, and financial mechanisms for strengthening the regional health authority and increasing opportunities for sectoral integration, so that the formulation, negotiation and implementation of regional health policies with an integrationist approach are viable and feasible. In addition, the political commitment must be strengthened to amend and harmonize national legal frameworks and regulatory standards and mechanisms that address economic<sup>52</sup> and professional aspects<sup>53</sup>, border issues<sup>54</sup>, social protection<sup>55</sup>, information systems<sup>56</sup>, and interinstitutional and intersectoral consensus building to advocate for changes in frameworks that create disincentives to the improvement of health determinants and the interests of social integration. Mechanisms must be established to enable each country to meet its commitments and honor its agreements, and the respective monitoring and evaluating mechanisms should be included.

A regional social health policy should set the standard for basic health levels in the population and establish levels of coverage and quality for health systems and services, respecting the development models chosen in each country, based on the common principles outlined by the countries in this Agenda, the renewal of Primary Health Care, and the achievement of the Millennium Development Goals. The policy should also promote social integration at the community level and the inclusion of social organizations in designing and implementing regional health policies, improving the systems for civil society participation in SICA/SISCA to strengthen interaction between governments and social organizations and foster coordination with other Central American mechanisms such as COMMCA, which monitors women's rights, and considering the participation of other important sectors united in this case in the Advisory Committee of SICA (CC-SICA).

Also, articulation with other sectors in the social subsystem should be strengthened with the support of SISCA in order to coordinate actions to optimize results.

International cooperation, interregional cooperation (CARICOM-SICA), cooperation among countries, and transborder cooperation are vital aspects of the integration process. Within the framework of the Paris Declaration<sup>57</sup>, regional negotiating capacity needs to be enhanced through the harmonization and alignment of external donors with the principles, values, and strategic objectives expressed in this Agenda in order to increase cooperation, achieve a more just and equitable distribution of resources, and devise appropriate mechanisms –such as a donor roundtable– for understanding, negotiating, and monitoring agreements.

## **STRATEGIC OBJECTIVE 2**

Strengthen the steering role of the National Health Authority within the framework of Central American integration

The ministries of health should efficiently fulfill their role as the health authority in managing the social production of health, intensifying their steering role, developing national and regional leadership capacity, and continuing their advocacy to ensure that health occupies a more prominent position on national and regional policy agendas, expressed in greater public resources for the sector<sup>58</sup> in both absolute and relative terms and active participation in the definition of policies to address health determinants. In this regard, the inclusion of subsectors such as drinking water and sanitation is part of the strengthening of governance, as they contributing to the social production of health. Dialogue, coordination, and collaboration between the ministries of health and the ministries of finance and planning should focus on the planning, stability and continuity of financial resource allocation and attainment of national human development goals.

The countries of the region are ready to develop common management systems that include accountability and joint strategic information and quality control systems to inform decision-making. Strategic health information should be declared in the public interest and for public use, and information systems should be set up to permit the monitoring of prices and the availability of drugs and other products of interest for health in the public and private sector. In order to strengthen evidence-based decision-making, it is both possible and necessary to adopt a regional approach to the production of quality information, defining, implementing, and feeding integrated information systems for epidemiological surveillance, the analysis of social inequalities in health<sup>59</sup>, exposure to risks<sup>60</sup>, the coverage and quality of health systems and services, monitoring of implementation of the primary health care strategy, sectoral financing, etc., with standardized guidelines for gathering data to generate comparable high-quality data in the countries. Intersectoral surveillance systems also need to be promoted at the regional level in collaboration with relevant sectors, including the water, sanitation, education, labor, and agriculture sectors.

The National Health Authority should promote the modernization and harmonization of national laws and regulations and adopt an intersectoral strategy that permits implementation of the International Health Regulations and addresses other public health risks in the region.

### **STRATEGIC OBJECTIVE 3**

Strengthen and extend social protection in health, guaranteeing access to quality health services

A regional policy is needed that will help remove financial and economic barriers that impede access to health and promote integrated health service systems to eliminate the significant fragmentation and segmentation that exist today<sup>61</sup>. Transnational social coverage should be extended, beginning with specific vulnerable groups<sup>62</sup>, with the goal that in the future that social protection covers the entire population, group insurance should be provided to seasonal migrant populations, and transborder cooperation programs should be implemented among countries, using an intersectoral approach<sup>63</sup> to increase health services coverage, cut costs, and deal with health emergencies and disasters.

It is necessary to support and strengthen the Regional Drug Policy that has begun to be implemented in the region. The regional policy should include negotiations and consolidated procurement of drugs and technologies (including family planning), the development of regional quality-control mechanisms, studies on drug quality, guidelines for the introduction of new drugs, the development of basic treatment regimens in line with procurement, and accountability systems for social control of expenditures in this category. Regional laboratories are urgently needed, as well as cooperation with an international entity that can certify and support the maintenance of existing laboratories and develop regional programs to increase access to state-of-the-art health technologies that can be acquired jointly, managed by one country, and offer services to the region.

### **STRATEGIC OBJECTIVE 4**

Reduce inequalities, inequities, and social exclusion in health within and among the countries

In the region gaps exist in living conditions and health care for the poorest, most marginalized vulnerable groups—that is, women, indigenous populations, Afro-descendants, migrants, rural inhabitants, and children. Identifying and recognizing those gaps should be the starting point to overcome them. It is essential to undertake joint efforts to determine the magnitude of these problems and identify the intersectoral action needed.

Sexual and reproductive health for men and women should be addressed from a human rights, gender, diversity, and intercultural perspective throughout the life cycle, and men should be encouraged to get actively involved in their own sexual and reproductive health care, as well as that of their family and their partners. The right to education must be clear for healthy sexuality to be experienced as a

basic health right and to emphasize the formulation of policies to ensure the integral development of adolescents, pregnant adolescents, and mothers. The capacity of health systems must be strengthened to better respond to the challenges of sexual and reproductive health, mainly prenatal and postpartum maternal and child care, complications of abortion, prevention and treatment of sexually transmitted infections (especially HIV/AIDS), cervical cancer detection, counseling and attention to domestic violence, information and access to contraceptives for women and sexually active adolescents, and attention to the unmet demand for family planning.

The health sector should support the management of migration, workers' health, the sexual and reproductive health of women workers, and migrant workers' health. Recognizing that migration stemming from structural poverty is a determinant of human development in the region, bilateral and regional mechanisms must be established for the protection of migrant workers. Workers' health care is equally important; formulation and implementation of an intersectoral policy that includes private enterprise, labor unions, and access to health services to meet this demand are a priority. Accredited regional diagnostic reference laboratories are needed to investigate industrial hygiene, occupational illnesses, ergonomics, and problems and poisoning from industrial chemicals.

Comprehensive health protection for the elderly should be guaranteed, with emphasis on maintaining function (active old age) and advocacy through a combination of economic and food subsidies as the foundation of social protection for this group.

### **STRATEGIC OBJECTIVE 5**

Reduce the risks and burden of communicable and noncommunicable diseases, domestic and social violence, and risks related to the environment and lifestyles

Regional strategies must be adopted that include components that promote healthy lifestyles and the diagnosis, treatment, and control of chronic noncommunicable diseases, especially cardiovascular disease, hypertension, cancer, diabetes, and chronic respiratory diseases, under the Regional Strategy on an Integrated Approach to the Prevention and Control of Chronic Diseases, and that incorporate the chronic disease care model in health services. It is also necessary to develop a strategy that includes regional ratification of the WHO Framework Convention on Tobacco Control and the monitoring of its implementation in the countries; adoption of the Diet and Physical Activity Strategy (DPAS) and mechanisms that address the shifting health risks in the environment: from the "traditional" risks from the impact of natural phenomena and underdevelopment to the "modern" risks associated with the unsustainable features inherent in development itself.

The private sector must be included by implementing a regional certification system for companies that comply with labor and environmental regulations and encourage healthy habits and the promotion of workers' health<sup>64</sup>.

In terms of communicable diseases, the regional strategy for HIV/AIDS control should be expanded and improved, and greater regional efforts made to reduce the burden of vector-borne diseases (especially dengue, malaria and Chagas' disease), standardizing the approach to vector-borne diseases throughout the region and adopting a binding regional goal that guarantees the elimination of some diseases as a public health problem in the medium term<sup>65</sup>.

Violence against women should be addressed at the regional level to reduce the number of women living in unacceptable situations of physical, sexual, psychological, and economic violence, strengthening intersectoral mechanisms to address this problem by connecting the health sector with the courts. Also, it is necessary to strengthen the offices of the medical examiner at the different levels of the health system. Regional action is needed to prevent social violence, encouraging the design of programs and social projects to protect families and other groups by promoting healthy lifestyles and settings. It is necessary to advance in the area of regional intersectoral analysis to identify the characteristics of violence, the correlation between violence, weapons possession, the illegal trafficking of people, drug and alcohol abuse, and the role played by the breakdown of the family and family violence and violence against women in these components. An intersectoral partnership to reduce violence, in which nongovernmental organizations participate, is also needed.

## **STRATEGIC OBJECTIVE 6**

### **Strengthen health worker management and development**

Health workers are what makes the health system run; an important part of the critical challenges in this area need to be addressed at the regional level. The region has made progress that should be reinforced or resumed. It is necessary to increase the countries' commitment to supporting the global mandates and those of the Region of the Americas in human resources development. Within the framework of the 10-year Plan for Human Resources Development 2006-2015, the formation of a permanent Central American Technical Commission for the Human Resources Development in Health should be promoted. Also, the Central America and the Dominican Republic Project on Human Resources for Health (which is to be approved through SISCA) should be supported, since its purpose is to secure regional support for policies, strategies, and good human resources management in health that are sustainable in the medium and long term.

A regional policy should encourage lasting partnerships between health and education sectors at the national and regional level, promote coordination with the Central American University Council (CSUCA) and research institutes in support of formation and development of human resources. Within the health and education connection, the conditions are ripe for setting up a regional accreditation and certification system for programs and career preparation offered by training institutions and creating a regional accreditation agency for health sciences training institutions (including technical personnel) and developing regulatory instruments. Progress must also be made in defining regional standards for the certification and recertification of technicians and professionals to facilitate the movement and

hiring of health workers among the countries of the region and address staffing shortages in particular areas. Cooperation among the countries in the region is vital, and the viability and feasibility of decentralizing the training of technicians and professional personnel in partnership with vocational schools and universities must be verified, formulating and implementing a regional strategy for increasing educational opportunities at several training institutions that can be used by all the countries. A continuing education strategy for health workers should be included through online learning and the use of distance learning technologies, telemedicine, tele-education, and in-service training for personnel in priority areas of public health and for developing intercultural medicine. Universities should actively participate, encouraging regional programs to standardize education in health for both undergraduates and graduates, in accordance with governmental commitments to restructure health systems toward primary health care.

Training programs in health should be standardized in the region and should support wage policies in the countries that provide incentives for health workers employed in rural areas<sup>66</sup> as part of a policy to reduce inequities in those areas. In addition, support should be provided for the production of strategic information for decision-making, and a surveillance system should be set up to facilitate health care for health workers.

### **STRATEGIC OBJECTIVE 7**

Promote scientific research and health science and technology development as well as the use/application of scientific evidence in public health policies

A regional science and technology policy should advocate for the allocation of a percentage of the GDP for health research and give priority to the preparation of national research agendas that are discussed at the regional level as part of a process that includes the development of a regional strategy on scientific health research, the creation of a Regional Ethics and Research Committee, the creation of a regional fund to finance priority research, and the involvement of universities and research institutions. The regional policy should also set up a program for managing and utilizing innovative health technologies. Regional initiatives already in place, such as the Central American Forum for Health Research, should be supported to back a regional strategy on essential health research, including research on the mainstreaming of the gender approach and ethnicity and health. The participation of Central America and the Dominican Republic in the Ibero-American Ministerial Network for Health Education and Research (RIMAIS) should be strengthened as well as research initiatives in science and technology for social development that promote national funds for science and technology.

In order to facilitate the production, circulation, and dissemination of knowledge, intersectoral and interinstitutional health and technology research nodes should be created and promoted, including the existing virtual health libraries.

### **STRATEGIC OBJECTIVE 8**

Strengthen nutrition and food security and reduce malnutrition with support from the region's specialized institution - the Institute of Nutrition of Central America and Panama (INCAP)

A regional policy in this field should be based on a national and regional intersectoral strategy that promotes nutrition and food security in all its critical components: availability, access to food in sufficient quantity and quality, consumption, biological utilization of safe, nourishing food, food and nutrition surveillance, information activities, food and nutrition education and communication for the population, consumer guidelines and the search for dietary alternatives, as well as monitoring of the basic food basket and advocacy to establish mechanisms to address food shortages and chronic diseases related to nutrition, a priority for the region. Health promotion in this field should get social organizations, nongovernmental organizations, and the media involved to support a diet that takes advantage of the nutritional value of local production, as well as breast-feeding as a nutritional action.

Food and nutritional security also play an important role in successfully meeting the Agenda's other strategic objectives, including: strengthening the steering role of the health sector and other sectors involved in human development, reducing inequalities, inequities, and social exclusion through application of the social determinants and primary health care approach, reducing the risk and burden of noncommunicable diseases, research and development of science and technology in nutrition and food, and reducing vulnerability to natural disasters and the effects of climate change.

This regional strategy should include the strengthening of research and human resources education in the field of food and nutrition, especially the strengthening of career paths in food and nutrition, nutrition research, and the importance of nutrition education in health science programs in all countries of the region.

### **STRATEGIC OBJECTIVE 9**

Establish mechanisms to increase coverage in the provision of safe drinking water and protect and improve the human environment, with support from the regional entity- the Water and Sanitation Forum for Central America and the Dominican Republic (FOCARD-APS)

Regional integration should be supported by FOCARD-APS, as the leading agency for coordination and sectoral planning. A regional water and basic sanitation policy should be promoted that includes a major effort to identify and mobilize financial resources at the regional level to strengthen the sector

based on four key elements: institutional strengthening, sectoral reform, changes in behavior based on best practices in hygiene, with emphasis on handwashing and the conservation of water, and expansion of coverage to ensure efficient and responsible sustainability in the delivery of services, based on the precept that “water is a fundamental human right for life and development.”

This policy should seek to give priority to sanitation in national development policies through the construction of national health agendas whose purpose is to implement instruments with clear strategies and concrete actions that can be implemented by key actors in the sector to produce a large-scale change in the health situation that promotes an increase in coverage through sanitary sewerage systems, wastewater treatment plants, and latrine building, including an expansion in the coverage of latrine-building programs in rural and marginalized urban areas and the promotion of comprehensive solid waste management under the 3Rs strategy (Reduce, Reuse, and Recycle). Also, it should be promoted the formulation and implementation of a comprehensive regional policy for hospital solid waste management and the strengthening of the institutional capacity toward this end. Integrated management of watersheds is equally important: priority should be given to safe drinking water and the promotion of management models for administering water resources, establishing incentives for their responsible use in coordination with the environmental authority and other secretariats of the Central American Integration System, such as the CCAD and the CRRH, with which the Central American Strategy for Integrated Water Resources Management (ECAGIRH for is Spanish acronym) is being promoted. In addition, there should be regional monitoring of the deterioration in air quality in cities of the region due to traffic and industrial pollution.

Finally, support should be given to strengthening the sector’s information system, through the identification of clear and measurable indicators that put the sector’s situation in the region into perspective; thus, the harmonization of basic concepts among the countries should be promoted.

### **STRATEGIC OBJECTIVE 10**

**Reduce the vulnerability to natural disasters, anthropic emergencies, and the effects of climate change**

A regional policy to reduce the population’s vulnerability to natural disasters, anthropic emergencies, climate change, and the climate change/disaster ratio should begin with intersectoral integration. The health sector should play a larger role in defining a regional policy to reduce risk, promote preparedness, and reduce the adverse health and environmental impact of natural and manmade disasters. The policy should support greater health integration within pertinent regional entities such as the Coordinating Center for the Prevention of Natural Disasters in Central America (CEPREDENAC in Spanish). Within this policy, partnerships should be forged with social organizations to implement programs with high coverage in community health, promoting their active involvement in disaster prevention and management.

Transborder activities should be advanced to reduce the adverse health impact of disasters by expanding plans that include alternative sources for water supply, food, and health services, coordinating with social support and disaster preparedness networks in high-risk border areas.

The creation of regional networks should be promoted, along with multidisciplinary groups and regional networks to strengthen national health programs for the management of risks, emergencies, and disasters. The countries of the region need to share experiences and good practices and form a humanitarian front to protect and save lives and mitigate the damage to health. It is also necessary to strengthen national assessments of the health impact of climate change, promote research, and develop strategies to adapt to climate change, as well as mechanisms for coordination among the organizations responsible for epidemiological surveillance and the institutions in charge of emergency and disaster management.

It is necessary to include a mental health component in strategies for reducing vulnerability to natural and manmade disasters and to guarantee health resources and services for potential disaster victims and survivors.

## NOTES AND REFERENCES

- <sup>1</sup> The XIX Summit of Central American Presidents, held in 1997 (also called PANAMA II) issued mandates that included enforcement of the Central American Social Integration Treaty. The Summit instructed the Council of Ministers to prepare and enforce the regulations to support the mandates as a legal framework for action. In the case of the Council of Central American Health Ministers (COMISCA), the regulation was approved in 2001 and is still in force. Chapter III, Article 4 of the COMISCA Regulations explicitly states that: “the Meeting of Ministers will a) define the general policy and set priorities and strategies for attaining COMISCA’s objectives; and b) exercise the steering role of the region’s health sector, identifying and prioritizing regional health problems that need to be addressed through a Central American health agenda and plan”. SCSA. COMISCA Regulations, San Salvador, 2001.
- <sup>2</sup> 2006 estimates are 50.3 million people; 50.1% female and 49.9% male. INCAP/PRESANCA. Indicadores de Situación de Seguridad Alimentaria y Nutricional en Centroamérica y República Dominicana, May 2007.
- <sup>3</sup> Population density ranges from 12 inhabitants per square kilometer in Belize to 332 in El Salvador. Economic Commission for Latin America. Statistical Yearbook for Latin America and the Caribbean, Santiago, Chile 2005.
- <sup>4</sup> The population growth forecast for the period 2005-2010 is 2.2%, showing a slight reduction over 2000-2005, except in Guatemala, which maintains a rate of 2.5%. With the exception of Costa Rica (2.1%), fertility rates are higher than the average rate in Latin America and the Caribbean (2.4%). Economic Commission for Latin America. Statistical Yearbook for Latin America and the Caribbean, Santiago, Chile 2005, and the Pan American Health Organization/World Health Organization. Health Situation in the Americas, Washington, D.C., 2007.
- <sup>5</sup> Ibid.
- <sup>6</sup> Leyva Flores R, Caballero M, Infante Xibillé C, and Bronfman M. VIH/SIDA y Movilidad Poblacional en México y Centroamérica: Respuestas Regionales en Contextos de Vulnerabilidad Social. Instituto de Salud Pública, Mexico 2006.
- <sup>7</sup> CEPAL, PMA, PNUD. Análisis del Impacto Social y Económico de la Desnutrición Infantil en América Latina Santiago, Chile, June 2007. The information on Belize was taken from the CSO Belize Census of 2000.
- <sup>8</sup> Informe Estado de la Región en Desarrollo Humano Sostenible 2008, Sinopsis. Programa Estado de la Nación-Región. Costa Rica. September 2008
- <sup>9</sup> Ibid.
- <sup>10</sup> The UNDP estimates that El Salvador and the Dominican Republic receive 4% of the total global remittances, while the total for Latin America and the Caribbean is 18%. In the same report, remittances are estimated to account for 3.1% to 22% of total of GDP in the region (Guatemala 3.1%, Honduras 7.5%, Dominican Republic 10%, El Salvador 17%). Almost 80% of these remittances are used to purchase food. Orozco M and Lapointe M. Migration: Remittances and the Rural Sector in Latin America. UNDP, New York 2005.
- <sup>11</sup> Informe Estado de la Región en Desarrollo Humano Sostenible 2008. op.cit.
- <sup>12</sup> In 2003, of the 18.7 people in the region living in poverty, 12 million lived in rural areas (64%). RUTA. Estudio sobre Trabajadores Rurales en el Istmo Centroamericano 2007.
- <sup>13</sup> This is seen in countries like Honduras and Guatemala, which have the highest rate of informal employment – above the Latin American average (50.3% of nonagricultural workers) – together with the greatest concentration of income. This contrasts with Costa Rica (less inequity), which, along with Panama, has lower levels of informal employment, below the average but with an upward trend. El Salvador is the only country where the trend for informal employment is moving downward but is still above the Latin America average (55%). Economic Commission for Latin America. Informalidad, Inseguridad y Cohesión Social en América Latina, Santiago, Chile 2007.
- <sup>14</sup> United Nations. Crime and Development in Central America. New York, May 2007.
- <sup>15</sup> United Nations Development Program. Human Development Report 2007-2008. New York 2008 (data from 2005).
- <sup>16</sup> United Nations Development Program. Human Development Report 2007-2008. New York 2008.
- <sup>17</sup> Central American Secretariat for Economic Integration (SIECA). Centroamérica en Cifras. San Salvador, January 2008.
- <sup>18</sup> Nicaragua, Honduras and Guatemala, with literacy rates of below 80%, have some of the highest infant mortality rates in the Americas (17.7 per 1,000 live births), as in the case of Guatemala (39 per 1,000), Nicaragua (31.0 per 1,000), the Dominican Republic (30.6 per 1,000), El Salvador (25 per 1,000), Honduras (23 per 1,000), Belize (19.6 per 1,000) and Panama (19.4 by 1,000). In contrast, Costa Rica, with an overall literacy rate of 94% and 96% for women, reports an infant mortality rate of 9 per 1,000 (among the lowest in the world). World Health Organization. World Health Statistics. Geneva 2007.
- <sup>19</sup> Calculations based on the Pan American Health Organization/World Health Organization. Health Situation in the Americas: Basic Indicators. Washington, D.C. 2007.

- <sup>20</sup> Ibid.
- <sup>21</sup> Data on percentage of deaths from diseases is estimated using the table of communicable diseases found in the Tomo I de Salud en las Americas, page 80, Table 3. Rates (100,000 population), proportion, and cumulative proportion (defined causes) of the 10 main causes of death, by gender. Data from 2002.
- <sup>22</sup> Calculations based on the Pan American Health Organization/World Health Organization. Health Situation in the Americas: Basic Indicators. Washington, D.C. 2007.
- <sup>23</sup> Ibid.
- <sup>24</sup> Ibid.
- <sup>25</sup> Although the 2002 WHO World Report on Violence and Health was published six years ago, it indicates that El Salvador (50.2 per 100,000) has the world's second-highest mortality rate from homicides (in a country without war) in the 10-29 year age group, surpassed only by Colombia (84.4 per 100,000). World Health Organization. World Report on Violence and Health. Geneva 2002.
- <sup>26</sup> Ibid.
- <sup>27</sup> Pan American Health Organization/World Health Organization. Health Situation in the Americas: Basic Indicators. Washington, D.C. 2007. Data from 2001 to 2006, depending on the country.
- <sup>28</sup> UNDP y UNIFEM. Perfil de Género en la Economía del Istmo Centroamericano. New York 2005.
- <sup>29</sup> Calculations based on the Pan American Health Organization/World Health Organization. Health Situation in the Americas: Basic Indicators. Washington, D.C. 2007.
- <sup>30</sup> UNAIDS Report 2007.
- <sup>31</sup> Ibid.
- <sup>32</sup> INCAP/PRESANCA. Indicadores de Situación de Seguridad Alimentaria y Nutricional en Centroamérica y República Dominicana, 2007.
- <sup>33</sup> World Health Organization. World Health Statistics. Geneva 2007.
- <sup>34</sup> United Nations Development Program. Human Development Report 2007-2008. New York, 2008.
- <sup>35</sup> INCAP/PRESANCA. Op.cit.
- <sup>36</sup> Ibid.
- <sup>37</sup> Pan American Tobacco Information Online System (PATIOS); for more information, see website ([www.paho.org/patiosHome.asp](http://www.paho.org/patiosHome.asp)).
- <sup>38</sup> In El Salvador, almost 43% of the population has no access to public health services, social security, or private insurance (DIGESTYC survey, 2002); in Guatemala, the percentage is 13-27% (Mesa-Lago C. Las reformas de salud de América Latina y el Caribe: impacto en los principios de la seguridad social. ECLAC 2005); in Honduras, it is over 30% (Mesa-Lago, *ibid.*); in Nicaragua, 28% (*ibid.*), in Panama, 20% (IACSS. Reforma de los esquemas de la seguridad social. Informe de la seguridad social en América 2004); and in the Dominican Republic, 16% (PAHO/WHO. Exclusion in Health in Latin America and the Caribbean, 2004).
- <sup>39</sup> Pan American Health Organization/World Health Organization. Iniciativa Regional de Reforma del Sector de la Salud en América Latina y el Caribe. Análisis de las Reformas del Sector Salud en Centroamérica y la República Dominicana. Washington, D.C. 2nd edition, July 2002.
- <sup>40</sup> The information on financing has been taken from the Nota Sobre Financiamiento, prepared by Public Policies, Regulation, and Health Financing (RF), Pan American Health Organization/World Health Organization, June 2008. Team coordinated by Rubén Suárez.
- <sup>41</sup> National per-capita health expenditure in these countries was around US\$213 and accounted for 7.9% of GDP, which is above the average for Latin America and the Caribbean (7.1% of GDP). On average, the value of health products and services consumption in Costa Rica (US\$411) is almost twice the regional average, more than four times the consumption level in Honduras (US\$95), and more than six times the per capita consumption in Nicaragua (US\$65).
- <sup>42</sup> Unless otherwise indicated, the statistics presented in dollars are at the 2006 value.
- <sup>43</sup> Pan American Health Organization/World Health Organization. Health Situation in the Americas, 2007.
- <sup>44</sup> In 2006, the portfolio of health projects financed by the World Bank and the Inter-American Development Bank rose to approximately US\$416 million. Annual expenditure was approximately US\$71 million, or US\$1.60 per capita. The amount of health expenditure financed with loans from these institutions accounted for less than 1% of annual expenditures in the region.
- <sup>45</sup> Estimates for 2000 are from the document: Invertir en salud para el desarrollo humano: gastos del sector salud y financiamiento en los países de la subregión; from PAHO/WHO in: Informe sobre El Estado de la Región 2003; and the Pan American Health Organization/World Health Organization. Health in the Americas, 2002. Washington, D.C. 2002.
- <sup>46</sup> Pan American Health Organization/World Health Organization. Health Situation in the Americas: Basic Indicators.

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Washington, D.C. 2007.

<sup>47</sup> Ibid.

<sup>48</sup> Ibid.

<sup>49</sup> No cases of polio or measles were reported in 2006, and diphtheria was reported only in Guatemala and the Dominican Republic, with 2 and 4 confirmed cases, respectively. The countries with the lowest immunization coverage are Nicaragua and Honduras, which reported less than 90% coverage. Ibid.

<sup>50</sup> SISCA-PAHO/WHO. Política de Medicamentos en Centroamérica y República Dominicana. Guatemala, 2006.

<sup>51</sup> SICA. International Forum on Harmonization and Alignment in Regional Cooperation in Central America. Forum in Vienna, May 2006.

<sup>52</sup> For example, drug procurement systems.

<sup>53</sup> For example, accreditation of institutions, curricular harmonization.

<sup>54</sup> For example, coordination of transborder health services.

<sup>55</sup> For example, definition of bilateral group coverage systems to provide social protection for migrants.

<sup>56</sup> For example, epidemiological surveillance, and the coverage and quality of health systems and services.

<sup>57</sup> On 2 March 2005 in Paris, ministers, heads of agencies, and other senior officials from approximately 90 developed and developing countries and officials from 27 assistance organizations endorsed the Paris Declaration on Aid Effectiveness: Ownership, Harmonization, Alignment, Results, and Mutual Accountability. The Paris Declaration is a milestone in global efforts to increase efficiency in the use of development resources and is a corollary to a succession of commitments and initiatives launched in the 1990s that include the Millennium Summit (2000), when the Millennium Development Goals were adopted; the Monterrey Conference (2002); the High-level Forum on Harmonization--Rome (2003), and the Marrakech Roundtable on Managing Development Results (2004).

<sup>58</sup> Absolute and relative increases in public health spending as a percentage of GDP.

<sup>59</sup> Data should be collected and analyzed by gender, age, and ethnicity.

<sup>60</sup> Behavioral, environmental, and occupational risks.

<sup>61</sup> Fragmentation is one of the determinants of the poor access, limited capacity, and inefficiency of health services in the region.

<sup>62</sup> These vulnerable groups include poor immigrants, both documented and undocumented.

<sup>63</sup> Including, but not limited to, basic water and sanitation services.

<sup>64</sup> Healthy companies, smoke-free and tobacco-free companies.

<sup>65</sup> SISCA. Protocolo Centroamericano de Desarrollo de Recursos Humanos en Salud, 2007.

<sup>66</sup> Includes salary, the right to rotation, continuing education, and other incentives.

## GLOSSARY

**Accessibility:** The absence of geographic, financial, organizational, and/or structural barriers to participation in the health system and/or to receiving health and other social services; it is a determinant of whether people can obtain needed services. PAHO/WHO. *Renewing Primary Health Care in the Americas*. Position Paper. Washington DC, 2005.

**Accountability:** Accountability is the process of holding actors responsible for their actions. For governments it includes the obligation to provide for and periodically disclose, in adequate detail and consistently, to all directly and indirectly responsible or interested parties, the purposes, principles, procedures, relationships, results, income, and expenditures so that they can be evaluated by the interested parties. It includes the need for transparency with respect to the degree of achievement of health in the population and the adequacy of mechanisms to achieve it. PAHO/WHO. *Renewing Primary Health Care in the Americas*. Position Paper. Washington DC, 2005.

**Equity in health services:** The absence of differences in access to health services for equal health needs (horizontal equity) and enhanced access or other resources for socially, demographically, or geographically defined population groups with greater health needs (vertical equity). PAHO/WHO. *Renewing Primary Health Care in the Americas*. Position Paper. Washington DC, 2005.

**Fragmentation:** Coexistence of several unintegrated small subsystems, which increases transaction costs and hinders the capacity to guarantee equitable access to and delivery of health services. PAHO/WHO. *Renewing Primary Health Care in the Americas*. Position Paper. Washington DC, 2005.

**Health Authority:** The Health Authority is the custodian of health-related public goods, and its basic purpose is the protection and promotion of the population's health. It entails the power of the State to influence the functions, responsibilities and substantive competencies that cannot be delegated, in order to effectively monitor health-related public goods. There are structural differences in the composition of the Health Authority based on the federal or unitary nature of the country and the institutional organization of the health sector. The Ministries of Health are the principal public repositories of the Health Authority and in that role are the primary entities responsible for exercising governance over the health sector. PAHO-USAID: *Health Systems Profiles. Methodological Guidelines*. Washington DC, 2006.

**Health Sector Steering Role:** Understood as the management of health-related public policies. In the context of the new scheme of relationships between government and society in the modern State, it is a characteristic competence of the government, performed through the national health authority. Its purpose is to implement decisions and public actions to fulfill and guarantee, within the framework of the adopted national development model, the health-related needs and lawful aspirations of the groups of social actors. It includes the following dimensions: formulate and lead, regulate and oversee, guarantee assurance, manage the financing, coordinate care delivery, and develop and promote the essential public health functions in the country. PAHO-USAID: *Health Systems Profiles. Methodological Guidelines*. Washington DC, 2006.

**Health system:** WHO defines the health system as that which "comprises all organizations, institutions and resources that produce actions whose primary purpose is to improve health." A health system can also be characterized by its main actors: the government or professional body that structures and regulates the system; the population, including patients, who as individuals and households ultimately pay for the health system (through taxes or other mechanisms) and receive services; financing agents, who collect funds and allocate them to providers or purchase services at national or lower levels; community and local organizations (e.g., voluntary organizations, health committees, private initiatives) who aid in organization, logistic support, direct and indirect financing, and (sometimes) service delivery; and the providers of services, who themselves can be categorized in various ways. Health systems can also be characterized by their main functions: stewardship (or oversight); financing (collecting, pooling and purchasing); creating resources (investment and training); and delivering services (provision).

PAHO/WHO. *Renewing Primary Health Care in the Americas*. Position Paper. Washington DC, 2005.

**Human Development:** "is a process of enlarging people's choices...by expanding human capabilities and functionings. At all levels of development the three essential capabilities for human development are for people to lead long and healthy

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lives, to be knowledgeable and to have a decent standard of living... But the realm of human development goes further: essential areas of choice, highly valued by people, range from political, economic and social opportunities for being creative and productive to enjoying self-respect, empowerment and a sense of belonging to a community.” The Human Development Index is one way of capturing the level of human development within a given country. It is composed of national levels of health (life expectancy), knowledge (attainment of primary education), and living standards (gross national income per capita). PAHO/WHO. Renewing Primary Health Care in the Americas. Position Paper. Washington DC, 2005.

**Intersectoriality:** The extent to which PHC is integrated with efforts to address health determinants that lie outside the health sector, such as water and sanitation, housing, education, and coordination of the development and implementation of a wide range of public policies and programs affecting and involving sectors outside health services. This requires close links between public, private and non-government areas both within and outside traditional health services whose actions have an impact on health status and access to health care such as employment, education, housing, food production, water and sanitation, and social care. Intersectorial approaches draw on all societal resources that influence health. PAHO/WHO. Renewing Primary Health Care in the Americas. Position Paper. Washington DC, 2005.

**Primary health care (PHC):** In 1978, the Alma Ata Declaration defined PHC as “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain... It forms an integral part of the country’s health system...and of the social and economic development of the community. It is the first level of contact on individuals, the family and community...bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. PAHO/WHO. Renewing Primary Health Care in the Americas. Position Paper. Washington DC, 2005.

**Quality-oriented:** The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. The main pillars of quality are: effectiveness; efficiency; optimality (balancing health costs against the effects of care); acceptability; legitimacy; and equity; It is composed of both technical quality and user satisfaction with services. PAHO/WHO. Renewing Primary Health Care in the Americas. Position Paper. Washington DC, 2005.

**Right to health:** The Constitution of the World Health Organization and international human rights treaties recognize the right to the “highest attainable standard” of health. A right to health emphasizes the link of health status to issues of dignity, non-discrimination, justice, and participation. The right to health encompasses both freedoms (e.g. freedom to control one’s own reproductive decisions, freedom from torture) and entitlements (e.g. a citizen is entitled to necessary healthcare and healthy living conditions). A rights-based approach requires obligations and accountability on the part of responsible agents (e.g. governments) to ensure that citizens may exercise their health claims. The right to health implies ethical conduct and responsibility on the part of health services providers, researchers, and policy-makers. Citizens’ rights include: the right to freedom from conditions that impinge on achieving the maximum level of health attainable; entitlements such as the right to healthcare and healthy living and working conditions; and expectations in terms of standards of ethical conduct in service provision and in research. Obligations of the state include: obligations to respect (refrain from interfering with the enjoyment of good health), to protect (states must take measures to prevent third parties from interfering in citizen’s health and its attainment), and fulfill (states must adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to meet the full realization of right to health). PAHO/WHO. Renewing Primary Health Care in the Americas. Position Paper. Washington DC, 2005.

**Social Justice:** is an ethical concept largely based on social contract theories. Most variations on the concept hold that as governments are instituted among populations for the benefit of members of those populations, those governments which fail to see to the welfare of their citizens are failing to uphold their part in the social contract and are, therefore, unjust. The concept usually includes, but is not limited to, upholding human rights and is also used to refer to the overall fairness of a society in its divisions and distributions of rewards and burdens. PAHO/WHO. Renewing Primary Health Care in the Americas. Position Paper. Washington DC, 2005.

**Solidarity:** Solidarity is considered a union of interests, purposes, or sympathies among members of a society to create conditions necessary to improve social conditions. It is exercised through active participation both individually and through organized efforts with others. Solidarity implies working together to achieve goals that could not be achieved individually.

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This occurs by forging common interests through intense and frequent interaction among group members. It is characterized by the motive of promoting group goals in their own right. For some, an adequate level of social solidarity is essential to human survival. PAHO/WHO. Renewing Primary Health Care in the Americas. Position Paper. Washington DC, 2005.

**Universal coverage:** Financing and organizational arrangements to cover the entire population, removing ability to pay as a barrier to accessing health services. PAHO/WHO. Renewing Primary Health Care in the Americas. Position Paper. Washington DC, 2005.



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## Executive Secretariat of the Council of Central American Health Ministers

**Dr. Rolando Edgardo Hernández Argueta**

Executive Secretary

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