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IN THE 21ST CENTURY

The preliminary analyses mentioned in Document CD45/18 are herein presented for the information of the 45th Directing Council.

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WORKING GROUP: PAHO IN THE 21ST CENTURY

THE CHANGING NATURE OF PARTNERSHIPS AND ALLIANCES IN INTERNATIONAL HEALTH DEVELOPMENT AND THE WORK OF PAHO[1]

Introduction

Partnerships and alliances are part of a long tradition in the political, social, and economic history of countries and play an important role in the rich history of international public health. The formation of the Pan American Sanitary Bureau more than a century ago is the unequivocal expression of the perceived advantages of coordinating work in health among the countries of the Region of the Americas and harkens to a time in history when nations were almost exclusively the key actors.

As would be expected, partnerships with a profound impact on health policies will continue to expand in this century. The challenge is to identify the risks and opportunities, as well as the strengths and weaknesses of the Organization to make the changes needed to make it as relevant as possible in this important, complex, and interdisciplinary sphere.

Since the historic International Conference on Primary Health Care of Alma Ata, promoted jointly by WHO and UNICEF in 1978, when the goal of health for all *by the year 2000* was officially launched, international agreements promoting objectives and goals in health have multiplied. All of them have expressly called for multisectoral participation that includes the private sector and NGOs, in the conviction that these goals cannot be met without their involvement.

The Millennium Declaration, issued at the Millennium Summit, held 6-8 September, attended by 191 countries, including 147 Heads of State and Government, constitutes a remarkable consensus among world leaders regarding the challenges that the world faces. In the Millennium Declaration, the countries reaffirm their confidence in the United Nations and its Charter to achieve a more peaceful, prosperous, and just world. They also recognize certain fundamental values essential to international relations in the 21st century: freedom, equality, solidarity, tolerance, respect for nature, and shared responsibility. The Declaration also seeks to strengthen the United Nations to improve its performance in the new century.

At the Millennium Summit, the participating leaders established eight specific objectives, known as the *Millennium Development Goals* (MDG) for the year 2015. They are, to: 1) Eradicate extreme poverty and hunger; 2) Achieve universal primary education; 3) Promote gender equality and empower women; 4) Reduce mortality in children under 5; 5) Improve maternal health; 6) Combat HIV/AIDS, malaria, and other diseases; 7) Ensure environmental sustainability; and 8) Develop a global partnership for development. Goal 8 has been reaffirmed at the Monterrey and Johannesburg meetings, which encouraged wealthy countries to adopt debt-relief measures, increase economic assistance, and give poorer countries access to markets and technology. These objectives provide a framework for the UN system to work in a more coordinated manner toward a common goal. The Millennium Declaration and Goals lend even greater legitimacy to the subject of partnerships and alliances as an absolutely fundamental strategy for development.

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[1] This work was commissioned to Peru at the Second Meeting of the Working Group on PAHO in the 21st Century, held in Washington on 23 April 2004. The report received critical input from officials of the Peruvian Ministry of Health, including Dr. Juan de Dios Altamirano, Head of the Cabinet of Advisors to the Ministry; Dr. Cesar Náquira, Director of the National Health Institute; Drs. José Castro and Julio Pedroza, Executive Directors of International Cooperation; Lic. Maritza Acosta and Carlos Alcazar; decentralization advisors on the POLICY project; and Drs. Marcial Ferro and José Orrego, interns at the Internship Program of the Ministry of Health's International Cooperation Office.

DEFINITION

Although the literature offers different definitions of partnerships and alliances, they are regarded as interchangeable concepts for the purposes of this document.

Alliances and partnerships respond to the special interests of different types of actors and are essentially geared to addressing the issues that interest their associates in a more organized, complete, and effective manner. What are most important are the area of interest and the purpose of these organizations, not their nature. Thus, organizations with diverse and even antagonistic interests can and have come together at specific moments in history to form strategic partnerships. The growing emergence of ever-more complex and unpredictable social, political, economic, and technological challenges in this century necessitates the convergence of new actors from all professions and disciplines to meet these challenges successfully.

Harmonizing interests among various actors can mean risking the loss of some sense of the objectives, but this is generally considered acceptable if the main objective is met. Obviously, this also focuses on the analysis of ethical aspects in alliances.

Globalization is making the subject of alliances increasingly more relevant, particularly those representing large private corporations and complex interests, because of how quickly the factors affecting them change. An example of these changes is the almost daily mergers or joint ventures between traditionally competing companies involving billions of dollars to collectively respond to new market opportunities.

Moreover, the persistence of social inequities and poverty requires experts from a variety of disciplines to tackle their causes with much greater emphasis and depth. Matters, such as defense of the civil right to health demand new types of actors, who by the nature of their action and tactics may even risk confrontations with governments—something that agencies such as WHO/PAHO cannot do because they are heavily dependent on their members.

The issue of public and private alliances has become an issue of growing importance, especially in industrialized countries, and these alliances are expanding to the most diverse areas. Countries in every region of the world are witnessing some form of public/private association. This is a complex area that requires further study in terms of its impact on public goods, priorities, exclusion, and equity.

To prevent new and powerful actors and changing scenarios from undermining the steering role of WHO/PAHO, the structure of the dynamics and interests involved must be understood in order to devise a proactive strategy in this area.

SWOT Analysis

A SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis of the relevant aspects of partnerships and alliances revealed the following.

Strengths
- Prestige as technical agencies specializing in health
- Legitimacy (mandate) among governments as a sectoral agency that sets standards in health
- Organizational structure in all the countries
- Extensive international experience in various aspects of health, particularly in normative matters and matters related to partnerships and alliances
- Agencies with both inter-American and international representation

Weaknesses
- Excessive sectoral focus
- Prioritization of the restorative view of health
- Political dependency on governments
- Limited financial resources
- Slowness and bureaucratization of responses
- Relatively little experience in local service management
- Little presence with actors outside the health sector

Opportunities
- Qualitative and quantitative improvement of intersectoral vision and participation
- Influence over the large volume of financial resources in ODA
- New ideas from new actors
- Influence over actors with little familiarity of the social aspects of economic policies
- Participation in matters with a major impact on health, such as the effects of drug patents on economic trade agreements, which are outside the decision-making mandate of PAHO

Threats
- The lack of coherence and multiplicity of actors, agendas, objectives, and interests
- Other actors with much greater capacity for expeditious decision-making with regard to financial resources than that of the Organization.
- Minimization of PAHO's role as the principal actor in the technical regulation in health

THE ACTORS

Other sectors
Sectors such as education, agriculture, transportation, communications, trade, industry, justice, tourism, and energy have a growing role in health, so their involvement in alliances and partnerships is essential. Education in particular must be part of any intervention strategy in matters related to health promotion. The diverse forums of the Ministries of Economy, Foreign Affairs, Agriculture, and Education, among others, offer great potential for the introduction of public health issues.

Multilateral agencies
The mandates of specialized agencies, such as UNDP, UNICEF, UNFPA, FAO, WFP, ILO, and UNEP, include actions that largely coincide with the objectives of WHO/PAHO. Moreover, these agencies have comparative advantages that complement the strengths of PAHO. This reality has led to the creation of several coordination mechanisms, such as the primary health care strategy, the integrated management of childhood illness, and polio eradication, among many others. Calls for greater coordination among UN agencies are part of UN reform and promote the creation of mechanisms for coordination among its agencies, including the Common Country Assessment (CCA) and the United Nations Development Assistance Framework (UNDAF).

Regional agencies
The Region of the Americas has an important role in regional and subregional agencies with great prestige and experience in matters that impact health in one way or another. These agencies include the OAS, the IDB, LAES, ECLAC, ORAS-COHU, and ADC, to name a few.

Bilateral agencies
The most important among them are involved in the official development assistance (ODA) offered by the Organization for Economic Cooperation and Development (OECD), which is a key financing source in the global fight against poverty. ODA includes bilateral assistance from donor countries and supplies multilateral organizations with resources for use on behalf of developing

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countries. The Development Assistance Committee (DAC) of the OECD monitors the ODA efforts of its member countries. However, it should be borne in mind that many donor countries have their own political or even commercial interests. The volume of ODA in health for all countries reached US$ 3.5 million per year by the end of the 1990s, representing one-fifth of the ODA available to all sectors. Latin America and the Caribbean received around 10% of this total.

Another way for industrialized countries to participate is by promoting strategies like sector-wide approaches (SWAPs) in health that encourage the formation of strategic partnerships among various sectors of governments, civil society, and NGOs to rationalize health system reforms. The European Union is emerging as a new actor with great political, technical, and financial influence in international health.

Financial agencies
During the 1980s, the Bretton Woods institutions began to place increasing importance on health in poor and middle-income countries. The presence of these actors, together with copious financial resources, introduced new priorities with the promotion of financial adjustment policies.

In the 1990s, the World Bank Group became the organization with the greatest influence on international health because of the growing weight of the resources invested, especially in large-scale projects. With the publication of the 1993 report "Investing in Health, " the World Bank adopted a proactive role in health policy, consolidating its influence. The World Bank has created the Comprehensive Development Framework (CDF). It is the main agency promoting poverty reduction strategies and has the greatest volume of resources for health projects throughout the world. The multi-year program against AIDS alone has $500 million for three years.

The monetary and economic adjustment policies of the International Monetary Fund strongly influence the quality of life and health. Association with this agency with its emphasis on economic policies can influence agendas, which should be centered on human well-being and not exclusively on the fiscal bottom line of countries.

Private foundations
At the end of the twentieth century, it was estimated that there were more than 45,000 private foundations in the United States, motivated by an amalgam of tax incentives and altruism. The economic influence of these entities is exemplified in the donations of the Bill and Melinda Gates Foundation, which reached US$ 23.5 billion in 2001. Even though Ted Turner made a donation in 1996 of a billion dollars over 10 years to the United Nations, the majority involved, a large part of which was channeled to public health programs via the United Nations Foundation, the majority of the resources from foundations go to the private sector and to NGOs. The Lilly, Ford, and Packard Foundations disbursed grants totaling roughly US$ 1.5 billion in 1999—more than three times PAHO's budget—channeled primarily to the private sector. According to the Foundation Center, donations from U.S. foundations for international health and population programs jumped from US$ 158 million to US$ 240 million between 1998 and 1999.

The Global Fund to Fight AIDS, Tuberculosis, and Malaria has already secured US$2 billion for country projects, out of its goal of US$ 10 billion. Constituted with private contributions, it has created ad hoc mechanisms for managing these funds, which it feels is more efficient than administration by governments or the United Nations/WHO/PAHO. Although WHO plays an important technical role, the use of the resources is basically in the hands of other actors.

One of the challenges posed by the emergence of these megafunds is maintaining rationality in priorities, since many have similar interests. An additional difficulty can be the barriers that relatively less developed countries face in meeting new technical or administrative requirements for accessing these resources. The growing importance of these funds also challenges partnerships and alliances to study ways of harmonizing country needs with the facilities for accessing these resources and to assess the advantages and disadvantages in terms of sustainability and equity, over channeling these resources via ODA.

Private enterprises

There are many different kinds of private enterprises, including health insurers and transnational manufacturers and vendors of equipment and supplies, as well as companies in general. The economic interest of these groups in promoting profit-driven interests in areas such as health reform and in promoting the privatization of health services through private groups interested in selling technology, services, or products must be taken into account. This is an element to consider when forming partnerships with these agencies, because of the possible conflict of interest.

Pharmaceutical companies

Pharmaceutical companies constitute a separate private-sector group because of their strategic role, their connections to medical alliances, and their financial size. The majority of these companies have the political backing of their national governments. Many of these corporations mobilize resources in the billions of dollars—higher than the budgets of the Ministries of Health in poor and middle-income countries. Their excessive promotion of the curative focus in health could be a conflict of interest. Successful negotiations throughout the world, including those in Region of the Americas, for access to more reasonably priced drugs to combat HIV/AIDS has recently demonstrated the advantages of countries and agencies working together.

Civil society

The importance of including civil society, the third sector, was highlighted at the 2001 Summit of the Americas in Quebec, when Canada addressed this subject as fundamentally political. The Summit in Quebec called on civil society to become more resolutely involved in implementing regional health initiatives. Civil society entities have been organized in various forums and are promoting regional events. One such event was the Civil Society Hemispheric Forum, held in Quito, Ecuador from 26 to 27 April 2003, in which proposals and recommendations were made to the OAS and its Member States, especially in the workshop "Participation in Hemispheric Processes," whose recommendations were to improve, strengthen, and enhance the mechanism of citizen participation in the Summits of the Americas and the OAS.

Religious groups

Religious groups, which vary in their capacity to exert influence, are important in promoting key issues, particularly sexual and reproductive health, community development, and participation. Many religious alliances are also remarkably adept at mobilizing the grassroots population and have access to the mass media, particularly radio.

NGOs

With their very broad spectrum of interests, capabilities, and resources, NGOs are increasingly important and play a very diverse role that is difficult to characterize. PAHO promotes NGO participation in work with governments on the analysis of health policies and dialogue on sectoral reform, as well as in working groups for program planning and execution. Since 1995, PAHO has had a mechanism in place to facilitate the official relations with certain national and inter-American NGOs, making it possible for them to share technical competencies and attend the meetings of the Organization's Governing Bodies.

Professional alliances

Professional alliances, especially but not exclusively those related to health, represent several million members in the Americas. Partnerships can be formed with their regional agencies in specialized areas. Some examples of professional alliances are unions, medical school alliances, and scientific societies.

Mass media
Large radio and TV companies are potential and actual actors with a great deal of influence on public opinion and on those who set health policies and priorities; thus, they should be preferred partners in alliances and partnerships.

Medical schools and university centers
There are over 1,000 medical and professional schools in the Americas, with which new types of partnerships can be explored to influence the orientation of students and professors and to benefit from their research and teaching capacity.

ROLES AND STRATEGIES FOR PAHO IN PARTNERSHIPS AND ALLIANCES

It is possible that the principal role of PAHO in the area of partnerships and alliances is coordination and the promotion of dialogue among actors in defense of public health. This task, which is on the border between advocacy and direct participation, requires consensus-building with actors with diverse organizational cultures, values, and objectives, and recognition of institutional weaknesses as well as strengths.

One of the areas where more emphasis is needed is on health determinants, which necessitates the inclusion of extrasectoral actors. The Ottawa Charter for Health Promotion provides a fairly specific definition of these sectors and actors. Other very important areas are the need for greater linkage with civil society and the promotion of complex agendas, such as the right to health and citizen participation in the social control of services. Growing evidence that efforts to expand service coverage and access to the poor are not sufficiently inclusive is another matter requiring the participation of actors with a profile that complements that of the Organization.

Strategies
Paradoxically, some of PAHO's core strengths can be vulnerabilities in developing partnerships and alliances. For example, its very close relationship with Ministries of Health creates mistrust among certain institutions, which view this as a limitation to independent decision-making. For this reason, it is important to expand the scope of participants to other sectors and entities with a greater presence in civil society when dealing with matters requiring a more critical position on certain health policies.

One strategy is to form specific partnerships to achieve limited goals. The starting point is the identification of an area or objective in which the Organization recognizes that it does not have sufficient institutional capacity. This leads to the identification of key actors according to the value added they can contribute to that particular partnership. Then, the parties involved need to agree on how to modify objectives, set goals, identify work modalities, and define responsibilities or roles of action. Various categories of partnerships have been established, based on their characteristics or the parties involved.

Another type of partnership is based on support from multipurpose forums, such as the Interagency Coordinating Committees, which participate in governments, NGOs, and civil society entities, where various issues can be promoted. There are several very relevant partnerships in Brazil, such as the Children's Group, which comprises a wide range of participants, including the Ministry of Health, scientific societies, advertising alliances, the Catholic Church, and individuals from the private sector. This group had a formidable influence on child health policies in the 1990s.

The demand to form partnerships and alliances can have also external origins and can be at the request from an old or new potential associate looking for the strengths that the Organization offers.

Finally, it should be pointed out that maintaining partnerships and alliances requires different types of resources, such as time, financing, and personnel. In any case, it is important to plan and provide the necessary means for keeping partnerships operational.

It can be concluded that the issue of alliances and partnerships is highly relevant, possibly vital, to keeping PAHO a key player in the changing health panorama of our Region.

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Regional and Global Public Health Goods in the 21st Century and their Relation to the PAHO Mandate

(Prepared by Argentina. Second Revision)

Introduction

Public health is at a crossroads due to the confluence of two megatrends: decentralization and globalization. One could conjecture that they might lead to conflicting responses. Although the slogan "think globally, act locally" is widely used, some of the new health challenges probably need a little contrary effort, that is, to "think locally and act globally."[1]

The decentralization processes involving the vast majority of health systems, especially in Latin America, encourage the interpretation of health status as a local problem. Furthermore, fiscal theory has been used to justify decentralization, holding that the provision of social goods, such as health services, should be approached from the minimum territorial and governmental unit capable of sustaining them financially[2] and managing them efficiently. Health problems are beginning to be fragmented regionally and locally. In many cases, this facilitates responses adequate to the particular needs of each place, but at other times, it leads to systemic inefficiencies such as the duplication of certain efforts while omitting others. In some cases, such as Argentina at the close of the 20th century, it came to the point of questioning the need to maintain a national ministry of health[3].

In an opposite sense, **globalization, if it does not introduce challenges such as the need to pool international efforts to reduce risks and take advantage of health opportunities, it at least accentuates them.** The idea of global public goods implies that there would be losses of economies of scale at the national level (and even more so locally) in facing certain health challenges--for example, combating certain epidemics. The imperatives imposed by capital see functional health as the means for setting a policy agenda to promote regional and subregional action. Thus, the need to guarantee certain public goods regionally or globally is appearing on agendas. Furthermore, globalization poses important changes not only for countries but for the agencies that cooperate with them.

The reasons for introducing this issue are to improve regional and global public health and to propose defining Global Public Goods and Services as a management tool that provides a new approach to the discussion of resource allocation and the financing of certain strategic activities with international financial agencies.

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[1] Regarding the use of metaphors like the one mentioned, it could be said that the image of thinking globally has no other value than that of an equivocal, unreal metaphor: it presupposes an actor who thinks from a "non place" located who knows where and certainly nowhere.

[2] See for example, Musgrove, Richard and Musgrove, Peggy (1983). *Hacienda Pública: Teórica y Aplicada.* McGraw-Hill. Madrid. Fifth edition.

[3] For a detailed analysis of this situation see: Rodrigáñez Riccheri, Pilar and Tobar, Federico. Hacia un federalismo sanitario efectivo. El caso del Consejo Federal de Salud Argentino (CO.FE.SA.), análisis y propuestas. Buenos Aires. Ediciones Isalud. 2004.

This paper is an attempt to move forward with this analysis. To that end, it examines the notion of global public goods and services for health and reviews the requirements for their delivery. Several premises are then identified that could guide the work of the Pan American Health Organization in its role in the management and production of these goods.

Globalization and its Impact on Health

In 2003, the SARS epidemic claimed thousands of victims in China and caused economic losses estimated in the billions of dollars. Although the cases recorded in the West were very low, the deployment of public health efforts involved rich and poor countries around the world[4]. Not only were there mobilizations and states of alert at most international airports, but also at small border outposts like that of Quiaca, which links southern Bolivia with northern Argentina. Something similar occurred with the threat of anthrax terrorist attacks, generating such deployment that it succeeded in posing a threat to several health systems and brought their weaknesses to light before the press and public opinion.

The globalization process, which has been accelerating in recent decades, is having an impact on peoples' health[5]. **Globalization is changing the nature of health needs, as well as the types of interventions adequate for meeting them. In addition to local problems, communities in general and health systems in particular must now increasingly confront the international transfer of health risks[6].** This transfer is associated with global environmental changes, population movements, regular trade and the trade in harmful legal products (tobacco, alcohol) and illegal substance (drugs), as well as with the dissemination of new medical technologies.

New health threats linked to or accentuated by globalization manifest themselves not only through infectious disease, but also the spread of unhealthy lifestyles or risky behaviors. In some African countries, a growing number of women, rejecting their racial identity, subject themselves to hazardous treatments to lighten their skin and refine their features to satisfy a Caucasian aesthetic. This risks increasing the incidence of melanoma (currently the only disease more prevalent among the rich than the poor) and other injuries, since many of these procedures are not performed by trained professionals. Another example is that more than half of the movies made in the world depict violence and foster an arms cult. In the United States, 80 million people own firearms, and some 1,500 deaths are recorded annually from household accidents with these weapons, not including homicides or intentional crimes. The majority of public schools have caught students carrying arms. What will happen when this model spreads around the world?

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[4] No halfway serious evidence exists that this concerned a problem that did justice to the press that it mobilized.

[5] Although this statement is correct, it is necessary to point out that the same thing happened every time intensive civilizing contacts occurred and nothing has surpassed the strategy followed by Great Britain in Africa with regard to malaria, which was dealt with as a question of national security.

[6] Controlling the international transfer of hazards and their associated harm frequently exceeds the capacity of national governments to protect their people. A report by the Institute of Medicine in the United States says that the distinctions between domestic and international health problems are losing their usefulness and frequently cause confusion. (Institute of Medicine. America's vital interest in global health: protecting our people, enhancing our economy and advancing our interests. Washington D.C., National Academy Press, 1997.)

Until recently, we held that globalization did not affect health as long as the sick were nationals and therefore, the responsibility of a particular country[7]. However, today **it is clearly undeniable that some of the new health challenges require international responses[8].**

The Concept of Global Public Goods

In the framework of the opportunities and positive effects that globalization can bring, it is possible to identify Global Public Goods and Services, whose benefits extend beyond national borders. These involve public goods whose benefits should be available to all population groups, regardless of their economic status, ethnicity, culture, and gender and across several generations[9].

Since from a strictly economic standpoint there are few health goods that can be considered purely public, a definition and specific taxonomy is proposed, distinct from the definition used in economics.

Pure Public Goods[10]: These possess two fundamental qualities: there is no rivalry for their benefits when they are used and they are not exclusive. For example, when there is peace, all the citizens of a country can enjoy it, and its enjoyment by one group in a country does not diminish the benefit for other groups.

Impure Public Goods: By virtue of the fact that there are few exclusively public goods and most of them have mixed benefits, those goods that partially meet either or both of the definition's two criteria are called impure public goods.

Kaul, I; Grunberg, I; and Stern, M (2001:4) define **Global Public Goods** as outcomes (or intermediate products) that tend toward universality in the sense that they benefit all countries, peoples, and generations. At the very least, a global public good would meet the following criteria: its benefits extend to more than one group of countries and do not discriminate against any population group or any set of present or future generations.

In principle, these goods should be available to all population groups, rich or poor, even across generations. Several authors emphasize the instrumental role of equity and justice, to the extent that together they help in providing other public goods and in defining the demand for public goods and setting priorities--that is, determining which public goods should be provided preferentially. Thus, it can be stated that the attainment of peace, equity, and justice bring widely shared results and benefits that deserve global interventions and efforts. Another case is **the fight against poverty, which, though not in itself a global public good, can contribute to other global public goods, because its alleviation benefits not only the poor, but the rest of society, strengthening peace**

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[7] See for example: González García, G. and Tobar, F. *Salud para los Argentinos*. Buenos Aires. Ediciones Isalud. 2004. Page 27.

[8] It should be mentioned that, according to international relations theory, States respond to the *self-help* principle and international cooperation follows after this, being considered *second best*.

[9] One criticism that can plausibly be made of this concept is that regardless of these attributes the population group disappears. It vanishes into the nebula of Humanity. In this sense, the problems of everyone are the problems of no one and no State contributes to anybody, but instead to itself or with the idea of profiting in the short or long term.

[10] Kaul, I; Grunberg, I; and Stern, M. point out that the concept of Public Goods has its roots in 18th century scholarship; David Hume debated the difficulties inherent in taking preventive measures for the "common weal" in his *Treatise of Human Nature*, published in 1739. Some 30 years later, Adam Smith analyzed similar concerns in his work entitled *An Enquiry into the Nature and Causes of the Wealth of Nations*.

and stability, improving health and the efficiency of market mechanisms, and reducing environmental degradation[11].

The appropriate provision and management of public goods has been advocated as crucial to being able to respond to the changes in social and economic relations wrought by globalization.

Many public goods became global, which means they cannot be adequately provided through national policies and efforts and require some type of international cooperation to make them accessible locally[12]. A precise definition of these goods is fundamental for effective public policy in conditions of growing economic openness and interdependence among countries.

Public Health Goods and Services

A public good has two characteristics: there is no rivalry for its use and no possibility of excluding anyone from its benefits. Food hygiene, protection from environmental risks, fluoridation of the water supply, and public health in general are, from an economic standpoint, public goods. So is health research. It is possible to come up with criticisms relative to the nonexistence of pure public goods. If the concern is goods that ought to be, these are Kantian goods that "must be" as desirable and justifiable in and of themselves.

In health, there are few cases of pure public goods, but many of meritorious goods. This means goods whose consumption by some benefits or harms others[13]. Alternatively, in stricter terms, those that, although not perfectly fulfilling the principles of non-exclusion and non-rivalry, generate significant externalities. In health there are several examples, both of negative externalities (or costs), as in the case of pollution, as well as positive externalities (or benefits), for example vaccines (an immunized person not only generates usefulness for him or herself but also eliminates the risk of contagion to others, generating a beneficial external effect).

It has been demonstrated that the market is not efficient at providing public and meritorious goods and services[14]. The institutional response in this case is public provision or else subsidies or charity (depending on the type of health system in the country). It can be said that both pure public goods and meritorious ones do not follow the pareto efficiency law, with the result that their greater consumption can add usefulness or benefits without additional charges or payments.

The best-known public goods are associated with epidemiological and health surveillance, health promotion, and environmental measures to counter risk factors. Everyone benefits from actions such as health promotion and the prevention of chronic disease, the use of insecticides to fight vectors associated with communicable diseases, and from urban and environmental sanitation measures.

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[11] However, it is appropriate to point out that since MacNamara launched, from the World Bank, his global strategy to fight poverty, it has multiplied around the world.

[12] Kaul, I.; Conceição, P.; LeGoulven, K.; Mendoza, R. "Why do global public goods matter today?"; "How to Improve the Provision of Global Public Goods?" in: *Providing Global Public Goods- Managing Globalization*, Oxford University Press, Oxford: 2003.

[13] For an in-depth treatment of this idea, see p. 4: Collier, Paul. *The initiative on defining, monitoring and measuring social capital,* Washington D.C. World Bank Social Development-Family Environmentally and Socially Sustainable Development Network. Available at:
http://www.worldbank.org/poverty/scapital/wkrppr/sciwp4.pdf

[14] In 1963, a future winner of the Nobel Prize in Economics, Kenneth Arrow, on market failures, demonstrated that in health applying the laws of the market alone makes the sick and most disadvantaged groups even sicker and more vulnerable.

Global Public Health Goods and Services at the Regional Level

The conditions most conducive to generating and distributing public health goods and services are found at the regional and subregional scale. Along these lines, general integration and health integration processes are being consolidated throughout the Region: the Caribbean, Andean Region, and Southern Cone. Some 30 economic integration agreements and bilateral and multilateral policies with varied levels of development exist in the Region of the Americas. **The production of regional public health goods takes on greater importance, then, when considering it from a regional and subregional perspective.** That same production involves a responsibility that transcends the exclusive responsibility of the States.

Classification of Global Health Goods and Services

Pure Global Public Goods and Services	In addition to peace, equity, and justice, which, as we said, have a demonstrated impact on the health of the population; the fight against poverty; epidemiological and health surveillance; environmental measures against risk factors; prevention of communicable disease; water fluoridation; food protection...
Global Meritorious Goods and Services	Vaccines; essential drugs to treat communicable diseases; health research; new diagnostic and treatment technologies. In general, these meritorious goods are highly subsidized by the State and by virtue of the fact that their externalities transcend borders they could be subsidized by regional blocs, global funds, international NGOs.
Other Global Goods and Services	Technical cooperation in public health, international agreements as intermediate goods that produce end goods, control of the trade in legal and illegal products harmful to health...

From a broad perspective, global health goods could be considered pure public goods and services, in the economic sense, and meritorious and other types of goods and services whose benefits reach beyond national borders and should be available to all population groups, regardless of their economic status, ethnicity, culture, and gender, over generations.

The joint identification of global and regional public health goods opens the way to attaining greater benefits for all, greater effectiveness, and economies of scale through the design and implementation of joint interventions (production, dissemination, exchange of those goods and services) among several countries, civil society organizations, and international cooperation agencies.

Thus, globalization could be taken advantage of as an opportunity for attaining greater equity in the field of health[15].

It follows from the current debate on globalization's impact on health that practical ways need to be found to manage the provision of global and regional public health goods. The formulation and implementation of policies related to the provision and management of public goods implies a process in which public, state, private, national, nongovernmental, and transnational actors participate.

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[15] It seems necessary to point out that in practice, globalization has accentuated the inequities between rich and poor countries and has generated inequality within countries.

International Health

International public health is an area where it is possible to secure greater benefits for all, economies of scale, and greater effectiveness in health promotion and in fighting disease, by means of joint activities among several countries. Thus, globalization can be seen as an opportunity for the field of health. However, it can also pose a risk, since it is also associated with an increase in inequality between nations that are competitively integrated into the market and those that remain on the sidelines.

Global health actions, furthermore, can generate externalities for investors seeking advantages in new subregional economies, such as those of MERCOSUR, the Andean countries, and CARICOM. These new externalities are achieved when networks form between states, between areas in a single nation, universities, civil associations, nongovernmental organizations, and international agencies and the will to cooperate increases[16].

Thus, **health problems currently pose challenges, concerns, and actions that transcend national borders, that can be influenced by circumstances in different countries, and that are better served by cooperative processes**. This implies a reciprocal influence between health affairs and international relations and an approach from a broader, more comprehensive perspective, which should involve not only different disciplines, but also an analysis of national and international health determinants. Global health requires the efforts of governments and other organizations to produce health and guarantee it as a global public good.

In this regard, promoting and coordinating the efforts of different departments within a government, different governments, academic institutions, and civil society actors can be effective in combating disease, prolonging life, and promoting access to certain social goods and services that are now global.

Borders are not currently true barriers that could halt the progress of many of the diseases that afflict humanity. This leads to consideration of whether health is a right of citizens or humanity, which calls for a different commitment from governments and agencies.

Theodore W. Schultz, winner of the Nobel Prize in economics in 1979, incorporated the idea of human capital development as an asset for society, a building block in its ability to grow and compete. As part of this theory of human capital, health, together with other sectors, constitutes the idea of human security.

International or global health is a function that is becoming ever more important within the institutional designs of the State, both in the health sector and the ministries of foreign affairs. In this regard, international health could be included within the Essential Public Health Functions postulated by the Pan American Health Organization and, at the same time, a health perspective in the international relations field could be developed.

Although the health conditions of each country's populations are largely the result of national biopsychosocial and political processes, insofar as they are public goods, health and its production, above all in an environment of globalization, require a series of conditions that goes beyond the borders of the health sector and of countries. This is why it can be thought of as a global public good.

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[16] Contrary to this hypothesis, it can be pointed out that the proliferation of sick populations is a way for laboratories to obtain comparative advantages and the globalization of their markets.

However, as mentioned, there are few health goods and services that obey the two basic rules for being considered public goods. The majority of health goods and services are private or are impure public goods.

The best-known public goods for health are associated with epidemiological and health surveillance, health promotion, and environmental measures against risk factors. In this regard, everyone benefits from actions such as health promotion and disease prevention, the use of insecticides to fight vectors associated with communicable diseases, and with urban and environmental sanitation measures.

The case of vaccines is special, since they can be considered private goods that primarily serve individual needs; however, immunization coverage has greater positive collective effects than the sum of individual benefits[17]. The same reasoning can be applied to essential drugs that can have collective preventive effects, especially when used in the treatment of communicable diseases. Nevertheless, when their supply is limited, they can be considered impure public goods.

Since the spread of the human immunodeficiency virus (HIV) was detected in the early 1980s, new bacteria and viruses have been identified, many with the capacity to spread worldwide. For other well-known disease agents, poverty, overcrowding, and environmental degradation have created the conditions for epidemics in several countries of the Region, as in the case of dengue, and in other regions, such as the outbreak of plague in India in 1997. The acceleration of international trade has precipitated new epidemics, such as cholera in Latin America and bovine spongiform encephalopathy in Europe.

At the same time, drugs can lose their effectiveness when resistance develops, as is happening with tuberculosis and malaria.

Like communicable disease control, the control of environmental threats can be considered a global public good, since there is no doubt about the negative health effects of the shrinking ozone layer, global warming, and toxic waste disposal, all of them planetary ills.

Furthermore, with globalization, the control of some noncommunicable diseases, traditionally considered private goods, is developing markedly public characteristics--for example, the control of tobacco and illegal drugs. In fact, many behavior-related health risks are not strictly private, due to the powerful influence of advertising, as occurs with tobacco, where second-hand smoke causes problems in passive smokers. Something similar could be said of the control of illegal addictive substances; international production and distribution networks are clearly a "public evil" that must be combated.

In short, **due partly to globalization, health is increasingly becoming a global public good, since the strong international linkages in trade, migration, and information flows have speeded up international disease transmission and the transfer of behavioral and environmental health risks**. In addition, the growing pressure on collective world resources such as air and water has generated shared environmental threats.

According to Lincoln Chen, et al., globalization is not simply accelerating long-term trends but introducing contextual changes that are qualitatively and quantitatively different with regard to disease risks, vulnerability for health, and policy responses. In addition,

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[17] When the quantity available is sufficient to meet national or regional demand, vaccination can be considered a process in the provision of public goods, but when they are scarce, vaccines are impure public goods.

Jamison, Frenk, and Kaul in 1998 stated that **although the responsibility for health continues to be mainly national, health determinants and the means for fulfilling that responsibility are increasingly global.**

However, the economic and social importance of the activities carried out by the "health production complex"[18] makes the sector and health policies a privileged arena for linking cooperation processes among the Region's countries. Beyond the now-traditional types of cooperation, common public policies between countries can serve as a means for promoting integrated regional development of the health production complex, creating intersectoral conditions for economic growth and social well-being in the countries involved.

Beyond the provision of public goods, the current debate on globalization highlights the need for finding practical answers for how to manage this provision in today's world, which includes different types of actors. The global "public" includes national populations; non-state for-profit and not-for-profit transnational actors; and states that are in the international arena to influence markets, civil society, and governments.

Although the formulation and implementation of policies related to the provision and management of public goods is a process made up of all the aforementioned actors, there could be incompatibility between the inclusive, multifaceted nature of many global challenges and the exclusive, fragmented manner in which public policies are usually formulated and implemented. Lack of consensus over the process can often obstruct consensus and political action.[19]

Financing of Global Public Goods

At present, many of the challenges are more of an intersectoral than sectoral nature, while international cooperation is directed more to countries than to problems. This situation has implications for cooperation aimed at providing global public goods that require research and debate, new instruments, innovative political responses, and additional sources and methods of financing.

Several authors suggest that adequate financing of global public goods requires special means, for example, the creation of funds that stress these goods. Cook and Sachs propose the allocation of financing on a more regional basis in the main problem areas.

Furthermore, to the extent that financing global public goods represents an increase in expenditures, resources could be released by reducing perverse tax incentives or incentives that promote "public evils" (UNDP, Human Development Report, 1998). Examples include a world tax on carbon emissions or on international air travel (Chen, Evans, and Cash), or a fee charged to inventors applying for patents that would pay for a world knowledge bank (Stiglitz).

Toward a New Configuration of the State

The situation described in the previous paragraphs with regard to the comparative advantages for capital and for the preservation of global health poses the need for strengthening certain functions within the institutional design of the State. An effective State is indispensable for having the goods and services--and the standards and

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[18] Gadelha, Carlos Augusto G. "Complexo da Saúde - Estrutura, Dinâmica e Articulação da Política Industrial e Tecnológica com a Política de Saúde." UNICAMP, 2002, mimeo.
[19] Kaul, I. et al., idem.

institutions - that will enable markets to prosper and people to live healthier, happier lives. In its absence, sustainable development cannot be achieved on either the economic or social plane (World Bank, 1997).[20]

In this new approach, improving the health of the population is not just the exclusive responsibility of the State, but of a network of actors as much in the national territory (politicians, career public servants, NGOs), as the supranational (intergovernmental?) (international agencies, transnational solidarity organizations, as well as market agents).

The construction of this new State with the capacity to link interests and to regulate and model behavior is what is known as stewardship.

Ministries of Health should strengthen their institutional capacity to guarantee certain public goods that are determinants of regional health. Thus, international health functions should be optimized, identifying the competencies necessary for their improvement. This would imply strengthening the capacity of the Ministries of Health to provide certain intermediate public goods, such as international regimens that contribute to the provision of public goods for health at the global or regional level.

Furthermore, regional integration processes provide an excellent opportunity for countries to share lessons learned and regulations, harmonize standards linked to specific health goods, and develop rational training processes aimed at institution building in the Ministries of Health.

The Role of PAHO/WHO in the Management of Global Public Health Goods and Services

In current conditions with events speeding up, distances becoming shorter, and swift social transformation, a significant challenge is to resolve existing tensions between equity in health and social exclusion; to this end international cooperation can develop effective mechanisms for global health protection. In the specific case of PAHO/WHO, the Organization should promote and participate in the debate on financing methods, promoting consensus and joint negotiations for the procurement of these goods and services, for example, drugs and strategic health supplies.

a) **Analysis of PAHO's role in the regional management of global public health goods and services:** Identification and joint characterization (Member States–Secretariat) of which public goods that are regional health determinants are needed most by the countries of the Region and an assessment of trends, current production status, and provision of those goods and their potential contribution to the attainment of the Millennium Development Goals (MDGs).

b) **Knowledge as a global public good:**

The efficient production and equitable use of global knowledge require collective action. The challenge facing the international community is whether we can make our current system of government, of cooperation, work in favor of the collective interests of all (Joseph Stiglitz).[21]

One of the main functions of PAHO/WHO is to manage knowledge about health; in this area the Organization facilitates the achievement of cooperative objectives by providing

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[20] Paraphrase of original.
[21] Paraphrase of original.

high-quality, reliable information about health status, health surveillance, harmonization of norms and standards, best evidence-based practices, etc.

The global revolution in information and the life sciences can offer important new interventions that benefit health. PAHO/WHO could negotiate, jointly with the Member States, **the purchase and/or generation of health information and databases** and guarantee more equitable access to all Member States.

Support for the sufficient egalitarian production, transformation, and dissemination of information for countries and regional and subregional blocs can help guarantee the priority public goods.

Strategies to disseminate and improve access to information should be based on the common problems identified by the countries.

Support for research on public health and health investment in the Region and its relation to economic, social, and human development can contribute to the formulation and implementation of public health policies.

c) **Support for consensus-building and for negotiating and managing international health agreements** based on the principles of equity and solidarity, making health a fundamental civil right. In this regard, support for initiatives from the MERCOSUR, Andean, and Caribbean countries, as well as Meetings of Ministers of the Americas, is strategic.

d) **Joint negotiations for procuring drugs and other strategic health supplies and technologies.** PAHO/WHO should extend its support for these negotiations to the entire Region. The regional negotiations on the price of antiretrovirals show how starting with a strategy to improve access to information, a database was created that permitted economies of scales in order to guarantee goods such as antiretrovirals and diagnostic reagents.

e) **Support for conducting regional and subregional economic evaluation studies** (updatable estimates - monitoring) of the social cost and the cost of regional and subregional intervention for diseases such as HIV/AIDS, malaria, dengue, Chagas' disease, and tuberculosis. (It is necessary to estimate the regional gaps country by country, as well as the cost of controlling these types of diseases). Calculate the proportion of GDP lost annually as a result of selected public health problems. Estimate requirements for knowledge, health services (technologies, HR, financing), international support.

f) **Characterization of the strategies employed up to now for disease prevention and control** (characterize and disseminate best practices and also undertake more widespread external evaluation of national responses), **step-up of regional and subregional information and expert exchange, and planning of joint activities with the countries.** To this end, the extent of the selected public health problem needs to be better understood in each country.

g) **Definition of "priority countries" by types of regional public health problems:** Just as five priority countries were selected for their health situation and economic development, priority countries could be selected for malaria, tuberculosis, Chagas' disease, etc., These countries, with PAHO/WHO support, would interact more closely with each other in a joint review of the current situation, strategies employed, new interventions, etc.

h) **Strengthening of the capacities Ministry of Health technical teams in the countries to negotiate and seek international health agreements** and to identify when a country's available resources need to be optimized and when additional resources are

needed to guarantee a timely, adequate supply of public goods that are regional health determinants.

i) Strengthen health's contribution to the generation of peace and regional and subregional security: In this regard, regional exchange on intersectoral interventions for violence prevention should be stepped up (emphasizing modification of the principal health determinants: nutrition, education, housing, employment, environment), together with information exchange on mental health care models (primary mental health care).

j) Cooperate to identify regional and subregional health needs: Identify health needs and equity gaps between subregions or countries; promote the best use and the advantages associated with the production and use of cost-effective regional public goods, coordinating with other sectors; promote the lowering of trade barriers, creating incentives and credit and financing facilities; and monitor and evaluate the processes.

k) Coordination of regional and subregional health needs: This process can be implemented by: 1) encouraging banks to finance attention to regional health demands; 2) supporting the development of networks or common regulations to meet needs; 3) supporting intergovernmental efforts to jointly produce regional public goods, 4) facilitating reciprocity by guaranteeing foreign visitors or tourists the same health rights as residents concerning access to health goods and services.

Conclusions

In a rapidly globalizing world, people's well-being depends on striking a balance not only between public and private goods, but between national, regional, and global public goods and services. Therefore, it is fundamental to have a clear understanding of their meaning; as we have said, these goods are defined as outcomes that tend toward universality insofar as they benefit more than one group of countries and do not discriminate against any population group or present or future generations.

This poses certain concerns about these goods, given that there is no international equivalent to national government institutions. For example, how can their provision be guaranteed? Who sets priorities for the allocation of resources? Who determines whether global public goods are in fact accessible to all population groups? These issues require research and debate on which roads to take, and this document is an attempt to contribute to these discussions.

In order to find an answer to a fitting role for PAHO/WHO in this search, we believe it useful to consider another criterion for classifying global public goods: that is, according to the place they occupy in the chain of production; we will thus have end or intermediate global public goods.

End global public goods are outcomes more than goods as such and can be tangible (such as the environment or the common heritage of humanity), or intangible (such as peace or financial stability).

Intermediate global public goods, such as international regimens, contribute to the provision of end global public goods. The purpose of identifying these goods is to emphasize areas where an international public intervention might be required in order to provide a given global public good; for example, the Montreal Protocol agreements would constitute an intermediate global public good for achieving chlorofluorocarbon reduction to obtain an end good such as the integrity of the protective ozone layer.

Thus, we can regard international regimens and agreements as important intermediate global public goods, since they are the basis of many other intermediate goods with global public benefits; for example, in the case at hand, health and

environmental surveillance systems, the Alma-Ata agreements and the Ottawa Charter, international health cooperation programs, the mandates of global conferences and health-related presidential summits, as well as agreements for the joint procurement of strategic supplies.

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MODALITIES OF TECHNICAL COOPERATION IN HEALTH

Introduction

Over recent decades, globalization has posed challenges to a wide range of societies, primarily because of the closer relationships it has prompted between countries and regions. The globalized world in which we now live, with its high degree interdependence and links between countries and regions, not only has political, economic, trade, technological, and environmental repercussions, but social ramifications as well, stemming from such factors as burgeoning human migration across borders for any number of reasons.

In terms of social ramifications, these circumstances have created (and will continue to create) significant health challenges not only at the local and national levels—where the capacity of the State to cope with these challenges and protect the population is often insufficient—but at the regional and global levels as well. One such example is the concern over the rise in certain diseases, as well as the emergence and reemergence of other communicable diseases.

Within this context, continued improvement in sustainable human development indices will call for consolidating efforts at the national, regional, hemispheric, and global levels to address and resolve situations that have resulted from these new trends and their serious impact on health.

The Pan American Health Organization (PAHO), as a specialized public health agency, must continue its role in providing technical cooperation. For more than a century, PAHO has been intimately involved in this area at the hemispheric level through its promotion and coordination of the *"efforts of the countries of the Western Hemisphere to combat disease, lengthen life, and promote the physical and mental health of the people."*[1]

PAHO must continue to support and assist the countries of the Hemisphere in improving health and health surveillance by establishing and strengthening a culture that values people's lives and health, supporting the creation of optimal environments and living conditions for offering greater opportunities, monitoring environmental conditions to control against risks and threats to public health, and supporting or strengthening optimal, effective, and timely mechanisms that respond to needs and demands as they arise.

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[1] Constitution of the Pan American Health Organization, 2001, Chapter I, Article 1.

In light of its important role, and to strengthen its capacity to adapt to changing circumstances, PAHO has initiated a process of reflection for organizational renewal aimed at more effectively and efficiently serving the interests of its member states.

To ensure that this renewal is suited to the changes and challenges ahead, the process must include a series of factors and actors that have played a powerful and significant role in a complex and interdependent scenario in which the State—which designs, implements, and evaluates both domestic policies and those promoted in the various international health forums—remains a *key* actor, but no longer the *only* actor. The current situation obliges us to consider the many public and private actors that have become involved in the field of international health.

In order to improve PAHO's structure and procedures and adapt to the changes and challenges produced by the changes mentioned above, it is necessary to undertake a prospective analysis of technical cooperation in health, seen from different perspectives. These include:

- Innovation and new modalities of hemispheric cooperation

- Country cooperation strategies

- Addressing the gaps between current and future aims in health, and

- Contracting, assigning, and adapting the workforce at PAHO Headquarters and the Representative Offices.

1.   Innovation and New Modalities of Hemispheric Cooperation

- To promote effective and timely action, PAHO must become more flexible to continually adapt to changes in the national and international environment. The global socioeconomic, environmental, and political scenarios have varied substantially.

- In recent years, many countries have improved their ability to solve their own problems, which means that they are ever-more demanding in terms of the quality, quantity, and duration of technical cooperation. In contrast, social and health conditions in many countries, rather than improving, have worsened.

- One of the principal challenges of this new international and regional context for PAHO is to strengthen its participation as an active partner in the technical cooperation process with the countries, and to promote cooperation among the countries themselves.

- The concept of **mutual collaboration or cooperation** must be fostered. We all have something to give or to offer, but everyone needs something as well.

- To take advantage of the immense range of public and private actors that have become involved in international health in recent years (academia, international agencies, foundations, etc.), and to heighten the impact and improve the quality of the benefits obtainable for our countries, PAHO should **seek support for countries or provide them with that support to search for strategic partnerships** with key entities or institutions (not necessarily governmental or intraregional). This would complement or even strengthen technical cooperation, to the benefit of the countries of the Hemisphere.

- PAHO could also **help and support countries in identifying, building, and developing their own capacity and strengths**, referred to as "best practices," and serve as a mechanism for promoting collaboration among countries. This will move the Organization away from a position of providing unilateral cooperation to one of supporting the promotion of these "best practices" among the countries themselves.

- In this way, with support from PAHO, the countries can become not only receivers or beneficiaries of cooperation, but also providers of it and role models for others in areas in which they have been identified as having greater strength or success.

- Gross domestic product (GDP) should no longer be used as one of the mechanisms for **classifying or measuring the well-being of countries**, since it lacks objectivity. Similarly, use of a single classification category (literacy rates, standard of living, maternal or infant mortality indices) should be avoided.

- Traditional methods of **grouping countries**, such as geography, neither represent nor reflect uniformity in terms of the realities or needs of the countries. Despite being part of a single region or subregion, different countries can have different, even abysmal, levels of well-being, which means that their needs may vary greatly as well.

- This heterogeneity makes it necessary to classify countries in terms of different variables, competencies, and needs, and to avoid using a single variable, since each country may be

ahead or behind in a given area, and each has its own needs or challenges, which may be different from or unrelated to the region or subregion to which it pertains.

- As a basis for identifying the extent to which countries have progressed in health, countries and their indicators could be classified on the basis of:

  o The progress made toward meeting the Millennium Development Goals, particularly those related to the health sector
  o Essential Public Health Functions (EPHF)
  o Most vulnerable groups (female heads of household, at-risk children and adolescents, the elderly, indigenous or Afro-Caribbean populations, etc.)
  o Ethnic-cultural origin
  o Groups of countries with weak health sector institutions
  o Groups of countries according to their national budgets for the health sector
  o The quality of the countries' human resources
  o The countries' research capacity.

- At the regional level, it is recommended that other classification elements or topics be included **that match countries and their technical capabilities,** so that successful experiences and best practices can be melded into "networks" (by topic or problem). This will strengthen teamwork, with more regional and sustainable approaches that extend beyond the term of any particular political administration.

- PAHO could provide major support and guidance to the countries in forming these networks and in developing the capacity to put together technical proposals that have strong approaches to particular problems and are specific to the region or country.

- Technical networks backed by PAHO that issue specific recommendations to the countries can greatly facilitate and support the efforts and policies of governments, which in the end are those responsible for decision-making and with whom it is therefore necessary to maintain strong ties. In the future, these networks could perhaps come to serve as authorities on various issues and be recognized as such by the countries and the region.

2. Country Cooperation Strategy

- By evaluating the health situation in each of the different countries, the cooperation strategy could **help to satisfactorily define and plan the cooperation provided by PAHO.**

- The strategy would **help the countries undertake an internal analysis** of their health challenges, weaknesses, needs, trends, critical events, and opportunities, as well as the strengths and adequacy of their national responses or contributions.

- In addition to making it possible to learn about the various country situations, an analysis of this type would facilitate, within the framework of a country's health situation as defined, better allocation or channeling of resources not only from PAHO but from other technical or financial cooperation actors or entities, hemispheric or otherwise.

- The design of the country cooperation strategy should be based upon and take into account the health policies and plans established by each government, which means that the strategy should be developed in close cooperation with the government, and at no time apart from it.

- This exercise can allow for a **broad and profound internal examination** that should include active participation and input from partnerships between the various technical groups involved in health at the country level: government, academia, civil society, development agencies, etc.

- The exercise will give PAHO a better understanding of the particular situation of each country.

- It would be especially useful **to define and target cooperation** toward areas identified as having greater weaknesses and needs, and to come up with solutions pertinent to the contexts of each country, avoiding the direction of efforts toward areas that are already advanced.

- In addition to determining countries' internal weaknesses towards which cooperation should be channeled, the strategies also can serve as an instrument **for defining or identifying the areas where countries are stronger,** or where there could be potential for their own cooperation—in other words, the strategies could help identify the countries' best practices.

3. Addressing the Gaps between Current and Future Aims

- In order to address new challenges or changing situations, it is critically important to visualize:

    o **Where** the country wishes to go
    o **With** what tools
    o **What** needs to happen
    o **Who** will participate, and
    o **What** mechanisms would be the most appropriate to meet the goal.

- There are topics that PAHO traditionally has not addressed in sufficient depth or with sufficient consistency at the individual country level. An example might be economic analysis of public health strategies. Given current trends, it is urgent that such analyses become part of organizational policy. Another example might be the issue of integrated information systems to define public policies and evaluate the effectiveness and efficacy of programs and activities.

- To **give greater impetus and comprehensiveness to the countries' health sectors,** discussions and definitions of health-related topics perhaps must gradually include not only academic and research institutions, civil society organizations, and the media (which provide substantial help with health promotion and disease prevention by fostering behavioral and attitudinal changes), but also Ministries of Economy, Environment, Planning, Education, and even Culture. Including these entities will promote greater sensitivity and awareness of health topics.

- Taking these other determinants and disciplines into account can help to achieve a more integrated concept of health that can promote greater and true sustainable development.

- It is important **that the countries define the role** of their Ministries of Health and health sector institutions, as well as other entities involved, in the monitoring and follow-up evaluations of health system policies and performance in the context of relevant issues such as state reform process and technological change.

- The authorities directly or indirectly involved in health must be provided with the conceptual, methodological, instrumental, and technological frameworks necessary to monitor ongoing or planned policies and actions.

- To achieve all of the above, it is essential to develop human resources for the health sector in order to effectively adapt to the changes already under way, as well as those envisaged in the future.

4. Contracting, Assigning, and Adapting the Workforce at PAHO Headquarters and Representative Offices

- **PAHO Headquarters personnel** should be distributed in a way that better responds to the geographical and epidemiological diversity that PAHO represents at the regional level. It is necessary to seek a balance.

- It is sometimes perceived that in the process of contracting Headquarters staff, there is insufficient consideration of their degree of knowledge about the situation at the country level. Staff at Headquarters either lack or lose a sense of the distinctive needs and characteristics of the different countries. This can result in actions based on an erroneous or altogether mistaken perspective.

- The **profile of the people assigned to the Representative Offices,** as well as their training and experience, should be strictly consistent with the health needs, problems, and challenges identified and prioritized by the countries themselves. In other words, personnel in the Representative Offices must accommodate to the host countries' needs and interests as previously identified in coordination with the PAHO Representative Office.

- In addition to the previously identified needs and interests of the host countries, the existing local technical capacity in the countries, which can vary substantially, must be considered when assigning specialized personnel to the Representative Offices.

- The bulleted items above show that the staffing needs of each Representative Office should in no way be addressed through a "one size fits all" approach, but rather by using standards adapted to each particular country.

- It is important to seek the type of quality and effective personnel that the countries need. Given the diversity and complexity of the issues to be addressed, it is necessary to avoid teams assembled by a small group of countries, which rely in turn on another small group of consultants, whose contributions are often of a general nature, with superficial analyses.

- It is critical that, regardless of the length of their assignment, Headquarters staff or consultants who arrive in the countries be clear that they are going to work and coordinate with local human resources. What must be avoided at all costs are **problems that undermine cooperation** and joint efforts, such as situations in which staff or consultants impose their work or point of view, or underestimate the local technical capacity of the host countries.

- To head off such situations, it is critical to have a clearly identified and well-prepared counterpart. If there is none, encouraging the creation of such counterparts in the country or institution involved is critical. PAHO can play an important role in making this happen.

- The **manner in which staff in the Representative Office are assigned** should be more democratic and inclusive. One way to achieve this might be to submit requests for short lists to technical groups and institutions, and then select personnel from those lists. During the process, it is very important not to allow political factors or interests to underestimate existing technical competencies and experience or preclude their selection.

- The **identification of human resource "competencies"**—understood as the skills, attributes, and behavior closely related to successful performance of the work of the national and international personnel assigned—as well as ongoing evaluation of such competencies--can support the process of contracting, assigning and adapting the workforce in both the Representative Offices and specialized PAHO centers.

- A permanent evaluation system could be established to **supervise contracted personnel,** particularly short- and medium-term consultants, **and to ensure that they are accountable** for the tasks to which they are assigned. The evaluation would include a survey to assess the performance of all the individuals and agencies—and not just government entities—involved in work associated with the Representative Office.

- Systems to evaluate performance and to supervise contracted personnel, particularly short- and medium-term consultants, are fundamental to achieving the established goals and objectives. To the extent that the expected or desired results are clearly spelled out to these personnel, they will be properly supervised and accountable for the work that they do.

- Beyond the evaluation and supervision of the contracted personnel, however, it is also critically important to establish efficient mechanisms to **evaluate, supervise, and monitor the activities supported or carried out** by both internal and external human resources.

Our countries are increasingly exposed to changes in the environment in which they operate, which is why they should try to reconcile the interests of globalization and the consequences of such complex interdependence with sustainable development.

In conclusion, PAHO must maintain its leadership in the Hemisphere in order to collaborate with the countries and support their efforts to tackle the health challenges stemming from globalization—challenges not only within the countries themselves, but also at the international level.

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"GOVERNANCE OF PAHO"

A PAPER

PREPARED FOR

THE WORKING GROUP OF THE EXECUTIVE COMMITTEE

ON

PAHO IN THE 21ST CENTURY

BY THE

GOVERNMENT OF BARBADOS

AUGUST 2004

I.INTRODUCTION

A Working Group of the Executive Committee on PAHO in the 21st century was established pursuant to resolution CD44.R14 of the 44th Directing Council Meeting.

This working group's reform initiatives were to cover every aspect of PAHO's operations with emphasis being placed on the following Terms of Reference:

- Challenges in public health in the Americas for the coming years.
- Evolving nature of partnerships and alliances in international development in health pertinent to PAHO's role.
- Regional and Global public Health goods in the 21st century and their relationship with PAHO's mandate.
- Modalities of technical cooperation in health.
- Governance of PAHO.
- Resources for Health.

This paper focuses on "The Governance of PAHO," which is Barbados' remit in the Working Group of the Executive Committee on PAHO in the 21st Century and will be centred on three main categories relevant to the governance of PAHO:

1. Structure and governing bodies
2. Function
3. Process with regards to relationship with stakeholders

II.OVERVIEW OF THE PAN AMERICAN HEALTH ORGANIZATION

The Pan American Health Organization (PAHO) is an international public health agency that functions as the hemispheric arm of the United Nations' World Health Organisation for the Region of the Americas, and as the health organization of the inter-American system. It provides technical support to member countries and stimulating cooperation among them in the areas of research, information management, health equipment and supplies, mobilisation of resources, policy development, development of health services, and training.

From its inception the Pan American Sanitary Bureau (PASB) focused strongly on cooperation. Article 59 of the Sanitary Code states:

> "Upon request of the sanitary authorities of any of the signatory governments, the PASB is authorized to take the necessary preparatory steps to bring about an exchange of professors, medical and health officers, experts or advisers in public health of any of the sanitary sciences, for the purpose of mutual aid and advancement in the protection of the public health of the signatory governments."

The principal goal of PAHO's technical cooperation is to promote self reliance in the development of its Member States through the building of

the countries national capacity. This involves countries collaborating among themselves with multilateral and bilateral support or directly with the international community as equal partners to define and achieve their health goals through activities that are determined by the countries needs and priorities. PAHO's mission in the Americas is to lead strategic collaborative efforts among member states and other partners to promote equity in health, to combat diseases and to improve the quality of and lengthen the lives of the people. To achieve this, it coordinates its efforts with the Health Authorities of its Member States, other International Agencies, other Governments and the Civil Society Community.

III. GOVERNANCE OF PAHO

Organizational governance may be understood in two dimensions. The first refers to the means through which authority is exercised in the management of the organizational resources; where issues of participation, legitimacy, accountability and transparency are essential.

The second refers to the ability to discharge functions effectively, efficiently and equitably through the design, formulation and implementation of policies, which is an act of protection and enhancement of the Organization. In general, governance can be understood as the structure and processes of policy and decision making that involves both the internal and the external actors and stakeholders.

In relation to PAHO, with reference to the aforementioned dimensions, the first refers to the Constitution of PAHO (legal framework and regulations) as it relates to its capacity to promote and guide policy in the interest of the Member States. PAHO governance is exercised through its Governing Bodies: the Pan American Sanitary Conference which is composed of all thirty-five Member Governments, the Directing Council which is also composed of all the Member Governments, and the Executive Committee of the Directing Council, which is comprised of only nine of the Member Government.

The second dimension, although overlapping with the first is more directly related to the Pan American Sanitary Bureau or the Secretariat of PAHO. This dimension of PAHO's governance refers to the protection and enhancement of the Organization on behalf of the Member States. This is expressed through the managerial process (planning, programming, budget approval and execution), while emphasizing accountability, performance and efficiency in processes and in staff development and appraisal. Being centred on the ability to discharge functions effectively, efficiently and equitably through the design, formulation and implementation of policies links PAHO's organizational development to governance in this case.

Functions of the Governing Bodies

PAHO's Governing Bodies Sessions can be viewed as an international service facility for the Member Governments. The sessions provide an arena in which Member States can meet, share experience, and negotiate

international agreements that require operational follow-up action. They also serve as a forum for the interchange of information and ideas as well as a communication medium for the Member States to coordinate activities, which require cooperation for the advancement of health and development in the Western Hemisphere.

The Member States through the Pan American Sanitary Conference and the Directing Council are responsible for reviewing the annual reports of the Executive Committee, assessing the countries budgetary quota contributions, as well as reviewing and approving the biennial programme and budget of the Organization.

The Director of the Bureau is elected by the Conference and if necessary the Council can elect an interim Director. The Conference meets every five years at the Headquarters of the Organization on a date fixed by the Director of the Bureau through Consultation with the Executive Committee. The Council meets once each year in those years in which the Conference does not meet.

The Executive Committee approves the provisional agenda of the Conference and Council Meetings, considers and submits the proposed programme and budget prepared by the Bureau's Director with any recommendations as it deems advisable to the Conference and Council. In addition, the Committee advises the Conference and Council of matters referred to it by those bodies or on its own initiative on other matters relating to the activities of the Conference, Council or the Bureau. Two regular meetings of the Executive Committee are held every year. One of these meetings is held immediately following the Council or the Conference meeting. Special meetings are held when convoked by the Director of the Bureau, either on his/her own initiative or upon request of at least three Member governments.

Unlike the Conference and the Council, which comprise representatives from all the Member States, the Executive Committee comprises only nine elected representatives from the Member States who are entrusted to discharge the above functions combined with making certain decisions on matters relating to the activities of the other governing bodies and the Secretariat. Governments not represented on the Committee, at their own expense can send observers who can participate without vote. This arrangement implies that the Executive Committee can make decisions without the input of all the Member States.

With regards to the Secretariat, the Director of the Bureau can restructure and organize the offices, divisions and sections of Headquarters, the Field Offices and PAHO centres as he/she deemed necessary for the execution of the programme of health activities authorized by the Organization. The Director also establishes financial rules, including guidelines and limits for implementation of these regulations, to ensure effective financial administration. The Director also creates the Strategic Plan and other guiding documents and policies for the bureau to carry out its functions. The aforementioned activities can be designed and implemented with or without the Member States participation or in some instances with the

participation of a selected number of Member States. Consequently, this may create communication problems between the Bureau's administration and the Member States, especially when the governments are not involved.

The provisional agenda and all working documents relating to the Conference or Council are prepared by the Director and are sent to the Members, Associate Members, and Observer States at least 30 days prior to the opening of a session. Copies are sent to the Director General of the World Health Organization.

Similarly, the Director of PASB prepares the Provisional Agenda of the Executive Committee. The provisional agenda and all working documents relating to the Committee are sent to the Members, Associate Members, and Observer States at least 21 days prior to the opening of a session.

For the good governance of PAHO, the Member States are responsible for ensuring that the Organization expresses their collective will to improve health in the Americas. In order to achieve this, the Member Governments allocate funds to the Organization and set health priorities at the national and regional levels that are reflected in PAHO's technical cooperation budget and programmes. In addition, the Member States assist with the management of PAHO's work in the countries and provide sound support and commitment to PAHO in general, for the fulfilment of the Organization's mission, mandate and goals.

Equally, the Organization must also assist the Member States in manifesting their collective will by executing the duties and functions specified in the Pan American Sanitary Code, and those assigned to it in the future by the Pan American Sanitary Conference or the Directing Council. To this end, PAHO must work closely with countries and governments to strengthen national capacities and to formulate and implement programmes. To achieve this objective, the Country Offices have a crucial role to play, and are therefore, central to PAHO's mission.

PAHO Country Offices must become the focal point for PAHO support to governments. In this capacity, the Country Offices must help countries to define and achieve their health goals, and to adopt and adhere to international health norms and standards. This includes supporting health authorities in their responsibilities for the formulation of national health policies to promote and sustain their national processes.

Along with the aforementioned, the Country Offices must also assist the Member States with planning and managing cooperative activities in the countries, with coordinating health matter within the countries and with external partners along with rationalizing the use of, and mobilizing, available resources.

Transitional Governance of PAHO

Initial Governance – First 40-50 years

During the first part of the 20th century, the state of public health was described in terms of the presence or absence of diseases, and thus preventing, controlling and in some instances eradicating diseases was the major thrust and primary focus of PAHO's programme of technical cooperation with the countries of the region. The Organization's principal remits was to receive reports on health conditions in the ports and territories of countries in the Western Hemisphere. The driving force behind this new impetus on health by the organization was trade and commerce, as diseases were being transmitted while the countries trade goods and services and as people travelled across borders.

The resources that were available to the Pan American Sanitary Bureau at its outset were meagre, the organizational had a small budget and the Staff was small and sometimes shared as there were no permanent posts. Travelling representatives throughout the 1920s performed most of the Bureau's work. The Pan American Sanitary Code, which was drafted in Havana in 1924, firmly established the quintessential role of the Bureau as the clearinghouse for regional health information.

Governance – Next 30-40 years

From the latter half of the 20th century, the thrust of the work of the Pan American Health Organization widened from its initial emphasis on infectious diseases to chronic non-communicable diseases and the development of health services to promote health and social development of its Member Countries. Trade and humanitarianism were the driving force behind this new emphasis on health, and PAHO's work was centred firstly on technical assistance to the countries but this soon changed to facilitating technical cooperation with and among the Member States.

The Directing Council at its first Meeting in 1947 adopted the Constitution of PAHO and this officially formalised the actions and operation of the organization. The Organizational structure was in place, which led to the development of effective policy making and planning as well as the formulation of health programmes, allocation of resources and the investment of funds on a rational basis. There was greater political involvement in the Organization through careful appointment of representatives to the governing bodies and the allocation of funds by Member Governments. The Ministers of Health also increased their involvement in the Organization by setting health priorities, participating in the governing bodies and other events and supporting PAHO's work in the countries.

There was also the establishment of special technical services to study public health problems, the Organization of national health activities, and the creation of urban and rural health units staffed with trained full-time health workers as the agency increased its country presence in its Member States.

Around the same time, the World Health Organization's (WHO) Constitution was adopted in New York in 1946 and entered into force on 7th April 1948. As a result, a modern understanding of health emerged and the concept of health was modified to adequately address new challenges facing health and subsequently, the World Health Organization [WHO] redefined health in its constitution as a state of complete physical, mental and social well-being and not the mere absence of disease and infirmity.

On the 30th of June 1949, an agreement between the WHO and PAHO was approved by the second World Health Assembly under Chapter XI of the Constitution of WHO. Article 2 of that agreement stated that *"the Pan American Sanitary Conference, through the Directing Council of the Pan American Sanitary Organization and the Pan American Sanitary Bureau should serve, respectively, as the Regional Committee and the Regional Office of the World Health Organization for the Western Hemisphere."*

Under this agreement, PAHO's retained its original constitution but adopted the Constitution of the WHO as well. The Pan American Sanitary Conference as the supreme governing body of PAHO could still adopt and promote health and sanitary conventions and programmes in the Western Hemisphere, provided that such conventions and programmes are compatible with the policy and programmes of the WHO and are financed separately.

In accordance with the provision of the Constitution of WHO and the agreement, the Director- General of WHO was to receive from the Director of the Pan American Sanitary Bureau, full information regarding the administration and operations of the Bureau. The Director of the PASB is also expected to submit the Bureau's annual budget estimates to the Director- General of WHO for consideration in the preparation of the annual budget estimates of WHO. A proportion of the budget of the WHO was allocated to PASB and the funds allocated to the PASB under the budget of WHO, were to be managed in accordance with the financial policies and procedures of WHO.

Governance – Past 20 years and into the future

Globalisation has become a major driving force in development, but it can have positive and/or negative consequences within and among countries. The phenomenon has the potential to adversely affect health worldwide and may jeopardize hard won improvements and gains in health, life expectancy and standard of living along with posing one of the greatest threats to global security.

Major concerns for health at national, regional and global levels includes the spread of new and emerging infectious diseases, besides the movement of diseases, the transport and distribution of vectors, contaminated food stuff, legal and banned toxic substances, pollutants and other health hazards are being transferred. There is an increasing prevalence of chronic non-communicable diseases, along with an escalation in violence, war and accidents, new threats such as bio-

terrorism, and other man made hazards as well as natural disasters. Migration of people and health workers is also further compounding the health situation.

To this end, globalisation has resulted in governments being no longer the sole agents acting in the global health arena. Health is increasingly being recognised as a global public good. There is currently a more holistic sense of the social nature of health and now that it is seen as a social product, there is no longer one entity that is exclusively responsible for producing health. Beyond national programmes, the global health field now includes new partnerships for technical cooperation including the private sector, civil society organizations, the multilateral sector, regional development banks, regional integration and political institutions, and various bilateral players.

Of all the new approaches being used to promote health in the globalization era, civil society partnerships, whether operating for profit or for humanitarian purposes has attracted the greatest attention. The impact of globalisation on health has motivated Civil Society Organizations (CSO) to new actions including health service delivery and renewed advocacy for basic health rights and access to health resources. Civil society organization activities have increased as a response to their perceived weakening of the national authorities under globalisation and the increasing strength of trans-national corporations. CSO networks now comprise non-governmental organizations, community groups, private foundations and humanitarian organizations, which have formed within and across countries to promote a wider and more trans-national support of public interests on global policy issues such as human rights, environmental concerns, debt relief, socio-economic development, and health.

Civil Society work has become more prominent due to increased public awareness and concern over the rights of citizens to participate in policies and processes that impact on global health. This is now combined with the growing demand for improved public accountability and responsiveness to citizens by governments. The growing role of civil society in development processes is not simply a response to political lobbies or to an increased scale of organization; but represents a shift in the understanding of development processes and the fulfilment of human development being dependent on concerted efforts of the state, together with citizens and their organizations in meeting the challenges of globalisation.

In Latin America and the Caribbean, the Regional Integration Blocs that were strengthened as countries responded to globalisation, has generated new demands for technical cooperation from PAHO and other multilateral and bilateral agencies. Some of the demands stem from new challenges that can be addressed through conventional cooperation among individual countries, while others require collective support from countries engaged in consensus building and the development of supranational policies and instruments.

This induction of new partners into technical cooperation processes for health has impacted on all parties involved and has broaden the predominantly economic and technological focus of technical cooperation in health to include issues of governance, health and human rights.

IV. A CONTINUED NEED FOR PAHO IN THE 21ST CENTURY

In the past, PAHO was the most significant multilateral partner that the Countries of the Americas allied with in relation to technical cooperation in health. However, in recent times due to the inter-sectoral nature of health and the impetus given to health and its relation to socio-economic development of countries at all levels, there has been an upsurge in the amount of national, regional and global stakeholders in Health in the Region.

Despite this high influx of new partners in health, international organizations like PAHO that provides technical support to countries still have an important role to play, as it is not just Member Governments that need strong technical guidance, but also the partners who are assisting the countries.

PAHO as an agency that renders technical support to countries, now have to institute a changing role and act as a broker in the new international cooperation arena. This changing role has already been manifested when civil society organizations in defining their agendas, seek the knowledge and experience of PAHO and their Member Governments in developing priority funding projects and programmes. As a result, PAHO has to sharpen its focus to concentrate resources where they will do the most good and to avoid duplication of effort, by setting criteria for its involvement in specific health issues, given the large number of players in the health field. It must continue to show leadership and coordinative capacity, which will help to rationalize the distribution of work between the various partners for more harmonious technical cooperation alliance. Within these new types of partnerships; resources mobilization, sharing of knowledge, technology and expertise, networking, planning, testing and evaluation must continue to be important functions of PAHO and its Member States' work.

Challenges for PAHO/WHO

A concerted effort for health and development, managed by PAHO will be a mechanism for the stakeholders in the Americas to meet the challenges and benefits from the opportunities of globalisation. Globalisation and public health challenges will result in the international community increasingly cooperating as it becomes more evident that different policy areas cannot be handled independently of each other.

PASB and its Member Governments must work towards enhancing and strengthening their collaboration and cooperation, with a view to fostering an enabling environment for partnerships for the implementation of global, regional and national mandates, developmental programmes and health projects.

Both PAHO and the Member Governments must develop systems for greater transparency and to improve their accountability. The effective coordination of health initiatives will include strengthening global partnerships and national health systems and ensuring that there is coherence between all the national, regional and global strategies and cooperation efforts. Well-coordinated technical cooperation administered by PAHO will be essential for countries to operate effectively and efficiently, since a fragmented regional health landscape will lead to duplication of efforts, increased wastage, inefficiency, combined with a regional failure to achieve the global targets and the inability to overcome the preceding challenges, which globalisation can place on health in the Western Hemisphere.

Consequently, for multilateral agencies like PAHO to fulfil their mandates and constitutional roles to their Member Governments and react effectively to the challenges of globalisation along with the changing needs and expectations of the Member States, there must be an organizational reform; which includes changes in governance, budgeting, resources allocation and negotiation processes within the organization.

There must also be an increased coordinated role for civil society organizations and a clearer definition of the appropriate role of the private sector concomitant with seeking out non traditional alliances and building partnerships of a reciprocal relationship nature that involves shared values, priorities, accountability and transparency. Thus the governance of PAHO must be critically assessed to give the organization direction and leadership capacity in the 21st century.

V. ISSUES

In keeping with the specific issues identified to be addressed under the Terms of Reference for "Governance of PAHO," the following suggestions were made in relation to each of the specific issues.

A. Structure and Governing Bodies

Specific Issue 1: Improve communication within governing bodies and amongst Member States.

Governing Bodies

With reference to communication within governing bodies and amongst Member States, the following suggestions are provided:

1. There must be timely sharing of information before and after sessions by the elected members of the Executive Committee with the other Member Governments as well as a feedback and feed-forward mechanism to solicit the other Member States' Comments, recommendation and suggestions on activities going before the Committee. This will ensure a broad input and greater involvement of all the Member States in the activities and functions of the Executive Committee.

2. Feed-forward and feedback mechanisms must be created for improved communication among the Bureau, Country Offices and Member Governments. This could take the form of the Bureau, PAHO Country Offices or Member Governments facilitating periodic sub-regional caucuses for reviewing, monitoring and evaluating programme of activities and management decisions. In order to accomplish this, Country Offices must ensure that delegations from countries are fully briefed on issues well in advance.

3. A Caucus meeting system may also have to be established for the Member States to meet prior to the start of sessions of the Conference, Council or the Bureau. This will provide time for preparing new items for discussion at the Conference, Council or the Bureau that may not be on the meetings' agendas and set up a medium to prepare, inform and reach consensus with all stakeholders on proposed issues to be included or addressed at the various Governing Bodies Meetings and Sessions.

4. The above approaches and mechanisms could also facilitate input from all the Member States into the different Working Groups of the Executive Committee and the various Task Forces established occasionally by the Pan American Sanitary Bureau to address pertinent issues related to the Bureau and the governance of the organization in general.

5. PAHO must ensure that it provides all policy documents along with records of management decisions and resolutions of Governing Bodies sessions via the internet in a timelier manner for rapid and easy access by users inside and outside the Organization

6. The Regional Integration Organizations of the different Sub-regions could also be represented at the sessions of the Executive Committee to channel and disseminate all the information and correspondence of the Executive Committee's sessions to non-elected or non-represented government from their political bloc. Thus these institutions could serve the Executive Committee and its several Task Force and Working Groups as a clearinghouse for the Member States.

7. Member States need to participate more in the Secretariat's agenda, with more of a bottom up approach in policy, planning and decision making activities. In instances were the bottom up approach is not feasible, involve the Member States in the design and implementation phase of policies, plans and programmes being design and implemented by the Secretariat. The Director of the Bureau must involve all the Member States in the operations of the Secretariat either through dialogue or through their active participation in the Bureau activities, similarly to what is now being done for the "PAHO in the 21st Century" assignment. In addition, it would be helpful if the Secretariat consults with Member States in the development of governing bodies' papers so that these documents reflect the interests, concerns and suggestions of the countries.

One of the major priorities for the twenty-first century for international agencies is to strengthen partnerships for health that bring together actors from the public and private sectors along with others stakeholders who have an interest in health, to work in concert towards the common goal of improving the health of populations in the most economical manner. In forging global partnerships with the civil society and recognising their contribution to technical cooperation and health development in countries, some non governmental organizations were given observer status in international organizations along with privileges to participate in technical meetings and forums. However, taking into consideration the challenges to come, a renewal process must be implemented on behalf of the civil society to promote their fullest participation in the design, implementation and evaluation of the policies and programmes of international agencies.

8. The Constitution of PAHO may have to be amended and provision made for the inclusion and active participation of the Civil Society Partners into the Governing Bodies of PAHO. These partners can be given Associate Membership with the rights and obligations attached to this rank. There will also have to be a rotation system similar to that of the Executive Committee so that the numerous and diverse actors of the Civil Society (donor, humanitarian aid, service providers, etc.) are equitably and transparently represented and accommodated into the Sessions of the Governing Bodies. However, accreditation, monitoring and evaluation of Civil Society Organizations and their activities will have to be carried-out periodically using criteria established by PAHO, the Member States and perhaps a Civil Society Association or Civil Society Accrediting Board, which may have to be established for this specific purpose.

9. Similarly, due to the holistic nature of health and the recent relationships formed in health such as "Health and Macro-economics," "Health and Tourism," "Health and Immigration," and "Health and Trade," other ministries or sections of government besides the national health authority have a vested interest in health. Therefore, as health becomes more and more an aspect of international relations, the governments will have to decide how to restructure its delegation and appointment of representatives to PAHO's Governing Bodies. The Constitution may have to be amended and provision made for not only health professional from the national health authority to comprise the delegation appointed to the governing bodies but other professionals from other arms of government as well. However, the health specialists must retain the leadership role in any delegation appointed to PAHO.

Specific Issue 2

Organizational and budgetary structure to fulfil the mission of the Governing Bodies and meet the needs of the countries

Suggestions

1. With reference to the organizational structure, the election or selection of the senior staff (Director, Deputy Director and the Assistant Director) appears to be mainly a political process. The Director is chosen by the vote of a majority of the Governments of the Organization, while the Director with the approval of the Executive Committee appoints the Deputy Director (often a United States of America national) and Assistant Director. A more formal transparent process for selecting the senior staff may have to be introduced, which will take other attributes into consideration other than political factors (for e.g. a technical process based on countries identifying candidates with considerable knowledge, skills and experience in the field of public health combined with the quality and quantity of public health work done by the candidate, or using a process of election similar to that instituted for selecting the members of the Executive Committee). This will ensure greater regional representation and cultural diversity in the selection of senior level staff and provide an equitable opportunity for all Member States to have candidates for consideration for these three senior level posts.

2. PAHO should disseminate the results, and implement any feasible recommendations from the study entitled "The distribution of budget allocation and other PAHO strategies for increasing the rate of collection of quota assessment." Furthermore, there need to be clear criteria for the distribution of budget allocation to countries along with transparency in selecting the indices for determining need/priorities in countries including the criteria and indices used for the priority countries (Haiti, Guyana, Bolivia, Nicaragua and Honduras).

3. Government financial contributions are calculated based on their income and thus some Member States quota contributions are higher than other. This has resulted in many governments questioning their rights and privileges within the Organization as well as how their financial contributions to the Organization are allocated and managed. At present, the voting privilege of Member Governments is dependent on whether the Governments meet their financial obligations to the Organization and each Member Government is entitled to one vote. However, if the Conference or the Council is satisfied that the failure of the Government to pay is due to conditions beyond the country's control, it may permit the Government to vote. To this end, is there now a need to re-examine voting privileges based on budgetary quota contributions.

4. There should be more delegating of programmatic and financial authority to PWRs with clear criteria and accountability processes in order for them to function effectively and quickly respond to countries' need. At present, the PWR's are only allowed to spend up to US$15,000 on any one programme. The Director must approve any amount greater than this.

5. In consonance with the Pan American Sanitary Bureau's core value of integrity: assuring transparency, ethical and accountable performance, the Member States need to be brought more into the auditing, monitoring and evaluating of PAHO's functions for greater accountability and transparency of its operational, managerial and financial practices and to ensure greater administrative and operational efficiency. This auditing and evaluation shall in addition to expenditure review, also look at performance review for the assessment of efficiency, effectiveness, impact, and outcome as well as for measuring the success of programmes. There shall be the establishment of a standing Audit and Evaluation Committee comprising elected representatives from among the Member States, Participating States, Associate Members, the Bureau and an independent organization. This will initiate a participatory approach to auditing and evaluation and guarantee the dissemination of the auditing and evaluation results to all stakeholders, ensuring optimal use of the two processes and their results.

6. Formalise the links between financial reporting and effective evaluation through the simultaneous production of an evaluation report on the implementation of the programme budget and the financial report for the same programme budget period to show Members States and other stakeholders that they are getting value for money with regards to funds invested in the organization.

7. PAHO must also institute measures to reduce cost and minimise wastage in the Organization to make up for the reduction in funding from various sources and to redirect funds to technical priority programmes.

Specific Issue 3

Assessment of regional centres

Evaluations of PAHO's regional centres have been undertaken on an ad hoc basis over its existence. In the past, these studies led to the closure or re-organization of some of the centres. The review of Sub-regional PAHO Centre and other collaborating agencies in the Caribbean are currently being undertaken and studies on some of them were also done in the past. These PAHO's centres are Caribbean Epidemiology Centre and Caribbean Food and Nutrition Institute.

Similar studies have been executed or are currently being carryout on other Regional Centres as well. The Pan American Foot and Mouth Disease Centre (PANAFTOSA) and the Pan American Institute for Food Protection and Zoonoses (INPRAZ) are two Centres that were identified for review.

Suggestions

1. The Regional Centres' programmes must be designed and implemented in consonance with national programmes and those of the Country Offices. An integrated approach and shared

agenda by the Regional Centres and Country Offices is needed when programming to avoid duplication and for the pooling of all resources toward addressing national needs and regional priorities as well as for the achievement of global targets. Where possible, the regional centres and country offices must design their programme budget together, utilizing a shared agenda approach. The Country Offices will have to be the main coordinating and implementation entity for the programmes in countries, but through this new integrated approach, the regional centres will play a supporting role in terms of conducting research, information management and specialised training within countries to increase regional evidence base decision making for projects and programmes combined with the implementation of certain sections of programmes.

2. Apart from the assessment of regional centres, Country Offices also need to be reviewed. The field office in El Paso Texas needs to be reviewed for viability, effectiveness and efficiency in relation to the contemporary operation of PAHO. Also with the ever-increasing focus on countries, the advent of the Country Cooperation Strategy and decentralization from headquarters to the field, the Office of Caribbean Programme Coordination should be evaluated for efficiency and responsiveness to all the small developing states it serves. Will there be sufficient resources available to adequately serve all of these territories?

B. **Function**

Specific Issue 1

Enhancing efficiency of PAHO by the use of country offices to build partnerships, capacity building and strengthening of institutions particularly for developing states.

Within the reorganization of PAHO, the Country Focus Initiative (CFI) and the Country Cooperation Strategy (CCS) established by the World Health Organization (WHO) will have tremendous impact on the governance of PAHO in the future. The CCS will incorporate civil society and the private sector efforts with those of PAHO and Member States. With the CCS approach, the State will no longer be recognised as the Member Government only but will now comprise the various social partners. This new conceptualised State will provide essential stewardship and sustain mutually supportive alliances in relation to national, regional and international targets. The approach will obtain data on changes in peoples' health and in the performance of their health systems.

Focusing on countries needs and priorities combined with a greater country presence should bring about better coordination and collaboration with the other organizations of the United Nations system and international community. Thus PAHO/WHO's work should complement and enhance the efforts of the other stakeholders and partners in health through joint planning at country, regional and global levels in support of countries.

<u>Suggestions</u>

1. In order to ensure that the Country Offices meets the needs of both the Member States and the Organization in an efficient and effective manner, PAHO through its Secretariat and its Governing Bodies must:
   - Develop guidelines for relations between Country Offices and Ministries of Health as well as other health institutions to promote a multi-sectoral approach to health development.
   - Develop an integrated country programme in collaboration with PAHO Specialized Centres, including definition of needs, policies and priorities of the country to facilitate more efficient, result oriented programme planning and implementation.
   - Assess priority health needs and develop the country plan in consultation with country leadership and other partners of the international Community.
   - Guarantee country participation in the selection process for PAHO/WHO Representatives as well as systems for formal clearance by the recipient country before the appointee can take up the position. The Country should have the final decision on the matter.

Specific Issue 2

Bringing focus to the operational side of what PAHO does.

<u>Suggestions</u>

1. PAHO is defined within its constitution as an institution of technical cooperation. The Organization in providing technical support to the countries must now mobilize the technical capacity already achieved by countries, to support not only national health development within individual countries themselves but also in other countries. To achieve this, the Organization must upgrade connectivity, cooperation and communication among the PAHO/WHO country office, regional centres and national health institutions, and exploit the advantages of information technology in order to achieve optimal knowledge management.
2. New mechanisms of technical cooperation need to be created and employed to promote greater participation of the different partners in the formulation and implementation of national, regional and global priorities as well as to promote, support and monitor the formulation and implementation of cooperative programmes among partners, especially those aimed at reducing poverty and achieving equity in health. The tools and systems needed for the above processes need to be designed collectively by PAHO and the Member States.
3. Developing country specific plans, which will combine the efforts of different programmes and ensure coherent technical support based on country needs.

4. In keeping with the Pan American Sanitary Bureau's core values of equity, excellence, solidarity and integrity, there should be a new focus on programme management:

    I. Priority setting following the concept of utilitarianism needs to be done. Criteria for establishing priorities will also need to be outlined.

    II. Programming by objectives based on the orientation of the General Programme of Work, setting priorities according to national objectives and global targets as well as setting targets for outcome (products). For this to be achieved PAHO's process of work must move from the process (measuring) of output to the process (measuring) of outcome and involve a reassessment of targets and a re-examination of need.

    III. Global targets such as the Millennium Development Goals will need to be integrated into countries priorities and programming to ensure that both the national and global targets, which the countries commit themselves to are achieved. This approach gives programme managers programmes that give effect to policy contained in the General Programme of Work, reflecting the needs of Member States and embodying a global vision.

    IV. Strategic budgeting/planning (3-5 Years) by specifying products or outcome on which work will be undertaken in the biennium consistent with the priorities and by which budgetary provision for major programmes can be made. Impact can be measured by utilising this approach.

    V. Improving accountability through systematic monitoring of implementation, progress and expenditure, and evaluation of relevance, efficiency, effectiveness, and where appropriate assessing the impact of outcome (measure and evaluate success).

    VI. Establishing good knowledge and information management systems through PAHO and its Member States. Investing in information technology and communication systems for the rapid access to and processing of information. This will be crucial if there is to be decentralization in the organization.

Specific Issue 3

Evaluation of the implementation of PAHO's Mandate.

<u>Suggestions</u>

1. Studies are needed to assess PAHO's evaluation process and the types of evaluations that are or should be undertaken by the Organization. This will provide pertinent information for making conclusions, formulating alternative approaches to policies and programmes and assist with the dissemination of the information. PAHO's stakeholders, especially the Member Governments, should conduct these studies. **See Structure and Governing Bodies, Specific Issue 2, suggestions 5 and 6** for the types of

evaluations that shall be undertaken by PAHO and who shall participate in these evaluations.

Specific Issue 4

Evaluation of Strategies and allocation of resources to carry out mandate.

Comments

1. See above comments at Specific Issue 3 (Evaluation of the implementation of PAHO's Mandate)

C. Process with regards to relationship with stakeholders

Specific Issue 1

Relationship between PAHO and WHO

Suggestions

1. One international health organization but two Constitutions (one for the Regional Office of the Americas and another for headquarters), PAHO can establish its own priorities and programmes. Reduced fund allocation from WHO to PAHO. Although the two Constitutions are similar, there may now be a need for one governing Constitution for PAHO and WHO.
2. There must be more inclusion of PAHO into WHO's committees, etc.
3. When and where appropriate, there must be One Programme of Work as is currently being implemented through the Country Cooperation Strategy. The CCS is one mechanism for improving relations between the two organizations.

Specific Issue 2

Reaffirm commitment as Member States to the Organization.

Suggestions

To reaffirm commitment as Member States to the Organization the:

1. Finance Ministries should allocate funds to the organization and make payment of financial contribution to the organization in a timely manner.
2. National Health Authorities should continue to actively participate in the sessions of the Governing bodies, assist the Secretariat with the negotiation and implementation of its work in the countries and provide political support when necessary.
3. Ministry of Foreign Affairs should use international relations to negotiate health in the international arena, establish links and networking with national, regional and global institutions interested

in PAHO's work and participating in the organization's technical meetings.

4. Congresses and Parliaments should provide legislation and regulations for better promotion of health, highlight the importance of health and development as part of their political agenda and press for funding for health at the regional and international levels.

Specific Issue 3

What is the view of the other Stakeholders of PAHO?

Suggestions

1. A Review of the Sub-regional Cooperation Strategy for Barbados and the Eastern Caribbean should be done in order for the results, recommendations, best practices and lesson learnt from this exercise to be shared and implemented in other sub-regions and Member States. The stakeholders that participated in this strategy represented the European Union, USAID, CIDA, IDB, Caribbean Development Bank, UNDP, FAO, UNICEF, UNIFEM and IICA.

2. A major Survey for the entire region should be conducted with selected stakeholders from Member Government, bilateral agencies, multilateral agencies, the scientific community, Political and regional integration institutions, civil society Organizations and among PAHO's staff, centres and country offices.

Specific Issue 4

Decentralization of resources and staff from Headquarters to Country Offices

Suggestions

There should be:

1. The decentralization of the technical staff and resources from regional to national levels and placing inter-country technical staff at sub-regional level with a responsibility for providing support to several countries in a sub-region.

2. The development of a more efficient financial management system that integrates regular and extra budgetary resources.

3. The empowerment of Country Offices with adequate financial & programmatic delegation of authority, along with increased accountability and review the level of delegation of responsibility given to PWRs and centre directors to make operations at the country level consistent with the Plan of Work developed based on the needs and priorities identified by the Member States and the Country Offices.

4. Chapter V, Article 21, sections B of the Constitution of PAHO states "when-ever possible, the widest geographical distribution shall be followed in regard to the recruitment of personnel," A study on and evaluation of PAHO's recruitment policy needs to be conducted to

address the geographical distribution inequalities in hiring staff from the Region. The study shall be designed to determine the factors inhibiting wider recruitment of nationals from all Sub-regions and recommendations should be made to redress any geographical recruitment inequality. This will make sure that recruitment is not only in harmony with PAHO's Constitution and its Core Values but also that there is greater language and cultural diversity in the Organization as well as an equitable distribution of staff from Latin America, the Caribbean and North America.

5. The establishment of formal, transparent processes and systems for the transfer, exchange or hiring of national technical staff for cooperative activities. This will involve changes in both PAHO and governmental rules and procedures for facilitating exchange of technical expertise. These new systems must include governmental commitment to the full release of employees for cooperative efforts as well as compensation and incentives, such as staff development and training opportunities, praise/performance/recognition awards, comfortable working conditions, supportive working environment, etc from PAHO as well as governments for national technical staff on assignments. Furthermore, the Organization will need to adopt more flexible employment contracts to ensure that the latest technologies and knowledge are available for the work of the Organization

6. There must be a formal, transparent process for staff to move between posts, countries and sub-regions. Candidates should be assessed not only for their technical competencies, but also for their ability to work in different cultural settings. Reassignment to different locations and, to some extent, to different programme areas should be encouraged, as such reassignments could broaden the understanding and capabilities of PAHO staff, promote an international perspective and increase the Organization's flexibility.

PAHO's Human Resources
(Prepared by the United States of America)

Introduction

The Working Group on PAHO in the 21st Century identified "Resources for Health" as a significant issue for consideration. This topic was subsequently split into PAHO's resources and resources "in-country" available to member states and further subdivided into financial and human resources. The Working Group tasked the PAHO Secretariat with the development of the section on "in-country" human and financial resources. The section on PAHO's financial resources would be developed by the "Consultative Group on Regional Budget Policy" under the direction of Dr. Karen Sealy, with input from members of the 21st Century Working Group. This did not occur. Subsequent to the July Costa Rica meeting, it was agreed that Brazil would work to develop this piece, as the Secretariat failed to produce the expected document. The remaining section on PAHO's human resources was tasked to the United States for development. In its first iteration, this piece overlapped with issues identified under "Modalities for Technical Cooperation in Health." This current draft incorporates the points made in the "Modalities" document, as well as other comments made by Member Countries via the website and at the Costa Rica meeting.

Training of PAHO Staff

The Working Group clearly delineated the need to increase capacity building in the countries and subregions. While this may appear to speak only to the issue of human resources in-country, PAHO personnel can play a critical role. Specifically, if effective capacity building is to occur in-country, then the PAHO personnel assigned must have significant training and expertise in sustainable capacity building. The PAHO Biennial Program Budget (BPB) for 2004-2005 proposes 1.85 million dollars for staff development. However, the description does not contain a category for specific staff training on particular priority areas. The breakdown of the allocation of these funds would be helpful for countries to review. Furthermore, it would be useful if priority areas delineated for staff training within the BPB should fall directly in line with priorities identified by Member Countries. Whereas it might be less efficient and financially difficult for every country office to have an expert on capacity building, PAHO headquarters could compile a small team of experts in this field that could be dispatched on an as-needed basis to countries or subregions to help in capacity building efforts.

The issue of training and appropriate expertise of PAHO personnel extends beyond capacity building. Countries have expressed concerned that the staff sometimes assigned the PAHO country office is unqualified or insufficiently trained to handle the issues that arise in that particular country. In some cases, the individual has basic training or knowledge in the area, but lack specialized skills. In this situation, short course-work or training might be sufficient to help that person perform in his/her job.

There are emerging issues within the region, which do not fall into PAHO's historical personnel composition, but which are emanating from the Director's new vision. This would include social communication experts, information management experts, and program managers, among others. PAHO should develop a strategy to identify who can fill these personnel gaps. Other PAHO technical experts may also need training in some of these areas.

PAHO Workforce Assignments in Headquarters and within the Region

The professional staffing at both Headquarters and country offices needs to be planned in such a way that responds to the geographical, cultural, and epidemiological diversity found in the region. Within Headquarters, sometimes contracted or professional staff assigned to work with a particular country have insufficient knowledge about the situation they are addressing at the country level. Staff may suffer from an "ivory-tower" perspective, losing touch or lacking a sense of the distinct needs and characteristics of the countries, their people, and how things function on the ground. Similarly, the profile of the people assigned to the country offices, as well as their training and experience should be strictly consistent with the health needs, problems, and challenges identified and prioritized by the countries themselves.

Identification of and communication with host country counterparts is absolutely essential when undertaking work in a country. It is critical, regardless of length of assignment, that field staff, Headquarters staff, or consultants are clear that they will be working and coordinating with local human resources. Such visitors need to be sensitive to local ideas, concerns, and problems and be careful not to impose their point of view or underestimate the capacity of the host country personnel.

In some instances, individuals have been assigned to positions for which they are unqualified. Perhaps this could be addressed if member countries were given a greater role in determining the requirements for a given position in the PAHO Office in their country. The selection/assignment process could be revised to be more democratic or inclusive. One possible option would be for PAHO to develop a short list of technical groups or institutions and allow the country to review it and participate in the selection process. This would contribute to achieving a better match between needs and resources. Furthermore, it may help reduce political factors from playing a role in the selection of human resources.

Evaluation of PAHO Staff

As part of an ongoing effort to produce quality collaboration and assistance, continued evaluation of human resources is necessary. Many Member States are unfamiliar with how PAHO personnel are reviewed and evaluated and should be informed on the current process. Nonetheless, evaluation is critical to maintaining a well-trained, high-performing workforce. Systems to evaluate performance of personnel, including short- and medium-term consultants, are necessary to achieving this goal. As part of the evaluation process, the identification of human resource "competencies"- understood as

skills, attributes, and behavior closely related to success performance of the work of the national and international personnel assigned – as well as ongoing evaluation of such competencies can support the process of contracting, assigning, hiring, and adapting the workforce in all PAHO facilities.

Hiring of PAHO Staff

Building on the need for appropriate staffing, another suggestion would be to identify a list of core competencies that are necessary in each of the PAHO country offices. Then, additional analysis would be required to determine the other core-competencies and skill sets required of staff working in a particular country. Existing local capacity varies dramatically among the countries and must be taken into consideration when undertaking this analysis. Central to this concept, however, is ensuring that PAHO Headquarters is geared to provide that set of workforce skills to personnel assigned to the field. This would best address the Working Group's concern that a "one-model fits all" approach to country offices is not working effectively.

The Working Group also expressed concern about the process of hiring and retaining consultants at both the country and Headquarters level. The group noted there seems to be little oversight for determining whether the consultants being hired are needed given the overall strategic areas of work identified by member states. Furthermore, the group suggested that there seems to be lax policy for determining the qualifications for consultants. One solution might be to develop a more stringent policy for the hiring and evaluation of short-to-mid-term consultants. However, direct country participation in this practice would probably be too burdensome both for member countries and PAHO.

PAHO currently encourages women to apply for careers within the organization. However, there is little activity to actively recruit and retain women in senior positions. Rising through the ranks at PAHO frequently implies a move from country to country or subregion to headquarters. For women, this generally implies a significant challenge due to family obligations.

The aging of the PAHO workforce also will pose a significant issue for the organization in the coming years. With retirement age of 62, there are a number of expert PAHO staff persons who will be retiring soon. This will present a number of gaps in the organization that PAHO will have to fill. It is not uncommon to see an individual retire from PAHO one day and then be re-hired as a consultant the next. That position may then go unfilled or revised.

Career Development

Junior staff do not always have opportunities to move up or grow within the organization. These individuals are building a wealth of organizational and technical expertise that could be capitalized on if training paths are created for qualified individuals to continue their career development. This would help to improve morale among staff.

Tenure, once pervasive in the UN system, has now become basically a thing of the past. While a tenure system creates the possibility of abuse of the system (e.g., employees becoming less productive once earning tenure, employers having difficulty in removing incompetent or unproductive staff, etc.), it also provides incentive, creates stability within the organization, and provides security for employees. It may be worth beginning a discussion on ways to incorporate a tenure system that provides these benefits while protecting against possible.

Decentralization of Resources and Staff from Headquarters to Country Offices

Country offices should be empowered with adequate financial and programmatic delegation of authority, in addition to increased accountability. Furthermore, the there should be a review of the delegation of responsibility given to PWRs and PAHO Center Directors to make operations at the country level consistent with the Plan of Work developed based on the needs and priorities identified by Member States and the Country Offices.

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CHALLENGES OF PUBLIC HEALTH FOR THE 21ST CENTURY

PRELIMINARY ANALYSIS -- DRAFT FOR DISCUSSION

TABLE OF CONTENTS

Introduction

The preliminary analysis of challenges for public health was prepared at the request of the members of the Working Group on PAHO (Pan American Health Organization)[1] in the 21st Century that met February 26-27 in Roseau, Dominica. The present document includes the revisions by the members of the Working Group suggested during their second meeting in Washington D.C, March 23.

The challenges for public health in the next few years could be grouped in three major feats:

- Complete the unfinished agenda, embodied for many countries in the UN Millennium Development Goals (MDG).

- Sustain achievements of the last two decades (vaccine preventable diseases, life expectancy, improve quality of life of years gained): protect vulnerable countries and populations where disparities are greater, foster emergency preparedness to face natural disasters and outbreaks.

- Tackle the new agenda with a population based approach, improved foresight and collaborative strategies, focusing on developing appropriate skills and competencies.

Although a challenge is commonly understood as a specific hurdle or difficulty, it can also become a summons to engage in special efforts that will turn this defy into opportunities and accomplishments. In the particular case of public health, the challenges focus primarily on the population, emphasizes disease prevention and prevention for the whole community, public service ethics, and a set of interventions aimed at environment, human behavior and lifestyle, and medical care

The present document seeks to approach the challenges for public health in the Region of the Americas with a futures' perspective in the context of key drivers of change and trends that shape health, health care. The context of health in the region is highlighted taking into consideration the main trends and conditions affecting population groups. The last sections of the document address the "unfinished agenda", mainly illustrated by the United Nations Millennium Goals and later, the new agenda of challenges with brief suggestions for an emerging agenda for action. The last section includes a summary table listing the challenges of public health that emerge from the analysis and which include those mentioned by the members of the Working Group of PAHO in the 21st Century.

THINKING IN FUTURE TENSE

Transformations in some sectors and issues are so deep that it may not be effective or even possible to solve some current problems with the same type of thinking used when these were generated. Uncertainty, complexity and interdependence characterize current regional and global frames of reference. This context makes nations, governments and organizations, public and private more permeable to the effects of external factors, and if

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[1] Resolution CD44R.14 of the 44th Directing Council of the Pan American Health Organization mandated the establishment of this working group with the purpose of examining the situation of PAHO in the 21st century.

unprepared, vulnerability to undesired and/or unexpected events will increase. Moreover, accurate understanding of the changing nature of issues or identifying new relevant issues may be hampered, therefore affecting the capacity to respond timely and appropriately. Therefore, successful navigation of the future to avert risks and harness opportunities under new rules depend on the capacity to anticipate, embrace change and adapt, calling for developing greater foresight capacity.

Thinking in the future tense with a keen awareness of the past and the present is germane to public health and medicine, when recognizing the considering the nature of the trends and the relevance of properly addressing the challenges of public health in the Region. Greater foresight allows harnessing the benefits of change and innovation. A forward view can produce useful insights to develop timely responses to challenges, since it enables greater awareness, reduces uncertainties, contributes to the identification of early warning signs and creates opportunities for action.

The Role of Futures and Scenarios

The field of futures studies is closely related to anticipatory disciplines, such as long-term planning, policy analysis and strategic management.[2] As the uncertainty and complexity has increased, governments, agencies and various organizations have increasingly used anticipatory methods and tools to explore multiple alternative futures, re-examine goals and priorities, support the renewal of strategies and motivate action through participation, thus drawing people together towards creating shared futures and goals.

Most futures work involves the creation of some kind of scenario. Scenarios are images of possible, plausible, desirable and undesirable futures. However, these images or stories of the future are not predictions; they are used as learning tools to change mental models and increase foresight. Creative and strategic thinking through scenarios adds organizational flexibility and support policy formulation. The process allows a collective approach to issues from multidimensional and transdisciplinary perspectives.

KEY DRIVERS AND TRENDS

Key drivers and trends are not good or bad in themselves, however they may exert different effects (positive (represent opportunities), negative (represent threats), or innocuous (no effect) on the issue of interest. Own situation, beliefs and positions define the interpretation of their effects as well as the responses.

Major key drivers of change or driving forces are defined as compelling forces that affect in fundamental ways all spheres of human activity, shaping human interactions (production,

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[2] The roots of future studies and foresight are found in Europe and the United States, their conceptual and methodological evolution in the Region of the Americas is linked to the history of social and economic planning and management. Many countries have engaged in the visionary construction of futures in diverse sectors, and some are involved in processes of technology foresight linked to public policy formulation through initiatives supported by the Organization for Industrial Development (UNIDO). See Costa Filho, A. *Planificación y construcción de futuro.* Instituto Latinoamericano y del Caribe de Planificación Económica y Social (ILPES). Santiago de Chile: ILPES; 1988 and Yero, L. Los Estudios del Futuro en América Latina. En: Medina Vásquez, J. y Ortegón, E. Eds. *Prospectiva: Construcción Social del Futuro.* Universidad del Valle, Cali.1997.

trade, work consumption, communications, practices, beliefs, attitudes, social and political relations, ethical standards and cognoscitive modalities). Globalization, changes in the natural environment, and science and technology are generally considered driving forces of change. Conversely, trends are continuous patterned events that shape the future of issues or objects of interest, they may be more localized, and their effects may not be as broad or the transformations so deep as those caused by key drivers. For the purpose of this paper, trends have been grouped in terms of the determinants of health, due to the nature of their effects on health outcomes and health care processes.

Globalization

Globalization has been defined and described in a many ways, and it is difficult to disagree that it is a critical, complex and uncertain driver of economic, political, environmental social, cultural, technological and cognitive transformations, with long-term implications. Globalization has driven the increased flow and exchange of goods and services between nations, of capital through companies or individuals, of labor, and of information.[3]

Although asymmetric and incomplete, the transformations have contributed to intensify the integration of national and subregional economies through trade, finance and production in a global market place mediated by interactive communication and networks of producers, suppliers and customers. The acceleration of interconnectivity has created "common virtual spaces" through the exponential expansion of internet, while e-commerce is rapidly becoming a new way of trading, shopping and banking. At the same time, it has also intensified the international transfer of health risks through humans, animals and foodstuffs, and also increased concerns for national security.

As greater permeability of national borders decreases the distinction between national, regional and global health, but represent an opportunity for synergism in cooperation through partnerships.[4]

Possible implications of globalization for public health

- Transnationalization and modification of patterns of distribution of diseases, health risks, work, lifestyles, behaviors, beliefs, attitudes and symbols...

- Higher interest in addressing the gaps between individuals and groups with access to the benefits of development and those who have not.

- Increased attention to issues related to trade and regulation of medical devices, pharmaceuticals, and intellectual property rights.

- Greater awareness of opportunities opened by the increased flow of information and knowledge to create synergisms in cooperation through partnerships.

- Greater concerns for health governance and equity issues as national decision making

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[3] Romanov, Roy J., Q.C. Building on Values: The Future of Health Care in Canada. Final Report. November 2002. Commissioner. Commission on the Future of Health Care in Canada, pp. 233. http://www.hc-sc.gc.ca/english/care/romanow/hcc0086.html

[4] Institute of Medicine. *America's Vital Interest in Global* Health, Washington, D.C.*IOM, 1997.*

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is increasingly interdependent and often shaped by interests and decisions in the regional and global sphere.

Environmental Change and Quality of Natural Resources

Population shifts, technological change, environmentally disruptive technologies and socioeconomic transformations contribute to shape the environment and the quality and quantity of natural resources. Although many of the effects are difficult to quantify or predict accurately, progressive environmental degradation, loss of biodiversity and the contamination of vital resources adversely affect health and well being and can generate long term social and economic costs and perhaps irreparable damage to the ecosystem.

The incidence and prevalence of communicable diseases (e.g. dengue, malaria), occupational injuries and chronic diseases associated with chemical and physical agents reflect the health effects of poor environmental quality. Furthermore, changes in climatic patterns contribute to the air pollution and aeroallergen levels, to the appearance and distribution of food, water and vector borne diseases, risk of malnutrition, droughts and famine, water shortages, and increase the frequency or severity of natural disasters. The latter cause physical and human devastation, population displacements, injury, death, and social and economic losses, sometimes setting national development back several years.[5]

Possible implications of environmental change for public health

- Improved knowledge about the effects of pollution of essential resources on diarrheal, respiratory and vector borne diseases and of environmental and occupational exposures to biological and chemical pollutant to respiratory diseases, cancers, birth defects and neurological conditions.

- Disrupted ecosystems and loss of biodiversity effects on human and animal health, agricultural production, economic productivity and sustainability of food sources.

- Diminishing fresh water sources seriously jeopardize human health, and may also be create political and armed conflicts that threaten peace and democracy.

- Greater demand for better regulation and compliance, and for environmentally friendly technologies.

Science and Technology

Science and technology, including those advances applied to communication and information technology dramatically change our lives, and increasingly challenging the scientific basis of medical and public health practice. These transformations have contributed to the expansion of economies of speed replacing economies of scale, the customization of products and services, the maximization of real time processes, and the rapid obsolescence of product life cycles...

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[5] WHO. *Climate change and human health-risks and responses.* Summary. World Health Organization: Geneva. 2003. http://www.who.int/globalchange/publications/cchhsummary/en/

Innovations in biotechnology, nanotechnology[6] and pharmacogenetics[7] will revolutionize prevention, diagnosis and treatment. Health-oriented telecommunications, medical imaging, satellite technology and other information systems will radically transform healthcare through teleradiology, telemedicine and telehealth.[8]

The unbridled development of scientific and technological innovations generates concern and actions about ethics, security and confidentiality to the forefront of the global agenda. Some of the topics addressed relate to ethical issues of social deployment of genetic individual information, accessibility to the benefits of innovations, bioethical repercussions of cloning, transplantation and the use of genetics in health care. Emerging issues being addressed include cyberthreats, disruption of essential functions by physical damage caused by terrorism and natural catastrophes, invasion of systems, blackmail, industrial espionage and data theft.[9]

Possible implications of science and technology for public health

- Heightened awareness about the ethical dimensions of health and health care, such as health equity, access to care, financing and regulation, transplantation, confidentiality of medical information, as well as issues related to life and death.

- Appreciation for the opportunities to apply science and technology innovations to improve health and medicine, including the search for equity-oriented technologies to forecast and manage health, epidemiological surveillance in "real time," telehealth in rural areas, and others.

- Applications to social development: networks to strengthen governance and accountability, channels and sites for retrieval and sharing, creation of knowledge as a shared renewable resource across borders.

The Determinants of Health: Trends Affecting Health Conditions

Changes in health status (either those that express reduction or improvement of adverse outcomes, increasing health gains and improvement of function) are the product of complex interactions of structural determinants (genetic endowment, the social and physical environment) as well as of process determinants (individual response through

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[6] Nanotechnology involves "research and technology development at the atomic, molecular or macromolecular levels, in the length scale of approximately 1-100 nanometer range, creating and using structures, devices and systems that have novel properties and functions because of their small and/or intermediate size, and the ability to control or manipulate on the atomic scale." National Nanotechnology Initiative. *What is Nanotechnology.* http://www.nano.gov/html/facts/whatIsNano.html

[7] Pharmacogenetics is the study of how genes affect the way people respond to medicines, including antidepressants, chemotherapy, drugs for asthma and heart disease, and many others, where outcomes will improve tailoring medicines to people's genetic make-ups and thus improve safety and effectiveness. http://www.nigms.nih.gov/pharmacogenetics/

[8] Daar, A.S. et al. Top ten biotechnologies for improving health in developing countries. *Nat Genet.* 2002 Oct; 32(2):229-32. Oct 2002. htp://www.utoronto.ca/jcb/pdf/toptenng.pdf. Pang, T. The impact of genomics on global health. *Am J Public Health.*2002; 92: 1077-1079. http://www.ajph.org/cgi/content/full/92/7/1077

[9] New York Academy of Sciences. *The Goals of Medicine.* 1997 New York: The Hastings Center.

biological characteristics and behavior and health care). Although effecting structural determinants may be beyond the scope of action the health sector, actual opportunities exist to contribute to the modification of health outcomes through effecting process determinants.

Demographics and Social Trends

By mid 2003, the population of the Latin American and Caribbean Region had reached 540 million. The projections indicate that this number will increase to 690 million people by 2025 and 789 by 2050, with an estimated population change of 46% between 2003 and 2050.[10]

About 77.4% of the region's population lives in urban areas, a figure lower only to that of North America.[11] Rapid urbanization (internal and also due to external migration) can further strain urban spaces, and be particularly injurious for poor and low income dwellers. As services are stretched to accommodate new populations, services and housing are further reduced in quantity and quality. Poverty, environmental degradation and limited access to basic sanitation and to quality recreation areas, often coupled with limited skills adversely affect individuals' social and psychological well being. Unless communities are resilient and socially cohesive, the risks of injury and death are exacerbated.

Migration continues to be an important trend, and 20 million persons have emigrated from the countries of the Region, three quarters to the United States, with women outnumbering men in intraregional and extrarregional migratory flows. Considering the importance of these trends, recent initiatives are focusing attention on the health dimensions of migration through a human rights framework, with a view to increase understanding about the plight of different types of migrants, the determinants of their movement and how governments and the international community can best address the inherent issues.[12]

With respect to education, the sector has been relatively protected from the deleterious effects of economic downturns since the late eighties. Governments have long recognized the value of education to sustain and achieve goals in other sectors, and have implemented appropriate measures to improve its quality. Primary education is virtually universal in the Region however; gaps are more noticeable in secondary education and for low income individuals where the attendance rate does not reach 35% as national average in any country in Latin America.

One important regional problem is school drop out; about 40% of children do not complete primary education and in 72% to 96% of poor families have heads of households with nine years of schooling or less. These facts have implications for health and the reduction of poverty, since getting out of poverty or avoiding becoming poor requires between 11 and

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[10] Population Reference Bureau. www.prb.org

[11] United Nations. *World Urbanization Prospects*. 2002. (2001 Revision)

[12] WHO. International Migration, Health and Human Rights. World Health Organization Geneva. 2002. http://www.who.int/hhr/activities/en/intl_migration_hhr.pdf

12 years of formal education in order to obtain work that would ensure sufficient income.[13]

The situation of women is highly relevant to the subject of discussion. Despite improvements in their social status, higher educational attainment and autonomy, the unequal distribution of power between the sexes continue to limit women's full participation in decision making at home, in the community and in society. For many women, the burden of work and family responsibilities contributes to perpetuate various forms of discrimination and violence, which in turn heightens vulnerability and hinders the full exercise of their rights.

Other social trends of relevance to public health are the growth of social movements and organizations linked to equity, health and human rights, many in the heart of international advocacy. This trend has been supported by other trends in social development thinking and action, and to the recognition of the value of enhancing endogenous variables for social development.

A central topic to the previous mention is the heightened relevance of social capital for development. Numerous efforts have centered on building the social capital of excluded groups and on community mechanisms for cooperative organization. These are built on the premise that as standards of social reciprocity are adopted and networks of interaction, support, and participation established, positive social indicators (school performance, general health conditions, social, economic and gender equity, gender and racial tolerance; and social freedoms) increase and negative ones are reduced.

Political

Democracy has galvanized in the region, and citizens assign greater value to democracy and to the respect of human rights. Political participation has increased in national and local governance instances, and the social dimensions of development have been recognized at the highest levels of government and global instances.

Although people in general value democratic institutions, the satisfaction with the way in which institutions exercise their authority and power, and on the performance of the governments has eroded. Social unrest, socioeconomic instability, insecurity can threaten democracy and effective governance. Inconsistencies or at least the perception of between electoral promises and actual performance are contributing factors. The latter may be affected by the potential diminished capacity of public institutions to formulate and enforce social and health policies, particularly distributive or regulatory policies that aim at improving equity and protect the public. Nonetheless, the governments of the Region are committed to efforts leading to improved performance, greater transparency and social responsibility.

The search for self-determination, the reempowerment of the population and communities, and effective citizen participation are still pending issues. In many cases, the transfer of

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[13] Hopenhayn, Martin. Educación, Comunicación y Cultura en la Sociedad de Información: Una perspectiva Latinoamericana. *Revista de la CEPAL*, No. 81, diciembre 2003, pp. 175-194.
http://www.eclac.cl/publicaciones/SecretariaEjecutiva/6/LCG2216PE/lcg2216e-Hopenhayn.pdf

decision-making from the national to the subnational levels has been incomplete or has not succeeded in adequately developing local institutional capacities. Similarly, the processes that foster autonomy in public administration have not always yielded greater efficiency and better quality services, and citizen control is still marginal or nonexistent.

The current context has redefined a new era of public policy where health is increasingly intersects with domestic and foreign policy, national and global security, sovereignty, governance, multilateral and bilateral strategies and national and international interests.[14] Human security has advanced to the forefront of the global agenda, and it is conceived as a "complement to state security, furthers human development and enhances human rights." This integrated approach centers on several issues for action aimed at protecting people's vital freedoms and fostering empowerment.[15]

Economics

The persistence and the severity of poverty and income inequality are pervasive obstacles to factors that exacerbate vulnerability to risks and social exclusion, thus hampering healthy economic growth and prosperous civil societies. Overall, Latin American and Caribbean countries are characterized by a slow and unstable growth, adverse structural patterns, unequal distribution of income, deterioration of employment and differential opportunities for trade. The Region has the highest GNI per capita of all regions, yet, it exhibits the greatest disparities and poverty levels are four times that of other regions with similar GDP.[16]

With respect to the reduction of poverty and indigence rates, these have stagnant since 1997. Between 1999 and 2002, the poverty rate rose from 43.8% to 44.0% while extreme poverty reached 19.4% of the region's population. Currently, about 225 million are considered poor, and about 100 million people are estimated as indigent.

	Number (in millions) and Percentage of Poor and Indigent[17]							
	2000		2001		2002		2003	
	Number	%	Number	%	Number	%	Number	%
Poor, non indigent	207	41.1	212	42.5	220	43.4	225	43.9

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[14] Lee, Kelly. *Health, Foreign Policy and Security: A Review of the Literature.* Discussion paper prepared for The Nuffield Trust. Programme of Work on Global Health and Foreign Policy. The Nuffield Trust, January 2002. http://www.nuffieldtrust.org.uk/policy_themes/docs/hfps.pdf

[15] See United Nations. *Human Security Now.* United Nations Commission on Human Security. United Nations; New York, 2003. http://www.humansecurity-chs.org/finalreport/pdf

[16] According to a recent publication, inequality in the Region is so appalling that even for countries with the best income distribution (Uruguay and Costa Rica), the Gini Coefficient is worse than for the most unequal Eastern European country.. De Ferranti, David et al. *Desigualdad en América Latina y el Caribe: ¿Ruptura con la Historia?* Estudios del Banco Mundial sobre América Latina ye I Caribe. Banco Mundial, octubre 2003. http://wbln0018.worldbank.org/LAC/LAC.nsf/ECADocByUnid/4112F1114F594B4B85256DB3005DB262?Opendocument

| Indigent | 88 | 17.9 | 91 | 18.2 | 95 | 18.8 | 100 | 19.4 |

The concentration of income presents regional variations, but for the most part and since 1997, it has remained unchanged or even worsened in most countries, a fact that seriously hampers the achievement of the goal of reducing poverty.[18] Moreover, data shows that life expectancy is greater in countries with high-income levels, and at similar income levels, life expectancy is greater in the countries with narrow income gaps. The average proportion of income for the poorest 40 percent of households is about 13, 6%i (extremes are Bolivia with 9, 5% and Uruguay with 21, 5%). The richest groups capture san average of 36, 1% of the income in Latin America (extreme values are 27, 3% in Uruguay and 46, 8% in Brazil).[19]

Extreme poverty, hunger and malnutrition are distinct phenomena with synergic and insidious consequences for physical and mental well being. This is specially so for children under 5 suffering from chronic malnutrition, because of its high prevalence and irreversible effects on school performance, psychological and physical development, seriously hampering their social and economic contribution to society. Approximately 54 million people in the Region suffer from some degree of undernourishment and about 20% was undernourished in some countries (Bolivia, Dominican Republic, Guatemala, Haiti, Honduras, Nicaragua), whereas in others the figure was below 5% (Argentina, Chile and Uruguay). While efforts are under way, improvements are slow. In recent years, greater awareness is prompting decisive actions to curb obesity in adults and most recently in children, which is a risk factor for several chronic conditions.

The current and future situation of the growing number of older adults is of equal concern. Considering that only two out of five older adults receive social security benefits in the urban areas, many continue working or return to work, generally in lower paying jobs and/or in the informal sector. This population group also tends to include a majority of women, have fewer years of school and gender disparities unfavorable to women, which places them at greater risk.

Unemployment and sub employment are contributing factors to poverty, particularly when volatility and uncertainty characterize economic activity Employment conditions have deteriorated and unemployment increased overall from 6% to 9% in the Region. Moreover, the informal sector has expanded and seven out of ten jobs created in urban areas occurred in the informal sector. The quality of work often preempts social security and

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[17] Alicia Bárcena, Secretaria Ejecutiva Adjunta de la CEPAL. Presentación, Objetivos del Desarrollo. Reunión de la Mesa Directiva Ampliada del Comité Especial de Población y Desarrollo del Periodo de Sesiones de la CEPAL. Marzo 10, 2004, Santiago, Chile

[18] Improvements reached over 0.05 of the Gini Index. CEPAL *Panorama Social de America Latina, 2002-2003.* CEPAL, Santiago, Chile. LC/G.2218. Noviembre 2003. http://www.eclac.cl/cgi-bin/getProd.asp?xml=/publicaciones/xml/0/12980/P12980.xml&xsl=/dds/tpl/p9f.xs

[19] The Latin American countries with the highest concentration of income as reflected on the Gini coefficient are as of 2002, Brazil (0,64) and Bolivia (0,61), followed by Argentina (0,59), Honduras (0,59), Nicaragua (0,58) and Paraguay (0,57). Uruguay (0,46) and Costa Rica (0,49) show the lowest coefficients.[19]

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health benefits protection, thus increasing vulnerability and exposure to risks. Important gaps exist between unskilled and skilled workers, and between formal and informal workers, the latter lacking social and health benefits as well as opportunities to advance.

Trends in the status and role of women in society are pertinent to understanding the dynamics of health, poverty and gender equity. In spite of improvements in education and social position, women are still more likely to be unemployed and overrepresented in the informal sector, concentrate on lower paying jobs and be subject to wage discrimination. In the case of women who are heads of households, they and their children are often drawn to more disadvantaged positions.

Social expenditures have redistributive effects that benefit the lowest income groups, and although the patterns are uneven, most countries have made efforts to increase the percentage of GDP allocated to social sectors. This is a positive trend in the Region when considering that average social expenditures increased from 10.4% to 13.1% of the GDP and very few countries reduced their social spending. Yet, the increases had little effect on the reduction of disparities[20]. Countries like Argentina and Uruguay for example protected social spending even under the strain of important reductions of GDP between 1999 and 2000. However, this situation was difficult to sustain by 2002 when the GDP constraints increased with an 11% reduction and social spending was reduced.

Measuring poverty and disparities in the Caribbean is more difficult due to the lack of household surveys and the comparability of data. However, some studies show that the incidence of poverty is highest in Haiti (80% of indigence). Dominica, Guyana, Saint Vincent and the Grenadines and Suriname show lower rates than Haiti but higher than those of the rest of the countries. However, Bahamas has very low rates of poverty and these compare favorable with other countries with high rates of economic development.

Among Caribbean countries rural poverty tends to be higher in rural areas, differing from the situation in Latin America. Unemployment rates are considered high, and according to ECLAC "there are important links between poverty and delinquency, drug trafficking, intrafamily violence and child abuse." Environmental health issues are of high importance in the subregion due to the occurrence of natural disasters, volcanic eruptions, and hurricanes affect seriously the poorest population of the subregion.[21]

Health Sector, Systems, and Services

Although health sector reforms promoted during the nineties were widespread and aimed at positive financial, structural and institutional changes, some relevant aspects of public health were neglected. One consequence of this situation, coupled with the effects of various trends, affected the capacity of governments to fully exercise their steering role and fully perform essential public health functions. A relevant trend that redefined a new

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[20] Regional public social spending rose until 2001 (from US$ 501 to US$ 552 dollars per capita). Panama, Uruguay, Argentina, Brazil, Costa Rica and Bolivia assigned a large proportion of GDP to social sectors in the mid-1990s, and the levels rose to between 18% and 26% of GDP by 2000-2001. CEPAL *Panorama Social de America Latina, 2002-2003.* Op. cit, pp.178.

[21] CEPAL *Panorama Social de America Latina, 2002-2003.* Op. cit, pp.60.

playing field with new or reposition stakeholders is embodied in some of the implications of the state and modernization processes. Although these have been asymmetric, they have encouraged the involvement of a variety of stakeholders, particularly those in the private sector. Their involvement has generated new dynamics and transformations.

A preliminary assessment of the impact of health sector reforms in terms of their guiding principles indicates the following:[22]

- Equity: Only few examples seem to have contributed to the reduction of gaps in the coverage of some basic services and programs, and in most countries, these are not affecting the reduction of gaps in the distribution of resources.

- Effectiveness and quality: Relatively little progress has been attained in improving the global effectiveness of the system, adherence to normative aspects of quality of care or user satisfaction with quality.

- Efficiency: More gains are registered in productivity and development of purchasing practices than in reorienting resource allocation (e.g. no major shifts of resources to channel resources towards problems with high externalities, or to increasing the degree of social protection in health.

- Sustainability: There are attempts to adjust expenditures to the revenues of the system, but very few countries are improving the medium or long term generation of resources for expanding or sustaining the current level of service provision. The high dependency of many countries on external financing, and the lack of mechanisms for substituting these flows of resources when they cease seem an aggravating factor.

- Social participation: Governments seem more receptive as a result of health sector reform plans, however, it remains to be seen whether greater social participation actually affects the reorientation of health sector reforms.

The segmentation of health system persists; while some countries have extremely low health expenditure, others are excessively dependent on external resources, making them highly vulnerable. Even when countries increased public resources for health and education, the increase represents a relatively small percentage when compared with the increase in out of pocket expenditures necessary to access these services. These trends have exacerbated the regressive impact on the poorest populations and few countries have been able to break away from their historical allocation of resources.

Although aging is generally considered a trend that will weigh heavily on health expenditures, some experts consider that the impact of demographic and epidemiological trends seems to have been overestimated. They contend that regardless of age, health expenditures are highest in the last few months of life, and that under this assumption,

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[22] Lopez Acuna, D. *Critical Issues in Health Sector Reform in Latin America and the Caribbean: An Agenda for the Future.* Presentation. The Next Generation of Reforms, Public Health, and the Millennium Development Goals in Latin America and the Caribbean. March 15, 2004 National Press Club, Washington, D.C. http://www.iadb.org/etica/sp4321-i/DocHit-i.cfm?DocIndex=1401

aging populations may enjoy longer and healthier lives, mortality and morbidity rates will decline and costs will be spread over several years.[23]

Health systems are likely to continue to evolve progressively with increased participation of the private sector and clear efforts to improve performance, quality and participation of patients. One important element to consider in their evolution is the high costs of medical technology and pharmaceuticals which are already adding pressure to some systems.

Public health thinking and practice continues to evolve to progressively include a population-based approach, disease prevention and health promotion strategies, a keen focus on empowerment of patients, responsibility for medical care and the recognition of the bioethical aspects of that care, and the inclusion of proactive health actions.[24] Conversely, the critical role of behavioral and sociocultural factors in the health and illness continuum is acknowledged, and that the pathways to health through non-medical determinants are better understood. Moreover, the increasing recognition of traditional and alternative medical practices exemplifies the acceptance of diverse ways to perceive health, protect and promote wellbeing, identify and manage disease. In spite of positive transformations, the curative model still prevails in health services, and the focus on the needs and participation of consumers can be improved.

Although public health and medical practice are changing towards more integration, greater focus on quality, performance and managerial specialization, health manpower issues remain a permanent concern. Considering the financial commitment and time required to effect positive changes in education and practice, and in some cases the sustained "brain drain" of professionals, transformations may take longer than expected and involve focused efforts by the governments.

The requirement for more effective collective action by governments, agencies, civil society, and enterprises to better manage these risk and opportunities is leading to reassess the rules and institutions that govern health policy and practice at the subnational, national, regional and global levels. The experience accumulated by the countries and their recognition of the value of promoting social practices to develop a culture of life and health, to create and maintain healthy settings, and most notably, the need to build citizenship on the basis of people's awareness of their role and responsibility to create and maintain health will undoubtedly contribute to success.

Trends in International Health Development Cooperation

Development thinking has rapidly evolved in the past decade to understand and apply the concept of human development, to recognize that development embodies broader goals,

[23] Savedoff, William D. Is *Anybody Listening? Ignoring Evidence in the Latin American Health Reform Debates.* A Health Note. SDS/SOC–Health Note No. 2. Inter-American Development Bank. Washington, DC. October, 2000.

[24] McEwon, T. Determinants of Health. *In: The Nation's Health,* ed. P.R. Lee, C.L. Estes and N.B. Ramsay. San Francisco: Boyd & Fraser Publishing Co., 1980. Evans RG and Stoddard G L. Producing Health, Consuming Healthcare. In Evans R G, Barer M L and Marmor T R. *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations.* Berlin: Walter de Gruyter, 1994. Marmot, T. and RG Wilkinson, eds. *Social Determinants of Health.* Oxford: Oxford University Press, 1999.

and to conceptualize "development as freedom."[25] The mutual contribution of health and socioeconomic development to wellbeing is better understood, and reflected in the recognized complementarity of partnerships. Moreover, health is gradually conceptualized as an investment rather than a mere expenditure.

Development partners are also assessing the effectiveness of their own cooperation, and they are challenged to improve current ways to do business and to design new ways that would allow optimal individual and collective work. Monitoring and evaluation activities have gained importance for the donors as well as for international agencies and recipient countries. These approaches aimed at improving policy and program development, increase knowledge and accountability and strengthen organizational development through the use of external accountability to promote learning and exchange of best practices, improve systems through integration with performance management systems, and use results for policy and program development.

Sector programs are moving to SWAPS (Sector Wide Approaches) with greater emphasis on collaborative and partnered approaches, accountability and performance assessment. Projects, on the other hand are shifting to a program approach, to portfolio based reviews and greater concerns about self evaluation, clear focus on goals, networking and greater use of communication and information technologies. However, hurdles remain with regard to seeking coherence between goals and strategies, implementation processes, ownership and dealing with uncertainty and complex environments.

Another important trend is the increased involvement of private sector entities and civil society organizations as partners in development. The introduction of the Global Compact in 1999, by the Secretary General of the United Nations opened the door to private sector partnerships on behalf of UN programs. Corporations and other organizations were called to adhere to nine principles aimed at improving their corporate social and environmental behavior, which has generated expressions of "new philanthropy" and grantmaking as partners in international health development. However, monitoring and evaluation of private sector activities is still weak in some countries, which calls for better implementation of performance standards through regulation and appropriate national strategies and policies.[26]

Finally, there are important attempts to expand traditional sources of funding known as Official Development Assistance (ODA).[27] Net ODA increased from $51.4 billion in 2001 to $58 billion in 2002, an increase of almost 13% in absolute terms (5%) considering inflation and fluctuations in exchange rates. ODA is two thirds bilateral in nature and it

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[25] Ocampo, José Antonio. *Rethinking the Development Agenda.* http://www.un.org/esa/usg_ocampo/books/pdf/lcl1503i.pdf. See: Sen, Amartya, Development as Freedom, Alfred A. Knofp, New York. 1999. Stiglitz, Joseph A, *More Instruments and Broader Goals: Moving Toward the Post-Washington Consensus.* WIDER Annual Lectures 2, Helsinki, January. 1998.

[26] Zammit, Ann. *Development at Risk: Rethinking UN-Business Partnerships.* A Joint Publication by the South Centre and UNRISD (United Nations Research Social Development). December 2003.

[27] ODA are provided by the official sector of a donor country to developing countries (except the most advanced) through grants and subsidized loans for promoting the economic development & welfare of the recipient country.

represents 0.23 % of GNI as compared to 0.22% in 2001. Since the 1970s, health-related ODA showed a long-term upward trend averaging 3.3% annual growth. Recent estimates presented by the WHO Commission on Macroeconomics and Health requests donors to raise ODA for health from current annual estimate of $6 billion to $27 billion per year in 2007 and $38 billion in 2015, urging developing countries to devote an additional 1% of their GNP to health by 2007 and 2% by 2015.[28] Based on commitments, the amount of health related ODA increased by $1.7 billion from an average of $6.4 billion in 1997-1999 to $8.1 in 2002. Provided that the commitments made at the 2002 UN Conference on Financing for Development held in Monterrey materialize, the trend should continue. However, the challenge remains to ensure that these resources in fact support the achievement of the MDGs.[29]

THE CONTEXT OF HEALTH

The current health situation in the region reflects its complex macrodeterminants; particularly, it mirrors the impact of demographic transition, epidemiological polarization, health policy effectiveness and health services performance on the peoples of the Americas in the last decades of the 20th Century.

The start of the 21st century has witnessed major achievements in health in the Americas. The achievements in health, however, appear as a heterogeneous regional mosaic. These gains are associated with improvements in overall living conditions, that is, greater access to education, water and sanitation services, primary care, cost-effective technologies and expanded immunization coverage, which have contributed to deter communicable and non-communicable diseases with serious impact on health.

However, mortality trends are also associated with an increase in risk factors like haphazard urbanization, sedentary lifestyles, female and young people smoking, violence, stress, depression and other mental health problems and other ill-health life-styles and behaviors. In addition to malnutrition, which affects millions of people, and changes in eating patterns are creating a trend toward the prevalence of diets associated with a higher risk of chronic diseases and ailments. Injuries and deaths from external causes, especially motor vehicle accidents, violence and drug abuse, are increasingly identified as causes of morbidity and mortality.

Life expectancy at birth increased by almost six years between 1980 and the year 2000, and part of these gains are due to the reduction of risks of dying from communicable diseases and perinatal conditions, reduction in mortality from diarrheas, nutritional deficiencies, acute respiratory infections and vaccine preventable diseases. Smallpox and polio have been eradicated and measles will soon be a disease of the past.

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[28] The breakdown includes $22 billion to developing countries, $3 billion for research and development on diseases of the poor, $1.5 billion for the Global Health Research Fund, $1.5 B for existing programs e.g., tropical diseases research, and $2 billion from WHO, the World Bank and others.

[29] WHO *Macroeconomics and Health: Investing in Health for Economic Development. World Health Organization:* Geneva. 2001. http://www.cmhealth.org/

Population growth rates have declined in almost all countries (current annual regional population growth rate is 1.3%), and a 50% reduction in fertility in the last 40 years has contributed to longevity increases. This in turn has contributed to the preponderance of chronic non-communicable diseases and a greater awareness of issues related to aging because of the economic effects of higher dependency rates on society.

One remarkable contribution to the

Some achievements in Health in the Americas, 1980-2000			
Indicator	1980	2000	% Change
Life expectancy at birth (years)	66.9	72,4	8
Literate population (%)	88	93	6
Infant mortality (per 1,000 live births.)	37,8	25,0	- 34
Immunization coverage (%): DPT3	45	91	100
Immunization coverage (%): OPV3	51	91	78
Immunization coverage (%): Measles	48	94	96
Total fertility rate (children/woman)	3,0	2,5	- 17
Access to drinking water (%)	76	90	18
Access to sewerage services (%)	67	85	27
Nurses per 10,000 population	23,1	40,2	74

achievement of these gains has been the reductions of information asymmetries between patients and providers, though improvements in health literacy through expanded knowledge sharing, which allows those with access to make better choices about their health and that of their families and communities.

The pattern of distribution of health gains is however uneven, and health status mirrors socioeconomic disparities, that is, societies that exhibit smaller income gaps (not necessarily those with higher income) tend to present better health status indicators and better access to water and sanitation. Improvements in average levels of health that are not accompanied by improvements in the distribution of those health gains among the population are insufficient to generate human capital and sustain human development.

Epidemiological Polarization

The mortality and morbidity profiles show the simultaneous dominance of communicable and non-communicable diseases (which vary with the living conditions of the populations). Health conditions reflect these profiles, whereby the corresponding social responses structured through the health system. The evidence suggests that epidemiological changes in terms of exposure to risks of disease, injury or opportunities to become healthier do not follow a linear and irreversible progression, yet they can coexist, reverse themselves, and be determined individually, historically, and socially.

In terms of demographic and epidemiological dynamics, life expectancy for both sexes and for all ages exhibits an upward trend. The proportion of people 65 years and over is increasing at a faster pace (nearly 2 times faster) than the population as a whole, which will have implications for resources. Yet, this trend has slowed down in some countries due

primarily to AIDS, diabetes and external causes, such as violence and non-intentional injuries.

Type and Characteristics of Transition	Countries
Incipient transition: (high birth rate, high mortality, moderate natural growth [2.5%]	Bolivia and Haiti.
Moderate transition (high birth rate, moderate mortality, and high natural growth [3.0%]	El Salvador, Guatemala, Honduras, Nicaragua, and Paraguay.
Full transition (moderate birth rate, moderate or declining mortality, moderate natural growth [2.0%]	Brazil, Colombia, Costa Rica, Ecuador, Guyana, Mexico, Panama, Peru, the Dominican Republic, Suriname, Trinidad and Tobago, and Venezuela.
Advanced transition (moderate or declining birth rate, moderate or declining mortality, natural growth under [1.0%]	Argentina, Bahamas, Barbados, Canada, Chile, Cuba, the United States, Jamaica, Martinique, Puerto Rico, and Uruguay.

Because of the specific contribution of different groups of causes of death to longer life expectancy varies among population groups. In general, communicable disease control contributes more years of potential life gained, while the increase in mortality from external violent causes, as well as from cardiovascular diseases and malignant neoplasms, contributes more potential years of life lost. The weight of disability in healthy life expectancy is garnering more attention, and its adequate documentation requires reliable and practical instruments.

Life cycle

Children and Adolescents: Mortality patterns in children vary widely, depending on the subregion and, although there is an overall-decreasing trend, major disparities in infant mortality rates exist among and within the countries of the Region. Between 1980-1985 and 1995-2000, the increased provision of basic services (e.g., water and sanitation), the availability of simple, cost effective technologies (e.g. oral rehydration therapy, immunizations and simplified protocols for the control of acute respiratory diseases), improvements in health literacy and the implementation of health promotion strategies and primary health care contributed to a pronounced decline in the proportion of deaths from acute diarrheal diseases and acute respiratory infections in this age group.

Adults: AIDS mortality among young adults (25-44) is taking a toll on life expectancy. Mortality trends in the 45-64 age groups in the Region show patterns differentiated by sex, in which the risk of dying for men is double that for women for certain diseases. Among adult males, diseases of the circulatory system persist as the leading cause of death in the majority of the countries, while for some, the external causes component is an important contributing factor to a greater risk of dying among this group.

Older Adults: A clear upward trend in life expectancy can be observed for both sexes, although women having a longer life expectancy in every country in the Region. The aging of the population is a significant demographic trend implies greater need and demand for health care and other services linked with the quality of life and family environment in this age group.

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Special Groups

Disabled People: The issue of disability is gaining importance due to the longer life with chronic/non-communicable diseases and the influence of unintentional injuries on health outcomes. This population will demand more care and require reliable and practical instruments to document the prevalence of the conditions affecting them. The inadequacy of social security in several countries of the Region forces families to shoulder the burden of the higher medical expenses, which will increase the burden on the public services and the families themselves.

Workers: The type of work performed is a risk factor in terms of mortality, years of potential life lost, years of life with disability and disability-adjusted life years. Occupational mortality was equal in magnitude to mortality from tobacco use. In Latin America and the Caribbean, barely between 1% to 5% of the cases of occupational illnesses are reported, due to underdiagnosis, underregistration, and underreporting of morbidity and mortality in the workplace. Thus, the data do not reflect traditional occupational health problems or emerging health problems stemming from the application of new technologies, much less the problems associated with the work. Nor do they reflect the health problems of workers without social security coverage.

Racial and Ethnic Groups

Indigenous peoples representing 400 different languages (mostly concentrated in Mexico, Peru, Bolivia, Ecuador and Guatemala) comprise about 6% of the population of the Americas and about 10% of the Latin American and Caribbean population. Afro-descendants [30] include between 150-200 million people. Together, both groups comprise almost 25 percent of the population of the Region.

Racial and ethnic groups tend to be highly vulnerable to injury, disease and death due to their generally disadvantaged social positions characterized by higher rates of illiteracy, fewer years of schooling, tend to hold lower paying jobs, may suffer from discrimination, migrate frequently and/or live in disaster prone areas. Those conditions heighten the impact of poverty on health, and health indicators for these groups (infant mortality, life expectancy as well as prevalence and incidence of certain conditions) are substantially lower than for other groups which call urgent attention from policy makers.

Specific Health Problems

Communicable Diseases: Although a number of traditional infectious diseases have been completely or partially controlled, they remain a significant problem in many territories and populations. Malaria, HIV/AIDS and other sexually transmitted infections, dengue and tuberculosis, among others, have resurfaced globally as important causes of morbidity and mortality. The emergence of epidemic diseases, like SARS, West Nile Virus, "mad-cow" disease and hanta-virus, add complexity to the health problems, as well as to the search for solutions. This trend generates higher demand for the development of local, national, regional and global capacity to warn of and respond to epidemics.

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[30] Almost 50% of the English speaking Caribbean, and important percentages of the populations of Brazil, Colombia, Dominican Republic, Haiti, Venezuela and the United States.

Chronic Non-communicable Diseases, External Causes and Health Risk Factors: Chronic diseases, injuries and disabilities are responsible for two thirds of reported mortality. As life expectancy increases, cardiovascular diseases and malignant neoplasms become manifest more frequently. The rise in the incidence of neoplastic and endocrine disorders such as diabetes mellitus type 2 and the still significant relative weight of cardiovascular disease in the mortality profile are an important epidemiological characteristic of the Region's populations.

The resulting epidemiological profile reveals the vulnerability of populations to natural, social and biological disruptions, and calls for the strengthening of public health information and surveillance networks at the national and international levels.

Possible Implications for Public Health

Documentation of Inequalities in Health

- Measure and analyze disparities in health to improve decision making with equity criteria, and monitor the ability of societies to adapt to changing environments.

- Enable better understanding of the relationships between socioeconomic determinants and health outcomes.

Early Warning and Response Capacity

- Build capacity in early warning systems at local, national, regional and global levels to anticipate and timely respond to epidemics, develop information, integrated public health surveillance systems and establish health situation rooms to monitor and evaluate the health systems and situations.

Use of Epidemiology in Health Policy and Planning

- Reinforce the institutionalization and professionalization of epidemiology in government policy-making structures and academics.

- Develop human capital and national capacity public health, including the proactive use of epidemiology in health management, planning, policy analysis and evaluation.

Generation of Epidemiological Intelligence

- Stimulate the production and produce relevant epidemiological evidence and knowledge to support the steering role in health and the discharge of public health functions with new tools and skills.

- Produce high quality situation analysis with a view to improve capacity for policy making, public practice and advocacy.

THE UNFINISHED AGENDA

The UN attention to health as a critical component of human development is clearly expressed in many of the global summits during the last two decades, and prominently so when during the 8th Plenary Session, 8 September 2000 when the United Nations adopted the United Nations Millennium Declaration (A/55/L.2) 5/2. The Members States requested the UN to devise a road map for the UN Millennium Declaration and later, consultations among international agencies (World Bank, the IMF, the OECD, and the specialized agencies of the

United Nations) the General Assembly recognized the Millennium Development Goals (MDG) as part of the road map for implementing the Millennium Declaration.

Many of the targets represent a compilation of other targets set by international conferences and summits during the nineties, which became known as the International Development Goals. The MDGs commit the international community to an expanded vision of development, one that vigorously promotes human development as the key to sustaining social and economic progress in all countries, and focuses the attention of the international community on fostering a "global partnership for development", including increasing the official development assistance to achieve the other goals. The goals have been commonly accepted as a framework for measuring development progress.

The Johannesburg Summit on Sustainable Development enhanced the MDGs by including a goal to reduce the number of people without access to sanitation to 50% by 2015, and an action plan to ensure sustainable global development. The Johannesburg Summit was the last stage of the process, from Doha over Monterrey to Johannesburg, which maps out an overall strategy for the realization of the Millennium Development Goals. There nations of the world committed to sustain the declarations with concrete action.

Three of the eight MDGs are health related (Reduce child mortality rates by two-thirds, reduce maternal mortality ratios by three-quarters; and halt, and begin to reverse, the spread of HIV/AIDS, malaria, and other diseases), as well as target 17 (In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries) under the goal addressing the development of global partnerships. Most of the other five goals and related targets and indicators are also closely linked to health (e.g. nutrition, education, gender, access to safe drinking water). Nonetheless, goal eight seems to be the one necessary to reach the other seven.

The emergence of large number of at-risk populations such as migrant workers and refugees worsens the predicament of communicable diseases. Effective solutions in the

Millennium Development Goals (MDGs)

Goal 1: Eradicate extreme poverty and hunger

Goal 2: Achieve universal primary education

Goal 3: Promote gender equality and empower women

Goal 4: Reduce child mortality

Goal 5: Improve maternal health

Goal 6: Combat HIV/AIDS, malaria and other diseases

Goal 7: Ensure environmental sustainability

Goal 8: Develop a Global Partnership for Development

future call for a strengthened national capacity to meet the goals of eradicating and eliminating diseases such as poliomyelitis caused by the wild poliovirus, measles, neonatal tetanus, congenital syphilis, Chagas' disease, trachoma, Haemophilus influenzae type B infection and micronutrient deficiencies (vitamin A, iodine, iron and folic acid) and controlling lead poisoning and silicosis.

Income distribution has positive effects on poverty reduction. Considering the current and expected distribution in Latin America and the Caribbean, unless

concentration of income improves in most countries, the poverty target set by the UN Millennium Declaration will not be reached.

Growth with redistribution would enable countries such as Mexico, Uruguay and Brazil to meet the target in less than three years, whereas none of them will be able to do so by 2005 without distributive improvements. Similarly, Costa Rica, Ecuador, Guatemala, Panama and El Salvador would reach the target by or during 2009, but are unlikely to do so without such a distributive change...[31] . ECLAC also indicates that despite improvements in food availability, only 13 countries will be able to reach the goal of reducing hunger by 2015. Nonetheless, four countries will not achieve the target of child malnutrition and 10 may not increase the availability of food and therefore halve the percentage of undernourished people.

The greater visibility of health has been accompanied by the establishment of special funds and initiatives that will tackle the unfinished agenda, and prevent further deterioration of health status in many countries. Some of these initiatives include UNAIDS, Global Alliance for Vaccines and Immunization GAVI, The Global Fund against AIDS, Tuberculosis, and Malaria GFATM , Roll Back Malaria, or Stop TB. In fact, the 2003 World Health report, Shaping the Future outlines the global health agenda for the coming decade, warning that that "without significantly strengthened commitments from both developed and developing countries, the MDGs will not be met globally, and outcomes in some of the poorest countries will remain far below the hoped-for achievements." [32]

THE NEW AGENDA

In addition to completing the unfinished agenda, and sustain the achievements, the new agenda is equally demanding because of its complexity and the peculiarities that it acquires in each particular regional and national context, and for population groups.

The challenges ahead highlight the disparities in health that increase social vulnerability, the volatile nature of economic growth and the threats to national security. The governments and key sectors are keenly aware of the need to reduce the gaps in health and in access to health care. Similarly, greater attention is being placed on the international dimensions of public health and to its intimate relationship with national and local contexts.[33]

The countries recognize the need for renewed efforts to prevent and combat risks and disease, and therefore a renewed way of thinking about the new generation of reforms. These need to center on the health of the population, improvements in public health interventions, and greater government capacity to craft good health policies, and

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[31] Improvements in income distribution have remarkable effects on poverty reduction; a 5% reduction in the Gini index may reduce by two to five years the amount of time needed to lower extreme poverty fifty percent. CEPAL *Panorama Social de America Latina, 2002-2003.* Op. cit.

[32] World Health Organization. *Shaping the Future.* World Health Report 2003. World Health Organization: Geneva, August 2003. http://www.who.int/whr/2003/en/

[33] Roses, Mirta. *Presentación: Etica y Políticas de Salud.* Día de Etica y Desarrollo en el Banco Interamericano de Desarrollo (BID). 16 enero 2004. http://www.iadb.org/etica/sp4321-i/DocHit-i.cfm?DocIndex=1401

strengthen the capacity of government in discharging essential functions of public health.[34] Health for all and primary care remain a vision and a strategy worth pursuing. Thus, the reorientation of health systems and services affirms these commitments through those principles that include universal access and coverage, equity as part of the search for social justice, health promotion, the intersectoral approach, and comprehensive health care, with a view to building socially effective health systems that are capable of producing health and that generate social satisfaction within the framework of respect for plurality and the principles of universality, social participation, joint financing, efficiency, and decentralization.

Conversely, the new development agenda calls for long term goals, policy coherence, ownership, participation and collaboration leading to measurable results. Therefore, international development stakeholders are increasingly focusing on setting priorities, target setting and performance management that would allow greater focus on evidence based policies to better understand and address the problems that cooperation intends to solve, and focus on results with greater accountability and commitment.

Summary of Challenges of Public Health[35]

Trend/Category	Challenges
Globalization and International Public Health	◙ Anticipating and protecting populations from the transborder risks of diseases and environmental contaminants, including biological and/or chemical terrorism. ◙ Addressing national health within a regional and global governance frame of reference and new rules. ◙ Strengthening existing forms of national and regional governance to tackle the social and economic effects of globalization on health. ◙ Harnessing the benefits of greater interconnectedness to improve knowledge exchange, collaboration in health, and management of technology transfers. ◙ Improving and/or developing greater foresight in health policy, public health and epidemiology. ◙ Balance individual and common benefits.
Science and Technology	◙ Ensuring the equitable and ethical deployment of scientific and technological innovations to improve the human condition.[36]

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[34] Institute of Medicine (IOM). *The Future of Public Health in the 21st Century.* Washington D.C., IOM, 1988 and 2002. http://www.nap.edu/books/030908704X/html/ PAHO. *Public Health in the Americas. Conceptual Renewal Performance assessment and bases for action.* Washington D.C.: PAHO, 2002. http://publications.paho.org/english/moreinfo.cfm?Product_ID=666&CFID=6150152&CFTOKEN=52383841

[35] Includes deliberations of Discussion Topics from February 26, 2003, First Meeting of the Working Group PAHO in the 21st Century, Dominica.

[36] A recent initiative funded by the Gates Foundation has identified "grand challenges." These are "a specific scientific or

	◙ Harnessing as well as producing Information and knowledge for evidence based decisions. ◙ Improving the information flows and the quality of information exchanged within and across the countries.
Natural Resources ad Quality of the Physical Environment	◙ Reducing the gaps in the provision of clean water and sanitation services, the contamination of water and air sources, and the risks of chemical contamination. ◙ Improving the regulatory framework and levels of compliance to avert environmental degradation and loss of biodiversity ◙ Lessening the impact of the growth of mega cities on health and well-being.

Health Problems	
	◙ Persistence of high infant mortality and fertility in some countries or parts of some countries ◙ Persistence of unacceptable high rates of maternal mortality. ◙ Non-communicable diseases, increases in injuries, obesity, new emerging diseases ◙ Malnutrition ◙ Communicable diseases and emerging problems (e.g. SARS, Avian 'flu, drug resistant diseases, and others). ◙ Social contexts and factors that affect the spread of drug abuse and violence, including intrafamily violence. ◙ Antibiotic resistance: inability of current international legislation to take on the collective responsibility to act effectively on epidemics and global pandemics.
Research	◙ Measure disparities and inequities in health, considering the gender, race and ethnicity dimensions. ◙ Produce quality and reliable data for evidence based decision making. ◙ Consider the needs of applied research as they relate to health priorities and needs ◙ Need to improve the definition of disease patterns.

Bioethics	▣ Growing concerns to address ethical issues posed by transplants, cloning, and genetics.
Resources	**Human Resources:** ▣ Ensure that competencies and skills are appropriate to respond to the challenges needed to tackle. ▣ Address globally, regionally and nationally the brain-drain, which require political stability and stable economies to retain competent professionals. **Financial (internal/ external)** ▣ Improving levels of funding internally and externally (total funding from external sources has diminished, and funding is also a bottleneck ▣ Improving equity in the distribution and utilization of financial resources. **Intangible resources/assets:** ▣ Preserving and improving the intangible resources needed to achieve goals, such as knowledge, prestige, intellectual capital, credibility, respect, reputation, trust, etc.
Public Sector Institutions	▣ Addressing issues related to the efficiency and equity of international cooperation in health. ▣ Understanding that public service reforms need to enhance efficiency and that "if service is inefficient, work is going to be frustrated/retarded." ▣ Seek ways to strengthen governance, technical quality and management of human and available financial resources. ▣ Developing and/or improving vision and leadership.
Health Systems and Services	▣ Improving health services coverage and patient referral. ▣ Developing more efficient, effective and equitable systems. ▣ Investing to achieve universal access to health care ▣ Understand and address the transformation of demand patterns, as well as issues related to health care quality and patient satisfaction resulting from reduced asymmetries between patient and provider. ▣ Greater efficiency of health expenditures and improved allocation of resources and management is needed, in addition to additional financial resources. ▣ Address and control the over utilization of medical interventions. ▣ Promoting adequate incentives and reduce financial insecurity ▣ Managing the increasing cost of medical technology and its

	deployment.
Development Cooperation	◙ Orienting more needed assistance to the achievement of health related MDGs in the Region.
	◙ Effectively build national capacity in planning and management of international cooperation, in light of current trends towards more bilateral cooperation and the systemic shift away from short-term projects toward program support and SWAP (sector wide approaches).
	◙ Improving multilateral approaches and collaboration to preparedness and mitigation in the national agenda
	◙ Improving advocacy to better position health in international political and economic agendas, raise awareness about the links between health and development and establish effective partnerships.

Considering the changing and complex nature of issues relevant to the topic of this paper, similarly, challenges do and will change in nature in the future, perhaps in unexpected or undesirable ways. Therefore, in order to understand and address these and future challenges, it will be necessary to monitor those trends that influence health and health care, as well as the behavior of providers, patients and organizations and agencies that are involved in cooperation.

The table below suggests some of these for consideration:

Determinants	Trends to Monitor
Demographics and Social Trends	◙ Population growth and changing structure, particularly its effects on aging and the needs of this population (chronic non-communicable diseases, impact on health services and demand for complex technology).
	◙ Migration (e.g. impact of illegal immigrants on health services, cost, security)
	◙ Effects of migration and urbanization on quality of life and health in urban areas. Effects of migration and urbanization on quality of life and health in urban areas.
	◙ Incidence and prevalence of violence (social, environmental, political and interpersonal)

Political and Policy - Related	▣ Locating and using available resources in more innovative ways
	▣ Manage political pressures stemming from an expansion in the number of social actors participating in decision making
	▣ Design and implement intersectoral public policies.
	▣ Seek to effectively address the lack or misuse of available human and financial resources.
	▣ Reduce potential threats stemming from economic crises, unhealthy environments, and risky behaviors.
	▣ Identify and address health disparities through political action and policy making.

Finally, there are signs of emerging issues that may become more important in the near future, and where some dimensions clearly intersect with public health. Some of these include for example:

- Understanding the Interplay of geopolitics, economics, religion and technology and their effects on health and the environment.

- Balancing competing needs of population growth and resources.

- Incorporating ethical considerations in global decisions.

- Recognizing and implementing appropriate actions derived from the greater complexity derived from the intersections of ethnicity, race, gender, sexual orientation and social class and their implications for health and health care and respect for human rights.

- Developing and sustaining democratic resiliency for socioeconomic stability and peace.

- Ensuring that the global convergence of information and communication technologies works for everyone.[37]

- Averting the risks of more destructive terrorism, and controlling it. .

- Stopping transnational organized crime from becoming powerful and sophisticated global enterprises which could affect decision making and health.

- Addressing issues of illegal trade of illicit drugs, arms, intellectual property, people, human organs and toxic waste to reduce their effects on health and well being.[38]

The current and future challenges underscore the preeminence of reaffirming health as a social and human right, extend social protection in health and develop their public health infrastructure. Improved governance, enhanced institutional capacity, increased foresight,

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[37] American Council for the United Nations University (AC/UNU). AC/UNU. The Millennium Project. Global Challenges for Humanity. htpp://www.acunu.org/millennium/challeng.html

[38] Naim, Moises. Five Wars of Globalization: Other Fronts. *Foreign Policy*. http://www.foreignpolicy.com/story/cms.php?story_id=2

accurate surveillance and continuing monitoring are needed to address accumulated and current challenges and to anticipate and respond to future ones. While each nation will identify its own priorities and strategies, success will depend in part on shared regional goals built on values and national achievements.