PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

134th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 21-25 June 2004

Provisional Agenda Item 4.2

CE134/10 (Eng.)
24 May 2004
ORIGINAL: ENGLISH

MILLENNIUM DEVELOPMENT GOALS AND HEALTH TARGETS

The Millennium Development Goals (MDGs) reflect the outcomes of decades of consensus building within the United Nations system and of UN world summits and global conferences. The present set of MDGs consists of 8 broad goals, 18 targets, and 48 indicators (see Annex). Health has a paramount role in the MDGs Compact and this has brought the investment in people's health to the very center of the new global development agenda. PAHO seeks to utilize this broader mandate and momentum as a key strategic entry point to put health high on the political agenda of countries, subregional bodies, and regional organizations and to strengthen cooperation with its partners.

The MDGs are an integral part of PAHO´s strategic priorities. They are related to the processes of supporting national health development and extension of social protection in health. MDGs and its related targets are a key dimension of PAHO's commitment to health policies with measurable outcomes. Of prime importance is the focus on equity between and within countries. The Organization is presently engaged in a significant effort to integrate and mainstream the MDGs into its program of work at regional and country levels, and eight lines of action have been identified.

The year 2004 constitutes the halfway point to the challenging deadline of 2015 for the achievement of the MDGs. This paper outlines PAHO´s role in support of Member States for the attainment of the MDGs and requests input from the Executive Committee as to the direction of this effort.

CONTENTS

Page

Millennium Development Goals (MDGs): a Focused Common Agenda

1. The Millennium Development Goals reflect the outcomes of decades of consensus building within the United Nations system and of UN world summits and global conferences, starting with sectoral initiatives such as Health for All in 1978 and the first Children's Summit in 1990. The goals emerged from the UN Millennium Declaration adopted by 189 countries in 2000 and were affirmed at the Monterrey UN Conference for the Financing of Development in March 2002 through the Monterrey Consensus, the World Summit on Sustainable Development in September 2002 in Johannesburg, and the launch of the Doha Round on international trade.

2. In adopting the MDGs, the international community reconfirmed agreements reached at earlier UN summits, such as the International Conference on Population and Development in Cairo (1994), the World Summit for Social Development in Copenhagen (1995), the Earth Summit in New York (1997), the World Food Summit in Rome (2002), and the General Assembly Special Session on Children in New York (2002) but has reinforced them through the 2015 deadline. The goals focus on poverty reduction, set clear priorities, and propose a commitment to partnership between the developed and the developing countries through the important addition of Goal 8 of the MDGs, which commits the rich countries to increase their support to reach the MDGs. The present set of MDGs consists of 8 broad goals and 18 targets. A set of 48 indicators has been proposed to measure progress (see Annex). Many international organizations and donor agencies have since refocused their programs of work towards the achievement of the MDGs.

3. None of the goals are new and for all of them a broad body of knowledge and interventions exist—with perhaps the exception of some of the challenges raised by Goal 8 on partnerships. But the key challenge of the MDGs is not technical but political: for the first time in history, the global community has given itself such a focused common agenda and has called on governments, civil society, the private sector, and international organizations to give priority to poverty reduction and to reduce the inequalities in access to key determining factors of development. The most recent UNDP *World Development Report 2003* refers to this shared responsibility between major stakeholders as the Millennium Development Compact. The definition of critical measurable thresholds provides a new sense of urgency and a perspective that goes beyond the sectoral lens through which issues such as education, health, and the environment are usually approached. Within the context of the MDG framework, they are understood as key investment areas for poverty reduction and human development.

4. The key challenge of the MDGs lies with progress on Goal 1—halving poverty and hunger by 2015—since the achievement of all other goals depends on poverty reduction, economic growth, and reduction of inequalities. The Region of the Americas is

already one of the most unequal in the world. Some of the Gini coefficients for income inequality in 1999 were 0.5 in Peru, 0.6 in Bolivia, 0.59 in Nicaragua, and 0.64 in Brazil[1]. The regional Gini coefficient for infant mortality in 1997 was 0.33[2]; a recent report[3] of the Economic Commission for Latin America and the Caribbean/United Nations Development Program (ECLAC/UNDP) shows that the number of poor people in the Region is increasing. Simulation models on 18 countries of Latin America and the Caribbean indicate that if present trends were to continue only 7 of the 18 countries would reach the objectives for reduction of poverty in 2015. These countries are: Argentina (before the crises), Chile, Colombia, Dominican Republic, Honduras, Panama, and Uruguay. A second group of six countries would continue to reduce the incidence of extreme poverty but at a very slow rate. These countries are: Brazil, Costa Rica, El Salvador, Guatemala, Mexico, and Nicaragua. The other five countries—Bolivia, Ecuador, Paraguay, Peru, and Venezuela—would see an increase in the levels of extreme poverty and will never reach the targets unless their poverty rates experience a major trajectory change.[4]

5. Strengthening the political commitment to the MDGs in the Region of the Americas is still a challenge; and despite a range of efforts to establish a monitoring system for the MDGs at country level, very few countries have fully integrated the MDGs into their policy process. The importance of country ownership of the MDG process was addressed at the recent high-level conference in Brasília on 17 November 2003, which brought together political leaders and representatives of regional organizations from throughout the Americas and highlighted the importance of achieving a political consensus for the implementation of the MDGs in the Americas. It reinforced the partnership principle inherent in the MDGs and spelled out the responsibilities of governments, legislators, civil society, and the international community. It also highlighted that the objectives and targets of the Millennium Declaration coincide with the mandates and priorities adopted in the Summits of the Americas.

6. The Quebec Summit of 2001 gave priority to the elimination of poverty within a context of equity, democratic governance, and environmental sustainability. During the Special Summit of the Americas in 2003, the governments of the Region agreed on the Declaration of Nuevo Leon, which delineates three closely linked objectives to improve the well-being of the people of the Americas: economic growth with equity to reduce poverty, social development, and democratic governance. In relation to health, social

---

[1] Economic Commission for Latin America and the Caribbean, Instituto de Investigación Económica Aplicada, United Nations Development Program. *Meeting the Millennium Poverty Reduction Targets in Latin America and the Caribbean.* 2002. (Libros del CEPAL No. 70).

[2] Pan American Health Organization. *Health in the Americas: 2002 Edition*. Washington, DC: PAHO; 2002. (Scientific and Technical Publication No. 587).

[3] Ibidem, footnote 1, page 5.

[4] Ibidem, footnote 1, page 5.

protection for health was also recognized as a key element for national progress and countries committed to broaden prevention, care, and promotion strategies, with a particular focus on the most vulnerable segments of society. HIV/AIDS was considered of particular concern, as well as emerging and reemerging diseases, including malaria and tuberculosis and others.

7. The Brasília Declaration is a call to action and implementation,[5] which is strongly reinforced by the fact that a recent analysis suggests that no country in the Americas will likely reach all of the MDG targets. Indeed some of the greatest challenges for the countries of the Americas lie within the health area. Presently, the Region as a whole does not seem set to reach the ambitious targets for infant and maternal mortality, although the situation varies markedly between the countries of the Region and different population groups, as well as between the targets indicators.

8. A PAHO case study shows that if current trends continue, the reduction in infant and under-5 mortality would reach 54%, well below the two-thirds established in the goals.[6] In 2003, the infant mortality varied between 5.3 per 1,000 live births in Canada to 80.3 per 1,000 in Haiti. The situation of maternal mortality is also extremely varied, estimated at 16 per 100,000 live births in Cuba and 680 per 100,000 live births in Haiti in 2000. Over the past decade, some countries saw an increase in maternal mortality and some others a significant decrease. Further, calculations from the IDB show that the annual reduction between 2000 and 2015 to reach the target varies enormously, with 1.6% in Uruguay and 15.1% in Panama.[7] The HIV/AIDS epidemic is well established in the Americas, with national HIV prevalence of at least 1% in 12 countries, all of them in the Caribbean, with HIV prevalence among pregnant women exceeding 2% in six of them. In most of the other countries of the Region, the epidemics are more concentrated in certain areas or population groups.

9. The incidence of malaria varies enormously in the countries of the Region, but it is estimated that in 2002 31% of the population of the Americas lived in areas with some potential risk of transmission of the disease. Over 80% of the currently reported cases originate in the nine countries that share the Amazon rain forest in South America. In 2002, there were 223,057 cases of tuberculosis in the Americas, 50% of them in Brazil and Peru. The cases have been slightly decreasing since 1999. Within the WHO strategy to control tuberculosis, efforts in the countries of the Americas have been concentrated in

---

[5] Inter-American Development Bank, United Nations Development Program, Government of Brazil, Economic Commission for Latin American and the Caribbean, World Bank. Brasília Declaration: Proposal for Implementing the Millennium Development Goals. 17 November 2003.

[6] Pan American Health Organization/World Health Organization. Area of Governance and Policy. Salud en los Objetivos de Desarrollo del Milenio. Unpublished paper. 2003.

[7] Inter-American Development Bank. Los Objetivos del Milenio en América Latina y el Caribe: Retos, acciones y compromisos.

implementing and expanding the Directly Observed Therapy Short-course strategy, which will contribute to reaching the MDG tuberculosis target. There is therefore a significant role and scope for joint action by Member States and PAHO—with the support of other partners at country level.

10. The MDGs have brought the investment in people's health to the very center of the new global development agenda. Three of the eight MDGs explicitly refer to health issues—reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria, and other diseases. Seven of the 18 targets are directly related to the responsibility of the health sector—Target 2 malnutrition, Target 5 child mortality, Target 6 maternal mortality, Target 7 HIV/AIDS, Target 8 malaria and other infectious diseases, Target 10 safe drinking water, and Target 17 essential drugs. This high priority assigned to health underlines the new consensus that health is not only an outcome of increased development but lies at its core. The MDG framework underlines the synergy between the eight MDGs; indeed they are presented as an indivisible package. For the World Health Organization, for PAHO, and for their Member States, such an approach reinforces the Health for All and primary health care principles and strategy, which also places health at the center of economic and social development. The MDGs therefore provide the public health community with an invaluable entry point to politics and economics.

11. PAHO is presently engaged in a significant effort to integrate the MDGs into its program of work at regional and country levels in order to strengthen the support to countries in the achievement of the MDGs. Eight overarching strategic goals have been identified:

- Advocacy: Increase awareness of the health priorities set by the MDGs through a wide range of policy dialogues, partnerships, and intersectoral action throughout the Region of the Americas.

- Policy: Intensify action on national health development, ensuring social protection in health particularly at regional and local levels to support MDG progress and integrate the work on MDGs with health policy initiatives on health goals and targets and outcome-oriented health policies in the Americas.

- Technical Assistance: Support countries in implementing their national strategies as applied to the MDGs that focus on health.

- Integration: Integrate the work on MDGs with other strategic efforts in health development in the Region of the Americas, such as the Commission on Macroeconomics and Health, the efforts by subregional bodies, and the

identification of regional public goods as initiated by the group on PAHO in the 21st century.

- Partnerships: Engage in and increase cooperation with other partners, particularly for implementation at the country level, to obtain results.

- Empowerment: Increase health literacy and empowerment of communities through a strong civil society involvement at all levels to reach the MDGs—with a special view to the inclusion of ethnic groups, indigenous populations, and women.

- Monitoring: Improve measurement and monitoring of progress through high quality disaggregated health data at regional, subregional, and country levels.

- Research: Initiate research to strengthen the evidence base and generate new knowledge, in particular relating to synergies for health and development with a focus on Goal 8.

12. This means that the PAHO strategy will work to ensure the interface of three approaches: an issue-and-priority group approach related to the specific MDG targets that have been set in health; a national health development approach that strengthens social protection in health to build on outcome-oriented health policies; and an implementation approach that strengthens intersectoral action and involves civil society. All levels of PAHO—Headquarters, centers and country offices—will need to work together in new ways to respond with the urgency dictated by the MDG process, including strengthening the country offices to facilitate and support partnerships and strategic alliances at the national level. Indeed the very fact that solutions exist but are not accessible to the poorest is one of the key driving forces of the MDG agenda and needs a special PAHO effort to create a truly concerted approach between countries that recognizes health is a regional public good, as is being explored by the Working Group on PAHO in the 21st Century.

13. A reorientation in policy and strategy which complements the technical solutions will need to be developed by the Organization. This will have implications for PAHO's work at the country level in support of the ministries of health, by working with other organizations and stakeholders to create the massive political and financial commitment that is needed at the country level. In short PAHO's response will be at three levels: technical, managerial, and political. It will also be closely linked to the process of developing the 11th General Program of Work of WHO, which—precisely because of the WHO commitment to the MDGs—will have a longer deadline, that is, 2015 as its goal.

MDG Policy Context and Implications for PAHO's Approach

14. When addressing the health MDGs, in particular, it is essential to keep in mind the wider policy context. The year 2004 constitutes the halfway point of the challenging deadline of 2015. Only if collective efforts at national and international levels are intensified will countries be able to fulfill the MDG commitments and goals. This is due not only to lack of good governance at the country level or insufficient development aid. The world is still grappling with the differential impact of economic restructuring in the face of rapid globalization, which brings with it new winners and losers in the development process. For example, more than 50 nations worldwide grew poorer over the past decade, and a number of countries in the Region of the Americas are facing significant economic decline or reduced growth. Highly uneven development and increasing inequities on a global scale have been one of the signature themes of the last decade.

15. In the face of such global uncertainties, the Millennium Development Compact as proposed by UNDP applies a new principle: rather than allowing the present level of resources to set the pace of development, governments of rich and poor countries, as well as international institutions, should start by asking what resources are needed to meet the MDGs. Most estimates point to a figure of at least US$ 50 billion annually at a global level in additional aid or a doubling of current aid levels. At present the international community has committed to increase aid volumes by about $16 billion annually. Calculations that have been undertaken by the Macroeconomic Commission for Health[8] show that for low income countries an additional $27 billion per year would be needed in donor funds to address the most essential services and interventions.. Increasingly these analyses are being taken to the country level in order to assess the country's absorptive capacity and the potential for scaling up interventions.

16. In view of the unfinished health agenda in many of the countries, there is significant concern about the shift of overseas development assistance (ODA) away from the Region of the Americas. A recent analysis of the development committee of the International Monetary Fund and the World Bank[9] shows clearly that even modest increments of ODA could play a significant role in helping to lower middle income countries, such as Guatemala or Peru, progress more rapidly towards reaching the MDGs. Bolivia is quoted as a country that has progressed rapidly towards several MDGs but still needs to do much on health. For example, the achievement of the health MDGs will require sustained increases in the share of public expenditures in the health sector: the

[8] World Health Organization. Report of the WHO Commission on Macroeconomics and Health. Fifty-fifth World Health Assembly. 23 April 2002. Geneva: WHO. (Official Document A55/5).

[9] International Monetary Fund and World Bank. Achieving the MDGs and Related Outcomes: A Framework for Monitoring Policies and Actions, 26 March 2003. (No. DC2003-0003).

cost estimate provided by the report lies at $160 million a year, which goes far beyond the means that can be achieved through reorienting national resources.

17. For upper middle income countries, this analysis argues that while the bulk of resources to reach the MDGs must come from domestic sources, ODA should complement and support clearly expressed national policies that address social exclusion and focus on particular regions, issues, or population groups. In the Americas, this applies to countries, such as Brazil and Mexico, where large regional differences prevail and inequalities are frequently linked to a complex history of social exclusion of indigenous peoples and afro-descendant population. Positive examples, such as the effort undertaken by the state of Veracruz, Mexico, in addressing inequalities in health and education, or the creation of the Secretariat to Promote Racial Equality (CEPPIR) in Brazil, can serve as guidance in other areas and merit additional support from donors to achieve the MDGs. Indeed, this highlights, especially for large countries, the need for ODA to support action at the subnational level, i.e. regional governments or municipalities that commit themselves to addressing the MDGs.

18. But the concern for many countries in the Americas lies much more significantly in the key areas that are addressed in Goal 8, in particular the access to global markets and new technologies. This is an aspect that needs to be underscored in order to strengthen the political commitment to the MDGs in this Region. The MDGs matter to all countries and all regions of the world, not just to the poorest. We must not repeat the misunderstandings that hindered the implementation of the Alma Ata Declaration, which was interpreted by some to be of relevance only to poor countries—at its worst, poor care for poor people.

19. And given that the Region of the Americas is defined by some of the highest social inequalities in the world, it is essential that its middle income countries address inequities and gaps in development which in turn frequently find their starkest expression in health inequalities. For example, the infant mortality rate in Brazil shows a significant gap when analyzed by race: in Bahía, a state in which the afro-descendant population is predominant, the rate is 51 per 1,000 live births, double that of those states with a Caucasian population majority, such as São Paulo or Rio Grande do Sul (24.63).

20. There is a need for countries in the Americas to examine many of their macroeconomic frameworks with an eye to the achievement of the MDGs and other health goals and targets; for example, how to reconcile external and internal flows, how to reorient the focus of national investment plans, how to reconcile the social dimensions of development with the various plans to expand trade and the free flow of people, goods, and services. Finally, in order to address inequality and redistribution, many countries will need to reconsider their approaches to taxation.

21. Within such a policy context, the PAHO MDG strategy will be based on two key premises:

(a) Within its approved program of work, PAHO understands the MDGs as an additional entry point to strengthen investment in health and put health high on the political agenda of countries, subregional bodies, such as MERCOSUR, the Amazonian Cooperation Treaty (TCA), the Andean Community (CAN), the Central American Common Market (CACM), the Caribbean Community and Common Market (CARICOM), and regional organizations. While the MDGs have a strong technical component and fit naturally into the technical work already done within the Organization, their key intention is to create a sense of urgency, political commitment, and democratic accountability within a new strategic vision for development and cooperation between countries. In health, they break new ground precisely by moving technical issues, such as maternal and child health and infectious disease control, to a new political level for countries (by having been adopted by Heads of State), for donors (by moving beyond an exclusive focus on aid), and for regional bodies and international organizations. Because of this, the MDGs also provide new opportunities for PAHO to work on a common agenda with multiple partners, both at the regional and country levels.

(b) The PAHO strategy assigns a very high relevance to Goal 8 in all its dimensions, including the special needs of landlocked countries and small-island developing states. Over the last decade, countries in the Region have been exposed to increasing social and economic risks in the context of global restructuring, political instability, and civil strife in a number of countries. Therefore, the role of PAHO will imply not only the support for the implementation of interventions and the monitoring of the progress achieved on the respective health goals and targets but also a systematic analysis of the larger contextual and policy determinants—trade agreements, economic policies, immigration policies, etc.—and their impact on health. PAHO's work on the central role of establishing expanded systems of social protection in the Region thus gains new importance. Because of the high importance of Goal 8, the cooperation between PAHO and the World Bank and the Inter-American Development Bank through the Shared Agenda gains increased importance.

MDGs as Part of PAHO's Commitment to Health Policies with Measurable Health Goals and Targets

22. The MDGs underline the need to have clear measurable goals for global challenges and give a clear message of the priority need to invest in people through health and education. A key policy principle of the MDGs is that external assistance is to be better aligned with a country's own development priorities and that countries improve

the quality of their policies, institutions, and governance in moving to implement the action necessary to reach the MDGs. For PAHO, this means that the MDGs constitute an additional entry point in support of good health governance and outcome-oriented health policies appropriate to the specific regional, subregional, and country context. They coincide with PAHO's ongoing commitment to a public health policy orientation based on universality, solidarity, and equity as well as to accountability and transparency through common indicators and efficiency through synergy, collaboration, and partnerships.

23. Setting health goals and targets is not new to the Region of the Americas. Already some countries in the Region have embarked on sophisticated processes of setting health goals and targets ranging far beyond the areas covered in the MDGs. This approach goes back to the 1970s when the United States of America first launched the Health Objectives for the Nation. Since then there have been significant experiences gained around the world in setting health targets and objectives. In particular, the European Office of the WHO spearheaded such a process since the early 1980s and is presently in a process of revising the European Health Targets in view of recent developments. Increasingly these new health policies have gone far beyond being health sector documents only and have been developed with the input of other sectors, professional groups, parliamentarians, and civil society. Indeed it is more and more seen as a necessity that such documents be adopted by parliament and constitute a strategy for the government as a whole and not just one sector. In recent years, the interest in such outcome-oriented health policies has also increased in the Region of the Americas, for example, in Chile.

24. Having for the first time a set of clearly identifiable health goals at the global level which are part of an overall development strategy and have been endorsed by Heads of State is of great value for the health sector. This is an acknowledgment of the understanding of health as a key factor for social and economic development and provides inroads to finance, planning, and development ministries. For the poorer countries in the Region, the health MDGs—which have overall government commitment and will be an integral part of any country strategy to address the MDGs—will also provide an invaluable entry point to get health on the agenda of economic and social development strategies, and loan and donor negotiations. In consequence, this means that the strategies and approaches of the health sector and of health organizations such as PAHO need to be adjusted accordingly.

25. The process and product of monitoring the MDGs should be country-owned and driven. It includes the definition of how the MDGs apply to the country situation and how their achievement needs to be addressed through national development strategies, policies, and programs. In many countries, it requires the development of sustainable statistical systems and skills to analyze and use data for policy-making and programming. National planning and policy frameworks defined by United Nations and Bretton Woods

institutions, such as the Country Common Assessments (CCA), United Nations Development Assistance Frameworks (UNDAF), and Poverty Reduction Strategy Papers (PRSPs), while having different purposes, timing and contents, can assist in the implementation and monitoring of the Millennium Declaration.

26. The indicators included in the 2002 revised CCA Indicator Framework include those used for tracking the MDGs and therefore can facilitate the monitoring of the goals. The CCA lays the basis for the UNDAF process, which in turn can be used as a planning tool to assist in achieving the MDGs. When seen as pro-poor strategies and not only growth-seeking approaches, PRSPs are also a process that can also help achieve the MDGs. Annual reports on the PRSPs may also be used as a tool for the interim monitoring of progress towards the Goals. In turn, MDGs can be used as an entry point for a social sector focus in the PRSPs. The data from the MDG reports and an analysis of their policy implications can help balance the macroeconomic focus of the PRSPs. Use of those different frameworks within the context of the MDGs may help to ensure the provision of basic social services targeted towards the poorest.

27. Understanding the MDGs as an essential component, and sometimes as a driving force, of accountable health governance and integrating the Goals as a centerpiece of national health development and intersectoral national health goals and targets are a necessary prerequisite for a meaningful translation of the MDGs within a LAC context. This is essential since in the Americas the MDGs are not being introduced into a void but into a policy-rich environment. In recent decades, the Region has experienced a sequence of health reforms which in some countries have weakened public health systems and reduced access to health services. The difficulty in meeting some of the health MDGs reflects this clearly.

28. For the better-off countries in the Region who have reached the MDGs as national averages, the development of broader health goals and targets can integrate the MDGs with setting targets with special reference to disadvantaged groups and regions—and provide an incentive to set more ambitious goals in population health with a focus on equity. A study by the World Bank[10] suggests that a strategy directed towards disadvantaged groups would make it possible to meet the health-related MDGs while generating complementary benefits in terms of distributive equity. A case study developed by PAHO indicates a similar potential.[11] An ECLAC study indicates that the MDG poverty reduction targets are only feasible if countries succeed in becoming both

[10] Gwatkin D. Who Would Gain Most from Efforts to Reach the Millennium Development Goals for Health. In: *Health, Nutrition and Population*. World Bank; December 2002.

[11] Ibidem, footnote 7, page 6.

progressively richer and less unequal, for example, through the combination of a GDP annual growth rate of 3% and cumulative reductions in inequality of about 4%.[12]

29. In summary, for PAHO the operationalization of the MDGs will be very context- and country-specific and will require political commitment, leadership, innovation, and creativity by all concerned. Within PAHO, the MDGs therefore fall within a policy framework that extends beyond a poverty reduction strategy to a commitment to universality of access to health services and strengthening of essential public health functions. The work of the technical units involved with the health MDGs will be based on the premise that countries in the Region cannot be satisfied with the minimum—meaning that they would have reached the MDG averages—but that there should be a strong will to raise the bar and set national health goals and targets of a broader nature and with a focus on equity.

MDGs: a Motor for Democracy and Accountable Governance

30. The MDGs must also be understood as contributing to transparent and accountable governance. There are strong expectations that the focus on results and accountability would allow for the MDGs to be a motor for democracy. Ideally communities would be involved in setting national goals and strategies, and they would monitor and debate government performance based on reliable data. One reason stated for keeping the MDGs simple and straightforward is to allow poor people to be part of the process. The UNDP *Human Development Report 2003* proposes that the MDGs should be posted on the door of every village hall, they should be part of the campaign platforms of politicians, and they should be the focus of popular and social mobilization efforts. Not only government but many facets of civil society, in particular poor communities themselves, should be involved in a participatory process which places the democratic achievement of the MDGs at the center of public policies in the Region of the Americas as a key element to improve people's quality of life.

31. The Brasília Declaration acknowledges the important role of civil society in attaining the MDGs and expresses the hope that the MDG process helps strengthen democratic institutions and supports social inclusion, a culture of peace, and human rights. In June 2004, a major civil society meeting will take place in Chile, the Latin American and Caribbean Seminar. The main objectives of the seminar are to facilitate dialogue, capacity building, and partnerships between the UN, governments, the private sector, and civil societies towards the attainment of the MDGs in the Region.

[12] Ibidem, footnote 2, page 5.

32. Health plays a key role in making the MDGs tangible for communities as households and individuals experience very directly how the lack of action on one set of the MDGs—for example, poverty reduction or gender equity—is reflected in poor health outcomes. Communities also experience how the lack of investment in primary health care and the public health infrastructure holds them back from being able to ensure their livelihood. Here we find one of the key challenges of the health MDGs and targets: the improvement of health outcomes will depend significantly on a mix of strategies and the synergy that develops between them—the improvement of the public health and health services infrastructure in terms of access, quality, and efficiency; significant changes in the attitudes and behavior of communities, professionals, and policy-makers; and finally practically all other policy arenas touched upon by the MDGs. The reduction of maternal mortality will depend on concerted action that includes women's education, good roads, access to emergency obstetric care, and changed community values. Furthermore, gender equality is not limited to a single goal, indeed it applies to all of them. Without progress towards gender equality and the empowerment of women, none of the MDGs will be achieved.

33. One of the key challenges to the health sector and to PAHO will be to find the inroads to ensure credibility with communities and to build new confidence in public institutions. This is of particular importance in countries that have experienced significant civil strife and great neglect of the needs of indigenous populations. The PAHO MDG effort needs to put particular focus on working with parliamentarians and regional, local, and community leaders in order to reach the poorest communities in the Region. Examples exist in other WHO Regions such as the Equity Gauge Alliance that has developed a methodology to do this successfully and that is starting to be explored for the Americas.

34. The MDGs can also provide PAHO with a platform to work in new ways with the private sector and with civil society including professional organizations, such as the public health organizations of the Region. The action on the MDGs must work towards a reinforced commitment of the countries of the Americas to the principle that is a hallmark of democracies—that they do not exclude citizens from access to health services on the grounds of their ability to pay.

MDGs as an Integral Part of PAHO's Renewal and Strategic Priorities

35. The MDGs clearly fit as an integral part of PAHO's renewal and strategic priorities that highlight the following objectives:

- Address determinants,
- Protect health as a public good and human right,

- Create a synergy of actors,
- Ensure fairness of distribution.

36. One way to look at the MDGs and targets from a health perspective is to classify them as follows: Targets 1 to 4 address the classic social determinants of health, such as poverty, hunger and malnutrition, gender discrimination, and education. Targets 9 to 11 address established environmental determinants of health, such as safe water and sanitation, pollution, and urban poverty. Targets 12 to 18 address the new global determinants of health ranging from trade to debt relief. While this group of targets is not as logically coherent as the others, it does draw attention to major problem areas of global development. There are of course a range of ways to define the health targets which in most cases include Targets 5 to 8, but can also be seen to include the targets on hunger and nutrition, essential drugs, and safe water.

37. Whatever the detailed approach, such a view allows us to see the synergy between the nonhealth and the health-specific targets and see the health targets of the MDGs as a contribution to poverty reduction and quality of life.

38. Successful examples on how to address the health challenges set by the MDGs exist throughout the Region, such as the yearly vaccination week in all the countries in the Americas, but the necessary scaling-up can only be achieved through additional aid. A recent discussion paper by WHO argues that even with higher rates of economic growth and faster progress on the "nonhealth" MDGs that have an impact on health outcomes, such as basic education, gender equality, and water and sanitation, for many countries, it will only be possible to reach the health and nutrition MDGs if extraordinary measures are taken to improve the coverage and quality of health and nutrition services.

39. Additional aid has the most beneficial effect if it flows towards clearly set priority areas at the country level—highlighting the need for sound domestic health policies and improved governance mechanisms, including national health goals and targets. This means that development aid will need to move increasingly from project funding to a focus on up-front costs that help establish sound policies and governance as well as capacity building and that reinforce national efforts to address poverty and inequalities within a broader policy framework. The process of implementing the MDGs therefore also supports countries in addressing a set of major gaps that are part of health policy development:

- the operational gap in building efficient and sustainable public health systems and responses;
- the governance gap in involving wide segments of government and society in a truly intersectoral and participatory effort;

- the equity gap in addressing the health needs of the poorest.

Focusing on Equity: Priority Countries and Populations

40. PAHO has defined a group of Priority Countries for concentrating efforts of technical cooperation during the coming years. These are: Bolivia, Honduras, Nicaragua, Guyana—all World Bank PRSP countries—and Haiti. Of these countries, a recent ECLAC analysis shows that Bolivia will probably see increases in inequity, and Nicaragua will make slower progress in reduction of poverty than desired. A combination of PAHO, PRSP, and ECLAC socioeconomic analysis leads to the following set of countries that will need urgent support for the MDG process: Bolivia, Ecuador, Guatemala, Guyana, Haiti, Honduras, Nicaragua, Paraguay, Peru, and Venezuela.

41. But a country focus alone is not sufficient since many of the health inequalities faced in the Region of the Americas are based on geography, ethnic origin, gender, and socioeconomic status. It is crucial to address the key pockets of poverty in a region with the highest inequality in the world and in many cases these are also border areas or geographically remote places. The unevenness of development in the Americas will require the MDG process to develop focused strategies for specific groups that address both what has been called the "new poverty," for example, female-headed households and groups that historically have been excluded.

42. These huge disparities will not be resolved by aggregate economic growth alone but will require systematic interventions to create more equity, for example, in access to health for high risk groups and high risk areas. Findings consistently show that even very small reductions in inequality can have very large impacts on poverty reduction. This criterion makes it necessary to link the PAHO MDG strategy to, for example, the rural poor in neglected regions, urban marginal groups (such as young people without work), or female-headed households. Examples are the Pacific Coast of Colombia, the Atlantic Coast of Honduras, or the Brazilian Northeast. The fact that these depressed areas are often also border areas means that any strategy will need to build on bilateral coordination and even on subregional strategies involving a group of countries.

Ensuring an Integrative Approach to the MDGs

43. Such a perspective highlights the need to link the work on the MDGs clearly to PAHO's work on health systems, essential public health functions, and human resources development. PAHO will concentrate in particular on supporting countries in developing an integrated approach to the MDGs, building on its work not only in the respective program areas, such as maternal and child health or infectious diseases, but will integrate this work with its efforts in health systems development and social protection. The focus will be the synergy needed between the different health dimensions that are addressed in

the goals and the different levels of sectoral responsibility. A series of working groups have already been established to allow for this interface, including the links to the "3 by 5" strategy.

44. The MDG process will require a reliable epidemiological and socioeconomic information analysis. This is still hampered by the varied sources of statistical information, the lack of harmonization, and the lack of disaggregation of data. For example, the UNDP, in the *Report on Human Development 2003,* assumes that the under-5 mortality rate in Latin America and the Caribbean was reduced from 56 deaths per 1,000 live births in 1990 to 35 per 1,000 in 2001 and that the current trend will allow the Region to surpass the 2015 goal. PAHO, using data from the Division of Population of the United Nations, reaches a different, less optimistic conclusion, estimating that the reduction in the period 1990-2001 was only from 54.5 to 41.4 deaths per 1,000 live births—this of course has significant policy implications.

45. PAHO's technical work will also look in greater depth at issues of efficiency within the health and social sector. In the 1990s, a majority of countries of Latin America increased the percentages of GDP devoted to social spending, but this increase did not obtain the expected results. This means that PAHO will need to support countries to not only increase spending in the health sector and/or on specific programs but also to assess which mix of allocations provides both the most cost effective interventions and the greatest reduction in inequities. Of central importance is the issue of human resources in health, which has been a long standing concern of the PAHO office and for which the High Level Forum on the health MDGs has now established a working group to explore the issue in more depth at the global level. As a clearinghouse of information in health through the Core Health Data Initiative, PAHO will be able to provide many of the data required in monitoring and analytical activities of the MDGs.

46. PAHO will also take a lead role in discussions with donors on the new principles that are emerging for development assistance. A much higher percentage of aid will need to be provided in a form that can finance the incremental costs of achieving the MDGs. Aid will need to be timely and predictable in order to initiate and sustain reforms. Donors need to accept country priorities for national goals and targets, move from project funding to direct funding and grants where appropriate, and show willingness to meet increased concurrent costs of health programs through budget or sectorwide support or funding of well designed sectoral programs. Countries in turn will need to scale up their efforts in improving accountable health governance and the efficiency of health systems and institutions. There will be an increased need to monitor and analyze action towards the

attainment of the MDGs and make available examples of good policy and governance practice and lessons learned.

Efforts within PAHO

47. A strategic MDG team has been established in the office of the Director of Program Management. It works closely with the working group on the MDGs that has been established within PAHO, which brings together designated MDG focal points throughout all program areas for each of the directly health relevant targets; focal point for monitoring, communication, and global partnerships; and focal points representing key systems issues: social protection in health, public health, primary health care, health promotion, and environmental health. The task of this group is to develop the policies and mechanisms to help PAHO improve its support to countries in their effort to reach the MDGs in the Americas. It meets regularly to discuss strategies and approaches and progress and to ensure the integration of the action proposals into the program budget. It is supported by an intranet site. Country offices will have full access to the deliberations of this group.

48. A mainstreaming effort is under way with all areas of work in the Organization, and this has been spearheaded by the Area of Family and Community Health. The goal is both a reorientation and a reorganization of the work of technical units, the development of special partnerships between programs to reach the goals, a different time allocation of PAHO staff in order to support the MDG process at the regional, subregional, and country levels, as well as the creation of a new type of an integrated technical support team to the countries. A range of individuals, units, and programs within Headquarters and the country offices are being encouraged to contribute to the MDGs and adjust their programs accordingly.

49. Important strategic partners for some of the priority targets have been identified, for example, the healthy municipalities program, the local and urban development program (see Target 11 in relation to slum dwellers), or the gender and health program. As many programs as possible will need to have the attainment of the MDGs as part of their program vision and strategy and to liaise with others. PAHO will need to move from program initiatives to synergistic MDG initiatives that can be monitored and evaluated for impact.

50. High priority is given to the activities in maternal and child health, HIV/AIDS, nutrition, and water and sanitation. An effort is under way to identify the MDG-related activities in the Biennial Program Budget, for example, by flagging those expected results that will contribute to reaching the MDGs. A similar effort is under way to identify

projects financed by external resources, and the MDGs constitute a priority in PAHO's work with PAHEF.

51. Finally the MDGs have been discussed with the PAHO/WHO Country Representatives at all three subregional meetings held over the last few months, and an effort is presently under way to analyze and systematize the experience at the country level with the monitoring and implementation of actions to support the MDGs. In short a significant effort is under way to both align PAHO's work with the MDG mandate and to make PAHO's work, and the work with partners, more MDG sensitive.

52. Some activities in support of the MDGs that are under way are to:

- Support policy initiatives that will focus on the achievement of the health MDGs in the Americas, in view of the upcoming Summit of the Americas in 2005.

- Increase cooperation with the partners of the shared agenda, the World Bank and International Development Bank, in monitoring and implementing the goals at the country level.

  Engage the public health community of the Americas, public health associations and schools of public health, in the achievement of the MDGs.

  Engage the subregional groupings, parliamentarians, and civil society throughout the Americas Region in a dialogue on the importance of the health goals for the achievement of MDGs.

- Create a special working group of the key countries for developing the MDG action zones.

- Engage in an intensive dialogue between ministries of health and ministries of education on synergies to reach the MDGs for a high-level intersectoral policy initiative to strengthen school health initiatives throughout the Region.

- Make a concerted effort to increase the health literacy of the poorest communities with a focus on MDG priority areas, with strong links to Goal 2 (education) and Goal 3 (women's empowerment).

- Undertake the initiative on accountability for health in the Americas, whose goal is to apply and improve PAHO monitoring and information systems and use innovations such as GIS for mapping the progress achieved. Links of course exist to the national health accounts project as well. Such an initiative would include not only measuring health progress with regard to the MDGs but also monitoring

the support and partnership developments outlined in Goal 8, which calls for increasing resource shifts from north to south and increasing donor coordination at country and local levels.

- Pursue municipal action plans for MDGs to involve the many health municipalities throughout the Americas in a strong MDG initiative with a special focus on the poorest communities.

- Strengthen PAHO´s intellectual and strategic leadership role, for example, in areas such as health and security, health and trade, health and democracy, etc.

- Create a high-level policy advisory group that will advise PAHO on its MDG strategy.

53. In summary, action for PAHO implies:

- Ensuring the integration of the MDG process on the overall strategic direction of PAHO and HFA;
- Providing expert assistance to countries;
- Identifying key obstacles and sharing solutions;
- Monitoring progress at global and regional levels and ensuring the high quality of data;
- Engaging actors at all levels for the MDG process;
- Mobilizing resources.

Action by the Executive Committee

54. The Executive Committee is requested to provide comments and suggestions regarding this paper so PAHO’s work in this field can be further refined.

Annex

Effective 8 September 2003

The 48 Indicators of the Millennium Development Goals	
Goals and targets of the Millennium Declaration	**Indicators for monitoring progress**
Goal 1: Eradicate extreme poverty and hunger	
Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than less than one dollar a day	1. Proportion of population below $1 (PPP) per day[a] 2. Poverty gap ratio [incidence x depth of poverty] 3. Share of poorest quintile in national consumption
Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	4. Prevalence of underweight children under five years of age 5. Proportion of population below minimum level of dietary energy consumption
Goal 2: Achieve universal primary education	
Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	6. Net enrolment ratio in primary education 7. Proportion of pupils starting grade 1 who reach grade 5[b] 8. Literacy rate of 15-24 year-olds
Goal 3: Promote gender equality and empower women	
Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015	9. Ratios of girls to boys in primary, secondary and tertiary education 10. Ratio of literate women to men 15-24 years old 11. Share of women in wage employment in the non-agricultural sector 12. Proportion of seats held by women in national parliament
Goal 4: Reduce child mortality	
Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	13. Under-five mortality rate 14. Infant mortality rate 15. Proportion of 1 year-old children immunised against measles
Goal 5: Improve maternal health	
Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	16. Maternal mortality ratio 17. Proportion of births attended by skilled health personnel
Goal 6: Combat HIV/AIDS, malaria and other diseases	
Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	18. HIV prevalence among 15-24 year old pregnant women 19. Condom use rate of the contraceptive prevalence rate[c] 19a.Condom use at last high-risk sex 19b.Percentage of population aged 15-24 with comprehensive correct knowledge of HIV/AIDS[d] 20. Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14
Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	21. Prevalence and death rates associated with malaria 22. Proportion of population in malaria risk areas using effective malaria prevention and treatment measures[e] 23. Prevalence and death rates associated with tuberculosis 24. Proportion of tuberculosis cases detected and cured under DOTS (internationally-recommended TB control strategy)
Goal 7: Ensure environmental sustainability	
Target 9: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	25. Proportion of land area covered by forest 26. Ratio of area protected to maintain biological diversity to surface area 27. Energy use (kg oil equivalent) per $1 GDP (PPP) 28. Carbon dioxide emissions (per capita) and consumption of ozone-depleting CFCs (ODP tons) 29. Proportion of population using solid fuels
Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	30. Proportion of population with sustainable access to an improved water source, urban and rural 31. Proportion of urban and rural population with access to improved sanitation
Target 11: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	32. Proportion of households with access to secure tenure

Goal 8: Develop a global partnership for development	
Target 12: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Includes a commitment to good governance, development, and poverty reduction – both nationally and internationally Target 13: Address the special needs of the least developed countries Includes: tariff and quota free access for least developed countries' exports; enhanced programme of debt relief for HIPC and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction Target 14: Address the special needs of landlocked countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly) Target 15: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	*Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries (LLDCs) and small island developing States (SIDS)* *Official development assistance (ODA)* 33. Net ODA, total and to LDCs, as percentage of OECD/Development Assistance Committee (DAC) donors' gross national income (GNI) 34. Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation) 35. Proportion of bilateral ODA of OECD/DAC donors that is untied 36. ODA received in landlocked countries as proportion of their GNIs 37. ODA received in small island developing States as proportion of their GNIs *Market access* 38. Proportion of total developed country imports (by value and excluding arms) from developing countries and LDCs, admitted free of duties 39. Average tariffs imposed by developed countries on agricultural products, textiles and clothing from developing countries 40. Agricultural support estimate for OECD countries as percentage of their GDP 41. Proportion of ODA provided to help build trade capacity *Debt sustainability* 42. Total number of countries that have reached their Heavily Indebted Poor Countries Initiative (HIPC) decision points and number that have reached their HIPC completion points (cumulative) 43. Debt relief committed under HIPC Initiative, US$ 44. Debt service as a percentage of exports of goods and services
Target 16: In co-operation with developing countries, develop and implement strategies for decent and productive work for youth	45. Unemployment rate of 15-24 year-olds, each sex and total[f]
Target 17: In co-operation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries	46. Proportion of population with access to affordable essential drugs on a sustainable basis
Target 18: In co-operation with the private sector, make available the benefits of new technologies, especially information and communications	47. Telephone lines and cellular subscribers per 100 population 48. Personal computers in use per 100 population and Internet users per 100 population

The Millennium Development Goals and targets come from the Millennium Declaration signed by 189 countries, including 147 Heads of State, in September 2000 (A/RES/55/2, at www.un.org/documents/ga/res/55/a55r002.pdf*). The goals and targets are inter-related and should be seen as a whole. They represent a partnership between the developed countries and the developing countries determined, as the Declaration states, "to create an environment – at the national and global levels alike – which is conducive to development and the elimination of poverty."*

[a] For monitoring country poverty trends, indicators based on national poverty lines should be used, where available. The recommended indicator for this purpose is "Poverty headcount ratio (percentage of population below the national poverty line)".
[b] An alternative indicator under development is "Primary completion rate".
[c] Amongst contraceptive methods, only condoms are effective in preventing HIV transmission. Because the condom use rate is only measured amongst women in union, it is supplemented by an indicator on condom use in high-risk situations (indicator 19a) and an indicator on HIV/AIDS knowledge (indicator 19b). The indicator "contraceptive prevalence rate" is also useful in tracking progress in other health, gender and poverty goals.
[d] This indicator is defined as the percentage of population aged 15-24 who correctly identify the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), who reject the two most common local misconceptions about HIV transmission, and who know that a healthy-looking person can transmit HIV. However, since there are currently not a sufficient number of surveys to be able to calculate the indicator as defined above, UNICEF, in collaboration with UNAIDS and WHO, produced two proxy indicators that represent two components of the actual indicator. They are the following: a) Percentage of women and men 15-24 who know that a person can protect herself from HIV infection by "consistent use of condom"; b) Percentage of women and men 15-24 who know a healthy-looking person can transmit HIV. Data for this year's report are only available on women.

[e] Prevention to be measured by the percentage of children under 5 sleeping under insecticide treated bed nets; treatment to be measured by percentage of children under 5 who are appropriately treated.
[f] An improved measure of the target is under development by the International Labour Organization (ILO) for future years.