

CHAPTER 1: HEALTH, A CRITICAL FACTOR IN DEVELOPMENT

1. During 2003-2007, the work of the Pan American Sanitary Bureau (henceforth PASB or the Bureau) has been framed by the broader context of the great humanitarian and social development ideals set forth at global and regional summits in the last decade and a half, which positioned health prominently on the global and regional political agendas. With the Millennium Declaration, ratified by the heads of 189 states in September 2000, these ideals were embodied in the eight Millennium Development Goals (MDGs).

2. These goals comprise an unprecedented global plan to combat the social ills that perpetuate underdevelopment: poverty; malnutrition; disease; illiteracy; socioeconomic, ethnic, racial, and gender discrimination; environmental degradation; political corruption; and, as an underlying factor, the failure to recognize the dignity of the human being. Even though only three of the eight goals in the Millennium Declaration bear a direct relation to health—child mortality; maternal mortality; and HIV/AIDS, malaria, tuberculosis, and other infectious diseases—there is a close interdependence and synergy among them all.

3. Since the Millennium Declaration, the MDGs have been bolstered by the Region's political leaders. At the Special Summit of the Americas (Monterrey, Mexico, 13 January 2004), the heads of state and government of the countries of the Americas endorsed the values reflected in the MDGs by centering their deliberations on equitable economic growth, social development, governance, and the need to protect safety in the hemisphere. At that Summit, the goal was set, among others, to provide antiretroviral treatment to at least 600,000 people with HIV in the Americas by 2005.

4. At the "Millennium Development Goals, Proposals for the Summit" Forum (Brasilia, 4 August 2005), the ministers and representatives of the governments of Argentina, Brazil, Bolivia, Chile, Paraguay, and Uruguay and delegates of civil society organizations discussed the factors thwarting attainment of the MDGs, particularly those related to health and sexual and reproductive rights. The Brasilia Declaration established a political consensus regarding the adoption of the MDGs in Latin America and the Caribbean, underscored the importance of alliances between countries for attaining them, and outlined the responsibilities of governments, lawmakers, civil society entities, and the international community.

Health and Development in Summit Declarations

Summits of the Americas

“We emphasize that one of the pillars of human development and national progress is social protection for health and, accordingly, we will continue to broaden our prevention, care, and promotion strategies as well as investment in this field in an effort to provide quality health care for all and to improve, to the extent possible, social protection for all people, with a particular focus on the most vulnerable segments of society.”

Declaration of Nuevo León, Monterrey, Mexico, 12-13 January 2004

“We will strengthen cooperation and exchanges of information in the struggle against chronic diseases as well as emerging diseases and re-emerging diseases such as HIV/AIDS, SARS, malaria, tuberculosis, avian flu, and other health risks.”

Declaration of Mar del Plata, Argentina, 4-5 November 2005

Ibero-American Summit of Presidents and Heads of State

“We share the concerns raised at the VIII Ibero-American Conference of Ministers of Health, regarding the number of victims that continue to be caused in the world by a curable disease such as tuberculosis. It has a toll of 5,000 lives per day, making this the leading cause of death in people with HIV/AIDS. In the context of this concern, we second the proposal that health should be made the key topic of an upcoming Summit, and that the possibility be considered of implementing a Pan-Ibero-American Plan of Action to halt this disease, in line with the United Nations initiative for 2006–2015. We request that the Ibero-American General Secretariat submit proposals aimed at promoting actions and initiatives in different sectors, such as business and labor, or others, with the aim of helping to deal with this scourge that is affecting our society.”

Declaration of Montevideo, Uruguay, 3-5 November 2006

Summits of the Río Group

“Heads of State and Government agreed that in order to respond to the challenges posed by poverty and hunger, and achieve the highest level of economic and social development for their peoples, efforts must be focused on the most vulnerable in the population, with special emphasis on action for providing universal education, basic health care, and potable water, safeguarding the welfare of children and women, programs for the empowerment of women and young persons of both sexes, as well as the promotion of gender equality. They therefore agreed to promote development policies in their respective countries which accord priority attention to programs aimed at the reduction of poverty and the fight against hunger, as well as the achievement of the Millennium Development Goals.”

Declaration of Turkeyen, Guyana, 2-3 March 2007

“Considering that millions of the Region’s inhabitants lack access to basic health services, the incidence of child and maternal mortality, communicable and non-communicable diseases and the general unavailability of health insurance, the Heads of State and Government reaffirmed their commitment to a health Agenda for the Americas as currently discussed by member states of PAHO/WHO.”

Declaration on Social and Human Issues, Guyana, 2-3 March 2007

5. With the MDGs, for the first time in history the world community has a common program based on clear, measurable goals, which urges governments, civil society, the private sector, and international organizations to give priority in their work plans to reducing poverty and creating more equitable access to the determinants of development. The MDGs are the culmination of a long history that began in 1977 with the call for Health for All in response to growing unjust health disparities. In Alma-Ata in 1978, the International Conference on Primary Health Care urged the governments of the world to safeguard the health of their people using a rights-based approach. Since then primary care has been a platform for health policies in the Americas to put health within the reach of everyone, regardless of their economic or social conditions or where they live. The MDGs, by placing health at the center of development policies, offer an invaluable opportunity to renew and redefine the primary care strategy and the goal of health for all, in light of current epidemiological and demographic conditions, and sociocultural and economic trends.

6. Health has also held a prominent position at the subregional level in the last quinquennium. The 45th Directing Council, meeting in September 2005, issued a mandate to support the health action plans in the various subregional integration processes in the Americas. In order to target the Pan American Sanitary Bureau's efforts to the needs of the different subregions, alliances were forged with the agencies responsible for coordinating the health actions of the integration processes. In 2006, for the first time, Biennial Program Budgets (BPs) with a subregional focus were implemented. Subregional technical cooperation programs were worked out with the Caribbean Community (CARICOM), the Central American Integration System (SICA), the Southern Common Market (MERCOSUR), and the Andean Community of Nations (CAN), for the purpose of strengthening the structures and mechanisms for health development that these agencies have created in their respective geographical regions.

7. The forums in each of the subregional bodies have been used for reviewing and negotiating work proposals. The XXV Meeting of Ministers of Health of the Andean Area (REMSAA) provides an example of this, where the Ministers of Health agreed to consolidate their efforts to promote access to drugs by preparing a work plan that includes a mass communication and public information strategy, to provide continuity in joint negotiations for AIDS drugs and other strategically important drugs. The ministers of foreign affairs in CAN approved the Integrated Plan for Social Development (IPSD) in September 2004, which includes health as a line of work and defines actions to be taken through programs and community projects on the following issues: epidemiological surveillance, improving health conditions in border populations, and guaranteeing people's access to drugs and other health inputs. The Pan American Health Organization (PAHO or the Organization) is actively supporting these initiatives, which are coordinated with the Andean Health Organization—Hipólito Unanue Agreement (ORAS CONHU). Worth noting is PAHO's active support of the preparations for the

III negotiations for Antiretrovirals and Reagents for HIV/AIDS, which the MERCOSUR member countries will be joining. This cooperation adds to the support that PAHO has been providing for meeting the objectives of the resolutions adopted by the ministers of health when they meet at REMSAA at least once a year. Among these, in addition to those already mentioned, PAHO provides technical support to the countries of the subregion for implementing the International Health Regulations, using standardized epidemiological surveillance instruments and procedures, in addition to supporting the work of the Andean subregional committees on intercultural health, malaria control (PAMAFRO), disaster preparedness and response, and human resources.

8. In MERCOSUR, work is being done both with the Meeting of Ministers of Health and with working subgroups for health, agriculture, and environment in addition to their various subcommittees. Eight issues were jointly identified that were translated programmatically into five projects for that subregion, covering the issues of information systems and communicating for health, border health, International Health Regulations, National Health Accounts, the integrated strategy for dengue prevention and control, subregional regulatory measures on health, and environmental and occupational health. PAHO is coordinating implementation of the MERCOSUR subregional work plan with the corresponding president pro tempore. In addition, the Organization is involved in the dialogue between the Andean and MERCOSUR subregional bodies to identify commonalities between the two subregions and to develop a South American health agenda.

9. Central America and the Dominican Republic are very actively involved in health integration activities. Twice a year the SICA Council of Ministers of Health meets, and every year the RESSCAD (Meeting of the Health Sector of Central America and the Dominican Republic) sectoral forum brings together ministers of health and high-level representatives from the social security institutions and water and sanitation sector. The resolutions and agreements that come out of these political decision-making and consensus-building bodies are aimed at the countries' common problems, among them the prevention and control of communicable and noncommunicable diseases, and diseases stemming from external causes, as well as health and sanitation service delivery. The recent issuance of the Subregional Drug Policy, approved at the XXIII RESSCAD, which includes a common list of drugs and joint negotiations, is another example of how integration is advantageous in terms of scale and managerial and epidemiological action in improving the public health of the subregion.

10. In the mid-1980s, the Caribbean established a strategic framework for health cooperation that focuses on joint action and resources for priority health areas in the Caribbean countries. In addition, CARICOM established the Council for Human and Social Development (COHSOD) for coordinating on social issues in the subregion, including health policies. The ministers of health meet at least once a year to address

subregional health issues and to approve the budgets and programs of regional health institutions. During the last decade, the heads of state requested a review of the role and functions of these regional institutions with a view to improving their effectiveness. At their most recent annual conference, in July 2007, the heads of state agreed to merge the five regional health institutions into a single public health agency for the Caribbean. This decision contributes to health integration and provides a platform for more effective coordination of subregional health initiatives.

The Regional Panorama at the Start of the New Millennium

11. Since the 1990s, PAHO, along with other United Nations agencies, called for a transformation of patterns of social inequity in order to mitigate the difficult health problems of Latin America and the Caribbean. Conditions in the Region in 2000 revealed a complex panorama. The estimated population was 832.92 million people; fertility and mortality rates were dropping, while life expectancy for males and females was increasing at all ages, with the consequent aging of the population. Nevertheless, the pace of aging was slowed in some countries because of increased mortality from traffic accidents, violence, substance abuse, and other external causes. Although the demographic transition had different characteristics in each country, a simultaneous burden of communicable and noncommunicable diseases began to emerge in all of them. Among communicable diseases, problems with emerging diseases, malaria, cholera, dengue fever, tuberculosis, and sexually transmitted infections, particularly HIV/AIDS, were especially serious. Noncommunicable diseases included mental illness, cardiovascular diseases, cancer, and endocrine disorders such as type 2 diabetes mellitus. Countries had still not eliminated neonatal tetanus, congenital syphilis, or Chagas' disease, while the demographic and epidemiological transition was creating demands that taxed the precarious public health services infrastructure.

12. In 2000, millions of people in the Region suffered from disorders related to a poor diet, including anemia, obesity, malnutrition, and micronutrient deficiency. Some population groups—among them indigenous people, children, adolescents, the poor, the unemployed, the elderly, and the uninsured—had special needs that the health care system was not meeting. Others, such as migrant and informal workers, were exposed to various chemical, biological, and mechanical risks without having even a modicum of protection.

13. Furthermore, at the outset of the quinquennium, there were persistent economic, political, and social factors in the Region that were hardly encouraging for health equity, and it was recognized that approximately 211 million people were affected by widespread poverty, undermining their ability to exercise citizenship rights and participate in global markets. Unfortunately, the Region of the Americas was and continues to be the region of the world with the greatest income inequality.

14. Although by 2002, most of the Region's countries had reached several of the objectives related to the goal of health for all, indicators revealed marked differences between and within countries, although these were masked by national and subregional averages. There were, in addition, enormous health disparities between different population groups broken down by income, sex, ethnicity, age, and other health determinants.

15. The Region's economic growth rate was quite slow at the beginning of the quinquennium. According to the Economic Commission for Latin America and the Caribbean (ECLAC), in 2003, the Region's economies grew by only 1.5% and the GDP per capita remained stagnant, after having declined in 2001 and 2002. According to an 18-country study done by the United Nations Development Program (UNDP), ECLAC, and the Brazilian Institute of Applied Economic Research (IPEA), the trends at the time indicated that only 7 of 18 countries—Argentina, Chile, Colombia, Dominican Republic, Honduras, Panama, and Uruguay—would reach the MDG poverty reduction targets by 2015.

16. However, the panorama in the Region was not entirely bleak. Noteworthy advances had been made in many countries due to the reinstatement or establishment of pluralistic governments that were more tolerant of movements defending the rights of special groups, like workers, women, and ethnic groups, and that concerned themselves more with the environment. New institutional development processes, such as decentralization and deconcentration, had contributed to increased citizen participation at the local level, although insufficient for reducing social and economic inequities. On the other hand, democratization and decentralization had begun to generate greater citizen participation in planning and managing health systems and services in the Region.

17. Uneven efforts to modernize the state apparatus and strengthen regulatory systems, coupled with the effects of globalization and economic and political instability, led to a loss of faith in the capacity of the State to ensure equity. Furthermore, economic trade liberalization had not benefited all countries to the same extent, but national economies were increasingly connected among themselves in a global marketplace. Volatility, uncertainty, and widespread instability had been caused by severe political and economic crises, such as the terrorist attacks of 11 September 2001 in the United States, the reappearance of foot-and-mouth disease and the consequent impact on livestock exports in some countries, and several natural disasters.

18. Despite some improvements, in 2002 gaps remained in the provision of clean water and sanitation services. Some 15.4% of the population of Latin America and the Caribbean still did not have access to safe water; nearly 20.8% lacked access to sanitation, and only 13.7% of the wastewater collected by sewerage systems was treated before discharge. Although an increasing number of the poorest households had water

and sanitation services, they were spending proportionately more of family income on these services. The treatment and sanitary disposal of the thousands of tons of waste produced daily in cities posed a serious problem, as did the biological, chemical, and physical contamination of the air, water, and soil from urbanization, industrialization, transportation, and consumption patterns.

19. Several natural disasters had aggravated the problem of inequity and had disproportionately affected people living in makeshift shantytowns in extremely vulnerable sites. These disasters revealed the fragility of social structures and a fatalism that keeps prevention from receiving the emphasis it is due.

20. In Latin America, progressive reforms of the state had been achieved. Health systems and services had undergone internal transformations, especially with regard to the structure and organization of the services they provide, their financing, and the participation of the private sector and of private insurers in the design and implementation of new models of health care and service delivery. However, none of this had the expected effects, and several areas needed greater attention: health infrastructure, the essential public health functions, social protection in health, equity in access to health care, human resources, and quality of care. The capacity for managing human resources, which are the most valuable assets of health systems, was weak throughout the Region. The distribution of personnel was very uneven, partly from the effect of migration in search of better jobs. Salaries were low, working conditions poor, and there was a lack of connection between training of health personnel and the needs of the health services.

21. Notwithstanding the growing popular interest in health, general well-being, and diet, attempts to influence individual lifestyles had little effect in general, with the sole exception of the healthy communities and *municipios* initiative. This was due in part to poverty and low levels of education in the target groups. Public health itself had been undergoing a transformation, and there was a greater understanding of the determinants of health and disease. Nevertheless, some essential areas were neglected; there was a lack of measures for improving population health, prevention, general well-being, communities, public health infrastructure, and services delivery. At the same time, new and unexpected challenges had arisen, such as the real threat of biological and chemical attacks and pandemics from emerging diseases, for which the health sector in all the countries had to prepare.

A 2003-2007 Strategic Plan Inspired by Equity and Pan-Americanism

22. At the start of a new period in the Office of the Director of the Pan American Sanitary Bureau, the Strategic Plan 2003-2007 (hereinafter “SP 2003-2007” or simply “the plan”) was adopted in February 2003 in accordance with Resolution CSP26.R18 of the 26th Pan American Sanitary Conference. This plan was the response to a regional

health panorama characterized by enormous social inequities and focused on seeking equity and on the principle of Pan-Americanism, understood as mutual assistance between the countries of the Region for solving their problems.

23. The plan contains eight priority areas of action defined by the Member States and, in accordance with international mandates in favor of social equity, concentrating the allocation and mobilization of resources in certain vulnerable groups and in the countries most overwhelmed by indebtedness and poverty. Bolivia, Honduras, Guyana, and Nicaragua had high levels of foreign debt that impeded investments in their health infrastructure, among the most precarious of the continent. Haiti, the most underdeveloped country in the Region, had the highest rates of maternal and infant mortality.

24. PAHO not only needed to provide direct technical support to these Member States, it also needed to direct the attention and assistance of other countries of the Region toward them. At the same time, the Bureau was facing the need for complementing its concentration on those countries with systematic interventions aimed at the most vulnerable, unprotected population groups: women, children, and the elderly, particularly in the pockets of urban and rural poverty, including areas of “new poverty” in large cities, and indigenous and Afro-descendent populations.

The Eight Priority Areas of the Strategic Plan 2003-2007

- Prevention, control, and reduction of communicable diseases.
- Prevention and control of noncommunicable diseases.
- Promotion of healthy lifestyles and social environments.
- Healthy growth and development.
- Promotion of safe physical environments.
- Disaster preparedness, management, and response.
- Ensuring universal access to integrated, equitable, and sustainable health systems.
- Promotion of effective health input into social, economic, environmental and development policies.

25. Naturally, the eight priority technical areas in the Strategic Plan are not separate, independent spheres of action; instead, the natural interrelationship between many of their components makes it necessary to seek more flexible and integrated ways of carrying out the work of the Bureau. For strengthening its operating capability, PAHO wants its institutional development to be based on six concrete goals that are also part of SP 2003-2007:

- Communicate quality information in a timely manner to enhance process and impact of technical cooperation;
- Generate and use strategic intelligence to anticipate and increase proactive responses to future challenges and to reap the benefit of opportunities;
- Become a valued member of mainstream scientific and technological networks, harnessing knowledge to address regional health development;
- Become a recognized leader in transnational and global issues that affect regional and national health;
- Foster a creative, competent, and committed work force that is rated exceptional by its clients;
- Be a high-performance organization and set benchmarks for similar international health agencies.

26. A mass joint advocacy effort with the Regional Directors of the United Nations Agencies successfully raised political leaders' awareness about the overriding importance of the Millennium Declaration. The message of fighting poverty and hunger and promoting equity began to resonate with the Region, where 80% of the poor reside in non-poor countries.

27. Although the MDGs established by the United Nations were taken into account when the SP 2003-2007 was developed, it was prepared before the regional MDGs and their targets had been completely defined, which then needed to be incorporated into institutional activities as an integral part of PAHO's work. The "Faces, Voices, and Places" initiative, launched by PAHO in August 2006, was developed to help the poorest communities of Latin America and the Caribbean promote equity and attain the health-related MDGs. Based on a health situation assessment in individual communities, interventions are planned and implemented with PAHO technical support. Each intervention is grounded in the empowerment of the people and the establishment of horizontal partnerships between the community and technical assistance providers.

The Strategic Managerial Framework for Technical Cooperation in 2003-2007

28. Responding to Resolution CE130.R1, a managerial strategy was developed for attaining the expected results of the SP 2003-2007, using a three-pronged approach, which sought to: (a) move the unfinished agenda forward, that is, address pending areas that have not made sufficient progress; (b) protect the accomplishments already made with regard to health; and (c) prepare the countries for facing future problems, as well as the more persistent, intractable problems in the regional health panorama.

29. Mindful of the need for renewal in the face of the rapid changes in its operational environment, starting in 2003 the Bureau has focused its strategic management on a program of institutional transformation and development with four internal objectives:

(a) cooperation that is more country-focused and better integration among and within the various levels of the Organization, including the World Health Organization (WHO); (b) a stronger capacity to act as a regional forum for debating and developing public health policy; (c) greater availability of health statistics and public health information for policy-making, program development, and continuous learning, with a view to generating, sharing, and analyzing information, forming networks, and forging partnerships; and (d) creating an enabling environment for innovation in the provision of technical cooperation.

Strategic Framework for the Technical Cooperation of the Bureau in 2003-2007

Conclude the outstanding health agenda:

- Reduce the high mortality rates for mothers, infants under 1, and children;
- Improve the health indicators of the poorest sectors of society, including indigenous and Afro-descendent populations;
- Fight persistent preventable or curable “neglected” diseases, among them filariasis, trachoma, parasites, plague, Chagas’ disease, brucellosis, and yellow fever;
- Reduce malnutrition and food insecurity in the poorest communities of the Americas; and
- Increase coverage of potable water supply and sanitation services.

Protect accomplishments already made:

- Increase vaccination coverage;
- Improve local health development and governance; and
- Improve public health in border areas and integrate subregional health concerns; improve primary health care, and develop and promote solid public policies for improving people’s quality of life.

Face new, unmet challenges:

- The spread of HIV/AIDS;
- Violence;
- Severe acute respiratory syndrome (SARS);
- Avian influenza virus;
- The smoking epidemic; and
- Natural disasters.

30. This institutional transformation is being carried out with the participation of the entire Bureau staff, the World Health Organization system, other United Nations agencies, and the Member States. These have actively participated in the process through the Working Group on PAHO in the 21st Century, established in 2003 to review the Organization’s situation at the dawn of the new century, and to ensure fulfillment of certain of the institution’s performance parameters.

31. At the 45th Directing Council, held in September 2004, and at the Annual Managers Meeting of October 2004, the Director replaced the four initial strategic objectives of the managerial strategy for the institution's transformation with five new ones that, like the previous ones, stressed leading the Bureau to better serve the needs of the countries, adopt new modalities for technical cooperation, secure itself as the regional forum on health in the Americas, become a knowledge-based/learning institution, and improve management processes.

The Working Group on PAHO in the 21st Century

In September 2003, the 44th Directing Council of PAHO adopted Resolution CD44.R14 to establish a working group to review PAHO's situation in the 21st century. The group was comprised of Argentina, Barbados, Chile, Costa Rica, and Peru, in their capacity as members of the Executive Committee for 2003-2004, and it was open to all the other PAHO Member States and other organizations wishing to participate that had experience in the area of institutional reform in the United Nations, ensuring equitable distribution among the subregions. The Working Group on PAHO in the 21st Century was charged with reexamining PAHO's vision, mission, and values and recommending strategic changes that will enable the institution to face the main health challenges of the new century in the Americas and to contribute to the goals the United Nations set out in the Millennium Declaration.

After numerous face-to-face and virtual meetings and a process of analysis and discussion among the Member States with the support of the Secretariat, its final report was submitted (document CD46/29) to the Executive Committee, with recommendations on different matters related to institutional reform: the main regional public health problems expected for the coming years; the evolving nature of the associations and partnerships characteristic of international health development that could affect PAHO's function; regional and global public health goods and their relation to the Organization's mandate; the different forms of technical cooperation in health; PAHO's governance; and the human, financial, scientific, and technological resources that the Bureau has in the current context. The creation of the Working Group on PAHO in the 21st Century represented a decisive step in the process of modernization, reforms and strengthening that has enriched the Bureau's work in the 2003-2007 period.

Modernization of the United Nations and the Alignment of PAHO with WHO

32. In 1997, the Member States of the United Nations instituted a program of far-reaching institutional reform in order to more efficiently integrate the areas under its purview—especially sustainable development, human rights, and poverty eradication—into national development plans and ensure the greatest impact and effectiveness of international cooperation. The goal of this reform was to respond more efficiently, in a way that was consistent and congruent with country needs. All the agencies, as well as many bilateral donors, international financial entities, and other key collaborators, committed to harmonizing their cooperation strategies and planning cycles. The United Nations Development Group (UNDG) grouped together all the development-oriented funds and programs of the United Nations bodies in order to facilitate global policy-

making. At the same time, the Common Country Assessment was implemented along with the United Nations Development Assistance Framework (UNDAF), as strategic platforms for promoting attainment in the Member States of the objectives set at global conferences.

33. The World Health Organization (WHO) soon joined UNDG, and in the 2003-2007 quinquennium the Pan American Sanitary Bureau, as the WHO Regional Office for the Americas, undertook a process of institutional transformation designed to harmonize its policies and strategies with those of WHO.

34. In 2003, PAHO joined the Regional Directors' Group of the agencies on the Executive Committee of the United Nations Group of Latin American and Caribbean countries: United Nations Development Program (UNDP), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), and World Food Program (WFP). This group meets quarterly to coordinate joint activities in the Region and discuss topics relevant to providing an impetus for development and United Nations reform. Thanks to this interagency work, a joint report of all the regional United Nations agencies was prepared, entitled *The Millennium Development Goals: A Latin American and Caribbean Perspective*, published in 2005 by the Economic Commission for Latin America and the Caribbean (ECLAC). PAHO prepared the chapter on health and the MDGs, with input from UNFPA.

35. Additionally, the Regional Directors' Group has been supporting Uruguay in the United Nations reform process, since it is the Region's only pilot country and the only middle-income country of the eight selected pilot countries.

36. In 2006, PAHO served as host agency for the meeting of the Regional Directors' Group for Latin America and the Caribbean and presented the most recent advances in vaccination. At that meeting, the Regional Directors' Group signed a declaration recognizing the immunization program as a public good.

37. PAHO is a founding member of the group of cosponsoring agencies of the Joint United Nations Program on HIV/AIDS (UNAIDS) and, as such, it has continued to organize and attend the group's ongoing meetings for strengthening the United Nations' response to HIV and AIDS in Latin America and the Caribbean. In June 2003, the Regional Directors issued a declaration pledging to strengthen political dialogue on HIV/AIDS with the governments; intensify collaboration in that area with regional and subregional entities, civil society, and associations of people living with HIV and AIDS; and mobilize international resources to help the countries counteract this serious public health problem.

38. Since 2003, PAHO has achieved progressively greater convergence with the WHO cooperation strategy, illustrated by results-based management and country-focused technical cooperation. At the direction of its Member States, PAHO also modified its regional budget policy and restructured its budget by work areas, and with this has grouped activities independent of structures and has facilitated the use of the budget as a strategic management tool. In this regard, PAHO has been a pioneer among international cooperation agencies.

39. Alignment with WHO is one of the outstanding features of the Strategic Plan 2008-2012 (“SP 2008-2012”). This is described in the last chapter of this report, since in the coming quinquennium the Bureau’s expected results will coincide completely with the expected results in the WHO Eleventh General Program of Work and with the WHO Medium-Term Strategic Plan 2008-2013. The Bureau was the first of the WHO Regional Offices to hold consultations with their Member States concerning the Eleventh General Program of Work 2006-2015.

Country-Focused Technical Cooperation

40. A key element of the strategic management of PAHO throughout 2003-2007 has been the Country Cooperation Strategy (CCS), a medium-term cooperation framework that has been part of the process of alignment with WHO. The CCSs are aimed at improving strategic planning of the work in the countries and at better integration of the technical support given to every Member State. Each CCS process begins with a careful local situation assessment and includes broad advisory meetings with actors and key partners in the health field. This approach has been so important during the 2003-2007 quinquennium that the Country Support Unit has been restructured and placed under the Director’s Office. Another very important measure was the creation of the Institutional Development Unit in 2006, which has marked a new stage, with continuous monitoring of the internal transformation process as an essential step toward achieving results-based management.

41. Once the CCS was established as a guide to the work at the country level in the medium-term, the Bureau began using it in Bolivia, Guyana, Honduras, and Nicaragua. In Haiti, a provisional cooperation framework was prepared during the political transition, which has enabled all the United Nations agencies and donors to coordinate their actions. Each CCS takes into account the MDGs, regional and subregional agreements, poverty reduction programs, and national health plans, as well as the information gleaned from national counterparts and development partners. In 2004, an advisory meeting was held of the Priority Countries Working Group.

42. All the priority country CCSs have highlighted the Bureau’s role as an entity that facilitates alliances with other agencies and strengthens national capacity to coordinate

international cooperation and sector leadership. The countries have participated in several activities that have been instrumental to this function: UNFPA and UNICEF, with the involvement of PAHO Honduras and Nicaragua, held a workshop to determine the most effective interinstitutional collaboration strategies and formulate regional operating plans for 2005-2006. Another workshop, on harmonization and alignment, organized by the Regional Development Banks, was held in Honduras in November 2004. The CCSs of four of the priority countries have been presented to the World Health Assembly and those for the five priority countries have been presented at PAHO Headquarters. The approval of 30 Technical Cooperation among Countries (TCC) projects in 2005 and 2006 were a clear manifestation of regional solidarity. The subregional integration mechanisms have been strengthened with the approval of their respective biennial program budgets (BPB) in 2006.

43. Since 2003, the Organization has notably increased its capacity to serve the development needs of the countries and has facilitated Member States' participation in subregional, regional, and global collective agreements addressing health. The preparation of the Bureau's technical cooperation framework for 2003-2007 has been a strategic milestone. This framework, together with its corresponding program and cooperation strategy, has been aimed at achieving a closer working relationship with countries; identifying the neediest countries and population groups and priority action areas; broadening the Organization's participation in global, regional, and national political debates on health; addressing the underlying problems that determine health status; building capacity at the local, national, and subregional levels; forging strategic partnerships with different members; initiating contact with other entities; and facilitating knowledge sharing within the Organization and between it and other entities.

44. The Bureau also participated more in political dialogue and consensus-building processes, reflected in the approval of the Health Agenda for the Americas by the Region's countries. The Bureau played an important role in the activities of the Inter-American System through the Summit Implementation Review Group (SIRG) and the Joint Summit Working Group (JSWG) of the Organization of American States (OAS), as well as on the activities of the Inter-American Institute for Cooperation on Agriculture (IICA) and the Inter-American Development Bank (IDB). It has participated in various interministerial meetings with the health, environment, education, labor, and agriculture sectors and in intersectoral actions on the determinants of health; and in dialogue with international financial institutions, the Fund for the Development of the Indigenous Peoples of Latin America and the Caribbean (Indigenous Fund), the Ibero-American General Secretariat, and the Ibero-American Youth Organization (OIJ).

45. In 2005, directives were prepared for obtaining the full participation of the countries and of all the levels of the Organization in the development of regional and national health plans. Furthermore, throughout the quinquennium, PAHO Country

Offices were participating more in the Bureau's institutional processes and decisions, and there was greater synergy among the areas and technical units, partly as a result of virtual meetings. In general, an integrated, interprogrammatic approach has been adopted for regionwide strategies, reflected in the establishment of working groups focusing on various areas, including epidemic preparedness and early warning systems, and preparedness and response to an influenza pandemic; nutrition and HIV/AIDS; cooperation with priority countries; and chronic diseases.

46. A decentralization policy has been adopted to facilitate service delivery. In 2006, the Caribbean Program Coordination was assigned the task of promoting health cooperation in the Caribbean (in its third phase) together with PAHO's subregional specialized centers: the Caribbean Food and Nutrition Institute (CFNI) and the Caribbean Epidemiology Center (CAREC).

47. Regional adviser posts have been decentralized to boost the capacity to provide technical cooperation by means of specialized capacity-building networks in each country. Regional technical cooperation from the Sustainable Development and Environmental Health (SDE) area has been decentralized to the Pan American Center for Sanitary Engineering and Environmental Sciences (CEPIS); the Women and Maternal Health Unit (FCH/WR) has been decentralized to the Latin American Center for Perinatology (CLAP); and the Veterinary Public Health area has been decentralized to the Pan American Foot-and-Mouth Disease Center (PANAFTOSA). The Pan American Institute for Food Protection and Zoonoses (INPPAZ) was eliminated in 2005 and its activities were integrated into those of PANAFTOSA. Furthermore, the PAHO/WHO representatives have been delegated greater authority over the procurement of services and contracting.

48. In September 2006, PAHO established the Office for the Eastern Caribbean for the purpose of improving its technical cooperation and enhancing its presence in those countries and territories. In addition to the staff of the Country Office in Barbados, four country program coordinators were hired and strategically designated to Anguilla, Antigua and Barbuda, and Grenada.

The Regional Program Budget Policy

49. The approval of the Regional Program Budget Policy (RPBP) by the 45th Directing Council in September 2004 was a very important step. The RPBP is an explicit framework for guiding the allocation of resources toward achieving the results-based management (RBM) objectives, as well as the expected results for the process of organizational change.

50. The new framework for resource allocation agreed upon by the Member States has modified some of the fundamental elements of the Organization's program budget

structure, allocating a greater proportion of resources to country programs; it has created a subregional level for the allocation of technical cooperation support in the context of the subregional integration processes; and it has laid the foundation for the allocation of resources among the countries according to their needs and according to criteria of equity and solidarity.

51. In accordance with the RPBP, resources come from the regular budget (Member State quota contributions), from the WHO contribution (regular and voluntary), and from other sources (voluntary contributions to the Bureau). The RPBP improves alignment between the programs of work of PAHO and WHO and thus makes it possible for the Bureau to align its efforts with global and regional needs and mandates.

52. The RPBP has introduced a new policy for the distribution of resources among the countries that consists of two components: one basic and another variable. The basic component covers 95% of the allocation to the countries and consists, in turn, of two parts: one fixed and one needs-based. The needs-based allocation depends on the country's health situation (determined by a composite index of health needs); the fixed part is equal for all the countries, respecting the Organization's principle of cooperation with all the Member States, regardless of their relative health status. The variable part of the allocation, which will not exceed 5% of the total resources allocated to the country, is meant to lend flexibility to the allocation process.

A new subregional budget component

53. The principal objective of the new program-based subregional budget component has been to increase PAHO's assistance to subregional health integration processes in the Americas. These processes are primarily based in the Caribbean Community (CARICOM), the Central American Integration System (SICA), the Southern Common Market (MERCOSUR) in the Southern Cone, and the Andean Community of Nations (CAN). The subregional allocation category also encompasses regular and extrabudgetary PAHO resources intended for the three subregional centers—the Institute of Nutrition of Central America and Panama (INCAP), the Caribbean Food and Nutrition Institute (CFNI), and the Caribbean Epidemiology Center (CAREC)—and for the PAHO U.S.-Mexico Border Field Office in El Paso, Texas.

Institution Building in Accordance with New Global Standards

54. At the beginning of the new century, the Organization found itself in an environment characterized by a predominance of new expectations and global standards for international agencies. The reform undertaken in the United Nations System and the Inter-American System is a reflection of the general interest in strengthening governance,

improving planning and management processes, and increasing accountability and transparency. The fundamental purpose of these changes is to ensure that all of the institution's activities help bring about desired change in population groups.

Results-based management

55. In the 2003-2007 period, PAHO implemented results-based management (RBM). This means that all its activities have revolved around given desired or expected results, in particular, the changes it seeks in the health status of its Member States' inhabitants. In PAHO, RBM has focused on planning, execution, and management of the measures designed to attain the expected results in the SP 2003-2007. RBM has involved a gradual change in the managerial culture, which was reinforced in the 2003-2007 quinquennium through a new strategic planning process, biennial program budget (BPB), and performance monitoring by the American Region Planning, Programming, Monitoring, and Evaluation System (AMPES). Internally, RBM has required changes in all strategic planning and evaluation processes, in the delegation of authority, in the accountability system, and in staff development programs.

Planning, monitoring, and reporting

56. Planning is a fundamental aspect of RBM that is carried out in the Bureau in accordance with a logical method for the design of results-based projects (logical framework). Its principal elements are the Strategic Plan, which determines the results expected by the Secretariat for the Region; the program budget, which is PAHO's basic operational document; and the unit work plans, which are the previously described biennial program budgets (BPB). Starting with the planned results in the program budget, each unit prepares its biennial work plan, linking its own expected results with the approved regionwide expected results.

Governance

57. Strengthening governance has been an essential aspect of PAHO's institution building. As a result of the review done by the Working Group on PAHO in the 21st Century, in 2005 the Executive Committee created the Working Group on Streamlining the Governance Mechanisms of PAHO, in keeping with decision CE137(D5), to review several aspects of PAHO's government, among them the process for choosing the Director of the Pan American Sanitary Bureau and improving the Governing Bodies' rules of procedure. In particular, the group examined the activities of the Subcommittee on Planning and Programming (SPP); the Subcommittee on Women, Health, and Development; and the Standing Committee on Nongovernmental Organizations, and recommended ways to simplify and reorganize them.

58. The SPP was replaced by the Subcommittee on Program, Budget, and Administration (SPBA), invested with new functions, among them analyzing technical cooperation policies; planning, programming, and budgeting; strategic plans, program budget, and reports on performance and evaluation; and monitoring mainstreaming of gender equality in the Organization; in addition to examining official relations with NGOs. The Subcommittee on Women, Health, and Development was also dissolved and it was recommended that gender equity and sensitivity be mainstreamed in all technical aspects of the Bureau's work and in the overall public health reports to the Executive Committee.

59. The general recommendations of the Working Group on PAHO in the 21st Century include improving communication within Governing Bodies and amongst Member States; promoting involvement of NGOs and other professional associations in the Bureau's work; implementing a more formal, transparent process for selecting candidates for top senior posts; providing Member States with data on the operational, managerial, and financial practices of the Bureau; improving efficiency of the Country Offices; and enhancing the relationship between PAHO and WHO. It also highlighted the work of the United Nations' Joint Inspection Unit in the review of results-based management and the recommendations of the internal and external auditors.

Road Map for Institutional Transformation

60. The transformation of PAHO stemmed from several internal initiatives launched in 2003 for the purpose of renewing the Bureau and adapting it to the requirements of SP 2003-2007. In its early stages, the process led to a new structure, to new ways of delegating authority, and to the establishment of the Executive Management Group. But this process was being undertaken at the same time the Bureau was trying to achieve the objectives of SP 2003-2007 with limited resources. In March 2005, the Director launched the Road Map for Institutional Transformation, containing 11 initiatives related to the five key strategic objectives in the management strategy. Eleven working groups were formed, each in charge of reviewing and analyzing one of the 11 initiatives and formulating recommendations to facilitate its implementation.

61. All the Road Map groups have issued recommendations that have been used in developing the expected results and setting the appropriate indicators for the Strategic Plan and the area-specific work plan for 2008-2012. Furthermore, since the launch of the Road Map, new political decisions have been made with guidance from the WHO and PAHO Governing Bodies, especially in connection with the deliberations and conclusions of the Working Group on PAHO in the 21st Century, the resolutions of the 45th Directing Council concerning the new Regional Program Budget Policy (RPBP), and the subsequent recommendations of the External Auditor.

62. The Road Map has raised awareness in the institution of the value of teamwork and has provided an example of long-distance collaboration between groups through the use of new communication technologies.

**The Strategic Objectives for Organizational Change and the 11 Initiatives
of the Road Map for Institutional Transformation**

- *Respond better to country needs*
Country-focused cooperation
Organization review of the units and program areas
- *Create a knowledge-based/learning organization*
Leadership development and learning
Knowledge management
- *Adopt new modalities of technical cooperation*
Regional public health plans
- *Make PAHO a regional forum for health in the Americas*
Public Health in the Americas Form
- *Enhance management practices*
Standards for accountability and transparency
Internal communication
External communication
Human resources strategy
Resource mobilization

Create a knowledge-based/learning organization

63. During the quinquennium, PAHO has implemented a strategy for knowledge management and information technology aimed at turning the institution into an authoritative source of public health information and a learning organization based on collaboration and on the formation of networks and associations. The Area of Publications (PUB) has generated many books and other technical materials of a practical nature for public health professionals, researchers, and other health workers, as well as for experts in other fields and people interested in the health problems of the American continent.

64. The Information and Knowledge Management Area (IKM) and the Information Technology Services Area (ITS) have worked together during the quinquennium on forming communication networks inside and outside the Bureau. As a result, connectivity

among the PAHO/WHO Country Offices has been improved, and virtual forums for teamwork have been created. The expanded use of *SharePoint* as a work platform has enabled more efficient collaboration on document preparation. Measures have also been adopted—virtual meetings, teleconferences, and electronic files—for reducing the costs of document preparation and distribution. In general, country support has improved thanks to the use of these and other communication technologies.

65. Various external communication networks have been formed, including one for Health in the Americas (2007); the Ibero-American Networks; the Regional Forum for Public Health in the Americas; and the Virtual Campus for Public Health, during the pilot phase of which more than 80 mentors were available for distance learning and 250 workers received training on the most pressing health public problems. The pilot phase led to reorienting the strategic model to one with an open, decentralized network approach. Institutions from six countries currently participate in the Campus with technical assistance from INFOMED. In the 2006-2007 period, the second phase was carried out, and the support served as a point of contact between the Virtual Campus for Public Health and the virtual health libraries system, promoted by the Regional Library of Medicine (BIREME) on the one hand and the PAHO policy on information and knowledge management on the other.

66. A new tool for virtual collaboration has been adopted by the Organization (*Illuminate Live!*), and personnel have been trained, with WHO support, on the Health InterNetwork Access to Research Initiative (HINARI) and Global Information Full Text (GIFT), which put a broad collection of journals and biomedical databases within the reach of WHO personnel around the world and public institutions in developing countries.

67. Improvements have been made in knowledge sharing between experts in various fields, as well as in staff members' abilities and skills, through the *Digital Literacy* training program; through *Help Desk*, a technological assistance system for staff members; and through courses and workshops on knowledge management, both at Headquarters and in the countries.

68. In 2006, a new Bureau website was created and websites were also created for the Country Offices and for the units and projects at Headquarters, in order to standardize the Organization's image.

69. A blog has been created on PAHO's website where the Director voices her opinions and engages in lively debate with health professionals in the countries. The blog is part of a communication strategy whose main purpose is to make PAHO a special and reliable source of public health information and to keep the people of the Americas informed about the activities of the Organization. Since the blog was created, it has

received more than 54,000 visits. Opinion articles by the Director have been published periodically by the main mass media in the Member Countries, leading to strengthened institutional presence throughout all subregions. Interviews have taken place, and special reports have been published in the press and in electronic and specialized information sources in the Americas and even in other regions.

70. Internationally known stars from the world of entertainment have actively participated in campaigns and other activities sponsored by PAHO for the promotion of public health in the Region: Don Francisco in the fight against obesity; Monica, the comic strip character, in the activities surrounding Immunization Week; and other artists belonging to the ALAS Foundation in the promotion of other causes, including the fight to eliminate violence against women and road safety promotion.

71. PAHO has produced public information materials and has distributed them to a very large audience. A number of staff members have given interviews on different aspects of public health in the Americas, and a number of agencies, wire services, and television programs have profiled PAHO programs and initiatives. Through the use of fresh, modern graphics highlighting significant information on key subjects, PAHO reached ever larger audiences. Special posters, folders, calendars, publications, and related items have also helped spread the word about the initiatives of the Organization, and a partnership with the NBA Washington Wizards basketball team showed PAHO health messages to new audiences.

72. PAHO's biannual magazine, *Perspectives in Health*, showed a growing audience throughout the world the human face of public health, and the Organization's newsletter, *PAHO Today*, helped audiences keep up with activities and programs.

Developing scientific and technical information and communication infrastructure and capacity

In the last five years, PAHO, through BIREME, has consolidated initiatives, programs, and information networks that guarantee equitable access to information and scientific knowledge. Prominent among these are the Virtual Health Library (VHL) and the Scientific Electronic Library Online (SciELO), through which PAHO has contributed to the dissemination of scientific and technical information and to the utilization of the knowledge, technologies, and innovations generated by scientific research and field experience. The Region as a whole and the vast majority of the countries have advanced steadily in the compilation, organization, publication, indexing, conservation, use, and evaluation of scientific and technical information.

In the last three years, expansion of the VHL in the Region has led to PAHO's participation in initiatives promoted by WHO, including the Global Health Library, which exports the VHL platform to other WHO regions; the ePORTUGUÊS network, which takes the VHL to Portuguese-speaking countries; and the TropIKA Initiative (Tropical Disease Research to foster Innovation and Knowledge Application) for research on infectious diseases that affect poor populations. BIREME cooperates with the United States National Library of Medicine (NLM) through the VHL and SciELO networks, and has strengthened its ties with Spain and Portugal.

The VHL and SciELO have entered the global knowledge economy through scientific information systems, networks, and services that operate on the Web, including NLM's PubMed, ISI/Thomson's Web of Science, Elsevier publishing company's Scopus, Google Scholar, Lund University's Directory of Open Access Journals in Sweden, and others. SciELO in particular represents one of the principal international initiatives for open access to scientific knowledge. The VHL and SciELO are also connected to other regional networks, such as the Virtual Campus for Public Health (VCPH); the Iberoamerican Cochrane Network; and the ScienTI network, run by national councils on science and technology that provide directories of researchers and research groups, institutions, and projects.

The VHL offers open access, universal, and up-to-date services, with interfaces in Spanish, English, and Portuguese, to the principal reference sources for national, regional, and international scientific and technical health literature.

In 2007, there were more than 100 VHL portals, with regional, national and subject-matter coverage in all Latin American countries and many Caribbean countries. The VHL has also facilitated the creation of virtual communities, practice communities, and learning and information environments in health institutions and settings, contributing in this way to social inclusion and access to information.

Adopt new modalities of technical cooperation

73. The Regional Public Health Plans have been the key to attaining this objective. These plans, collectively developed by the countries, represent a regional commitment to addressing the most pressing public health problems comprehensively and with clearly defined goals, objectives, and strategies. They constitute a call to collective action and are a strategic and unifying tool linking the activities of a network of national entities—from the public and private sector, institutions and centers, NGOs, financial agencies, and

civil society—in order to efficiently achieve common goals and objectives with support from international organizations such as PAHO. The Regional Public Health Plans serve as instruments of governance and negotiation that promote democratic stability and contribute to countries' social development.

74. The Regional Public Health Plans also include novel cooperation modalities, such as horizontal cooperation among and within countries, and among academic, scientific, and research institutions; the establishment of revolving funds and trust funds to promote economies of scale; the manufacture of inexpensive, good-quality supplies, materials, products, drugs, and food; cooperation with a subregional focus; and interprogrammatic work in the Secretariat through the creation of working groups, joint missions to countries, focus on priority countries, joint projects among different programs, creation or expansion of virtual networks, and mobilization of resources for joint projects.

Standards for accountability and transparency

75. A number of the recommendations of the Road Map working group in charge of this initiative have been channeled through the Integrity and Conflict Management System (ICMS), under the corresponding Coordinating Committee, made up of the Grievance Panel, the International Labor Organization's (ILO) Appeals Board, the mediator, the head of the Ethics Office, the Area of Human Resources Management (HRM), the Office of Legal Affairs (LEG), and the Staff Association; the ICMS Focal Point in each country; Internal Oversight Services; and the Information Security Officer. The purpose has been to improve mechanisms for individual and institutional accountability through clearly defined, communicated, and implemented policies and procedures governing standards of conduct for staff members, conflict of interest, financial disclosure, reporting of complaints, relationships with partners and governments, and the use of the PAHO and WHO names and logos.

76. The accountability system is part of PAHO's overall internal system for institutional governance and supervision. It defines the flow of authority and its purpose, as well as the responsibility inherent in the exercise of that authority. In PAHO, accountability occurs at different levels: (a) in the units, through AMPES and the BPB; (b) at the individual level, through the personnel performance evaluation process (PPES, which was automated in 2006); (c) through the PAHO competencies; (d) through existing financial and staff regulations and rules; and (e) through the existing model for delegation of authority. In the 2003-2007 quinquennium, the PAHO accountability system was brought into line with that of WHO.

77. During the quinquennium, the Administrative Management Operations Unit was created, based on the experience of the work done by the special adviser for field activities. Broader institutional monitoring and development functions were formulated,

and outfitting of the Office of Internal Audit was completed. Improvements were also made in the areas of Finance and Procurement (FAMIS/ADPICS), Financial Management, Personnel (PAS), Staff Health Insurance (SHI), Map Products Information System (MAPS), Correspondence Tracking System (CTACS), Leave Tracking System (LTS), Payroll, and various Web/Intranet applications.

78. In 2007, a thorough review and revision was undertaken of all delegation of authority and accountability processes, in line with the current resource mobilization strategy. The Bureau's competencies model was updated to give greater added value to technical cooperation. The review of staff member competencies and strategic alignment of personnel in the Caribbean Program Coordination (CPC) office were begun.

Internal and external communication

79. Much progress has been made with regard to strengthening internal cooperation, networking, teamwork, and information and knowledge sharing. This can be seen in the internal interprogrammatic working groups in the technical areas and at the area managers' quarterly meetings. The knowledge management strategy and the Road Map have given rise to initiatives that have facilitated internal communication.

80. In 2005, the Road Map working group did a market survey in the Member States and among personnel and other interested parties to determine what the international community expected from PAHO. The results revealed the need for making communication more transparent, speeding up organizational change, improving efficiency, and achieving more cohesive leadership. The direction that the institutional transformation is taking was validated and greater emphasis was placed on forming institutional and intersectoral alliances. The study also revealed that PAHO holds a significant and unique place in the field of public health in light of its technical capacity, knowledge, presence in the countries, close relationship with national authorities, and the dedication of its staff.

The human resources strategy

81. In line with a related activity undertaken by WHO in 2005, the Bureau initiated a Strategic Assessment and Resource Alignment (SARA) exercise. The activity is designed to ensure that management unit objectives, functions, and resources (primarily human resources, but also finance and others) are both well defined and clearly aligned with the Organization's strategic priorities.

82. A new competency model is being instituted as an essential tool for achieving greater strategic alignment. Staff members are being assigned to those functions where their respective competencies are more needed, and an individual development plan is

being prepared that will make it possible for each staff member to acquire or improve the competencies they need for performing their functions. Generic post descriptions are being prepared for all positions. The inclusion of hiring goals for each sex and geographical area in the Strategic Plan 2003-2007 represents a great step toward mainstreaming gender equity as PASB policy.

83. Steps have also been taken to improve the system for personnel evaluation and for awarding prizes and incentives. A Learning Board led by the Assistant Director was created to determine staff development priorities. A learning plan was also created to determine the needs of each office and develop annual plans for improving staff members' skills and competencies. Several national and regional level managers participated in the Global Leadership Program. In addition, a policy on HIV/AIDS in the workplace was developed.

84. PAHO received almost US\$2 million in funds from the WHO Global Learning Program, which were used to strengthen project management, leadership, knowledge management, communications, and technology skills, among others. The successful execution of these learning funds in PAHO was recognized by WHO and used as a model for other regions. PAHO staff members directly supported the creation of a similar learning framework in WHO's EURO and AFRO regions.

85. PAHO offices in priority countries were strengthened through the assignment of program officers responsible for supporting national health development through negotiations with other sectors, resource mobilization, and coordination of alliances with donors.

86. In order to strengthen a work environment based on the respectful treatment of colleagues and partners and in accordance with the principles of the Organization, PAHO has implemented three important policies: (a) Policy on the Prevention and Resolution of Harassment in the Workplace (2004), (b) Code of Ethical Principles and Conduct (2005), and (c) HIV/AIDS in the Workplace (2006). PAHO also created an Ethics Office, which investigates any alleged violation of these policies. This office and these policies, to which all PAHO staff members are considered accountable, constitute the basis for an Organization that defends the principles of ethical conduct and takes action when these principles are violated.

87. The Organization entered into a contract to develop an automated database (Expertise Locator System), which became operational in 2007. The database improves the identification of experts and the transparency of the recruitment process, while leveling chances for candidates in all countries.

International Cooperation and New Partners in a Globalized World

88. Until 2001, 11% of all official development assistance (ODA) was allocated to the Region of the Americas, but that percentage has been gradually declining, down to 9% in 2005. Everything indicates that this figure will not be increasing again in coming years. This situation should be seen as a result of the increase in the mobilization of resources for Africa, for the countries affected by the tsunami in Southeast Asia, and for resolving armed conflicts in the Middle East.

89. The total monetary contribution for ODA in the world increased from approximately \$6.9 billion in 2003 to \$103.9 billion in 2006, and health cooperation has increased at an annual rate of 5.4% in the last 15 years; however, these increases have not been felt in the Region of the Americas.

90. In the 2003-2007 quinquennium, the Bureau put a lot of energy into mobilizing resources and forming strategic alliances and partnerships. It kept up constant dialogue with partners in the international community, among them bilateral agencies, which made it possible to select issues of mutual interest through a comparison of the agencies' cooperation policy priorities and the public health priorities of the Region' countries and of the Bureau.

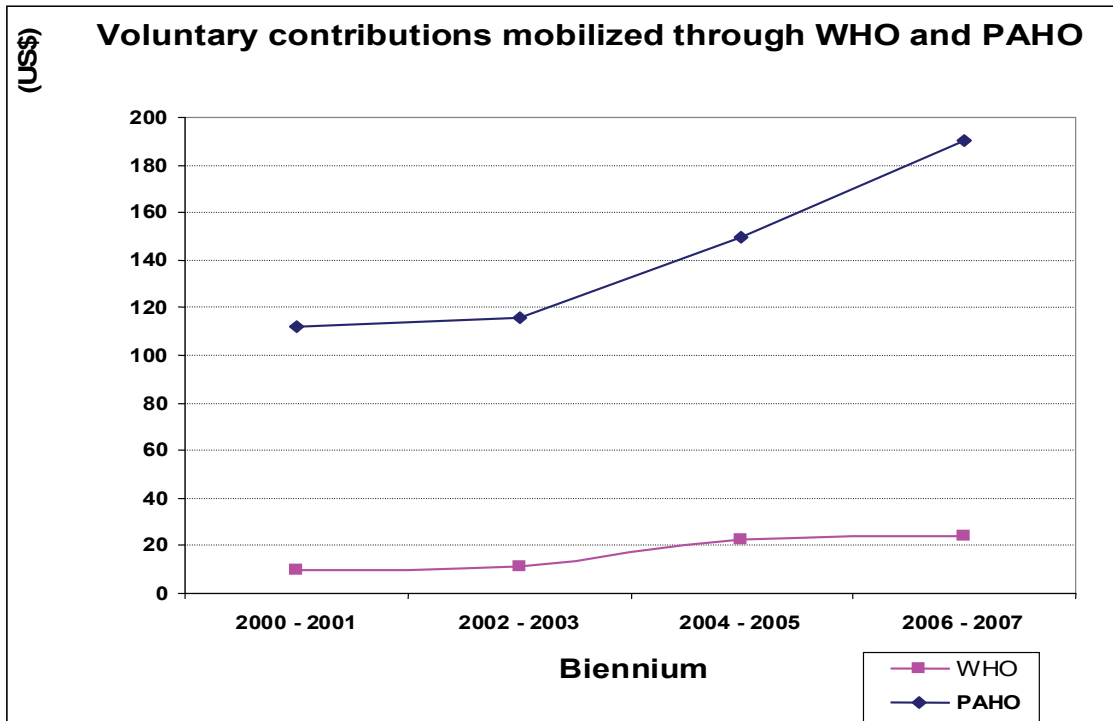
91. PAHO optimized its dual role as the specialized health agency of both the United Nations System and the Inter-American System, by means of its privileged contact with the Organization of American States. It took the following fundamental aspects into account when evaluating opportunities for new alliances and for strengthening resource mobilization:

- The implementation of programs aimed at attaining the MDGs.
- The proliferation of potential partners in the health field at the global and regional levels, including the emergence of new partnerships with the private sector.
- The decision of the Organization for Economic Cooperation and Development (OECD) to give greater importance to the processes of harmonization and convergence by strengthening the steering role of governments in developing countries.
- The likelihood of epidemiological emergencies or emergencies from natural disasters and bioterrorism.
- The need for boosting the institutional capacity of the ministries of health to respond to the new challenges posed by adherence to the new International Health Regulations (IHR).

High-level forums on the harmonization of development assistance

92. During 2003-2007, two high-level forums on harmonization and alignment for international aid effectiveness were held: the first in Rome in 2003 and the second in Paris in 2005. At the 2003 forum, the main multilateral development banks, international and bilateral organizations, and country representatives issued the Rome Declaration on Harmonization and pledged to adopt measures to ensure, among other things, that development assistance is provided in keeping with the priorities of the partner country and that harmonization activities are adapted to the country's situation. Two later years, the Paris Declaration on Aid Effectiveness translated the general consensus reached in Rome to increase efforts regarding harmonization, alignment, and management into mechanisms for monitoring the progress made. These new initiatives and approaches to international cooperation implied new opportunities for the health sector in priority setting and resource mobilization.

93. PAHO has internalized the provisions of the Rome and Paris declarations. The program-based approach to cooperation, initiated in the 2002-2003 biennium, rapidly bore fruit and was expanded considerably in the 2006-2007 biennium. This has made it possible for the Bureau's technical and budgetary programming for a given biennium to form the basis for negotiating the mobilization of resources and establishment of agreements. The program-based approach has been designed to encompass planning, programming, monitoring, and evaluation. This program-based approach has also been promoted through several political dialogue and negotiation meetings with traditional partners. Noteworthy among these are the meetings with Norway, the Canadian International Development Agency (CIDA), the Swedish International Development Cooperation Agency (SIDA), the United States Agency for International Development (USAID), and the Spanish International Cooperation Agency (AECI).



**PAHO Performance Evaluation by Douglas Lindores (Canada)
and Leif Lunde (Sweden)**

To build partners' confidence, assessments were made of the Bureau's capacity to adopt a new orientation toward collaboration and the establishment of partnerships. The corresponding reports, prepared in 2004 by experienced advisers from Canada and Sweden, showed very satisfactory results. This made it possible for the Bureau to continue with negotiations on programming with these two countries.

The report by Mr. Douglas Lindores, for the Canadian International Development Agency (CIDA), concluded that PAHO as an institution is a common good that belongs to the Region of the Americas. Thus, strengthening it is a task that contributes to the implementation of specific programs and projects for improving health in general. It was also found that PAHO is respected in the Region and that its personnel and its different systems are of the same, or better, quality that those of other multilateral agencies.

The report by Mr. Leif Lunde, for the Swedish International Development Cooperation Agency (SIDA), found that PAHO, despite depending on WHO, stands out as being independent and self-confident. It has a greater presence at the country level than many specialized global agencies of the United Nations, and with over a century of experience, the Organization is one of the oldest multilateral bodies in existence. PAHO has a very clear vision and mandate and very solid links with governmental entities and the ministries of health in the countries. Its strategic approach coincides, in this regard, with that of other sections of the United Nations, and thanks to this, PAHO has forged partnerships for promoting its vision, goals, and strategies with skill and dedication.

During the quinquennium, several consultations were held with bilateral partners to reexamine the collaboration established with them, evaluate the progress made as a result of that collaboration, and make needed changes or adjustments. At first, the consultations were one-on-one, but starting in early 2005, the decision was made to hold joint consultations with some of the Nordic countries, such as Sweden and Norway, and it is hoped that beginning in 2008, advisory meetings involving several partners will be held.

An interesting example of these joint consultations is the Partnership for Health Preparedness (PHP). This consortium of donors (CIDA, Canada; DFID, U.K.; ECHO, European Union; and OFDA, USAID) contributes to PAHO's disaster preparedness and mitigation activities. The PHP functions as a mechanism for liaison and dialogue with, and collective reporting to, these central donors, who support disaster risk reduction in the health sector in Latin America and the Caribbean.

Networks and alliances

94. In 2005, the Ibero-American Summit in Salamanca approved the creation of four Ibero-American health cooperation networks: the Donation and Transplant Network, coordinated by Spain; the Public Health Teaching and Research Network, coordinated by Costa Rica; the Tobacco Control Network, coordinated by Brazil; and the Drug Policy Network, coordinated by Argentina.

95. Since 1999, PAHO has been a member of the Alliance for Cervical Cancer Prevention (ACCP). This group of five international organizations—EngenderHealth, the

International Agency for Research on Cancer (IARC), JHPIEGO, the Pan American Health Organization (PAHO), and PATH—with funding from the Bill & Melinda Gates Foundation, has been working toward a shared goal: to prevent cervical cancer in developing countries.

96. In order to maximize collaboration among the partners and carry out joint activities, ACCP formed a steering committee and created four working groups. The Alliance's work has made it possible to evaluate the feasibility and effectiveness of various screening and treatment methods for preventing cervical cancer.

97. The Regional Interagency Task Force for Maternal Mortality Reduction, comprised of PAHO, the World Bank, the Inter-American Development Bank, UNICEF, UNFPA, USAID, the Population Council, and Family Care International, supports and advances international initiatives, among them the MDGs and the Safe Motherhood Initiative. In February 2004, the Task Force signed a joint declaration pledging to collaborate on promoting action to fight maternal morbidity and mortality and trying to establish partnerships for mobilizing the financial resources needed at regional, subregional, and national levels.

98. To support neonatal health actions in the Region within the continuum of maternal, newborn, and child care, an interagency alliance was created, comprised of PAHO, UNICEF, USAID, CORE Group, BASICS, Plan International, the Latin American Association of Pediatrics (ALAPE), Save the Children, the Saving Newborn Lives initiative, and other entities. The alliance has published a strategic consensus on neonatal health and will support the Regional Neonatal Operational Plan that will be presented to the Bureau's Governing Bodies in 2008.

99. In October 2004, WHO launched the World Alliance for Patient Safety at PAHO Headquarters. The Alliance and various international experts and forums have pointed out the need to include the patient's voice in initiatives to improve the quality and safety of health care. To that effect, PAHO has coordinated two regional workshops (San Francisco, May 2006; Chicago, June 2007) with the participation of patients and several collaborating centers, and is currently providing guidance to the Alliance in designing a Pan American network of patient leaders who will carry out awareness-raising projects in the countries of the Americas.

100. In addition to patient safety, other factors go into the making of safe hospitals. One of them is response capacity when disasters occur, that is, the ability to hold up during a crisis and to continue functioning when most needed. PAHO's Member States have made important strides in this regard. The alliance with the United Nations' International Strategy for Disaster Reduction (ISDR) will help disseminate knowledge about these critical issues. Plans for the Campaign for Disaster Reduction 2008-2009

were triggered by concern over safe hospitals. This alliance, for which PAHO provides technical cooperation, will help garner the support of international partners for the ISDR's national platforms for disaster reduction.

101. PAHO is also a member of the Inter-American Coalition for the Prevention of Violence, established in June 2000, as are the Inter-American Development Bank, UNESCO, OAS, Centers for Disease Control and Prevention (CDC), World Bank, and USAID. In March 2007, the Coalition's members met in a high-level meeting at PAHO, where they ratified their commitment to fighting violence.

102. In the context of the Regional Strategy on Nutrition in Health and Development, approved by the 47th Directing Council in September 2006, the Organization has participated in interagency efforts to develop and implement activities to promote optimal nutrition.

103. During the quinquennium, PAHO has received financing from its main international donors, including the Canadian International Development Agency (CIDA), USAID, the Spanish International Cooperation Agency (AECI), the Swedish International Development Cooperation Agency (SIDA), and the Norwegian Agency for Development Cooperation (NORAD). It has also promoted alliances for mobilizing cash and non-cash resources from philanthropic foundations and other civil society entities, notable among which are the Bill & Melinda Gates Foundation, the Bristol-Myers-Squibb Foundation, the Ford Foundation, the WK Kellogg Foundation, the United Nations Foundation, the International Red Cross and Red Crescent Movement, Rotary International, and the Catholic Medical Mission Board (CMMB).

104. Since 1968, PAHO has received invaluable support from the Pan American Health and Education Foundation (PAHEF), a U.S. public philanthropic organization. For the period 2003-2007, the program contributed approximately \$7,877,715 to impact health and health education in PAHO/WHO member countries. Through its Expanded Textbook and Instructional Materials Program, it distributed 784,107 textbooks and training manuals, and 197,710 medical instruments at a reasonable price to hundreds of low-income students and health workers in 19 countries of the Region.