

REGIONAL CONSULTATION OF THE AMERICA ON THE 11TH GENERAL PROGRAM OF WORK OF THE WORLD HEALTH ORGANIZATION

14-16 February 2005

Meeting Report

1. The first of a series of regional consultations to be undertaken by WHO on the 11th General Program of Work of the World Health Organization took place in the PASB/AMRO office in Washington DC, 14-16 February 2005. Participants included Member States Representatives, representatives of Regional Members of the Executive Board, Public Health Experts, and Key Partners such as International Organizations, UN agencies and NGOs.
2. The following is a summary of the discussions that took place including inputs and recommendations for the further development and enrichment of the 11th General Program of Work (GPW). The report is divided into sections corresponding to the Opening Session, six plenary sessions, and Closing Session.

I Opening Session

3. Dr. Mirta Roses, the Director of PASB/AMRO opened the meeting by introducing Dr. Anders Nordstrom, ADG for General Management, who is in charge of the process of formulating the 11th GPW, and indicated that this is the first regional consultation on the 11th General Program of Work. She noted that the GPW is a mandate of WHO and that on this occasion the Director General has called for a ten year plan to coincide with the MDGs. The process of developing the GPW has been highly participatory so far with the item being discussed at PASB/AMRO's Subcommittee on Planning and Programming, Executive Committee and Directing Council. It was also discussed during the Executive Board which recommended the regional consultations which will take place in all regions between February and March 2005. She emphasized the importance of the discussions and recommendations which will be consolidated into a draft proposal to be presented to Regional Committees in 2005 and the Executive Board and the World Health Assembly in 2006 for final approval.
4. Dr. Anders Nordstrom, WHO, thanked AMRO for organizing the consultation and indicated that WHO is looking to the long term strategic direction of the organization and that the GPW is a key opportunity to look further ahead to critical opportunities and project for the longer term taking into account what Members States have to say in terms of what is needed and expected from WHO. He made reference to the four background papers and outline to

stimulate the discussion of what the GPW should entail and that the comments of the participants will be highly appreciated.

5. Ms. Lina Reinders, WHO, went on to further describe the process of the development of the 11th GPW and its content. She indicated the development of an outline that was presented to the Regional Committees in 2004 and Executive Board in 2005, the formulation of scenarios, background papers and studies as well as consultations based on scenarios during the Executive Board seminar in Iceland (Dec. 2004) and discussions during WRs meetings in the different regions. She further stated that the draft document will be refined for the other regional consultations based on the comments of the PASB/AMRO Consultation and that all comments and recommendations will be collected and utilized to finalize the 11th GPW. She elaborated on the four scenarios that were developed to help envision what the future may look like emphasizing that the GPW is broader than looking at scenarios. It looks at how the world and health have changed and how health is both a tool and a goal in and of itself and how WHO can work together with the global community in the next ten years. The 11th GPW will be a key strategic planning document recognizing that health is the responsibility of all partners and that each has a role to play.

6. Dr. Daniel López Acuña, DPM, PASB/AMRO, made a presentation on critical issues in the definition of roles and responsibilities of WHO for the period 2006-2015, highlighting critical issues in global health, global health governance, and in defining the roles and responsibilities of WHO:

- Critical Issues in Global Health: Improving Quality of Life, Reducing Inequities in Health, Attaining the MDGs, Contributing to Human Security, Advancing Health as a Human Right
- Critical Issues in Global Health Governance: Building a Consensus on the Global Collective Intentionality in Health, Developing a Strong Global Public Health Movement and Leadership, Increasing Harmonization and Alignment in International Cooperation in Health
- Critical Issues in Defining the Roles and Responsibilities of WHO: Setting Norms and Standards, How Directly Involved Should WHO be in Humanitarian Action and Relief?, Building Institutional Capacity at Country Level, Promoting the Right Investments in Health

7. A detailed elaboration on these issues is contained in the power-point presentation he made (See PAHO/AMRO webpage).

Comments

8. Dr. St. John (Barbados) stated with regards to the first issue identified (improving quality of life) that they have had a mid-point evaluation of their HIV/AIDS program and the result is that behavior change is required. In reference to the fifth issue (advancing health as a human right), she pointed out

that the Government has a large set of social welfare provisions including no user fees at point of service, free drugs for those under sixteen and over sixty-five years of age, and free treatment of HIV/AIDS which is considered a human right.

9. Dr. Antonio González Fernández (Cuba) expressed that the participation into the development of the GPW seems to have only taken place in Directing Councils and Executive Committees and that the discussions with the necessary depth may have not taken place at the country level. A question was raised regarding the ten year span for this GPW and that he did not see the logic in a ten year plan that doesn't coincide with other periods.

10. Ms. Mary Lou Valdez (United States) expressed that a clearly stated objective for this consultation was necessary as well as clarity as to what was the expected result at the end of the three day meeting. She also suggested that it would be useful to refer to additional documentation such as WHO's corporate strategies and core functions contained in the 10th GPW. She emphasized the importance of the provision of science, evidence and data to feed into the development of the 11th GPW and that countries need this information to be able to contribute.

11. Regarding the objective of the meeting, Dr. Nordstrom, WHO, indicated that over the last 6-9 months discussions have taken place regarding the process of developing the 11th GPW with four main chapters and that the Executive Board has been very supportive that as opposed to past GPW this be a broader and more global program. What is expected now is to go into the substance of the four main chapters and that this stage requires further inputs and recommendations from the countries to develop the substance and be able to have a draft by October 2005. This stage is still informal and the focus should not be on the text of the background papers but rather on what the content should be.

12. Dr. López Acuña, DPM, PASB/AMRO, indicated that previously the GPW used to be five year program with a focus on the internal programming of WHO and were policy documents that were limited in scope to the work of the Secretariat. Today the territory of Global Health and Global Health Governance is broader and more complex, and the GPW is more of a policy document of WHO's role in Global Health. The 10th GPW was more of a corporate strategy document and not really a forward looking one. With the 11th GPW, the goal is to have a macro policy defining the future strategic direction for the work of the World Health Organization, both Member States and the Secretariat. He noted that this consultation should therefore enrich the process.

13. Dr. Roses, Director AMRO/WHO, emphasized that at this moment we are trying to orient what the role of the GPW should be. Member States have requested that we look at the state of Global Health and determine what WHO's

role should be. These discussions are not isolated and countries could participate in additional ways. She reiterated that PASB/AMRO has introduced the topic of the 11th GPW in various opportunities including through the country cooperation strategy exercises which have taken place in many countries of the Region. These exercises have helped to determine the role of PASB/AMRO and now what is needed is a consensus to develop the 11th GPW. She also mentioned the importance of other discussions currently taking place such as summits, assemblies, ministerial meetings, etc. which can serve as platforms to provide additional inputs and to further debate, enriching the process of developing the 11th GPW. In addition, countries are developing their own National Development Plans and these discussions should produce inputs as well.

II Plenary Session 1: *Positioning Health in the Political, Economic, Social and Development Agenda*

Chairperson: Dr. Jose Roberto Ferreira, Brazil

14. Dr. Anders Nordstrom (WHO) presented a summary of background paper # 1, emphasizing key issues from past decades that remain valid for the 11th GPW, like Alma Ata and PHC, Health Promotion movement and other Charters, World Development Report 93, Commission on Macroeconomics and Health, etc. The 11th GPW should also refer to health as part of recent international summits agendas. Participants were invited to express their views on the validity of the issues raised in background paper # 1 for the 11th GPW, with particular focus to its conclusions and the how health should be defined.

Comments

15. Dr. Antonio González Fernández (Cuba) suggested that the document should be entitled: “Building a healthier world”, its prologue and presentation should be merged in a single section signed by WHO DG and proposed the inclusion of a section on “Health and Quality of Life”.

16. Mr. Sebastián Tobar (Argentina) asked the Secretariat to clarify the distinction between public and meritorious goods, since most of the health goods belong to the latter.

17. Dr. Anders Nordstrom (WHO) explained that the documents on the 11th GPW discussed in the last PASB/AMRO Directing Council and WHO Executive Board have very similar texts, the first part of which has now been addressed by the Consultation’s background paper # 1.

18. Mrs. Mary Lou Valdez (United States) said that different national contexts add new epidemiological and demographic stresses to health, which impose

competing demands to countries, like for instance the case of aging, healthy lifestyles, road safety and healthy cities.

19. Dr. Paul Gully (Canada) suggested that the document must establish a clear distinction between health values, problems, risks and strategies.

20. Dr. St. John (Barbados) indicated that instead of ranking the above elements, the document should consider the time and resources required to address them.

21. Dr. Anders Nordstrom (WHO) insisted on the question on how the document should order the different topics of values, determinants and health in different agendas.

22. Dr. Paul Gully (Canada) reiterated his view that that the analysis of determinants should lead to the consideration of what can or should be done to address those determinants at different levels by different partners.

23. Dr. Lopez Acuna (PASB/AMRO) indicated that it is also important to consider the dimensions of health in other agendas—i.e. security, investment for development, human rights—and how to take the opportunities they're offering for health, in addition to and beyond our own sectoral view. There is a need to build a practical advocacy construct to highlight the influence of health on other sectoral agendas.

24. Mrs. Mary Lou Valdez (United States) asked whether the 11th GPW will be a practical guide for daily work or a policy paper guiding dialogue on public policy. Will it be something just for WHO's work or also for other partners?

25. Dr. Nordstrom (WHO) expressed the expectation that countries themselves will define how to address the issues of determinants, health inputs to development and mutual dependency between health and other sectors. Other countries have also suggested the topic of health and quality of life raised by Cuba. At the same time, it would be useful to have more discussion on global public goods, values and national contexts as mentioned above. Different populations and nations will bring different health challenges and conflicting health priorities, demanding different roles from WHO, its partners, and national sectors.

26. According to Dr. Roses (PASB/AMRO), it is necessary to reach some consensus regarding four issues: a) evolution of the concepts of health and public health; b) health issues in the public agenda during the next decade; c) health linkages beyond the health sector and d) response from the health sector to these challenges. Therefore, it is necessary to reach a common formulation of the critical themes in the global agenda in order to readjust the document.

27. Dr. Paul Gully (Canada) stated that WHO should understand the meaning of global public goods for other sectors in order to be able to share with them its own ideas about this topic.

28. Dr. Nordstrom (WHO) indicated that this topic is based in the Monterrey consensus. There is relevant literature and research about its implications for health and other sectors, like intellectual property rights, research and development, etc. He made reference to the special group created to this end co-chaired by Sweden and France.

29. Dr. Lopez Acuna (PASB/AMRO) mentioned that this topic will be discussed in greater detail during the upcoming plenary session on this topic (plenary session 5), which was also considered during PASB/AMRO's Managers Meeting in 2003, in collaboration with the UNDP. He also insisted on the need to make explicit why new public health policies and practices have to be addressed given socio-economic, political and environmental changes in the global arena.

30. Summarizing the discussion, Dr. Nordstrom (WHO), suggested the following consensual points: a) agreement on basic values: Alma Ata, WHO Constitution, etc; b) interdependence of health determinants and sectors; c) implications for health and other actors; and d) strategies for the future.

31. Mr. Tobar (Argentina) suggested that human resources in health should be seen as key political actors in this process.

32. Dr. Nordstrom (WHO) agreed that the improvement of health services makes the employment conditions of human resources part of the agenda.

33. According to Dr. José Roberto Ferreira (Brazil) the document is very concentrated in the health sector. WHO should take the initiative to convene other sectors to discuss it, reassuming the protagonist role taken by the World Bank in 1993. A decade ago, the analysis of the public health crisis led WHO to define the Essential Public Health Functions in response to that crisis, as a move within the health sector. PAHO's "Health as a Bridge to Peace in Central America" was a successful inter-sectorial initiative. It is necessary to invite other actors to define health in the new socio-economic and political scenarios.

III. Plenary Session 2: *Health Situation, Challenges and Opportunities in the Next 10 Years*

Chairperson: Mrs. Mary Lou Valdez, USA
Part 1: Background Paper No. 2

34. Ms. Mary Lou Valdez. (United States) called the second background paper before the attention to the participants. Ms. Lina Reinders, (WHO) highlighted the main health challenges identified at both the global and national levels. She raised two questions as the 'main agenda' for the panel discussion in

regard to the health situation in the next ten years, the first question being posed as to what are the most critical trends, challenges, and opportunities; the second as to what is the best way to organize them to reflect value elements, appropriate action and make partner roles more evident.

35. Dr. Ruth Levine, (Center for Global Development), offered some reflections on health trends, challenges and opportunities as related to three so-called 'tensions'. First, the tension between thinking of health as a good, a right for all, an end in itself versus thinking of it as an instrument to an end of other goods, as for instance economic growth; this second view requiring a focus on specific diseases as opposed to the broader view of population health implicit in the first one. Secondly, a so-called 'time-dimension' tension, that arises between the provision of health services on a consumption needs basis versus as an infrastructure investment for future needs; the first view implying a more divisible population, whereas the second one focusing on long-term signals of innovation in health in the market, more specifically between prevention and treatment options available (AIDS as an example). Thirdly, directly linked to the fundamental question of 'how to know if successful', the tension between measurement of outcomes versus assessment of performance of health systems; two clearly different perspectives as to how they dictate where the money goes.

36. Dr. Nils Kastberg, (UNICEF) presented a brief comment on their perspectives on Background Paper 2—basically agreeing on the strong focus in the Millennium Development Goals (MDG) and the interrelationship and interdependence among nations, and expressing their vision of WHO in ten years as an organization that continues to strengthen its normative role around the globe.

37. He discussed the 'four big challenges' as seen from a more regional perspective instead of the global one. The first challenge arises from the worrisome perception that most countries will not attain the MDGs, particularly those directly related to health and to poverty. Four perceived threats were identified in this respect: i) economic development models in place continue to generate disparities and current investments are not reducing them; this is not just a matter of economic differences, but profoundly affecting the health of the population; ii) inefficiencies in the use of public resources: '*la ciudadanía*' (the community) believes they are being wasted or otherwise channeled to feed corruption; iii) WHO is perceived to stand too close to the Ministries of Health to be able to take the step back needed to be seen as an advocate of good governance and efficiency regarding these issues; and, iv) lack of public policy accountability: how to create an awareness of what is expected to improve at every level from national to provincial to municipal is still an unsolved issue. A second 'big' challenge is how to overcome the level of social exclusion currently present, particularly affecting indigenous and Afrodescendant populations, in a region in which as much as one-third of its population continues to live in exclusion, for historical reasons and for instance today, in terms of access and utilization of health services. A third 'big' challenge has to do with what he called

a ‘threat to progress in health’: violence, in both its public and family ‘faces’, including sexual violence and, by juxtaposition, the issue of sexual and reproductive rights. A call was made on the need of disaggregated data to assess the situation more accurately and, more urgently, to guide better policies and strategies. A fourth big challenge in the Americas is the AIDS pandemic, related in part to the previous three challenges; a so-called ‘disaggregated strategy for AIDS’, specially focused in socially excluded populations, without creating more stigma, was deemed a necessity. In his concluding remarks, Dr. Kastberg raised two other points seen as opportunities for WHO’s work over the next ten years: one was the use of local healers and local wisdom as integral elements of its health strategies and programs; the other referred to the use of an intersectoral approach to evaluate health needs locally as a way to define the plan for the next ten years.

Comments

38. Ms. Mary Lou Valdez, (United States) emphasized the realization of the incredible power of data to build an understanding of the populations’ health.

39. Dr. Paul Gully (Canada) made reference to how WHO should see behind trends to better guide the setting of more effective policies accordingly; this whole issue was perceived as a fundamental challenge for WHO in the next ten years. He also highlighted the strategic and social roles of WHO in the reduction of underlying, profound inequalities in data availability and quality (the so-called ‘data divide’), as well as in the analytical capabilities at national and local levels to assess population health and interventions’ health impact.

40. Dr. Gerry Dafoe (global health consultant), emphasized the issue of the need and challenge for WHO to strengthen partnerships in order to enhance its own key role in policy and programs and to build global consensus in international health issues.

41. Ms. Valdez, (United States) noted the need to address more effectively the distinctive challenges and opportunities in governance, health policy, and other dimensions discussed between the global and the regional levels.

42. Dr. St. John, (Barbados) called the attention to the need to amplify the ways in which WHO can move forward in mobilizing resources, and collaborating with NGOs.

43. Dr. Kastberg, (UNICEF) referred to the need to strengthen intersectoral and interagency harmonization.

44. Dr. Ferreira, (Brazil) referred to the need to enhance the consultative process both within Member States and civil society to allow broader intersectoral and interinstitutional approaches, particularly to better document views and actions from the social sector.

45. Ms. Marisol Gutiérrez Serrano, (Nicaragua) seconded this comment.

46. Other themes that need to be stressed, as identified by the Plenary, include the challenge of building a Program for the global level but still useful at the local level; the issue of priority setting and who is driving the agenda, from both the policy and the budget perspective; how much evidence does WHO have for each priority and what would be the best or optimal strategies for each identified challenge; a more balanced approach among main issues (short vs long term; prevention vs treatment, etc.) and how WHO will move from data to knowledge to policy generation to action, given the nature of the challenges addressed, their 'bottlenecks', the evolution of public health risks involved, and the response at different levels given to these challenges. Other issues introduced to the discussion were the catalytic role of WHO, as opposed to a merely normative one; the need to consider border issues; the contention of health as a right and not just a need or a charity; and the focus on strengthening existing strategies instead of creating new ones.

47. Dr. Nordstrom, (WHO) pointed out that the 11th GPW needs to define how WHO moves from principles to practice.

48. Mr. Tobar, (Argentina) mentioned that one highly regarded point, in terms of its increasing relevance within the Region of the Americas, is that of the subregional level's role in the supranational integration of health agendas vis-à-vis globalization.

49. Dr. Lopez-Acuña, (PASB/AMRO) reaffirmed the growing importance of the subregional approaches as a key issue for public health development in the Region, as reflected for instance, in the new PASB/AMRO Program Budget Policy.

50. In a closing remark, Dr. Nordstrom, (WHO) reminded participants that WHO is a Member State's organization, and so is the General Program of Work. As to whether WHO needs more 'reform', a clearer strategic direction can be gained by defining WHO's core functions and, in that regard, the driving question to Member States should be: 'what do you expect from WHO to be more clear of what?'. The case of UNAIDS was invoked as an illuminating example of WHO being back at the table doing things that it is expected to do; moving outside the UN system being an even bigger challenge.

Part 2 : Critical Components of National Health Development Processes During the Next 10 Years

51. Dr. López-Acuña, (PASB/AMRO) presented the critical components of the National Health Development (NHD) processes for the next 10 years, emphasizing mainly four key elements: First, the recognition of the fact that international technical cooperation efforts and impact on social, economic, political, and health processes aimed at the NHD are mediated by the sphere of State and social interventions for NHD which, in turn, are aimed at the major macrodeterminants of population health and the policies that influence them.

52. Second, the NHD processes in the Region are inextricably linked to the MDG processes and the collective intentionality put in place to attain them. Third, 'reaching the neediest' is, by itself, a goal of paramount importance in the NHD processes and comprises an equity perspective, the corresponding need of disaggregating information, and the provision of social protection in health.

53. Fourth, the strategic relevance considering the 'missing middle', by strengthening the public health infrastructure, extending social protection in health, developing the health workforce, and redeveloping health services' operational capabilities.

Comments

54. Dr. Damian Greaves (Saint Lucia), posed the broader question of what the real role for WHO is and should be and how strong it is in the international health decision-making arena.

55. It was argued that WHO has not had a clear agenda on strategic issues and this consultative process is set to do something about that. The normative role of WHO is quite clear globally, though there clearly is plenty of room for improvement. A question mark arises on the issue of a more definite role in the technical implementation of programs, possibly with the sole exception of global surveillance. On the other hand, there is also the issue of how to get and sustain political will for WHO roles in the ever-changing, and increasingly complex, global health challenges.

56. Another point highly debated was WHO's role in the MDGs, as well as in other dimensions of health not covered by the MDGs; mental health as an example. It was agreed that the MDGs provide an excellent, unique common place to start, given the fact of its broad acceptance and political commitment around the world among governments and agencies: a great value for WHO. In that regard, the extreme importance of better and more efficient mechanisms for harmonization and alignment among stakeholders was recognized, for which WHO has a strong commitment.

57. Finally, the need to translate the MDG agenda into action was stressed, and that it should be comprehensive and connected to NHD processes, and not just 'categorical' interventions nor the attainment of just the 'literal' goals.

IV. Plenary Session 3: *Global Health Agenda and Global Governance in Health*

Chairperson: Dr. Paul Gully, Canada
Part 1: Background Paper No. 3

58. Dr. Paul Gully (Canada), introduced the session and referred to background paper # 3, summarizing the most important issues.

59. Ms. Lina Reiners (WHO), introduced the topic of the Global Health Agenda noting that the paper was built on previously developed work such as Health for All and the MDGs. She listed the overall goals presented in the paper and stated their interrelatedness noting that the Global Health Agenda and Global Governance involves more players than just WHO.

60. Dr. Gerald Dafoe (global health consultant) asked if WHO really needs to develop a new Global Health Agenda, and highlighted that the Millennium Development Goals (MDGs), approved by 189 countries, has already set a new Global Development Agenda with a focus on health. WHO should take the lead, building consensus and partnerships for an expanded agenda based on the MDGs.

Comments

61. Dr. Rafael Schiffino (Dominican Republic) reminded participants that priority should be given to the poorest communities and to the protection of budgetary resources for public health programs. WHO should work to build capacity in network development to strengthen communities and it also has a role to play in protecting health programs at the national level.

62. Dr. Tobar (Argentina) mentioned that “governance” refers to institutional capacities, and that WHO should contribute to strengthen national capacities and be able to coordinate with others. The role of WHO is to assist countries not intervene in issues of national sovereignty.

63. Dr. Ferreira (Brazil) stated that in order to develop a comprehensive program of work for WHO and the countries, it will be necessary to promote a greater involvement of all of them, not only with the health sector representation but also from other sectors which can help in improving the health of the population. This implies applying here two of the more important recommendations of Alma-Ata, namely, social participation and intersectorality. He also emphasized the importance of Human Resources which represent the more important resource utilized in the area, and asked for a better clarification about the reasons for introducing this change in the formulation of the 11th GPW of WHO.

64. Dr. González Fernández (Cuba) expressed that Member States should ensure that WHO maintain and exercise its leadership and therefore, WHO should be strengthened. WHO must care for global health, based on the primary health care strategy, in partnership with other institutions and networks.

65. Dr. López Acuña (PASB/AMRO) indicated that the background paper is considering two different although interrelated issues: the global health agenda and global governance in health. The global health agenda has to consider much more than health problems, and should reflect the “collective intentionality” of countries in coordinating their efforts to address the main priorities in which it is possible to have impact. On the other hand, WHO –and the World Health Assembly- is no longer the only decision making body on health at the global level. The multiplication of global health initiatives (GHI), with multiple partners and multiple governance mechanisms will require a specific role for WHO in order to ensure harmonization and alignment in setting the agenda, defining priorities, channeling resources, coordinating implementation and articulating the initiatives of multiple partners.

66. Dr. Ferreira (Brazil) mentioned the need to reduce the transaction costs of international cooperation and ensure ownership by the countries, and highlighted the potential role of national institutions and networks which have developed the capacity to be responsible for technical cooperation activities.

67. Dr. López Acuña (PASB/AMRO) emphasized that organizations like the Gates Foundation, the Global Fund and probably in a near future the IFF, are constituting new realities in setting and financing the health agenda, for example in immunizations. Will this allow the necessary common vision for the global health agenda?

68. Dr. Greaves (St. Lucia) recognizes that there is a myriad of players, bypassing WHO and sometimes usurping its role. At an international level, there is a risk that health could be seen as an object of diplomatic negotiation between countries, and compromised in the process. He emphasized that the Global Health Agenda and Global Governance are interrelated.

69. Dr. Gutiérrez Serrano (Nicaragua) stressed that national capacity has to be strengthened, in particular in supporting local and national networks, and in protecting the financing for health priorities.

70. Dr. Alfredo Solari (IDB) indicated that the MDGs are not reflecting completely the situation of all countries. We need to be clear on the Global Health Agenda, then we can look at to what the Governance should look like. WHO is an intergovernmental organization and should prioritize the following functions:

- supporting national health programs
- establishing and implementing global health regulations
- establishing a supranational epidemiological surveillance system
- identifying the knowledge that is lacking and generating and disseminating it
- organizing joint responses to specific health problems or crisis.

71. WHO should welcome the participation of all other players, making sure that they have a role as it is impossible for one institution to do it on its own.

Part 2 of Plenary Session 3: U.N. High Level Panel on Threats, Challenges and Change. Implications for Global Health and Global Security

72. Dr. López Acuña (PASB/AMRO) introduced the content of this report to the UN Secretary General, emphasizing the preeminence given to health as a key element in international security and peace. The HLP identified six main interconnected threats to international peace: Interstate conflict; Civil War; Economic and social threats; Weapons of mass destruction; Terrorism; and Organized International crime. In the face of these threats, the HLP made several recommendations regarding health that have implications for WHO's role and responsibilities. Among the recommendations was a call for the strengthening of public health systems (including capacity a country level) by undertaking a major global initiative to rebuild local and national public health systems throughout the developing world. Other recommendations included a call to the World Health Assembly to provide greater resources to WHO's Global Outbreak Alert and Response Network and a that the Security Council should consult the Director-General of WHO to establish the necessary procedures for working together in the event of a suspicious or overwhelming outbreak of infectious disease. Regarding the MDGs, the recommendation was made that this initiative be placed at the center of national and international poverty reduction strategies which among other things implies the need to redress the dramatic shortfall in resources required to meet the MDGs.

Comments

73. Dr. Rafael Schiffino (Dominican Republic) recalled that WHO should coordinate the global health agenda, supporting planning at the national level, and monitor and assess the results.

74. Ms. Valdez (United States) agreed on the five functions for WHO that were proposed earlier by the IDB delegate, and recommended that WHO should integrate the recommendations of the UN report into the 11th GPW and asked how these recommendations can become a reality at the country level. She added that WHO will have to support strengthening national capacity and infrastructure to deal with health and security, both at national and international

level. In particular, international epidemiological surveillance makes WHO unique.

75. Dr. Solari (IDB) said that the six international threats that are mentioned in the UN report are not of equal importance in all regions. In the Americas, poverty and international crime (especially drug-related) are the most relevant. There is already an existing agenda on poverty reduction and organizations such as PAHO/WHO, IDB and others should integrate actions and plans in considering issues such as illicit drugs, that are an increasing threat in the region.

76. Dr. Nordstrom (WHO) indicated that WHO should capitalize on the place that has been given to health in this report. WHO should dialogue with the UN in order to develop a coherent approach to the MDGs. There is also a need to clarify the role of WHO in areas where it does not have primary responsibility, even if it is important for health. WHO needs to change in order to work with others in those areas. In that sense, WHO has an important function helping the health sector to interact positively with other sectors.

77. Mr. David Strawczynski (Canada) recommended that WHO could investigate on threats, for example on the present situation, trends, determinants, and public health infrastructure. This will be very useful for improving public health capacities to respond to these specific threats.

78. Dr. López Acuña (PASB/AMRO) agreed that each threat has a relative weight in each region. For example, the situation in Central America 20 years ago led PAHO/WHO to launch a very important and successful major initiative, “Health as a Bridge for Peace”, articulating an integrated response through which health contributed largely to peace and development. WHO will have to move to address the agenda and some recommendations contained in the UN report. Among those, the recommendation proposing collaboration between WHO and the UN Security Council will represent a great challenge for WHO.

V. Plenary Session 4: *Roles and Responsibilities of WHO in the Next 10 Years*

Chairperson: Hon. Damian Greaves, Saint Lucia
Part 1: Background paper 4

79. Dr. Anders Nordstrom (WHO) presented background paper # 4, “Roles and Responsibilities of WHO in the Next 10 Years”, stressing the need to think about how WHO’s role will change in light of environmental changes. Some of the issues highlighted were key elements that contribute to WHO’s comparative advantage in leading the process to create a new global health agenda, while recognizing the need for WHO to continue to devise new processes and modalities which draw on the respective and complementary strengths of Headquarters and of regional and country offices while recognizing that WHO’s

six core functions are still the most relevant for moving forward with the Global Health Agenda. Dr. Nordstrom mentioned however, that the core functions still leave many issues unresolved, necessitating thorough discussions before making choices which will shape the WHO Secretariat in the coming years. Some of these issues which are further developed in the paper include: health beyond the absence of illness; Leadership; Priorities; Global vs. country level; Country level work; Development policies; Relationships with ministries of health and governments; WHO and other organizations; and new alliances and partnerships.

Comments

80. Dr. Greaves (St. Lucia) mentioned that WHO has a special role in health among the many actors in the sector. The missing middle of “infrastructure” has been discussed in previous sessions. The issue now is the future role of WHO.

81. Dr. González (Cuba) stated the need to better focus the role of WHO. WHO’s constitution lists 22 functions that are not identical to the six proposed. To avoid confusion they should be called work areas or something else. WHO’s leadership role has been effective in the past, but should adapt to the emerging new challenges. There is a need to review the approaches defined for the 10th GPW. The values defined in Alma Ata need to be reaffirmed. The basic functions defined are essential but not exhaustive. Several questions are posed (e.g. national vs. global interventions, new partners, etc.) and they should be discussed in depth. The proposal for an ideal WHO should be carefully reviewed. A main point is that WHO should have enough resources to guarantee its independence and not be unduly affected by the influence of donors.

82. Dr. López Acuña (PASB/AMRO) noted that this discrepancy between the six functions of the 10th GPW and the many more reflected in the Constitution should not be seen as a contradiction, but an opportunity to better define what needs to be done at this time.

83. Dr. Anders Nordstrom (WHO) indicated that WHO should be prepared to, and strengthened for reaction in cases of outbreaks.

84. Ms. Valdez (United States) indicated that the critical roles of HQ, regional and countries should be discussed and clearly delineated in the 11th GPW. The issue of whether WHO relations need to be limited to Government and Ministries was posed. WHO cannot be everything to everybody. WHO should consider sharing some functions with other organizations.

85. Dr. Nordstrom (WHO) stated that the roles of WHO need indeed to be as clear as possible. There are roles that are not clearly acknowledged or explicit. An example is procurement on behalf of governments (i.e. hospital equipment), a service that is very much appreciated but not listed as a core function of WHO.

86. Dr. Lopez Acuña (PASB/AMRO) noted that operational support is very relevant in the Americas. Procurement on behalf of governments in the Region is as big as operations in financial terms as the whole technical cooperation program funded with regular budget. These instrumental aspects need to be considered in the analysis. The coordination of technical cooperation is also considered a very important contribution. WHO should not undertake all of it, but should participate in its coordination being a partner and an honest broker.

87. Dr. Gonzalez (CUBA) mentioned that other actors do participate in health, and it is a good idea to incorporate them into the dialogue. But WHO should keep its leadership, as it centers in health. UNICEF, for example, works in health, but also in other sectors.

88. Dr. Ferreira (Brazil) mentioned that concentrating on basic core functions may result in a smaller WHO. The model of technical cooperation that is being used implicitly is based in “bringing” expertise, an old paradigm. Most countries now have expertise, however they still behave as in the past. Technical cooperation should focus in countries with the most needs, and reassign personnel and resources accordingly. Rather than consider it competition, WHO should take advantage of this. This would require a more flexible approach to contracting and use of expertise in countries. Furthermore, there is still a very high ratio of fixed to temporary as well as of administrative to technical staff. WHO is not in a position to compete, in terms of salaries, with the IFIs for personnel. Finally, Collaborating Centers are not effective with current arrangements. Being a center is more of a symbol than a source of expertise due to a lack of resources to operate. A similar thing happens with mechanisms of technical cooperation among countries which is very cumbersome to operate.

89. Dr. Lopez Acuña (PASB/AMRO) stated that the 11th GPW should address both functions and modus operandi and not just be what to do, but also how to do it. Networks of national expertise need to be developed to complement staff. The 11th GPW should also advance on innovative modalities of technical cooperation. New modalities may result in a more efficient organization that could do more without additional resources.

90. Dr. Walcott (Barbados) stressed that WHO should focus and not dilute. It should not pass resolutions that are not then implemented. Follow up should be ensured to review the impact of resolutions. Perhaps WHO should relinquish some areas of work.

91. Dr. Lopez Acuña (PASB/AMRO) mentioned that it is important to define the mandatory nature of resolutions and its binding nature in the definition of the future strategic direction for the organization. Harmonization and alignment are part and parcel of this process. But it requires a leadership role, based on National Health Development processes. An example could be AIDS where support to National AIDS programs rather than compartmentalized interventions

should be the rule. This could be done at the national, subregional, regional and global level and would articulate the role of the different players. There is a need to define these spaces not just the within the internal governance of WHO, but also with relevant external partners in order to ensure a common direction. This honest broker role is not always acknowledged but it is important.

Part 2 of Plenary Session 4: *WHO role in crises, emergencies and complex situations*

92. Dr. Poncelet (PASB/AMRO) made a presentation stressing that tolerance for risk in health is decreasing, meaning that WHO intervenes earlier or when there are fewer cases and intervention is greater than in the past. He pointed out that the sector faces the challenge of having many roles regarding disasters, ranging from preparing rules and norms to act as relief provider, as well as relief coordinator, and provider of technical cooperation for prevention. The roles need to be in the context of strengthening national capacity. The different roles can be sometimes contradictory and in events compete for resources. A review of priorities was recommended.

93. Dr. Kastberg (UNICEF) noted that WHO's role is important, but should also consider non-sectoral participants as well as interagency coordination. UNICEF cooperated with the strengthening of the governmental capacity. WHO should also enhance preparation of guidelines and normative approaches to inputs for disaster management. It should also foster delivery of services during the emergency. There are several key participants that need coordination. Finally, the role of WHO in complex emergencies should be enhanced.

94. Dr. Dafoe (global health consultant) mentioned that in Canada the model has shifted to infrastructure development. There has been emphasis on reinforcement of existing teams rather than creating new ones.

95. Dr. St. John (Barbados) stated that it is difficult to make the case for prevention. It is also easier to mobilize funds for "visual" support, like food supplies, than for planning efforts although important too. This would be an important role for WHO. In particular, sometimes local health workers are affected by the disaster, and there is a need to be supplemented from the outside, another role for WHO.

96. Ms. Valdez (United States) stated that the capacity building role is critical for countries to be prepared and respond faster. This is a country level activity. Normative function remains a core global or regional level function. Governments and donors would appreciate knowing the relevant role of all UN system or donors participation. This would result in more efficient support to emergencies. Thus partnership development is crucial. Coordination is necessary also for longer-term sustainable development. All these functions need resources allocated.

97. Dr. Poncelet (PASB/AMRO) mentioned that no uniform approach has been taken on disaster preparedness in the Americas. For example, Canada's approach to preparedness is based on a decision to invest on prevention that has not been followed in other countries. However, inventories have been attempted in several countries, and as a result corrections have been made before the events occur. Capacity building helps in multiple types of emergencies. It is the long-term solution, but takes time to develop, and sometimes resources are available for short-term interventions, as was the case with the Tsunami. This flow has resulted in some agencies refusing further resources for lack of absorptive capacity. This poses a dilemma between accepting additional resources for relief and building capacity, a less visible but more effective approach. Definitely there is a need to allocate more resources for emergencies as well as on whether to enhance prevention or relief, but this implies countries' decisions. Certainly there is a need to improve coordination with other partners, but there is a need for guidance in order to focus better.

98. Dr. Kastberg (UNICEF) stated that there are diverse types of emergencies in the Americas, both natural and man made. PASB/AMRO plays an important role and therefore needs to be strengthened to be able to respond to both. But there will also be a need to improve knowledge on rights and legislation to assist victims. Coordination will allow partners to know the respective roles and responsibilities of everybody, an important aspect. Finally the reduction of exclusion should be promoted.

99. Dr. Lopez Acuña (PASB/AMRO) mentioned that governing bodies have shown interest and highlighted the importance of impacts of recent disasters. Not just the "classical" response, but also in terms of the impact on systems, particularly in crisis situations. This includes capacity building and investing on preparedness and disaster relief. Harmonization and alignment are important in the relief process and coordination in the reconstruction period. This should never substitute national leadership. There is a delicate balance to be addressed.

100. Dr. Poncelet (PASB/AMRO) stated that some countries are not aware of how much damage could have been avoided by considering prevention in the construction of infrastructure. There is still much to be done in this respect. Reduction of damage due to prevention is clearly perceivable. Cuba was a good example of how proper prevention can save lives. Prevention is not expensive. A common hospital's costs do not go up more than 1-2% to make it disaster (hurricane) resistant. Rehabilitation on the other hand reaches about a third of the original cost.

VI. Plenary Session 5: *Global Public Health Goods and their implications for the work of WHO in the next ten years*

Chairperson: Hon Jerome Walcott, Minister of Health, Barbados

101. Dr. Cesar Viera (PASB/AMRO) introduced the topic which focused on the definition of Global Public Goods (GPG) from an economic perspective establishing the distinctions between private, meritorious and public goods. Current initiatives in health such as the prevention of HIV/AIDS, TB and malaria, Global Health Research, International Health Regulations, Surveillance and Emergency Response, and the health components of the HIPC and PRSP initiatives were highlighted as examples of GPG in health. Future possibilities of GPG approaches and initiatives in health for WHO and countries were identified, such as the implications of the Millennium Development Goals and the Monterrey Consensus; the reduction of inequities in health; the current discussion on the International Finance Facility; the proposal of a Global Fund Against Hunger and Poverty, and the probable effects of the proposal on International Redistribution (Tobin) Tax. Similarly, the introduction drew attention to the direct implications of the 11th GPW for a new Global Governance for Health, the convergence among global, regional and subregional initiatives, the access to and the affordability of health goods and services, the implications of the Doha Declaration on public health, the need for managed migration of health professionals, and the presence of health in development and trade agencies.

Comments

102. Mr. Tobar, (Argentina) made the remarks that WHO and PAHO don't work only with GPG, but, in fact, may work proportionately more with meritorious goods. An example is the cooperation with countries on Vaccines and Essential Drugs and Medicines, involving joint negotiation for best prices and collective purchasing of these critical goods. The consideration of GPG in health should transcend what is 'fashionable' or 'trendy' or a conceptual debate to permeate political and managerial considerations. Work with GPG in health in technical cooperation implies taking into account considerations of economies of scale and the search for positive synergies between countries.

103. Dr. Dafoe (global health consultant) recommended that when WHO is reviewing the relevance and implication of global public health goods, with regard to the 11th GPW, they consider that GPHG is generally perceived as an obvious good, such as immunization. However, the understanding of GPHG is less clear when tied to international legislation such as WTO. He suggested that there needs to be greater involvement, for example in free trade negotiation, by health expertise and civil society groups so that they, in turn, can provide a much clearer understanding of the GPHG at the community level.

104. Some proposals were suggested regarding the functions of WHO and PAHO in their cooperation with Member States in matters regarding GPG.

- Identification and characterization of the GPG that are of importance for the countries. This implies a regional diagnosis of GPG and the implications for the attainment of the MDGs.
- An active role in the distribution of knowledge and information on GPG. Examples are the Basic Data Initiative, epidemiologic surveillance, and gathering of good experiences in the Region.
- Support countries in developing institutional capacities to promote effective participation or negotiation of international agreements, treaties and commitments.
- Support countries in joint negotiations for best prices of essential and critical goods, such as retroviral drugs.
- Support the design and execution of regional studies for economic evaluation and health impacts.

105. The current lack of a clear definition of GPG was recognized by delegates of Cuba and the United States. It is a concept that is presently under evolution and development. It is a relatively new concept in the social policy area, but is an old and well known concept in the economic field. The lack of a clear definition of GPG, beyond the limits of the economic debate, is a source of difficulties for countries in making decisions about GPG policies and interventions. Terms used in the 11th GPW will need to be well defined and agreed upon by Member States.

106. Dr. Greaves (St. Lucia) recognized that the discussions on the 11th GPW provide a great opportunity for Member States to debate, to perfect the concept of GPG in health, to establish some principles of action for WHO, and to define a global / regional health agenda.

107. The Secretariat raised the need for a complementary approach from the political and legal perspective (involving considerations on the right to health) was highlighted. The debate about GPG in health and its implications for the work of WHO needs to be related to globalization and other international trends. When we look at GPG in health from the perspective of the right to health, some goods, such as essential medicines, should be treated as global public goods and not merely meritorious goods. A social approach to the understanding of the concept of GPG in health was introduced with reference to the collective efforts (involving governments, civil society, families, mothers, etc) developed in the Americas. Examples are the Expanded Immunization Program, networks of public health laboratories, epidemiological surveillance, the Revolving Fund for Vaccines, etc. These initiatives represent collective and participatory efforts in search for the common good that should be considered as GPG in health.

108. A very important issue was raised by the Ministers of Health of Saint Lucia and Antigua and Barbuda regarding human resources in health (HRH). If HRH are essential to the development of equitable and effective health systems, and

knowledge in health is recognized as a GPG, then HRH should be considered as a GPG. In this regard, the serious problem of migration of health professionals was raised, especially of nurses, from many countries in the Caribbean and the Region as a whole (as well as in the rest of the world) to more developed countries in the context of lack of regulation of international labor markets. The importance of WHO and PAHO to include this as a priority in the agenda of technical cooperation and the 11th GPW for the next years was recognized. The importance of technical cooperation for the development of criteria for management of HRH migration was stressed. Another important aspect mentioned in this regard was the need for human resources experts to help Member States in the area of workforce development and retention and that WHO should coordinate regional needs in terms of the demand for HRH as well as medicines and technology.

VII. Plenary Session 6: *WHO and Harmonization and Alignment Processes*

Chairperson: Dr. Antonio D. Gonzáles Fernández, Cuba

109. Dr. Philippe Lamy (PASB/AMRO) made an introduction stating the need of improving coordination among partners and the need to have WHO strengthen its leadership role in this area.

110. There are three key milestones that need to be considered:

- UN Millennium Summit of 2001.
- UN Monterrey conference March 2002.
- OECD/DAC High Level Forum on Harmonization in Rome in Feb. 2003. Its final declaration provides a starting point for improving Harmonization and alignment.

111. Some regional events are also to be considered:

- Regional Workshop on Harmonization and Alignment Coordination in LAC, Tegucigalpa, Honduras in Nov 2004 organized by the IDB.
- PASB/AMRO Regional Workshop on Harmonization, Nicaragua December 2004.

112. The objective of this “movement” is to strengthen the coordination of international cooperation by the beneficiary countries and to develop the harmonization of efforts among parties.

113. Special reference was made to the High Level Forum on Harmonization in Rome where a high level participation of international cooperation agencies and countries established commitments to eradicate poverty and promote sustainable development. In the final declaration, participants agreed to adapt assistance to

country needs, harmonize policies and practices, introduce incentives for harmonization, simplify donor practices and promote harmonization criteria.

114. A second High Level Forum (II HLF) will take place in Paris in March 2005 organized by DAC/OECD. The main objective is to strengthen national authority and coordination among donors and countries.

115. For health, there is the need to address questions on profits and benefits having an impact on health, keeping in mind the approved WHO principles, looking forward to accelerate the attainment of the MDGs and reduce inequities,

116. To attain the objectives in Alignment and Harmonization there are many strengths in the social sector. For example, the health sector as such has the development of national health plans, monitoring systems in place, inter-agency commissions and sectoral discussion tables with international agencies and other civil society institutions. The Ministries of Health face the challenge for assuming harmonization based on these strengths.

117. However, there is the need of a strong political will and leadership, the need of working on opportunities for consensus building, and spaces for citizen participation.

118. Harmonization and alignment at the national level must face global challenges posed by globalization issues that affect the national Health sector, the question is how will harmonization respond to initiatives in collective public health, through mechanisms that will avoid duplication of efforts. Among other questions to be discussed are: how will health benefits reach the general population, will health be a priority sector for social investment or just an expense.

119. In summary: WHO could lead harmonization efforts and play a significant role in facilitating inter sectoral activities with MOH.

120. Financial cooperation is critical in health sector development. Therefore, we have to think of mechanisms such as Sector Wide Approaches (SWAP) to improve focus on budgetary issues or inter sectoral programmatic focus, responding to national needs. Consideration should be given to the fact that in many cases a comprehensive approach to develop the role of the health sector may be more a leadership role than a mandated role. There is a need to articulate the roles of Ministries, WHO and donors and rationalize transaction costs associated to duplication of efforts.

121. An outlook for the future: There is the need of a solid process of coordination to strengthen sectoral planning and creating basis and bridges for a continuous discussion.

122. Harmonization is not an end in itself but an instrument that requires alliances. WHO must help ensure that harmonization takes place in order to meet health objectives. It should look at ways to better coordinate with donor countries. Donors should not place conditions nor discard national health priorities.

Comments

123. Ms. Valdez: (United States) stated that information on these processes is highly relevant and appreciated.

124. Dr. Lopez Acuña (PASB/AMRO) mentioned that there is a need for a broader dialogue; harmonization and alignment processes are happening at a fast pace orchestrated by DAC/OECD. Even though it has engaged multilateral and bilateral agencies and countries, it has not yet permeated all agencies that quickly. WHO and PAHO are trying to monitor, analyze, summarize and share these developments both in this regional consultation as well as in the working group of PAHO in 21st Century. After Rome, there was a decision to do regional discussions. IDB organized a consultation in Honduras but the UN System was not initially involved. PAHO/AMRO was present in Tegucigalpa, but there was no special attention given to health and little reference to MDGs. Harmonization and alignment should be monitored carefully. We need to respond to the questions: What do we want out of this process? What are fundamental objectives for health out of this harmonization? There is the need of ownership by country as a driving force or all processes may risk distortion. How will aid be aligned with national priorities? There is the need to reduce transaction costs of international cooperation in health. This is why we should articulate better how health will contribute to this harmonization process.

125. Dr. Leus (WHO) stated that the HLF discussion on health MDGs addressed the issue of harmonization in fragile states. He stated that MOH leadership is critical and must articulate priorities. How strong is the MOH vis a vis Ministries of Finance and how do we bring MOF and others on board to larger strategies like SWAPS or PRSPs? There is a question of global partnerships at country level. How are they articulating with national needs? Partnerships must be held accountable. Most debate occurs in OECD/DAC and not all OECD countries are involved. New donors channel considerable resources but do not take part in the DAC dialogue.

126. Dr. Fernández (CUBA) stated that the first step is for countries to take ownership of their agenda. What are country priorities? How can it be extended at global level? How can WHO maintain harmonization? There is a need to take stock of new challenges and WHO should primarily focus on coordination and partnerships at country level.

127. Dr. Lamy (PASB/AMRO) mentioned that there is a need to motivate member states to be important actors in these processes.

128. Dr. Leus (WHO) said that the health sector must assume a country level position and be able to establish dialogue with IFIs to be sure health is considered an investment and not a cost. This process is moving at a fast pace. The UN system should be part of the technical cooperation to support the Health Sector in establishing dialogue with the financial sector. There is the need of linking global, regional and national dialogue. Health has space at national level but must respond beyond that level. Harmonization for harmonization's sake is not helpful, particularly when the dynamics could turn into pushing a new global harmonization model, contrary to the preeminent need for country ownership. WHO must support Ministries of Health so long term national policies can be developed and be the reference point for coordination.

129. Dr. Gutiérrez Serrano (Nicaragua) stated that this is a challenge at both the national and international level. Nicaragua has had difficulty in coordinating activities with donors. Agencies are developing different types of coordination mechanisms and supporting different sectors. A clearly defined common agenda with donors is key to establishing points of convergence in priorities. These priorities should be coordinated within the framework of MDGs. These processes should be developed by countries and WHO must help in follow-up. We do not know the availability of resources at the international level. WHO could facilitate the exchange of information at the technical level.

130. Dr. Fernández (CUBA) mentioned that International agencies are demanding and that countries lack resources on how to better respond in preparing projects or proposals. There is the need for better technical support in this regard.

131. Dr. Tobar (Argentina) stated that Argentina has not had clear knowledge of this harmonization process, however, Argentina has a defined national health plan within the framework of MDGs. There has been dialogue with the Ministry of Finance, indicating that our health indicators are performance indicators and the economic approach defines our priorities. He stated that WHO and PAHO's role in disseminating this process of harmonization would help make this work effective.

132. Dr. Cosentino (Peru) mentioned that they are just learning the new terminology. Peru is in a special situation because they do not fall in the category of major recipient of aid, but some indicators in certain regions are as bad as in Africa. These indicators are hidden in national aggregates. Unfortunately, some important donors are going to other regions of the world. If we are not strong at the national level we will lose competence. He mentioned the attempts to promote SWAPs in his country, and noted the difficulties since the finance ministry either does not get involved with the approach or does not have confidence in the process.

133. Dr. Fernández (Cuba) stated that information should be disseminated from high levels to low levels.

134. Mrs. Williams (Barbados) mentioned that WHO should be brokering at the global level before it reaches national and regional levels. If we have a model for interaction we can initiate a coordinated approach in which to work. It is good to listen to countries experience. We need to standardize how we interact.

135. Dr. Lopez Acuña (PASB/AMRO) highlighted 2 recommendations for WHO's 11th GPW: (1) The role of WHO as honest broker in articulating global health initiatives, and other parallel mechanisms with existing mechanisms. (2) The important role for WHO to work with member states in building institutional capacity, for partnerships and coordination at country level. He gave an example of the work in Nicaragua.

136. Dr. Lamy (PASB/AMRO) stated that there is space for articulating national agendas at the international level. PAHO can support member states in articulating plans at global, regional, sub regional and national levels.

137. Dr. Fernández (CUBA) mentioned that harmonization and alignment are just instruments in achieving better health. WHO has a role to play in cooperating with member countries.

CLOSING SESSION: *Summary of the main issues and recommendations identified during the consultation*

Chairperson: Dr. Lopez Acuña, DPM, PASB/AMRO

138. Dr. Lopez Acuña chaired this session on behalf of the Director and thanked all participants for the active interventions and the fruitful deliberations that were presented as part of the debate during these three days.

139. Secondly, he mentioned that the Secretariat was working on the summaries of the sessions and that a detailed report (including the remarks and comments made by the participants) would be distributed electronically to all and published in the website (www.paho.org/governingbodies). This will allow participants to include any additional changes or comments. These summaries will also be used as input for the PAHO in the 21st Century Meeting, scheduled for 17-18 February. Interconnection between the two processes has to be ensured.

140. WHO will provide feedback from the rest of Consultations that will take place in February and March of this year.

141. Dr. Lopez Acuña highlighted that this report will be a very important input for WHO and will be shared among many other actors such as academics,

NGOs, etc., before being submitted to the Regional Committee sessions in September 2005.

142. This input will help and improve WHO in two ways:

- a) structuring the different chapters of the 11th General Program of Work
- b) gathering key ideas or topics related to, for example, Global Public Goods, Harmonization and Alignment, humanitarian assistance and even the recommendations of the UNHLP, which cannot be excluded from the debate.

143. This will also help identify challenges regarding the Global Health Agenda and Governance in particular. Dr. Lopez Acuña mentioned that this issue was highlighted by the United States Representative: The importance of the interconnection and cross cutting issues at global, regional and country levels. There is a clear need for the 11th GPW to include this perspective and reflect Country Focus and Country Presence.

144. Another aspect that Dr. Lopez Acuña mentioned was the one related to the topic of Harmonization and Alignment and the issues which were mentioned in the discussions. There should be a more ongoing dialogue since this is a very dynamic process with considerable implications for the work of WHO.

145. As Dr. Roses and Dr. Ferreira said during the sessions, that there is nothing that precludes having discussions at the country level. Dr. Lopez Acuña mentioned some of the meetings which will take place this year that could be an excellent opportunity for discussions. To name a few: the Interministerial Agriculture and Health Meeting (Mexico, April), the Conference of Ministers of Health and Environment (Argentina, June), the Pan American meeting of Ministers of Health on Health Related MDGs (Argentina, June), Subregional Meetings within MERCOSUR, Andean Community, Central American Integration System, the People's Health Assembly (Ecuador), including an ample number of NGOs etc. These are opportunities to get additional inputs and feedback from not only Member States, but also from donors, NGOs, private sector, etc.

146. Dr. Lopez Acuña insisted on the fact that if there is debate at country level, it will be important to document and share it. This process is at a very initial point of debate and there are many opportunities for discussions.

Comments

147. Dr. Antonio González Fernández (Cuba) said that there was a first outline of the 11th GPW distributed but it is not related to the debate that has already taken place. So he suggested there should be an outline, chapters defined, etc. in order to have an in depth analysis.

148. Dr. Lopez Acuña (PASB/AMRO) explained that a process of redefining that outline is taking place, rounds of regional consultations will take place and with all those inputs a new outline and draft of the 11th GPW will be prepared.

149. Ms. Lina Reinders (WHO) added that so far only the background papers which were distributed in these sessions are the only documents available. There is no working draft of the 11th GPW as it is in the process of consultation. Consultations will take place in February and March and then an update of these consultations will be presented to the World Health Assembly in March and finally a first draft of 11th GPW will be submitted to Regional Committees.

150. Ms. Mary Lou Valdez (United States) mentioned that it is important to create spaces for discussions from this first consultation and take advantage of additional opportunities before the Regional Committees. NGOs and the private sector should also participate. There has to be ownership by States. This consultation was very fruitful and this effort has to be maximized.

151. Dr. Lopez Acuña (PASB/AMRO) added that there were advantages and disadvantages in being the first in the round of consultations. The advantage is that there is more opportunity to orient the debate and add inputs to continue with the process; the disadvantage is that the background papers are still at a very first stage of production.

152. Finally, Dr. Lopez Acuña (PASB/AMRO) thanked all participants stating that this is just the beginning of a process which is crucial for the definitions of functions for WHO and the evolution of the Global Health Agenda.

- - -